STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 No deficiencies were cited as result of the complaint investigation. Event ID #64OT11.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, resident statements, staff interviews and record review the facility failed to report an allegation of physical abuse to the Administrator when a resident reported she thought she was going to be killed when staff jerked her in bed for 1 of 1 allegations of abuse (Resident #147). The findings included: A policy titled "Abuse/Neglect Policy" revised on 01/17/14 read in part, -Reporting allegations of abuse without fear of reprisal, report to supervisor, Director of Nursing and Administrator. Identification: -Administrator and Director of Nursing will be made aware of the event. Investigation: -The Administrator, Director of Nursing and/or designee work together during the investigation to determine the appropriate course of action. -When an incident or suspected incident of patient abuse or neglect is reported, the Administrator or designee investigates the	F 226	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F 226: Development of Abuse/Neglect, ETC policies. This facility believes each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, mistreatment, neglect and misappropriation of property. The facility has developed policies that focus on seven components: screening, training, prevention, investigation, protection and reporting/response. Some of the ways this is achieved for Resident # 147, a grievance form was	12/14/15

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

Electronically Signed | 11/23/2015

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F 226	Continued From page 1 incident. Resident #147 was admitted to the facility on 12/18/14 with diagnoses that included hemiplegia, cerebrovascular accident and depressive disorder. The most recent Minimum Data Set (MDS) dated 09/06/15 specified the resident had moderately impaired cognition and required extensive assistance with activities of daily living. Observation on 10/29/15 at 9:00 AM revealed Resident #147 was in her room sitting in her wheelchair and stated to nurse #1, "They jerked me up with no warning and nearly killed me, there I was just lying there and they jerked me so hard they nearly took my hide off." Nurse #1 replied, "Really?" And she continued to draw the Resident's blood and left the room. Observations of Nurse #1 revealed she left Resident #147's room and proceeded to go to another resident's room to draw blood. On 10/30/15 at 10:45 AM the Administrator was interviewed and reported that she had not received any new allegations of abuse. On 10/30/15 at 11:17 AM nurse #1 was interviewed on the telephone. She explained that she was not an employee of the facility but worked as a nurse at another facility owned by the same corporation and was asked to come to the facility to help on 10/29/15. She added that she received annual abuse/neglect training and that she was trained to report any allegation of abuse immediately to her supervisor. Nurse #1 confirmed she was in the room with Resident #147 and Resident #147 complained that her legs were hurting from the way two nurse aides readjusted her legs. Nurse #1 explained that she	F 226	completed. DON interviewed Resident #147 on 10/30/15 and resident denied any abuse and recanted original statement. Resident was assessed on 10/26/15 and 11/2/15 skin intact. Administrator followed up with Resident #147 on 11/4/15 and on 11/5/15 24 hour was sent. Allegation unsubstantiated. Staff from other facility was in-serviced by DON. Because all residents are at risk for this cited deficiency the following has been achieved. All staff were in serviced for the facility policy for reporting allegations of abuse/neglect to the administrator and or DON immediately. All new employees are trained and receive a copy of the facility policy for reporting abuse neglect during the initial orientation period. Company employees who are called in from other facilities to assist this facility will sign a copy of the company abuse neglect policy to ensure awareness for the correct procedure to follow if an allegation is expressed. The DON will retain a copy of the signed policy and procedure in the DON office. To enhance current compliance and under the direction of the Administrator, on 11/5/15 & 11/20/15 all staff were re in serviced per state and federal regulation for the reporting of allegations of abuse neglect. This training emphasized the importance of maintaining a safe, environment for residents without fear of retaliation, and timely reporting of any allegation of abuse /neglect. An audit of all residents was conducted on 11/25/15	

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F 226	Continued From page 2 asked the resident if she needed pain medication and the resident told her she was feeling better since the incident. Nurse #1 stated that she did recall Resident #147 stating, "They jerked me up with no warning and nearly killed me, there I was just lying there and they jerked me so hard they nearly took my hide off." Nurse #1 stated that she was concerned about the resident's complaint of pain and reported to a "hall nurse" the resident was in pain from an "incident." Nurse #1 did not report the details or allegation from Resident #147 that she was "jerked" by staff. Nurse #1 did not know the name of the "hall nurse" that she reported the concern of Resident #147's pain. She offered no explanation why she did not report the allegation of being "jerked up" by nurse aides. On 10/30/15 at 11:20 AM the Administrator was interviewed and explained that since she had assumed her role she expected to be notified of all allegations of abuse for investigation. She stated that any suspicion of abuse or a grievance that referenced mistreatment would be brought to her attention immediately. The Administrator was not aware of Resident #147's allegation that staff had jerked her in the bed. The Director of Nursing (DON) was not present during the annual recertification. On 10/30/15 at 11:40 AM Nurse #2 was interviewed and stated she was the nurse assigned to Resident #147 on 10/29/15. She stated that no one shared any concerns with her regarding Resident #147 being in pain and/or an allegation of abuse. She stated that if staff notified her of an allegation of abuse she would immediately notify the DON and/or Administrator	F 226	regarding abuse concerns, with grievances and allegations filed as needed. Effective 11/19/15 a performance improvement plan was implemented for QAPI under the supervision of the administrator to track all allegations of abuse, monitor grievances for proper identification of abuse/neglect and report abuse to state agency. Administrator has initiated family and resident surveys to be completed monthly by social worker with a focus area on abuse concerns. Any abuse concerns from survey will be followed through by the Administrator. Weekly Quality zones rounds will address concerns of abuse and will be ongoing. The administrator or designated supervisor will perform the following systematic changes: report any identified concerns, are immediately addressed and corrected on the spot. Findings are documented and presented during the quarterly quality assurance committee meeting for further review or corrective action.	

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F 226	Continued From page 3	F 226		

and respond to the resident.

On 10/30/15 at 12:20 PM the Western Regional Director reported that she had started an investigation after becoming aware of the allegation on 10/30/15 and had determined that Nurse #1 reported the allegation to Nurse #3.

On 10/30/15 at 12:30 PM Nurse #3 was interviewed and reported that Resident #147 was known to make "false accusations" that staff hurt her. She stated that Nurse #1 told her on 10/29/15 that Resident #147 was in pain but she could not remember the time of day but thought it was "just before lunch time." She stated she waited about 30 - 45 minutes before she went to Resident #147 to "clear up" what had happened. Nurse #3 stated she asked Resident #147 how she was doing and if anyone had been mean to her. Nurse #3 stated that Resident #147 reported that when 2 nurse aides used the lift it caused her to hurt but that it wasn't uncommon for her to hurt "all over" since her cerebrovascular accident. Nurse #3 stated she did not speak with staff to find out if an incident had occurred during a transfer or attempt to determine who had transferred the resident because the resident did not report that anyone had been "mean" to her. She stated that she did not perceive that any harm had occurred and did not forward the concerns to the Administrator. Nurse #3 stated she was trained to take all allegations of abuse seriously and when an allegation was made to keep the resident safe and report the allegation immediately to the Director of Nursing. Nurse #3 stated she was not aware Resident #147 told Nurse #1 that, "They jerked me up with no warning and nearly killed me, there I was just lying there and they jerked me so hard they nearly

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F 226	Continued From page 4 took my hide off." Review of Resident #147's medical record revealed there was no documentation of pain or assessment of pain following the alleged incident on 10/29/15. On 10/30/15 at 4:10 PM the Administrator was interviewed again and stated that Nurse #1 was not a facility employee and that she was not aware of what abuse/neglect training Nurse #1 had received. The Administrator explained that Nurse #3 was a facility employee and that she would have expected the nurse to notify her on 10/29/15 of the concern that the resident was in pain after an "incident." During this interview the Administrator presented a grievance card dated 10/29/15 completed by nurse #3 that Resident #147 complained of pain after being transferred by staff. The Administrator reported she was not made aware of the "grievance" until 10/30/15. On 10/30/15 at 4:18 PM the Administrator asked to clarify that Nurse #3 was the treatment nurse, not a supervisor but had administrative responsibilities.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews the facility failed to maintain dignity	F 241	F 241 Dignity and respect: The facility has a policy to promote care	11/27/15

