STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514 NOV 0	A. BUILDING _____ NOV 03 2011 B. WING _____ 2011	C 10/06/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID # 6B1T11.	F 000	This plan of correction will serve as compliance with requirements of 42 CFR, part 483, and Subpart B. Preparation and submission of the plan	
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 staff interview and record review the facility failed to provide 1 of 3 sampled residents (Resident #51), reviewed for activities, with adequate in-room visits by the activity department. Findings include: Resident #51 was admitted to the facility on 08/17/10. The resident's documented diagnoses included cerebrovascular accident, intracranial hemorrhage, diabetes, and seizure disorder. A 08/26/10 Activities Resident Assessment Protocol (RAP) documented, "Resident is not responsive to us when we go in her room. Resident was very active before her stroke. Resident has a diagnosis of a stroke. Resident is at risk of isolation and we will proceed to care plan. No referrals at this time." A 08/03/11 Annual Minimum Data Set (MDS) assessment did not identify any daily activity preferences for Resident #51. The 08/03/11 Care Area Assessment (CAA) Summary	F 248	of correction is in response to HCFA 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Nash of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Nash contends that it was in substantial compliance with the requirements 42 CFR, Part 483, and Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Nash submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 10-30-11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 documented the resident triggered for activities, but an activities CAA was not developed. In addition, the summary documented activities was not carried to care plan. Review of the record maintained by the facility's activity department for in-room visits revealed Resident #51 only had received two in-room visits from 04/01/11 through 10/06/11, on 04/07/11 and 05/20/11. At 10:11 AM on 10/06/11 the Activities Director (AD) stated Resident #51 received in-room visits rather than attending group activities, although the resident might currently enjoy church and music programs, because the resident was rarely up out of bed. The AD reported she was sure Resident #51 had not attended any group activities at least since July 2011. According to the AD, Resident #51 had begun responding verbally to staff in the last two to three months when they spoke to her. She explained prior to this the resident was verbally non-responsive. She commented she recalled stopping by to visit with Resident #51 on 09/29/11, and when she mentioned fishing on her vacation, the resident began to talk to her about fish. However, the AD stated she forgot to log this 09/29/11 in-room visit. The AD reported Resident #51 did not exhibit behaviors, but might talk out loud in a group activity if she heard something mentioned which interested her. At 11:13 AM on 10/06/11 nursing assistant (NA) #2 stated in the last two to three months Resident #51 was crying out when she began her shift at 7:00 AM. The NA reported this behavior was quickly resolved when she spoke to the resident	F 248	**F248** For the resident found to be affected: For resident #51-Activity Director updated resident's care plan on 10-24-11 to include "Activity Focus" For residents having the potential to be affected: All other current residents were audited on 10-24-11 and 10-25-11 by Regional QA Nurse by reviewing last full assessment to determine if activity triggered and if decision made to proceed to care plan and review of care plan to verify if care plan completed for activities. Corrective action was taken as indicated. Measures put in place: In-service provided to Activity Director on 10/24/11 by Social Services Director on proceeding to care plan and care plan formulation.	

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F 248	Continued From page 2 and interacted with her. She explained it was like the resident was craving some attention and conversation. The NA commented she did not see anyone from the activity department visiting with Resident #51, but thought the resident would benefit greatly from social interaction in an in-room environment. The NA remarked it was amazing how, over the last two to three months, Resident #51 would now talk, participate in conversations, and respond to questions. However, she reported the resident would probably not benefit from group activities because the resident became anxious and agitated when the staff attempted to use the lift for transfers. At 3:48 PM on 10/06/11 the AD stated she realized Resident #51 was becoming more responsive and interactive over the past couple of months through personal observation. She reported the facility's in-room visit program included reading a large variety of materials to residents, singing to residents and playing music for them, and sensory activities which involved tactile stimulation. At 3:52 PM on 10/06/11 NA #3 stated the transformation in Resident #51 over the past two to three months was remarkable. She explained the resident used to be verbally non-responsive, and then one day when she (the NA) was talking to the resident's roommate, Resident #51 just joined in the conversation, staying with the topic of conversation and making sense. The NA reported the resident continued to reply and join conversations when spoken to. According to NA #3, Resident #51 might talk out in group activities, but would enjoy the stimulation provided by in-room visits. She stated she had not seen	F 248	Monitoring: Director of Nursing or designee will monitor 5 residents last full MDS and care plans weekly x 4 weeks, then monthly x 3 months to ensure any triggered area for activities was proceeded to care plan as indicated, Any area of identified concern will be addressed by the QA committee for further action plan.	

