STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

(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 a result of the complaint investigation of 7/21/16 Event ID# N1RL11.	F 000		
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 record review and staff interview the facility failed to follow interventions for contractures for 1 of 2 sampled residents (Resident #60) who had orders for splitting or a hand roll. The findings included: Resident #60 was admitted to the facility on 8/21/15 with a diagnosis that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side and contracture of left hand. The most recent Minimum Data Set (MDS) assessment dated 4/26/16 revealed Resident #60 required extensive assistance with the use of to complete activities of daily living and had upper and lower extremity impairments. Resident #60 was coded on the MDS assessment as being cognitively intact as evidenced by a brief mental status score of 13. Although Resident #60 was coded as cognitively intact according to the quarterly MDS assessment, the resident was not interviewed. Review of Resident #60 ' s care plan dated	F 282	FOR THE RESIDENT AFFECTED: Resident #60 was evaluated by therapy staff on 8/12/16. New orders were received on 8/15/16 to begin left upper extremity splint to be worn 6 hours q shift as tolerated and hand roll when splint is off for contracture prevention. FOR THE RESIDENTS WITH POTENTIAL TO BE AFFECTED: A contracture audit was completed by the staff development coordinator (SDC) on 8/12/16. Referrals were made to therapy as indicated. SYSTEM CHANGES: Nursing staff were inserviced by DON and SDC on 8/11/2016 regarding ensuring splints are applied as ordered, following care plans, documentation of refusals, skin assessments and skin care related to splints and contractures and rehab communication form.	8/18/16

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

Electronically Signed | 08/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 1 4/29/16 revealed Resident #60 was a risk for skin breakdown related to decreased mobility, weakness, incontinent of bowel bladder, diagnosis of Diabetes Mellitus (DM), contracture of left hand with risk for compartment syndrome. The goal stated Resident #60 would have no further preventable skin breakdown though next review. The goal further stated Resident #60 would have no preventable signs/symptoms of compartment syndrome (updated 7/20/16). The interventions initiated on 7/15/16 stated splint/wash cloth to left hand as ordered. Observe skin for irritation/breakdown. Monitor for signs and symptoms of compartment syndrome indicated on 7/20/16. Review of Resident #60 ' s Kardex report revealed a section identified as ADL ' s. The ADL section stated splint/wash cloth to left hand as ordered. Observe skin for irritation/breakdown. Observation on 7/18/16 at 11:27am revealed Resident #60 being assisted out of an activity by an unknown nursing assistant (NA). Resident #60 was observed to not have on a left hand splint or a hand roll. Observation on 7/19/16 at 8:50am reveled Resident #60 to be lying in bed. She is observed to not have on a splint or hand roll to her left hand. Her left hand was observed as held in a balled position as evidenced by 4 digits being held inward toward Resident #60 ' s palm. Observation on 7/20/16 at 9:03am revealed Resident #60 to be lying in bed. Resident #60 was observed to not have a left hand splint or a hand roll. (Hand roll on the resident ' s right on the night stand. The contracted hand was on the left. Interview with NA # 1 on 7/20/16 at 9:10am revealed Resident #60 had hand splint that she had on during the day. She further revealed she	F 282	CNAs were inserviced by the DON and SDC regarding reviewing each patient's Kardex and following the plan of care, reporting change in condition by the Stop and Watch form regarding ADLs and decreased ROM, application of splints and handrolls and documentation in the kiosk and skin care with residents with contractures. A communication form has been initiated between therapy and nursing to be completed by therapy in the event of contracture or risk of a developing contracture. Therapy staff were inserviced by rehab manager on 8/12/16 on the communication form. Those residents not on therapy caseload will be evaluated at least quarterly related to decreased range of motion and risk of contracture by case manager nurse. The RAI GO400 Functional Limitation in Range of Motion steps for assessment will be utilized. The 'Stop and Watch' tool form is completed by nursing staff when there is a change of condition related to decreased ROM/ADL of resident. QA/MONITORING: The DON/ADON and SDC will audit 3 residents with orders for splints weekly for 3 weeks then monthly for 3 months to ensure residents with orders for splints/devices are in place as ordered.	