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F 241	Continued From page 5 during meals when staff stood over residents while they fed residents during 2 of 2 meal observations. (Resident #78). The findings included: Resident #78 was admitted to the facility on 08/27/10 with diagnoses which included mood disorder, depression, and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 08/16/15 indicated Resident #78 was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #78 required extensive assistance with eating and required 1 staff assistance during meals. The MDS revealed Resident #78 was coded with no rejection of care. During continuous observations on 10/27/15 starting at 12:48 PM Nurse #3 who was medium height carried a meal tray into Resident #78's room and placed it on an over bed table on the right side of the bed. There was no chair in the room for Nurse #3 to sit on. Resident #78 was lying on his back with the head of the bed slightly elevated and Nurse #3 stood over Resident #78 and looked down at him while she fed him lunch. During continuous observations on 10/28/15 starting at 8:25AM NA #5 who also was medium height carried a meal tray into Resident #78's room and placed it on an over bed table on the right side of the bed. There was no chair in the room for NA #5 to sit on. Resident #78 was lying on his back with the head of the bed slightly elevated and NA #5 stood over Resident #78 and looked down at him while she fed him breakfast. During an interview on 10/30/15 at 11:01 AM	F 241	for patient in a manner and environment that maintains or enhances each patient's dignity and respect in full recognition of his or her individuality. Dignity means that in their interactions with the patient, the staff carries out activities that assist the patient to maintain and enhance his/her self-esteem and self-worth. This is achieved for resident # 78 as follows: Nurse # 3 and Nurse Aide #5 were reeducated for resident rights during assistance with meals to sit at eye level position to the resident. An additional chair was placed in this room so staff performing assistance can sit when assistance is required during meals. Since any resident who requires assistance during meals is at risk for this cited deficiency, direct care staff were in serviced for resident rights and dignity during assistance with feeding. Under direction of the Director of nurses, audits have been completed during 1 meal daily Monday through Friday x 2 weeks, observing in dining room and random resident rooms to ensure chairs are available and that residents who require assistance are treated with dignity during meals ensuring the staff member providing the assistance is properly seated while assisting the resident. To enhance current compliance and under the direction of the Director of nurses audits will be completed during 1 meal daily 3 times weekly in the dining room and random resident rooms during course of the meal to ensure staff are seated during meal times when assisting	

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F 241	Continued From page 6 Nurse #3 stated she was supposed to sit down when she fed residents and was not supposed to hover over them. She confirmed she stood while she fed Resident #78 his lunch on 10/27/15 and sometimes she just didn't take the time to sit down when she fed residents. Nurse #3 revealed some resident rooms had chairs for them to sit in but if there was not a chair in the room there were chairs available that they were supposed to take to the room when they fed residents. Nurse #3 further revealed she had jumped in to help out at the spur of the moment and didn't think to go get a chair. During an interview on 10/28/15 at 8:38 AM NA #5 stated she normally stands to feed Resident #78. NA #5 confirmed she stood to feed Resident #78 during his breakfast because there was no chair in the room. NA #5 further stated that Resident #78 takes his time but normally eats well. On 10/30/15 NA #5 was not available to interview further and attempted telephone calls were not answered. During an interview on 10/30/15 10:10 AM the Director of Nursing (DON) stated it was her expectation that nursing staff should sit next to residents while they fed them. She stated if there was not a chair in the resident's room to sit in, there were chairs available and they should go get one to sit on while they fed a resident. During an interview on 10/30/15 at 11:47 AM the Assistant Director of Nursing (ADON) stated it was her expectation that nursing staff should sit eye to eye while feeding residents. The ADON further stated if there was not a chair in the room to sit in they should go and get one. The ADON explained she would definitely expect the staff to	F 241	residents. These audits will be done x 2weeks, Then random audits during various meals will be done prn to ensure staff follow facility policy for assisting residents with eating. The Director of nursing is responsible for monitoring and compliance and reports concerns to the quarterly QA meeting for further review and corrective action as indicated.	

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F 241	Continued From page 7 sit to feed residents and they know this was for the dignity of residents.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to accommodate resident's needs by placing furniture in room where resident could not see the television and clock and placing the night stand out of her reach for 1 of 1 residents sampled for accommodation of resident's needs (Resident #128). The findings included: Resident #128 was readmitted to facility on 10/20/15 from acute care hospital with diagnosis of: cerebral vascular accident with left side hemiplegia, chronic pain, depression, and a history of cervical pain. Review of most recent comprehensive Minimum Data Set (MDS) dated 08/27/15 revealed that Resident #128 was cognitively intact and required extensive assistance of two staff members for bed mobility, transfers, and toileting. It also revealed that Resident #128 required extensive assistance of one staff member for dressing and eating. The MDS also revealed that Resident	F 246	F 246 Accommodations for needs/preferences It is this facility's policy that each patient has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other patients would be endangered. This was achieved for Resident # 128 by immediately rearranging her room to her preference during the survey, For other residents with the potential to be affected all staff were in serviced regarding resident rights for choices and preferences, with emphasis that environmental changes are made per individual resident request or responsible party who acts on behalf of the resident. The regional nurse consultant made rounds of current residents who were interviewed to ensure rooms are arranged	11/27/15

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F 246	Continued From page 8 #128 had functional limitation in range of motion to one upper extremity and one lower extremity and also indicated hemiplegia was present. Observation on 10/28/15 at 9:22 AM Resident #128 was lying in bed with left side of bed against the wall with feet facing the window in the room. Resident #128's neck was positioned to the right side with a neck pillow and she was facing the wall as this was natural position for her. The only items that were in her sight were the light fixture and a calendar on the wall. Her night stand was behind the bed against an adjoining wall not in Resident #128's reach. Interview on 10/28/15 at 9:22 AM Resident #128 stated that she wanted her bed turned so that she could see her clock and the television and also have night stand in reach. Resident #128 began to cry and stated "I can't turn my head" and "I can't even see the clock and it makes me so sad." Resident #128 stated that she had told staff about wanting to turn her bed so she could see the television and clock and was told that "they would have to get in touch with maintenance." Resident #128 confirmed that she could not reach her night stand. Observation on 10/28/15 at 3:23 PM Resident #128 was lying in bed with right side of bed against the wall with feet facing the door to the room. Her neck was positioned to the right side with neck pillow and she was facing the door. Resident #128's night stand remained against an adjoining wall and not in Resident #128's reach. Interview on 10/29/15 at 9:09 AM Resident #128 stated that she could see the clock but is unable to see the television and could not reach her night stand. She also stated that it was fine that she could not see the television because she wanted her roommate to be able to see the television. Interview on 10/29/15 at 9:31 AM with a	F 246	as the resident prefers. No other concerns were identified. Each resident and or responsible party is provided a copy of resident's rights on admission. Staff was in-serviced for resident's choices and that resident rooms are set up as per the resident or responsible party request and maintained with room changes. Any change of the bed location or other equipment in the room must be requested by the resident or responsible party. The DON is responsible for monitoring compliance and will rounds on new admissions to ensure the room is set up to meet the resident needs and preference. Any concerns identified are immediately addressed on the spot, documented and reviewed at the quarterly QA committee meeting.	