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F 248	Continued From page 3 anyone from the activity department in the resident's room, but did not think that many in-room visits were made in the afternoon and evening. At 4:03 PM on 10/06/11 the Assistant Director of Nursing (ADON) stated the AD was responsible for developing the Activities CAAs, but she was not sure why an Activities CAA was not written in conjunction with Resident #51's 08/03/11 Annual MDS assessment. She reported Resident #51 was gotten out of bed at least once weekly, although the resident did have some problems with nausea when in an upright position. The ADON commented she was aware of Resident #51's increased responsiveness over the past two to three months. She stated social isolation was a concern when residents were virtually bed bound. Therefore, the ADON reported in-room visits became increasingly important to provide bed bound residents with stimulation and interaction. According to the ADON, at least one in-room visit per month, at a minimum, was a reasonable expectation to be provided by the facility's activity department.	F 248		
F 318 . SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION 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	F 318	**F318** For the resident affected: For resident #51 her right hand wrist splint was located in the laundry on 10/7/11.	

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F 318	Continued From page 4 by: Based on observation, staff interview, and record review the facility failed to apply an orthotic (splint) for wrist contracture and pain with range of motion (ROM) for 1 of 4 sampled residents (Resident #51) whose ROM was reviewed. Findings include: Resident #51 was admitted to the facility on 08/17/10. The resident's documented diagnoses included wrist contracture, cerebrovascular accident, intracranial hemorrhage, diabetes, and seizure disorder. A 05/31/11 Initial Plan of Treatment for Occupational Therapy (OT) documented, "Client is ... resident of this facility with R (right) elbow/wrist/hand contracture resulting in loss of motion. Problem areas include pain with ROM, loss of motion affecting participation with ADLs (activities of daily living), and loss of joint integrity...." A 06/08/11 physician's order initiated use of an orthotic to treat Resident #51's right wrist/hand contracture. A 07/12/11 OT Discharge Services Progress Summary documented, "Client received skilled OT services to restore movement in right elbow/wrist/hand in order to improve quality of life. Client discharged due to tolerating orthotic wear for 4 hours and referring to Restorative Nursing 5-6x/week for ROM program and orthotic application. Client demonstrates decreased pain with RUE (right upper extremity) ROM since initial evaluation, especially with R wrist, as demonstrated by decreased verbalizations and	F 318	<u>For other resident's with the potential to be affected:</u> All other residents with splinting devices were audited on 10/10/11 by SDC to ensure splints were in place as ordered. No other areas were identified. <u>Measures put in place:</u> In-services were held on 10/7-10/12/11 by DON and ADON with nursing and laundry staff related to splints related to timely notification of restorative nurse and timely resolution of missing splints. <u>Monitoring:</u> Director of Nursing or designee will audit all residents with orders for splints daily x 2 weeks, then weekly x four weeks, and then monthly x 3 to ensure splints are in place as ordered. Any area of identified concern will be addressed by the QA committee for further action plan.	

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F 318	Continued From page 5	F 318		

facial grimaces. She is able to tolerate R elbow flexion to 30 degrees and wrist flexion to neutral, however, she continues to rest with R elbow and wrist extended. She is able to tolerate R wrist/hand orthotic for 4 hours w/o (without) discomfort of skin/joint integrity issues."

On 07/18/11 the problem "Restorative Needs--PROM (passive range of motion) BUE and BLE (bilateral upper extremities and bilateral lower extremities) ... apply splint to R wrist and hand...." was added to Resident #51's care plan. Interventions to this problem included, "Splint/Brace assist program" which started 07/26/11.

On 10/04/11 at 10:18 AM Resident #51 was resting in bed. Her right hand/wrist was extended outward, and she did not have an orthotic in place.

On 10/05/11 at 9:56 AM and 11:13 AM Resident #51 was resting in bed. Her right hand/wrist was extended outward, and she did not have an orthotic in place.

On 10/06/11 at 10:02 AM and 11:10 AM Resident #51 was resting in bed. Her right hand/wrist was extended outward, and she did not have an orthotic in place.