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F 282	Continued From page 2 was unaware of any other intervention in place other than the use of the hand splint. She stated she used the Kardex to identify resident ' s needs. Interview with NA#2 on 7/20/16 at 9:18am revealed Resident #60 had a brace that when put on when she is out of bed. She indicated the brace was to be taken off while the resident was in bed. NA#2 indicated there was no other intervention other than Resident #60 ' s hand splint. NA#2 stated staff were to use the kardex when identifying a resident ' s needs. Interview with NA# 3 on 7/20/16 at 9:22am revealed she applied Resident #60 splint in the mornings when she gets out of bed. She further revealed staff occasionally put a wash cloth in the residents hand as well. She indicated she identified the resident ' s needs by reviewing the residents Kadex. Interview with the Staff development coordinator on 7/21/16 at 9:08am reveled she oriented facility nursing staff to Point click care system (PCC). She provided orientation in regards to navigating the PCC system and where to get information in regards to individual resident needs. The staff development coordinator further revealed she informs the staff on the use of the Kardex. The Kardex was updated per the Residents plan of care. Interview with the MDS Coordinator on 7/21/16 on 9:10am revealed she update resident care plans by physician order. She revealed the updates to the resident care plan would reflect on the residents Kardex as well. She indicated that the expectation of staff were to follow the care plan as written. Interview with the Assistant Director of Nursing (ADON) on 7/21/16 at 9:15am revealed updates to the care plan pulled over to the cardex that was utilized by NA ' s. The DON indicated that	F 282	A one time audit of care plans for those residents with splints and decreased ROM will be done by MDS staff and care plans will be updated as indicated. MDS Coordinator/case manager will audit 3 resident care plans with splints/devices monthly for 3 months to ensure contractures are care planned adequately to reflect devices ordered. Any areas of identified concerns will be addressed at the time and any continued concerns will be addressed in facility QA meetings.	

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F 282	Continued From page 3 when the NA ' s pull up the resident on the keiose they could see the residents demographics and special instructions. The ADON stated Resident #60 did not like the use of the hand roll and would remove it on her own. She identified that staff should monitor the resident and put the hand roll back in her hand. She further indicated that staff should have been documented the resident ' s refusal to wear the hand roll. The ADON revealed she did not see any refusals documented and refusal had not been reported. It was her expectation that staff follow the written plan of care and communicate refusals so the necessary department could implement necessary interventions.	F 282		
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to identify the development of a contracture in 1 of 3 residents who had a right hand contracture (#79). Findings Included: Resident #79 was admitted to the facility on 1/12/2012 with a diagnoses that included Alzheimer ' s Disease, Abnormal Weight Loss, Abnormal Posture, Muscle Weakness and	F 317	FOR THE RESIDENT AFFECTED: Resident #79 was referred to therapy on 7/21/16. New orders were received for therapy on 7/21/16 and the care plan was updated as indicated. FOR THE RESIDENTS WITH THE POTENTIAL TO BE AFFECTED: A contracture audit was completed by the	8/18/16