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F 246	Continued From page 9	F 246		

Maintenance employee revealed he had assisted with moving Resident #128 to her current room on 10/06/2015 and Resident #128 had not requested any furniture to be moved or rearranged.
Observation on 10/30/15 at 8:45 AM Resident was lying in bed with head of bed against wall with her feet facing the bathroom. Her neck was positioned to right side with neck pillow in her natural position. Resident #128 is able to see the clock and television. Resident #128's night stand remained out of reach.
During an interview on 10/30/15 at 9:34 AM Resident #128 confirmed that she was able to see her clock and her television. She confirmed that the night stand remained out of reach.
Interview on 10/30/15 at 11:57 AM with Nurse Aide (NA) #4 revealed that she used to take care of Resident #128 when she was in a different room just down the hallway. NA #4 stated in previous room Resident #128 was able to see clock and television and her night stand was close to the bed on her right side and she was able to reach into her drawers and get her Bible or anything else she needed out of the night stand.
Interview on 10/30/15 at 12:19 PM with Administrator revealed that Resident #128's room had been set up based on a previous residents needs and stated that "they should have paid more attention how they can accommodate both resident's needs." The administrator further stated she expected that staff would have some discussion prior to room changes regarding how they could accommodate the needs of both residents in the room. The administrator was not aware if a staff member had asked Resident #128 how she needed her room set up.

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F 248	Continued From page 10	F 248		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide structured activities of interest for 2 of 3 sampled residents (Resident #128 and Resident #78). Findings included: 1. Resident #128 was readmitted on 10/20/15 with diagnosis that included cerebral vascular accident with left side hemiplegia, chronic pain, history of cervical pain and depression. Review of comprehensive Minimum Data Set (MDS) dated 08/27/15 revealed that Resident #128 was cognitively intact and required extensive assistance of two staff members with transfers and locomotion on and off unit required total assistance of one staff member. The MDS indicated Resident #128 was interviewed for daily activity preferences and revealed it was very important to go outside to get fresh air when the weather was good and very important to participate in religious services or practices. Review of the activity participation log from 07/01/15 through 10/29/15 revealed Resident #128 had attended 7 out of 453 activities that	F 248	F 248 Activities meet interests/needs of each resident: Resident # 128 was in the hospital 39 days of her stay which accounted for decreased activity participation. Activity Director has identified interest/ preferences for Resident #128 by interviewing resident and updating the care plan for this resident. Activity Director and assistant will inform and invite resident to activities encouraging choice and attendance. Nurse and NA will be informed of resident interest and offer resident assistance to be out of bed for out of room activities that she would like to attend. Resident will be assisted to go outdoors as weather permits and as she chooses and can tolerate. NA will be educated to turn on resident radio per her request. Activity Director and Assistant will provide in- room activities with visits and rounds. A participation log will continue to be used to document residents participation. In order to better track residents' participation, the Activity Director and	11/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 11	F 248		

were provided to residents. None of those activities that Resident #128 attended included going outside and two included attending religious services or practices.

Review of the quarterly activity progress note dated 09/01/15 at 5:53 PM revealed Resident #128 was alert and verbal. It also stated Resident #128 was in her room most of day and Resident #128 would read her Bible but not was not interested in looking at magazines since she had her stroke. The note also stated that activities would continue to encourage.

Review of care plan for activity/recreational needs dated 10/28/15 stated "assist to and from activities as needed, needs encouragement to participate, will read at times, prefers to stay in room, may come to music program, 1:1 visits with her in room, per resident ' s choice." The goal stated "resident will attend activity events of her choice daily through next review."

Review of quarterly activity progress note dated 10/29/15 at 7:54 AM read, in part, that Resident #128 is alert and verbal and stayed in her room most of day per her choice. Resident #128 does read her Bible but not interested in looking at magazines since having a stroke. Activities will continue to support and encourage.

Observation of Resident #128's room on 10/29/15 at 9:33 AM room revealed a music box on bedside table but it was not turned on.

Interview with Nurse Aide (NA) #6 on 10/28/15 3:25 PM revealed that has never seen Resident #128 up in her wheelchair, she stated that Resident #128 has never asked to get out of bed

assistant will note hospital days and refusals on the activity participation log when residents are in the hospital and/ or refuse. This will provide a more accurate activity attendance record.
Resident #78 has been interviewed for current interest and preferences.
Based on current interest and decline in out of bed time, the care plan had been revised and resident will be provided in – room visits and socialization several times weekly. One/one visits will be recorded on participation log and response noted.
Resident prefers individual activities at this time.
NA will be educated to turn on Resident #78's radio and activity staff will offer magazines and ensure with visits and rounds that activity supplies are within reach.
All residents who prefer to be in-room, with frequent hospitalizations or changes in activity preferences could be potentially affected. The activity director has completed audits of current residents and identified residents requiring one/one visits. An audit of preference has also been completed with all long term residents to assure interest / preferences are current per care plan.
An audit of resident's preference will be completed when a resident is scheduled for a quarterly review, annual and with significant changes in status all changes will be documented in care plan which will reflect new or different interest. Activity staff will provide assistance when residents are moved to different rooms as well to ensure activity supplies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 12 to wheelchair and to her knowledge Resident #128 does not participate with activities and has not seen activity staff working with Resident #128 in her room. Interview with the activity assistant on 10/28/15 at 3:37 PM revealed that she does in-room visits with Resident #128 and that entailed talking and socializing with her. She stated that she tries to invite her to daily activities but she prefers to stay in her room. She also stated that she always refused to come to music when invited. The activity assistant stated that the activities director is off this week and she was unable to find the activity participation log for Resident #128. Interview with NA #7 on 10/29/15 at 9:16 AM revealed that she is not aware if Resident #128 participated with activities or not, she has not seen activities staff in her room working with her. She stated that if Resident #128 was up in wheelchair she would offer to take her to activities. Interview with Resident #128 at 10/30/15 at 9:34 AM stated that she doesn't feel like the activities staff does enough activities with her. She stated she would like to go outside and would like to read her Bible but her glasses have been missing for a while. She also stated she would like to play bingo and would like to go to church. She stated that staff did not offer to take her to church. She confirmed that the activity assistant does come and see her in the evening usually once a week and had visited her last night. She also confirmed that no one offered to take her to activities today. Resident #128 stated her Bible was in her nightstand and asked me to obtain it for her.	F 248	materials are moved and arranged per resident preference. The Activity Director will provide ongoing communication and in-services to NAs and nurses. Audited resident preference and care plans for accuracy weekly x 4 weeks, then monthly x 3 months then quarterly. All findings will be brought to QAPI quarterly for review and additional correction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 13	F 248		

Upon inspection of the nightstand no Bible was located.
Observation of Resident #128's room on 10/30/15 at 9:34 AM revealed a music box on bedside table that was not turned on.

Interview with the Director of Nursing (DON) on 10/30/15 at 10:07 AM revealed that activities were certainly resident's choice if they attend or do not attend. She would expect staff to offer to take all residents to activities. She stated that she expected in-room visits to be of resident choice and to provide things the residents liked during those in-room visits and she knew that they do the best they can to meet the needs of the residents. She also stated that she knew that they offered residents to come out of their rooms on a daily basis.

Interview with the Administrator on 10/30/15 at 12:33 PM revealed that she had only been at the facility for 7 weeks and she had identified that there were more things they could have been doing in regards to activities to get more residents involved. She stated that she expected all staff to offer and assist as needed in getting residents to activities and not just residents that are up out of bed. The Administrator also stated that staff needed to do a better job of communicating to residents that needed assistance in getting out of bed that wanted to attend the daily activities. The administrator also stated that the activities director had been out of work for several weeks and the activity assistant was the hands on person in the department and she had been trying to fill both duties since the activity director had been out.