At 11:13 AM on 10/06/11 nursing assistant (NA) #2 stated restorative was supposed to apply a splint daily to Resident #51's right wrist and hand, and it usually stayed on the resident all day. NA #2 acknowledged the resident did not have a splint in place when she pulled the covers back on her bed.

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F 318	Continued From page 6 At 1:35 PM on 10/06/11 restorative NA #3 stated Resident #51 was discharged from the restorative program on 09/28/11. While participating in the program the NA reported Resident #51 received PROM to her BUE, and the NAs applied a splint to her right hand/wrist. According to NA #3, the splint was supposed to be worn by the resident for four to six hours a day. She commented sometimes the resident would tell the staff to stop when they tried to apply the splint. However, she explained once the staff explained why the resident needed the splint, the resident agreed to its application. However, the NA stated due to comfort issues the splint was usually left in place for only four hours a day. She reported that about two weeks prior to discharge from the restorative program Resident #51's splint disappeared. She commented it was usually kept on the top shelf of the resident's closet. NA #3 stated restorative notified Occupational Therapist (OT) #1 that Resident #51's splint was missing, and continued to provide the resident with PROM services. At 2:02 PM on 10/06/11 OT #1 stated therapy became involved with treating Resident #51 when family expressed concerns about the resident's right hand/wrist extension contracture. She explained the resident expressed pain with ROM involving her right wrist. According to the OT, the resident received ROM, E-stim treatment, and orthotic application through the therapy program. She reported the resident was discharged to the restorative program for continued PROM and orthotic application. The OT commented Resident #51 was supposed to wear the orthotic for up to four hours daily, and to her knowledge, the resident was still wearing the orthotic. She	F 318		

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F 318	Continued From page 7 stated a restorative NA mentioned to her on one day that she could not find Resident #51's orthotic, but there had been no further reports that the device was missing. The OT explained she thought the orthotic was found because there had been no further reports from restorative of it still missing, and no one from restorative had completed a referral form requesting therapy follow-up with the orthotic. She reported the orthotic improved Resident #51's ROM in her right hand/wrist, but did not change the resting position of the right hand/wrist. At 2:18 PM on 10/06/11 NA #2 stated she was told today that the hall NAs were responsible for putting Resident #51's splint on her right hand/wrist since the resident was discharged from the restorative program. She explained this was the first time she was informed about this new responsibility. According to the NA, she was unable to find the resident's splint which was usually in her closet or in the seat of her geri-chair. At 3:52 PM on 10/06/11 NA #3 stated she worked with Resident #51 for the last couple of months, and had never seen a splint on the resident's right hand/wrist or in the resident's room. However, she reported restorative may have removed it by the time her shift began.	F 318		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	**F364** For the residents affected and for the residents with the potential to be affected: Kitchen staff were in-serviced 10/7-17/2011 regarding nutritional	

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F 364	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to preserve the vitamin and mineral content of a green vegetable by exposing it to prolonged heat on the steam table. Findings include: At 9:47 AM on 10/05/11 the cook stated she was not going to steam the broccoli for regular diets until right before the trayline began operation because otherwise it would turn olive green and the texture would be mushy. At 10:03 AM on 10/05/11 the cook placed a quarter tray pan of pureed broccoli on the steam table. The wells of the steam table were set on high with abundant steam generated by hot water in the bottom of the wells. Food temperatures were taken at the steam table on 10/05/11 beginning at 11:52 AM. A calibrated thermometer inserted in the pureed broccoli registered 179 degrees Fahrenheit. The lunch trayline began operation of 10/05/11 at 12:00 noon. At 3:26 PM on 10/06/11 the Dietary Manager (DM) stated she did not like for green and orange vegetables to sit on the steam table for more than 30 minutes before the trayline began operation. She reported if the vegetables remained on the steam table for longer than that they became mushy, and some of the vitamin and mineral content was destroyed.	F 364	compromise of oversteaming of green vegetables. Measures put in place: Kitchen staff were in-serviced 10/7-17/2011 regarding proper steam time of green vegetables. Monitoring: Dietary Manager or designee will monitor steaming of green vegetables process weekly x 3 then monthly x 3 to ensure proper steaming process. Any area of identified concern will be address in the QA committee for further action plan.	