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F 317	Continued From page 4 Anemia. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 5/9/2016 revealed Resident #79 was totally dependent on staff for all activities of daily living (ADL ' s), had no impairments in range of motion (ROM) in upper extremities and had received no skilled therapy or restorative treatment during the last assessment period. The MDS further indicated Resident #79 cognition was extremely impaired. Review of the care plan dated 5/9/2016 revealed no care plan for range of motion or contracture prevention. Review of the nursing notes an assessment titled " nursing head to toe assessment " dated 7/6/2016 revealed that resident had full range of motion to all extremities. Review of occupational therapy evaluation dated 3/18/2016 revealed Resident #79 was referred to therapy for abnormal posture and a decline in transferring requiring increased staff assistance. It also revealed Resident #79 ' s right upper extremity had up to 50% ROM with a hypertonic tone and severely impaired gross and fine motor control. Review of the care plan dated 5/9/2016 revealed no care plan for range of motion or contracture prevention. Review of the nursing notes an assessment titled " nursing head to toe assessment " dated 7/6/2016 revealed that resident had full range of motion to all extremities. An observation of Resident #79 on 7/18/2016 at 11:14 am revealed the resident was lying in bed	F 317	SDC on 8/12/16. Referrals to therapy were made as indicated and care plans were updated as indicated. SYSTEM CHANGE: Nursing staff were inserviced by DON and SDC on 8/11/2016 regarding ensuring splints are applied as ordered, following care plans, documentation of refusals, skin assessments and skin care related to splints and contractures and rehab communication form. CNAs were inserviced by the DON and SDC regarding reviewing each patient's Kardex and following the plan of care, reporting change in condition by the Stop and Watch form regarding ADLs and decreased ROM, application of splints and handrolls and documentation in the kiosk and skin care with residents with contractures. A communication form has been initiated between therapy and nursing to be completed by therapy in the event of contracture or risk of a developing contracture. Therapy staff were inserviced by rehab manager on 8/12/16 on the communication form. Those residents not on therapy case load will be evaluated at least quarterly related to decreased range of motion and risk of contracture by case manager nurse. The RAI GO400 Functional Limitation in Range of Motion steps for assessment will be utilized.	

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F 317	Continued From page 5 with both eyes closed. The resident ' s right hand was curled up in a fist position. An observation of Resident # 79 on 7/20/2016 at 9:56 am revealed the resident was lying in bed with both eyes closed. The last 3 fingers of the residents right hand were curled inward toward her palm; the thumb and second finger were touching and partially curled inward toward her palm. The resident was asked if she could open her fingers but she was unable to follow directions. An interview with Nurse #2 on 7/18/2016 at 2:44 pm revealed that the resident did have a contracture to the right arm. An interview with Nurse #1 on 7/20/16 at 3:18 pm revealed that she not aware of Resident #79 having any contractures. She stated Resident #79 ' s right hand was drawn up some, but believed the resident could still open her right hand and she had observed it opened. An observation of resident #79 with the Director of Rehab and the occupational therapist on 07/21/2016 at 8:31 am. The resident was lying in bed with eyes closed. The therapists asked Resident #79 to try and open the right hand. The resident did not open her hand or follow instructions. The therapists then stroked and gradually opened the fingers on Resident #79 ' s right hand. As they were working to open the fingers Resident #79 grimaced and stated "it hurts". Observation of the resident ' s right hand revealed the last 3 fingers were stiff and bent and the skin surface on the inner right hand was dry and cracked. Interview with the therapists revealed that the resident could have developed	F 317	The 'Stop and Watch' tool form is completed by nursing staff when there is a change of condition related to decreased ROM/ADL of resident. QA/MONITORING: The DON/ADON/SDC will audit randomly 6 residents weekly for 3 weeks then monthly for 3 months for decreased ROM/contracture development. A one time audit of care plans for those residents with splints and decreased ROM will be done by MDS staff and care plans will be updated as indicated. The MDS/case manager will audit 3 resident care plans with splints/devices monthly for 3 months to ensure contractures are care planned adequately to reflect devices ordered. Any areas of identified concerns will be addressed at the time and any continued concerns will be addressed in facility QA meetings.	

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F 317	Continued From page 6 the contracture since the last occupational therapy evaluation March 18, 2016; especially because the resident was totally dependent on staff and was not actively using her hand. They also stated the resident would benefit from a splint to prevent the right hand contracture from progressing. An interview with the restorative aide on 07/21/2016 at 8:55 am revealed that Resident #79 had not received any restorative therapy in the last 2 years. An interview with nurse #2 on 07/21/2016 at 9:01 am revealed that resident #79 did have a contracture to her right hand. She stated that she was not aware of any splint or device ordered for the right hand. An interview with nursing assistant #4 on 07/21/2016 at 9:12 am revealed that she has provided bed baths and showers for Resident #79. She stated that she tried to clean the residents right hand by putting her finger in the palm of the residents hand to get the fingers to open so she could wash the inside of her hand. She also stated that she had not reported any changes in Resident #79 ' s right hand to her charge nurse or therapy. An interview with the Assistant Director of Nursing (ADON) on 07/21/2016 at 10:09 am revealed that her expectation was that the nursing assistants and nurses should have identified the decline in range of motion for resident #79 ' s right hand and made a referral to the therapy department.	F 317		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		8/18/16