2. Resident #78 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 14	F 248		

08/27/10 with diagnoses which included mood disorder, depression, and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 08/16/15 indicated Resident #78 was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #78 required extensive assistance with eating and required 1 staff assistance during meals. The MDS revealed Resident #78 was coded with no rejection of care.

Review of the current care plan revised 08/04/15 identified Resident #78 had decline in out of bed time and decline in out of room activity and socialization.The care plan further identified Resident #78 required one on one visits to provide support and encouragement. The goals and interventions developed for Resident #78 included Resident would be engaged in socialization during one on one visits once weekly and a once a month music activity.

Review of the Client Activities Participation (CAP) log dated from 07/01/15 through 10/29/15 revealed there were 453 offered activities. The CAP log further revealed Resident #78 attended 6 activities during the four month period at a calculation of 1% participation and 180 residents were listed which detailed 150 of the residents attended 6% or less of the activities offered. Review of the monthly log sheets revealed Resident #78 received in room music on 07/15/15, 08/19/15, and 09/16/15. No in room one on one activities were documented.

Review of the activities departmental notes for the past three months indicated Resident #78 was able to voice his needs to staff. The notes further revealed no documentation of one on one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 15	F 248		

activities provided once weekly and no documentation of offers or refusals to attend activities.

Resident #78 was observed alert and awake as follows:
On 10/27/15 at 12:48 PM Nurse #3 was observed feeding Resident #78. The head of the bed was raised and the bed was raised high. Nurse #3 was standing over the resident feeding him. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/28/15 at 10:09 AM Resident #78 was in bed with the bed in the low position. His eyes were open and he was turned facing towards the wall. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/28/15 at 5:04 PM Resident #78 was in bed in the low position. His eyes were closed, the call bell was on his lap and a fall matt was observed beside the bed. A radio was on his bedside table but was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/28/15 at 6:07 PM Resident #78 was in bed in the low position with the head of the bed raised. His meal tray was on the tray table set up in front of him and he was feeding himself an ice cream. NA # 9 was observed entering his room and encouraging him to eat his sandwich also. NA #9 stated sometimes he feeds himself sometimes he does not. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 16	F 248		

#78's room.

On 10/29/15 at 9:40 AM Resident #78 was observed in bed with the bed in a low position. He was facing the wall and his bed covers were up and his eyes were closed. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

ON 10/28/15 at 8:25 AM NA #5 who was of medium height carried a meal tray into Resident #78's room and placed it on an over bed table on the right side of the bed. There was no chair in the room for NA #5 to sit on. Resident #78 was lying on his back with the head of the bed slightly elevated and NA #5 stood over Resident #78 and looked down at him while she fed him breakfast. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

During an interview on 10/30/15 at 12:20 PM the Assistant Activities Director (AAD) stated she was familiar with Resident #78 and that he used to come to activities in the past but he had declined and not attended activities in several months. She further stated that every other week she goes down his hall with an activity cart and offered Resident #78 magazines and books but he declined most of the time. The AAD revealed she socialized with him for a while even if he refused reading materials from the activity cart. The AAD further revealed there were no other one on one activities specifically provided for Resident #78 and there was no other activity provided one on one for the alternate weeks that the activity cart was not provided. The AAD explained that once a month a lady came to the facility and went to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 17	F 248		

Resident #78's room to play music. The AAD further explained he did not have a radio and the facility did not have funds to purchase radios for individual rooms. The AAD was unable to explain why Resident #78's activity goal was for him to only attend one activity per week and stated he should have been going to activities at least once per week for stimulation. The AAD further stated that she had been doing all the activities since the Activity Director had been out on leave.

During an interview on 10/30/15 at 10:10 AM the Director of Nursing (DON) her expectations were for the AAD to provide in room one on one activities of the resident's preferences and as care planned. The DON further stated they offer books to read, in room socialization with them to promote one on one activity of their preference to the best of their ability. The DON confirmed the ADD was assuming all activity duties while the Activities Director was out on leave.

During an interview on 10/30/15 at 11:47 AM the Assistant Director of Nursing (ADON) stated it was her expectation for resident's to attend meals in the dining room for socialization, and for the AAD to provide in room one on one activities of the resident's preferences and as care planned. The ADON further stated they offer books to read, in room socialization with them to promote one on one activity of their preference to the best of their ability. The ADON confirmed the ADD was assuming all activity duties while the Activities Director was out on leave.

During an Interview on 10/30/15 at 12:33 PM the Administrator (AD) revealed that she had only been at the facility for 7 weeks and she had identified that there were more things they could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 248	Continued From page 18 have been doing in regards to activities to get more residents involved. The AD further revealed that she expected all staff to offer and assist as needed in getting residents to activities and not just residents that are up out of bed. The AD stated that staff needed to do a better job of communicating to residents that needed assistance in getting out of bed that wanted to attend the daily activities. The AD further stated that the activities director had been out of work for several weeks and the activity assistant was the hands on person in the department and she had been trying to fill both duties since the activity director had been out.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair plastic corner molding that was broken with sharp edges across from the dining room at the intersection of the administrative hall and the hall leading to east and west wings, failed to repair resident doors with broken and splintered laminate (Room # 215, #216, #217, #304, #305, #306, #307, #401, #407, #408, #409, #410, #412 and #413) on 3 of 5 skilled facility hallways, failed to repair broken and splintered laminate and wood on smoke prevention doors on 2 wings (300 hall and East hall entrance), and failed to repair wallpaper stained with a black substance in 1 resident room	F 253	F253: Housekeeping and Maintenance Service On 11/2/15 to 11/6/15 all identified areas were repaired: splintered laminated doors #215, #216, #217, #304, #305, #306, #307, #401, #407, #408, #409, #410, #412 and #413. Broken plastic molding on intersection of administrative hall and east wing, splinted laminate on smoke doors 300 hall and East hall entrance. And stained wallpaper in room #404. The entire facility has potential of being affected. To prevent the same deficient	12/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 19 (Room # 404 A). The findings included: 1. a. Observations of plastic corner molding near the floor across from the main dining room at the corner of the administrative hall and the main hallway leading to east and west wings on 10/28/15 at 12:59 PM revealed the plastic corner molding was broken and protruded outward with sharp edges. Observations on 10/29/15 at 10:20 AM revealed the plastic corner molding across from the main dining room at the corner of the administrative hall and the main hallway leading to east and west wings was broken and protruded outward with sharp edges. Observations on 10/30/15 at 2:30 PM revealed the plastic corner molding across from the main dining room at the corner of the administrative hall and the main hallway leading to east and west wings was broken and protruded outward with sharp edges. 2. a. Observations of Room #215 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door. Observations on 10/29/15 at 10:20 AM revealed the door of resident room #215 had broken and splintered laminate on the edges of the front bottom half of the door. Observations on 10/30/15 at 2:30 PM revealed the door of resident room #215 had broken and splintered laminate on the edges of the front bottom half of the door. b. Observations of Room #216 on 10/28/15 at 12:59 PM revealed the door of the resident's	F 253	practice from occurring Audit of all room doors and hall doors has been initiated at the rate of 2 halls per week with completion on Nov. 23rd. An auditing tool has been created for the doors indicating date door identified, date door repaired. Audit tool created for peeling wallpaper and scuffed walls with audit of 1 hall every week with completion by Dec. 14th. Preventative Maintenance schedule has been added for doors and peeling wall paper. Rooms and doors will be checked on a monthly basis by maintenance. Administrative staff quality zone rounds, which are completed weekly, have been updated to include splintered doors, peeling wallpaper and any physical plant concerns. Daily in stand- up physical plant concerns will continue to be discussed to include any newly identified wallpaper or paint and door issues. All QZ (quality zone) round sheets will be reviewed by the Administrator and areas of concern will be forwarded to the Maintenance director. Maintenance director will have 24-48 hours to complete any repairs. Maintenance director will conduct weekly audit of doors and rooms x 4 weeks, then biweekly audit of doors and rooms x3 months then monthly as a preventative maintenance. The Administrator is responsible for overseeing and monitoring compliance and documents concerns which are presented at the quarterly QA meeting for further review and additional corrective action if indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 20	F 253		

room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #216 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #216 had broken and splintered laminate on the edges of the front bottom half of the door.