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F 371 SS=E	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 observation and staff interview the facility failed to obtain the appropriate strips to monitor the strength of a bleach-based solution used to sanitize kitchen preparation surfaces, failed to clean the face of the fan blowing on the food preparation area of the kitchen and to clean rack shelving upon which kitchenware was stored, failed to discard kitchenware which was damaged, failed to cover all food items which were transported to resident halls, and failed to label and date food items which were opened. Findings include: 1. At 9:13 AM on 10/05/11 a dietary employee took a rag from a red bucket containing a bleach-based solution, and wiped down the food preparation table where she had been slicing key lime pie. At 9:18 AM on 10/05/11 the dietary employee attempted to use a strip, manufactured to monitor the strength of quaternary-based solutions, to check the strength of the bleach-based solution in	F 371	**F371** For the residents affected and for the residents with the potential to be affected: The buckets were discarded on 10/5/11. RTU premixed cleaner replaced bleach on 10/5/11. The fan was cleaned on 10/5/11. The shelving was cleaned on 10/6/2011. The damaged kitchenware was discarded on 10/5/11. The unlabeled dated opened items were all discarded on 10/6/11. The food items in the cart are all covered/or nursing staff was directed on 10/7/11 to close door after removing tray from cart. Measures put in place: Inservices held in dietary department regarding cleaning product, cleaning of fan and shelves, discarding of damaged kitchenware and labeling and dating of opened food items 10/7-10/17/11. ADON and DON inserviced 10/7-10/12/11 regarding closing food carts/covering food items.	

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F 371	Continued From page 10 her red bucket. The strip did not change color. Therefore, the strength of the sanitizing solution could not be determined. At 9:24 AM on 10/05/11 the cook used a cloth from a red bucket containing a bleach-based solution to wipe down the preparation surface where she had used raw hamburger to make a meat loaf. At 9:27 AM on 10/05/11 the Dietary Manager (DM) and dietary employees stated they did not have any white strips which changed different shades of blue when inserted in solutions containing bleach. The DM reported the only monitoring strips they had in the kitchen were the ones used to check the strength of the quaternary-based solution in the three-compartment sink system. At 9:32 AM on 10/05/11 bleach-based solution from a red bucket was used to wipe down a cart used for transporting meal trays. At 9:38 AM on 10/05/11 the cook used a cloth from a red bucket containing a bleach-based solution to wipe down the preparation surface where she made Cole slaw (the same preparation surface where she made the meat loaf). At 3:26 PM on 10/06/11 the DM stated she started her job in the facility on 07/15/11, and the facility did not have any and did not obtain any strips to check the strength of bleach-based solutions even though they were using bleach in their red sanitizing buckets. 2. During the initial tour of the kitchen on	F 371	Monitoring: The fan and shelving are on a routine scheduled cleaning. The fan will be cleaned at least monthly and sooner as indicated. The shelving will be cleaned at least weekly and sooner as indicated. The Dietary Manager or designee will audit for undated and unlabeled open items weekly x 3 then monthly x 3. The Dietary Manager or designee will audit for the following: cleanliness of fan, cleanliness of shelving, damaged kitchenware, and food items left uncovered weekly x 3 then monthly x 3. DON/ADON or designee will monitor staff for closing food carts/covering food items weekly x four weeks and then monthly x 4. Any area of identified concern will be addressed by the QA committee for further action plan.	

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F 371	Continued From page 11 10/03/11, beginning at 10:53 AM, a fan was blowing on the food preparation area of the kitchen. The face of the fan was dusty and dirty with several strands of dust blowing from it. The shelves of a rack storing tray pans, baking pans, and metal bowls, turned face down, were coated with a film of dust and dirt. During food preparation observation on 10/05/11, beginning at 8:54 AM, a fan was blowing on the food preparation area of the kitchen. The face of the fan was dusty and dirty with several strands of dust blowing from it. During the observation the cook prepared Cole slaw, meatloaf, chopped green pepper and onion, and pureed broccoli. In addition, tray pans, baking pans, and metal bowls were being stored face down on rack shelving which was coated with a film of dust and dirt. At 3:26 PM on 10/06/11 the DM stated it was the responsibility of the maintenance department to clean fans, and the cleaning was done on an as-needed basis. The DM reported the dietary staff were responsible for cleaning storage racks and units in the kitchen. She commented she was unsure when the kitchen racks were cleaned last, and did not think the racks were on the daily cleaning schedule which she developed. 3. During the initial tour of the kitchen on 10/03/11, beginning at 10:53 AM, the non-stick coating on a frying pan hanging above the three-compartment sink was scratched, and the coating was beginning to peel off in places. At 10:27 AM on 10/05/11 2 of 11 cups, kept in the dining room for residents and visitors who wanted beverages, were cracked.	F 371		