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	345269	A. BUILDING _____ B. WING _____	C 07/21/2016

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F 318	Continued From page 7 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow physician orders and therapy recommendations for 1 of 3 sampled residents (Resident #60) who had a left hand contracture. The findings included: Resident #60 was admitted to the facility on 8/21/15 with a diagnosis that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side and contracture of left hand. The most recent Minimum Data Set (MDS) assessment dated 4/26/16 revealed Resident #60 required extensive assistance to complete activities of daily living (ADL) and had upper and lower extremity impairments. Resident #60 was coded on the MDS assessment as being cognitively intact as evidenced by a brief mental status (BIM ' s) score of 13. Although Resident #60 was coded as cognitively intact according to the quarterly MDS assessment, the resident was not interviewed. Review of Resident #60 ' s care plan dated 4/29/16 revealed Resident #60 was a risk for skin breakdown related to decreased mobility, weakness, incontinent of bowel bladder, diagnosis of Diabetes Mellitus (DM), contracture	F 318	FOR THE RESIDENT AFFECTED: Resident #60 was evaluated by therapy staff on 8/12/16. New orders were received on 8/15/16 to begin left upper extremity splint to be worn 6 hours q shift as tolerated and hand roll when splint is off for contracture prevention. FOR THE RESIDENTS WITH POTENTIAL TO BE AFFECTED: A contracture audit was completed by the SDC on 8/12/16. Referrals to therapy were made as indicated and care plans were updated as indicated. SYSTEM CHANGE: Nursing staff were inserviced by DON and SDC on 8/11/16 regarding ensuring splints are applied as ordered, following care plans, documentation of refusals, skin assessments and skin care related to splints and contractures and rehab communication form. CNAs were inserviced by the DON and SDC regarding reviewing each patient's Kardex and following the plan of care,	

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F 318	Continued From page 8 of left hand with risk for compartment syndrome. The goal stated Resident #60 would have no further preventable skin breakdown though next review. The goal further stated Resident #60 would have no preventable signs or symptoms of compartment syndrome (updated 7/20/16). The interventions initiated on 7/15/16 stated splint/wash cloth to left hand as ordered. Observe skin for irritation or breakdown. Monitor for signs and symptoms of compartment syndrome indicated on 7/20/16. Review of Resident #60 ' s occupational therapy discharge summary dated 7/7/16 stated staff would appropriately don and doff appropriate orthotic to Left upper extremity (LUE) and monitor skin condition for effective contracture management and joint protection. The diagnosis identified Resident #60 had a contracture of the left hand. The discharge plan stated slim grip II splint LUE 4 hour wear time. Review of Resident #60 ' s physician order electronically signed on 7/7/16 stated Resident #60 was to use a washcloth hand roll for LUE when splint is not on every shift for complaints of pain. Review of Resident #60 ' s physician order electronically signed on 7/8/16 stated Resident #60 was to use LUE slim Grips II splint 4 hours to 8 hours as tolerated every day and evening shift. Observation on 7/18/16 at 11:27am revealed Resident #60 being assisted out of an activity by an unknown nursing assistant (NA). Resident #60 was observed to not have on a left hand splint or a hand roll. An interview was attempted with Resident #60 on 7/18/16 at 2:00pm. The resident was unable to be interviewed as evidenced by not answering questions that were asked and requiring redirection to the topic without success.	F 318	reporting change in condition by the Stop and Watch form regarding ADLs and decreased ROM, application of splints and handrolls and documentation in the kiosk and skin care with residents with contractures. A communication form has been initiated between therapy and nursing to be completed by therapy in the event of contracture or risk of developing a contracture. Therapy staff were inserviced by rehab manager on 8/12/16 on the communication form. Those residents not on therapy caseload will be evaluated at least quarterly related to decreased range of motion and risk of contracture by case manager nurse. The RAI GO400 Functional Limitation in Range of Motion steps for assessment will be utilized. The 'Stop and Watch' tool form is completed by nursing staff when there is a change of condition related to ROM/ADL of resident. QA/MONITORING: The DON/ADON and SDC will audit 3 residents with orders for splints weekly for 3 weeks then monthly for 3 months to ensure residents with orders for splints/devices are in place as ordered. A one time audit of care plans for those residents with splints and decreased ROM will be done by MDS staff and care plans will be updated as indicated.	