c. Observations of Room #217 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #217 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #217 had broken and splintered laminate on the edges of the front bottom half of the door.

d. Observations of Room #304 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #304 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #304 had broken and splintered laminate on the edges of the front bottom half of the door.

e. Observations of Room #305 on 10/28/15 at 12:59 PM revealed the door of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 21	F 253		

room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #305 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #305 had broken and splintered laminate on the edges of the front bottom half of the door.

f. Observations of Room #306 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #306 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #306 had broken and splintered laminate on the edges of the front bottom half of the door.

g. Observations of Room #307 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #307 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #307 had broken and splintered laminate on the edges of the front bottom half of the door.

h. Observations of Room #401 on 10/28/15 at 12:59 PM revealed the door of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 22	F 253		

room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #401 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #401 had broken and splintered laminate on the edges of the front bottom half of the door.

i. Observations of Room #407 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #407 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #407 had broken and splintered laminate on the edges of the front bottom half of the door.

j. Observations of Room #408 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #408 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #408 had broken and splintered laminate on the edges of the front bottom half of the door.

k. Observations of Room #409 on 10/28/15 at 12:59 PM revealed the door of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 253	Continued From page 23	F 253		

room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #409 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #409 had broken and splintered laminate on the edges of the front bottom half of the door.

l. Observations of Room #410 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #410 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #410 had broken and splintered laminate on the edges of the front bottom half of the door.

m. Observations of Room #412 on 10/28/15 at 12:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #412 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #412 had broken and splintered laminate on the edges of the front bottom half of the door.

n. Observations of Room #413 on 10/28/15 at 12:59 PM revealed the door of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 24	F 253		

room had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the door of resident room #413 had broken and splintered laminate on the edges of the front bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the door of resident room #413 had broken and splintered laminate on the edges of the front bottom half of the door.

3. a. Observations of smoke prevention doors on 300 hall west wing on 10/28/15 at 12:59 PM revealed the doors had broken and splintered laminate on the edges of the front of the bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the smoke prevention doors on 300 hall west wing had broken and splintered laminate on the edges of the front of the bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the smoke prevention doors on 300 hall west wing had broken and splintered laminate on the edges of the front of the bottom half of the door.

b. Observations of smoke prevention doors at east wing entrance on 10/28/15 at 12:59 PM revealed the doors had broken and splintered laminate on the edges of the front of the bottom half of the door.
Observations on 10/29/15 at 10:20 AM revealed the smoke prevention doors at east wing entrance had broken and splintered laminate on the edges of the front of the bottom half of the door.
Observations on 10/30/15 at 2:30 PM revealed the smoke prevention doors at east wing entrance had broken and splintered laminate on the edges of the front of the bottom half of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 253	Continued From page 25	F 253		

door.

4. a. Observations in room #404 A on 10/28/15 at 12:59 PM revealed the wallpaper had black streaks down the wall next to the resident's bed. Observations on 10/29/15 at 10:20 AM revealed the wallpaper in room #404 A had black streaks down the wall next to the resident's bed. Observations on 10/30/15 at 2:30 PM revealed the wallpaper in room #404 A had black streaks down the wall next to the resident's bed.

During a tour of the environment on 10/30/15 at 4:30 PM with the Maintenance Director and Administrator the Maintenance Director described the plastic corner molding at the floor across from the main dining room next to the administrative hall as a butt plate and confirmed it was broken and needed to be replaced. He explained he put wood filler and sanded wood on resident room doors twice a year when he worked on the frames, hinges and latches. He explained nursing staff could put in maintenance requests for repairs but he had not received any requests to repair the broken wood and laminate on the resident room doors or smoke doors. He stated he had started fixing some wallpaper in resident rooms but was unaware of the black streaks on the wallpaper in room 404 A and stated it looked like it was caused by an over spray of glue.

During an interview on 10/30/15 at 4:45 PM with the Administrator she stated it was her expectation for the maintenance department staff to fix things in a timely manner. She further stated she expected for the Maintenance Director to walk around the facility and check and fix things and to take care of problems when he saw them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to follow the activities care plan for 1 of 3 sampled cognitively impaired residents reviewed for activities (Resident #78). The findings included: Resident #78 was admitted to the facility on 08/27/10 with diagnoses which included mood disorder, depression, and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 08/16/15 indicated Resident #78 was moderately cognitively impaired for daily decision making. The MDS further indicated Resident #78 required extensive assistance of 1 person with eating during meals. The MDS revealed Resident #78 was coded with no rejection of care. The activity Care Area Assessment (CAA) dated 04/07/15 stated Resident #78 was a long term care resident who required extensive assistance with all activities of daily living including recreational and social activities and could be at risk for decline for socialization due to his reliance on others and his cognitive impairments. Review of the current care plan revised 08/04/15	F 282	F282 Services by Qualified person/per care plan: Resident #78 has been interviewed for current interest and preferences. Based on current interest and decline in out of bed time, the care plan had been revised and resident will be provided in – room visits and socialization several times weekly. One/one visits will be recorded on participation log and response noted. Resident prefers individual activities at this time. NA will be educated to turn on Resident #78's radio and activity staff will offer magazines and ensure with visits and rounds that activity supplies are within reach. All residents who prefer to be in-room, with frequent hospitalizations or changes in activity preferences could be potentially affected. The activity director has completed audits of current residents and identified residents requiring one/one visits. An audit of preference has also been completed with all long term residents to assure interest / preferences are current per care plan. The Activity Director will provide ongoing	11/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282	Continued From page 27 identified Resident #78 had a decline in out of bed time and a decline in out of room activity and socialization. The care plan further identified Resident #78 required one on one visits to provide support and encouragement. The goals and interventions developed for Resident #78 included Resident would be engaged in socialization during one on one visits once weekly and a once a month music activity to provide support and encouragement. Review of the Client Activities Participation (CAP) log dated from 07/01/15 through 10/29/15 revealed there were 453 offered activities. The CAP log further revealed Resident #78 attended 6 activities during the four month period. Review of the monthly log sheets revealed Resident #78 received in room music on 07/15/15, 08/19/15, and 09/16/15. No in room one on one activities were documented. Review of the activities departmental notes for the past 3 months indicated Resident #78 was able to voice his needs to staff. The notes further revealed no documentation of one on one activities provided once weekly and no documentation of offers or refusals to attend activities. Resident #78 was observed alert as follows: On 10/27/15 at 12:48 PM Nurse #3 was observed feeding Resident #78. The head of the bed was raised and the bed was raised high. Nurse #3 was standing over the resident feeding him. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room. On 10/28/15 at 10:09 AM Resident #78 was in	F 282	communication and in-services to NAs and nurses. Audited resident preference and care plans for accuracy weekly x 4 weeks, then monthly x 3 months then quarterly. All findings will be brought to QAPI quarterly for review and additional correction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282	Continued From page 28	F 282		

bed with the bed in the low position. His eyes were open and he was turned facing towards the wall. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/28/15 at 5:04 PM Resident #78 was in bed with the bed in the low position. His eyes were closed, the call bell was on his lap, and a fall matt was observed beside the bed. A radio was on his bedside table but was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/28/15 at 6:07 PM Resident #78 was in bed in the low position with the head of the bed raised. His meal tray was on the tray table set up in front of him and he was feeding himself an ice cream. Nursing Assistant (NA) # 6 was observed entering his room and encouraging him to eat his sandwich also. NA #6 stated sometimes he fed himself sometimes he did not. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

On 10/29/15 at 9:40 AM Resident #78 was observed in bed with the bed in a low position. He was facing the wall, his bed covers were up and his eyes were closed. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

ON 10/28/15 at 8:25 AM NA #5 carried a meal tray into Resident #78's room and placed it on an over bed table on the right side of the bed. There was no chair in the room for NA #5 to sit on. Resident #78 was lying on his back with the head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282	Continued From page 29	F 282		

of the bed slightly elevated and NA #5 stood over Resident #78 and looked down at him while she fed him breakfast. The radio on the bedside table was not turned on. There were no magazines, books or puzzles in the Resident #78's room.