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	345514	A. BUILDING _____ B. WING _____	C 10/06/2011

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F 371	Continued From page 12 During an inspection of kitchenware on 10/05/11, beginning at 10:30 AM, the dividing walls in 1 of 24 sectional plates were cracked, the dividing walls in 5 of 24 sectional plates were chipped, 7 of 45 cups were cracked, and 3 of 4 frying pans with non-stick coating were scratched with the coating beginning to peel in places. At 3:26 PM on 10/06/11 the Dietary Manager (DM) stated staff were supposed to notify her when they found cracked, chipped, scratched, or damaged kitchenware. She reported the damaged kitchenware was disposed of and replaced with new, undamaged kitchenware. The DM commented using cracked, chipped, and scratched kitchenware increased the possibility that bacteria could collect in the imperfections. 4. During lunch dining observation on 10/03/11 the cart containing meal trays was observed on the 300 hall at 12:20 PM. The door to the cart was open, and remained open until the last resident meal tray was removed from the cart at 1:00 PM. The peach and blueberry desserts, the pureed desserts, a bowl of greens, and a bowl of gelatin were not covered. At 3:26 PM on 10/06/11 the Dietary Manager (DM) stated enclosed carts with doors were to be used to transport meal trays to residents who ate on the hall in their rooms. She reported the doors to these carts were to stay closed between removal of trays and set up of resident meals in the rooms. 5. During the initial tour of the kitchen on 10/03/11, beginning at 10:53 AM, a storage	F 371		

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F 371	Continued From page 13	F 371		

container of yams, a gallon container of heavy duty mayonnaise which was half full, a 8.5 pound container of picante sauce which was half full, a gallon container of sweet and sour sauce which was 2/3 full, a gallon container of fat-free Catalina dressing which was 3/4 full, a gallon container of barbecue sauce which 3/4 full, and a gallon container of honey mustard dressing which was 1/4 full did not have labels or dates on them. These items were found in the walk-in refrigerator, and the dressings and sauces had receipt dates on them, but did not have dates on them indicating when the containers had been opened. In addition, Boston cream pie, a chopped green vegetable, tater tots, French fries, cubed potatoes, pork chops, and chicken patties in the walk-in freezer, which had been opened and partially used, did not have labels and dates on them. In the dry storage room a 16-ounce package of brown gravy mix, a 25-pound bag of seafood breader, a foil bag of vanilla wafers, a 2-ounce package of sugar-free lemonade, a 24-ounce package of fruit punch mix, and a 24-ounce package of gelatin mix, all of which were opened and partially used, did not have labels and dates on them.

During a follow-up observation of the kitchen storage areas on 10/05/11, beginning at 10:07 AM, a storage bag containing green and red peppers, a storage container of barbecue sauce, a gallon container of heavy duty mayonnaise which was 1/4 full, a 8.5 pound container of picante sauce which was half full, a gallon container of sweet and sour sauce which was 2/3 full, a gallon container of fat-free Catalina dressing which was 3/4 full, a gallon container of barbecue sauce which 3/4 full, and a gallon

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F 371	Continued From page 14 container of honey mustard dressing which was 1/4 full did not have labels or dates on them. These items were found in the walk-in refrigerator, and the dressings and sauces had receipt dates on them, but did not have dates on them indicating when the containers had been opened. In addition, Boston cream pie, coconut pie, French fries, tater tots, cubed potatoes, and a storage bag of carrot/broccoli mix in the walk-in freezer, which had been opened and partially used, did not have labels and dates on them. In the dry storage room a 24-ounce package of gelatin mix and 2 two-ounce packages of sugar-free lemonade mix, which were opened and partially used, did not have labels and dates on them. At 3:26 PM on 10/06/11 the Dietary Manager (DM) stated the cooks usually monitored the storage areas for labeling and dating as they gathered food items during food preparation tasks. She reported labeling and dating was important to make sure the oldest food items were used up first (FIFO). The DM commented all food items which were opened, all leftovers, and all food items removed from their original packaging should be labeled and dated.	F 371		