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F 318	Continued From page 9 Observation on 7/19/16 at 8:50am reveled Resident #60 to be lying in bed. She was observed to not have on a splint or hand roll in her left hand. Her left hand was observed as held in a balled position as evidenced by 5 digits being held inward toward Resident #60 ' s palm. Observation on 7/19/16 at 2:45pm revealed the named resident lying in bed. The named resident did not have on a splint or a hand roll in her left hand. Her left hand was observed as held in a balled position as evidenced by 5 digits being held inward toward Resident #60 ' s palm. Observation on 7/20/16 at 9:03am revealed Resident #60 to be lying in bed. Resident #60 was observed to not have a left hand splint or a hand roll. Her left hand was observed as held in a balled position as evidenced by 5 digits being held inward toward Resident #60 ' s palm. Interview with (nursing assistant) NA # 1 on 7/20/16 at 9:10am revealed Resident #60 had hand splint that she had on during the day. She further revealed she was unaware of any other intervention in place other than the use of the hand splint. She stated she used the Kardex to identify resident ' s needs. Interview with NA#2 on 7/20/16 at 9:18am revealed Resident #60 had a brace that was put on when Resident #60 was out of bed. She indicated the brace was to be taken off while the resident was in bed. NA#2 indicated there was no other intervention other than Resident #60 ' s hand splint. NA#2 stated staff were to use the Kardex when identifying a resident ' s needs. Interview with NA# 3 on 7/20/16 at 9:22am revealed she applied Resident #60 splint in the morning when she got out of bed. She further revealed staff occasionally put a wash cloth in the residents hand as well. NA#3 indicated she identified resident ' s needs by reviewing the	F 318	MDS Coordinator/case manager will audit 3 resident care plans with splints/devices monthly for 3 months toensure contractures are care planned adequately to reflect devices ordered. Any areas of identified concerns will be addressed at the time and any continued concerns will be addressed in facility QA meetings.	

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F 318	Continued From page 10	F 318		

residents Kadex.
Interview with the Staff development coordinator on 7/21/16 at 9:08am reveled she oriented facility nursing staff to point click care system (PCC). She provided orientation in regards to navigating the PCC system and where to get information in regards to individual resident needs. The staff development coordinator further revealed she informed the staff on the use of the Kardex. The Kardex was updated per the resident ' s plan of care.
Interview with the Assistant Director of Nursing (ADON) on 7/21/16 at 9:15am revealed updates to the care plan would pull over to the Kardex utilized by NA ' s. The DON indicated that when the NA ' s pull up the resident on the keiose they could see the residents demographics and special instructions. The ADON stated Resident #60 did not like the use of the hand roll and would remove it on her own. She identified that staff should monitor the resident and put the hand roll back in her hand. She further indicated that staff should have been documented the resident ' s refusal to wear the splint or the hand roll. The ADON revealed she did not see any refusals documented and indicated refusals had not been reported for Resident #60. The ADON stated it was her expectation that staff follow the written plan of care and communicate refusals so the necessary department could implement necessary interventions.
Interview with the Rehabilitation Director on 7/21/16 at 10:45am identified Resident #60 as having a left hand contracture. Upon the rehabilitation directors review of Resident #60 ' s OT discharge summary dated 7/7/16 indicated Resident #60 was provided a Left hand orthotic for contracture management. The Rehab director revealed nursing staff were aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

(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 318	Continued From page 11 interventions put into place via carafe plan and Kardex. The Rehabilitation Director stated it was her expectation that staff follow the interventions for contracture management and commu8incate instances in which a resident would refuse to wear or would not tolerate a splinting device. The Rehab Director stated nursing would refer a resident to therapy in the instance a splint was not used or refused so additional measures could be implemented for contracture management or another device could be attempted.	F 318		