During an interview on 10/30/15 at 12:20 PM the Assistant Activities Director (AAD) stated she was familiar with Resident #78 and that he used to come to activities in the past but he had declined and had not attended activities in several months. She further stated that every other week she went down his hall with an activity cart and offered Resident #78 magazines and books but he declined most of the time. The AAD revealed she socialized with him for a while even if he refused reading materials from the activity cart. The AAD further revealed there were no other one on one activities specifically provided for Resident #78 and there was no other activity provided one on one for the alternate weeks when she did not take the activity cart down the hall. The AAD explained that once a month a lady came to the facility and went to Resident #78's room to play music. The AAD further explained he did not have a radio and the facility did not have funds to purchase radios for individual rooms. The AAD was unable to explain why Resident #78's activity goal was for him to only attend one activity per week and stated he should have been going to activities at least once per week for stimulation. The AAD further stated she provided an activity cart with magazines books and puzzles on alternate weeks down the hallways and she offered reading materials to Resident #78. The AAD revealed she had been doing all the activities since the Activity Director had been out for medical leave. The AAD further revealed Resident #78 sometimes would take a magazine to look at. The AAD showed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282	Continued From page 30	F 282		

check off sheet that revealed if a resident attended an activity and stated she was unable to provide any other documentation for tracking.

During an interview on 10/30/15 at 10:10 AM the Director of Nursing (DON) her expectations were for the AAD to provide in room one on one activities of the resident ' s preferences and as care planned. The DON further stated they offer books to read, in room socialization with them to promote one on one activity of their preference to the best of their ability. The DON confirmed the ADD was assuming all activity duties while the Activities Director was out on leave.

During an interview on 10/30/15 at 11:47 AM the Assistant Director of Nursing (ADON) stated it was her expectation for residents to attend meals in the dining room for socialization, and for the AAD to provide in room one on one activities of the resident ' s preferences and as care planned. The DON further stated they offered books to read, in room socialization with them to promote one on one activity of their preference to the best of their ability. The ADON confirmed the ADD was assuming all activity duties while the Activities Director was out on leave.

During an Interview on 10/30/15 at 12:33 PM the Administrator (AD) revealed that she had only been at the facility for 7 weeks and she had identified that there were more things they could have been doing in regards to activities to get more residents involved. The AD further revealed that she expected all staff to offer and assist as needed in getting residents to activities and not just residents that are up out of bed. The AD stated that staff needed to do a better job of communicating to residents that needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 282	Continued From page 31 assistance in getting out of bed that wanted to attend the daily activities. The AD further stated that the activities director had been out of work for several weeks and the activity assistant was the hands on person in the department and she had been trying to fill both duties since the activity director had been out.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review the facility failed to provide mouth care for a dependent resident for 1 of 1 sampled residents (Resident #43). The findings included: Resident #43 was admitted to the facility on 05/03/11 with diagnoses that included dementia and others. The most recent Minimum Data Set (MDS) dated 08/08/15 specified the resident had moderately impaired cognition, had no behaviors, did not reject care and required extensive assistance of one person for personal hygiene. Resident #43's oral/dental needs care plan updated on 09/05/15 specified she required extensive assistance twice daily and as needed with oral care for her natural teeth. The care plan goal was that dental hygiene would be maintained daily.	F 312	F312 ADL care provided for dependent residents: This facility has a policy that any patient who is unable to carry out activities of daily living receives the necessary services to maintain grooming, personal care & oral hygiene . This is achieved for resident # 43 by in servicing the Staff member involved during the survey. Resident #43 receives oral care daily and as needed provided by staff and it is documented in the electronic healthcare record. Resident # 43's RP was contacted and gave permission for resident to be seen by contracted in house facility dentist upon next visit Nov. 30th. Resident #43 was assessed by ADON and no negative outcomes observed from this cited deficiency.	12/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 312	Continued From page 32 On 10/28/15 at 12:29 PM a family member of Resident #43 was interviewed on the telephone and asked if Resident #43 received the help she needed with cleaning her teeth. The family member reported that she did not think staff assisted Resident #43 with brushing her teeth as often as they should because of the condition of the resident's teeth. On 10/28/15 at 12:45 PM Resident #43 was in her room eating lunch, observations were made of the resident's teeth that revealed she had white matter accumulated in between her teeth. On 10/29/15 at 9:20 AM Resident #43 was in her room in bed. Observations were made of the resident's teeth that revealed she had thick white matter accumulated in between the bottom teeth and white matter accumulated along the gum line of her bottom teeth. Observations of the resident's top teeth revealed they were dirty. On 10/29/15 at 9:35 AM nurse aide (NA) #1 reported that she was going to provide morning care on Resident #43. NA #1 proceeded to get supplies for providing care that included body wash, linens and lotion. Observations of the supplies NA #1 stated she was going to use on Resident #43 did not include a toothbrush, toothette or toothpaste. Resident #43 granted permission to be observed during her morning care. Observations of the morning care from start to completion revealed that NA #1 did not offer, ask or attempt to provide mouth care for the resident. On 10/29/15 at 10:12 AM after the continuous observation of morning care, NA #1 stated she	F 312	All residents who require assistance with oral hygiene are at risk for this cited deficiency. Using the facility details report a 100% audit was completed for all residents who require staff to perform oral care. This audit was completed under the supervision of the director of nurses on 11/21/15. Direct care staff was in serviced for facility policy to perform oral care for dependent residents. To further enhance compliance the following has been achieved. Under supervision of the Director of nurses 5 staff members are observed weekly for delivery of proper oral care x 4 weeks, then 3 observations are performed randomly weekly for 4 weeks for delivery of oral care. The Director is responsible for compliance and documents and reports concerns to the QA committee quarterly for review and additional corrective action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 312	Continued From page 33	F 312		

was finished and stepped out of the room to assist other residents. NA #1 offered no explanation why she did not provide mouth care for Resident #43.

On 10/29/15 at 4:30 PM observations were made of Resident #43's mouth that revealed she still had accumulation of white matter in between her bottom teeth, along her bottom gum line and her top teeth were dirty.

On 10/30/15 at 9:15 AM NA #2 was interviewed and stated she had just completed morning care for Resident #43. He explained that Resident #43 had finished breakfast and after eating her breakfast the NA changed the resident, washed and dried her face. NA #2 stated he didn't know if the resident had a toothbrush and that he had not provided mouth care. NA #2 explained that he was going to go back later and brush her teeth. NA #2 observed Resident #43's teeth, observations revealed the teeth were dirty with white matter accumulated in between the bottom teeth and along the bottom gum line. Resident #43 was interviewed and stated she had not had her teeth "brushed at all this month." The Resident added that she would allow staff to brush her teeth if it was necessary.

On 10/30/15 at 9:32 AM Nurse #2 was interviewed and reported that mouth care was included in daily during morning care for residents. Nurse #2 observed Resident #43's teeth, reported they were dirty and that she needed her teeth brushed.