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	345514	A. BUILDING 01 - MAIN BUILDING B. WING _____	11/01/2011

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K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/1/2011 at approximately 9:00 AM onward the following was noted. 1) The oxygen storage rooms at both east and west nurse stations were not self closing. 42 CFR 483.70(a)	K 029	This plan of correction will serve as the facility's allegation of compliance with requirements of 42CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey conducted 11/1/2011 and does not constitute an agreement or admission by Autumn Care of Nash of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. For the residents found to be affected and for those having the potential to be affected: Door closures installed to both oxygen storage rooms on 11/3/11. Measures put in place: Door closures will remain on doors and in working order. Monitoring: Environmental Services Director or his designee will perform audits to check door closures weekly for 4 weeks and then monthly thereafter to ensure they continue to operate appropriately. Any problems will be addressed immediately with repair. Results of these audits will be brought to Quality Assurance team for review and any necessary further action.	11/3/11 11/3/11 11/14/11
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	For the residents found to be affected and those having the potential to be affected: Fire drills will be put on an annual calendar, and shared with SDC/Administrator to ensure all shifts receive drills at least quarterly. Measures put in place: Drills will be scheduled and held at least quarterly per each of 3 shifts on annual schedule by Environmental Services Director, with copy to SDC. Monitoring: SDC/Administrator will audit fire drill records monthly on ongoing basis to determine compliance. Results will be brought to the Quality Assurance team for review and any necessary further action.	11/14/11 11/17/11 11/17/11

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

Administrator — 11/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/1/2011 at approximately 9:00 AM onward the following was noted. 1) Documentation indicated less than the required number of drills were held on third shift of the 2nd quarter of 2011. 42 CFR 483.70(a)	K 050		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/1/2011 at approximately 9:00 AM onward the following was noted. 1) The smoke duct detectors located in the HVAC units were not maintained clean and in good operating condition. Location - HVAC unit in the attic area for kitchen. 42 CFR 483.70(a)	K 054	Duct detectors were cleaned on 11/2/11. For the residents found to be affected: Duct detectors were cleaned on 11/2/11. For the resident with potential to be affected: Facility checked by Env. Services Director to determine if any other fire ducts existing needed cleaning. None found. Measures put in place. Fire ducts will be inspected monthly and cleaned as needed to ensure proper functioning and cleanliness. Monitoring: Monthly audits will be performed by Env. Services Director to ensure ducts are clean or cleaned if needed. Results will be brought to the Quality Assurance team for review and for further action as needed.	11/2/11 11/17/11 11/17/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	For the residents found to be affected and for those having the potential to be affected: Fire sprinkler inspection contractor contacted and contracted with to provide quarterly, semiannual, and annual inspections of sprinkler systems. Facility's Env. Services Director will keep records of needed inspections and follow up with contractor to ensure inspections are completed via a calendar/notebook. Measures put in place: Calendar/notebook will be kept and monitored for required inspections by firesprinkler inspection contractor monthly.	11/14/11 11/17/11

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K 062	Continued From page 2 Based on observation on Tuesday 11/1/2011 at approximately 9:00 AM onward the following was noted. 1) Interview with facility staff and documenting review confirmed the fire sprinkler inspection contractor is performing annual inspection and testing only. There was not documentation of quarterly or semiannual inspection and testing performed within the past 12 months. 42 CFR 483.70(a)	K 062	Monitoring: Administrator will inspect notebook monthly to ensure inspections are occurring. Results of these audits will be brought to Quality Assurance team for review and any needed action.	11/17/11
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/1/2011 at approximately 9:00 AM onward the following was noted. 1) Documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority	K 144	For the residents found to be affected and those having the potential to be affected: Generator load bank test was completed by contractor. Measures put in place: Monthly load test will be completed by Environmental Services Director or annual load bank test will be performed annually. Monitoring: Administrator/ designee will audit generator test records monthly to ensure load test is being performed monthly . Results will be brought to the Quality Assurance team for review and any necessary further action.	11/9/11 11/17/11 11/17/11

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K 144	Continued From page 3 having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483.70(a)	K 144		