On 10/30/15 at 9:55 AM the RN Supervisor was interviewed and reported that nurse aides were expected to follow resident's care plans. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 312	Continued From page 34 explained that during morning care nurse aides were to offer assistance with mouth care. On 10/30/15 at 3:00 PM NA #3 was interviewed on the telephone and explained that she was assigned to care for Resident #43 on 10/29/15 from 3 PM to 11 PM. She stated that mouth care was provided before assisting a resident to bed. NA #3 stated that she didn't recall brushing Resident #43's teeth because she thought the resident refused. NA #3 could not remember if she notified the nurse of the refusal of care or if she documented that the resident refused to have her teeth brushed.	F 312		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to discard ice cream stored ready for use past the use by date. The findings included: An initial tour of the kitchen was made with the facility corporate registered dietitian (CRD) on	F 371	F 371: Food storage and preparation: No patients were harmed by the alleged deficient practice. There were only (4) 4 ounce portions of the sugar free sorbet in the freezer, they were discarded when found on 10/26/15, and they were not served to any patients.	11/27/15

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F 371	Continued From page 35 10/27/15 at 10:15 AM. During the tour observations were made of frozen items stored ready for use in the walk-in freezer. Stored ready for use were 4 individual cartons of "sin-free" orange sherbet with the use by date of 04/25/15. The CRD was interviewed and stated that she was not sure if freezing ice cream suspended the use by date but would contact the food supplier for verification. On 10/27/15 at 3:20 PM the Dietary Manager (DM) was interviewed and explained that the ice cream was past the use by date and should have been thrown out. He added that he checked the freezer weekly for use by dates and removed any item out of date. He stated it was an oversight. On 10/30/15 at 10:00 AM the CRD provided an email response from the ice cream manufacturer that specified, "although the product is safe for consumption, I would discard if it has exceeded its use by date rather frozen or not."	F 371	Storage practices and used by dates were thoroughly examined by the Food Service Manager on 10/26/15, to assure no residents were at risk of receiving food past the use by date. No other items were found in the department. In-service education was conducted for all dietary staff by the Food Service Manager and his assistant on 11/6/15 and ongoing to reinforce food storage practices, rotating foods and labeling/ dating. QAPI tracking tool is used to track use by dates of foods sto5red in the kitchen. Monitoring is done 2x weekly by the Food Service Manager for one month, then weekly for one month, and then random monitoring as part of ongoing QAPI compliance. Findings are corrected immediately and reports od QAPI monitoring are presented by the Food Service Director at the monthly QAPI meetings.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		11/27/15

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F 431	Continued From page 36 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to remove expired medications from 1 of 5 medication carts. The findings included: A review of facility's policy on "Medication Storage in the Facility" dated June 2012 read in part "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from pharmacy, if a current order exists."	F 431	F 431: Drug records label/store drugs and biologicals: It is the policy of this facility to have a Licensed Pharmacy consultant who reviews medications on a monthly bases. The Licensed pharmacy consultant or pharmacy nurse consultant periodically reviews med carts and med rooms for outdated/expired medication and disposes of these meds per policy. The expired medication discovered during the survey was immediately returned to the pharmacy. The expired medication had never been used for any resident. Additionally each medication cart was	

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F 431	Continued From page 37 An observation of the 200 hall medication cart on 10/29/15 at 2:00 PM revealed a card of 14 cyclobenzaprine 5 mg (milligrams) tablets that contained a manufacture expiration date of 08/20/15. Interview with Nurse #4 on 10/29/15 at 2:15 PM revealed that each nurse was responsible for checking the medication cart for expired medication when they took responsibility for the medication cart at the beginning of their shift. Nurse #4 stated that she had gone through the medication cart on Tuesday 10/27/15 and had missed the expired cyclobenzaprine 5 mg tablets. She also stated the pharmacy had been in the building and had gone through the medication cart on Tuesday and did not remove the expired medication. Interview with Assistant Director of Nursing (ADON) on 10/29/15 at 2:31 PM revealed that nurses were responsible for checking their medication carts daily for expired medications and that she would expect all expired medication to be removed from the medication cart and returned to the pharmacy. She confirmed that the pharmacy had visited earlier in the week and had gone through the medications carts and rooms.	F 431	checked after discovery of this expired medication and none were found during the survey. To enhance the current compliant practice the following has been achieved. Licensed nurses were reeducated to check the medication carts and medication rooms daily prior to the administration of a medication for the expiration date during the survey process. Further all licensed nurses were in serviced for checking all expiration dates prior to administration of the medication. Any medication discovered outdated or expired is to be immediately removed and disposed of per policy. Under supervision of the director of nurses weekly audits of each med cart and medication room are performed to ensure staff are following policy to dispose of outdated/expired medications. Any concerns are immediately addressed on the spot. These audits will be done weekly x 1 month, then randomly. Findings are documented by the Director of nurses who presents them at the quarterly QA meeting for review and further corrective action as indicated.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		11/27/15

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F 441	Continued From page 38 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to implement isolation precautions for 1 of 1 resident diagnosed with Methicillin Resistant Staphylococcus Aureus (MRSA) in a wound on his left foot. (Resident #134).	F 441	F 441: Infection Control prevent spread Linens: It is the policy of this facility to provide a safe, sanitary, and comfortable environment and to	

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F 441	Continued From page 39 The findings included: Resident #134 was admitted to the facility on 06/15/15 and lived in a semi-private room with a roommate. Resident #134's diagnoses included osteomyelitis (infection in bone), long term use of antibiotics and a pressure sore on left heel. A review of a significant change MDS dated 10/11/15 indicated Resident #134 was moderately impaired in cognition for daily decision making and required extensive assistance for activities of daily living. A review of a care plan titled wound care needs indicated in part to monitor effectiveness of dressing, observe for changes in skin integrity and observe for signs and symptoms of infection. A review of a nurse's note dated 10/21/15 at 11:01 AM indicated Resident #134 came back from the wound clinic with new orders for dressing changes. The notes revealed new orders were faxed to the pharmacy, the physician was aware of new orders and Resident #134 would have a follow up appointment on 10/28/15 at 9:45 AM. A review of a microbiology report indicated a wound culture was completed from a wound on Resident #134's left heel on 10/24/15. The report revealed the wound culture indicated MRSA and "infection control precautions must be taken." A review of infectious disease physician orders with a facsimile (fax) time stamp of 10/27/15 at 2:44 PM indicated intravenous Vancomycin (antibiotic) 1000 mg every 24 hours for 6 weeks for a diagnosis of MRSA, pseudomonas (a gram negative bacteria) and osteomyelitis.	F 441	help prevent the development and transmission of disease and infection. Resident #134 was immediately placed in contact isolation during the annual survey. Neither resident #134 nor any other resident experienced a negative outcome as a result of this cited deficiency. The nurse involved was immediately in serviced for the facility policy for placing residents in isolation as ordered by the physician, obtaining the isolation equipment, and scheduling the order for the isolation in the electronic health record. For other residents with potential to be affected by this cited deficiency the following has been achieved: All licensed nurses were in serviced for the facility policy to place a resident in isolation as ordered by physician or as indicated per lab culture report. This includes obtaining the proper isolation equipment and placing an order for isolation in the resident electronic health record. To enhance current compliant practice, an audit was performed under the Supervision of the director of nurses. 100% of all new admissions and Current residents with orders for any type of culture or CXR since 10/31/15 were audited to ensure that isolation precautions had been initiated if indicated. No other residents were identified. Under supervision of the director of nurses all new admissions will be audited to ensure isolation precautions are	

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F 441	Continued From page 40 A review of physician's orders dated 10/27/15 indicated in part pharmacy was to dose Vancomycin intravenously for indication and diagnosis of MRSA and osteomyelitis. A review of a weekly wound note dated 10/27/15 at 6:49 PM by the wound care nurse indicated the wound on Resident #134's left heel was 2.5 centimeters (cm) length x 5.0 cm width x 1.5 cm depth. The notes revealed the wound bed was dark pink tissue with moderate amount of drainage and was on intravenous antibiotic therapy for diagnosis of osteomyelitis. A review of a nurse's note dated 10/27/15 at 7:08 PM by Nurse #5 indicated in part, new orders were received from an infectious disease physician to stop Ceftriaxone (antibiotic) and "start intravenous Vancomycin 1000 milligrams every 24 hours for 6 weeks and draw labs for complete blood count and serum creatinine" (to check kidney function) on 10/27/15. A review of a nurse's note dated 10/27/15 at 9:42 PM by Nurse #5 indicated Resident #134 remained on an antibiotic for treatment of osteomyelitis and MRSA and no signs or symptoms of adverse reactions were noted. During an observation on 10/29/15 at 9:23 AM Resident #134 was lying in bed and his roommate was seated in a wheelchair between their beds. There was an intravenous pump next to Resident #134's bed but there was no isolation sign on the door and there were no isolation supplies in the room or outside the room in the hallway.	F 441	initiated as indicated and ordered. Discrepancies are immediately addressed and corrected with the staff member on the spot. The DON is responsible for overseeing and monitoring compliance and documents concerns which are presented at the quarterly QA meeting for further review and additional corrective action if indicated.	

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F 441	Continued From page 41	F 441		

During an interview on 10/29/15 at 10:00 AM, Nurse Aide #8 confirmed she took resident #134 to the shower room earlier that morning and gave him a shower and he had a dressing on his left foot.

During an interview on 10/29/15 at 4:26 PM with the Administrator and Regional Director they explained they were not aware of Resident #134's diagnosis of MRSA until surveyors requested information about the diagnosis earlier in the day. They stated they had called the wound clinic and had found out Resident #134 went to the wound clinic on 10/21/15 and wound cultures were done on his left heel and the results were sent to the infectious disease physician. They explained Resident #134 then saw the infectious disease physician on 10/27/15 who had received the wound culture results and the office faxed the order to the facility which indicated Resident #134 had MRSA in his left heel. They confirmed Nurse #5 received the fax from the infectious disease physician's office and processed the orders on 10/27/15 and she should have immediately placed Resident #134 on isolation precautions. They stated Nurse #5 had access to the computer to review Resident #134's medical information and should have known he had not had a diagnosis of MRSA before and should have called the physician's office to get clarification about the diagnosis. The Administrator further stated it was her expectations for nursing staff to follow isolation procedures for residents who were identified with a diagnosis of MRSA.

During a telephone call on 10/29/15 at 9:29 PM Nurse #5 stated she got the fax regarding Resident #134's new antibiotic orders from the infectious disease office late on 10/27/15 after the

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	345511	A. BUILDING _____ B. WING _____	C 10/30/2015

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F 441	Continued From page 42	F 441		

office had closed and she put the orders in to pharmacy for the new intravenous medications. She confirmed Resident #134 had a new diagnosis of MRSA but she did not initiate any contact isolation precautions. She stated she was aware Resident #134 should have been placed in isolation once he had a diagnosis of MRSA but she had overlooked implementation of any isolation precautions.

During an interview on 10/30/15 at 10:45 AM with the Assistant Director of Nursing in the absence of the Director of Nursing she stated it was her expectation when a resident was identified with MRSA for the nurse to move the resident to a private room and place an isolation sign on the resident's door. She further stated the nurse should have also set up isolation supplies so staff and visitors would be aware to wear gowns and gloves and to take extra measures for protection and prevention of the spread of infection.

During an interview on 10/30/15 at 3:50 PM with the infection control nurse she stated her expectation was Resident #134 should have been put on contact isolation precautions and moved to a private room as soon as Nurse #5 received the new diagnosis of MRSA. She further stated she expected for him to be moved to a private room due to infection and to prevent cross contamination because the wound on his left heel was a draining wound. She explained it was the facility practice to move residents from a semi-private room to a private room when they had a diagnosis of MRSA.

During an interview on 10/30/15 at 3:55 PM with the wound care nurse she confirmed Resident #134 had moderate drainage from the wound on

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F 441	Continued From page 43 his left heel. She explained the wound first started as a blister on his heel and had deteriorated since he was diabetic and had poor circulation and extreme swelling of his left lower leg and foot. She further explained Resident #134 had been receiving oral antibiotics but was ordered intravenous antibiotics last week because the infection had spread into the bone. She confirmed she had not been told Resident #134 had a new diagnosis of MRSA until late yesterday afternoon and he should have been placed on isolation precautions as soon as Nurse #5 received the orders and diagnosis from the infectious disease physician's office.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		11/27/15

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F 520	Continued From page 44 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place February 2015. This was for one recited deficiency that was originally cited January 2015 on a recertification survey and subsequently recited in October 2015 on the current recertification survey. The deficiencies were in the area of reporting an allegation of abuse. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F226 Reporting allegation of abuse per facility policy: Based on observations, resident statements, staff interviews and record review the facility failed to report an allegation of physical abuse to the Administrator when a resident reported she thought she was going to be killed when staff jerked her in bed for 1 of 1 allegations of abuse (Resident #147). During the recertification survey of January 16, 2015 the facility was cited for failure to follow their abuse policy for investigating an allegation of abuse by staff for 1 of 3 residents (Resident	F 520	F 520: QAA committee members/meet quarterly plan: This facility has a policy to maintain a quality assessment and assurance Committee consisting of director of nursing services, a physician, designated by the facility and at least 3 other members of facility staff which meets at least quarterly QAPI meetings are held no less than quarterly and prn to focus on any area of concern. Staff were reeducated for the facility policy for reporting allegations of abuse neglect, including per regulation the definition of an allegation of abuse/neglect and the requirement for reporting all allegations to the administrator or director of nurses. Effective 11/19/15 a performance improvement plan was implemented for QAPI under the supervision of the administrator to track all allegations of abuse, monitor grievances for proper identification of abuse/neglect and report to the state agency within the required reporting times, 24 hours and 5 days. The administrator initiated family and resident surveys to be completed monthly by the	

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F 520	Continued From page 45 #109). On the current recertification survey and complaint investigation the facility was cited again for failure to follow their abuse policy for reporting an allegation of physical abuse to the Administrator for 1of 1 allegations of abuse (Resident #147). An interview on 10/30/15 at 4:59 PM with the Administrator revealed that she had only been at the facility for 7 weeks and they were scheduled to have a Quality Assessment and Assurance (QA) meeting 10/29/15. She stated that she could not speak to the fact if anything had successfully made it through the QA process because she was new to this building. She stated she was keeping an abuse tracking log and making sure everything was reported as appropriate and that she would continue to bring abuse to the QA meeting monthly instead of quarterly as previously done at the facility. The administrator stated she expected her nurses to report allegations of abuse to her so that she could have spoken to the resident and immediately started her investigation. The administrator stated that she has had a recent turnover of administrative staff and that lots of education would be needed. She planned to go over the entire process immediately with her staff and reinforce that all allegations of abuse must be reported to her so that she could make the determination of whether it constitutes abuse or not. She also stated that she could not speak to how this reeducation would be different from the last time this was cited because she had only been there at the building for 7 weeks.	F 520	social worker with a focus on the area of abuse concerns. Weekly quality zone rounds by department heads are completed with a focus on abuse/neglect allegations and will be ongoing. The administrator is responsible to monitor compliance and reports identified concerns to the quarterly QA committee meeting.	