

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>345351</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>1/6/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>AUTUMN CARE OF SALUDA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 ESSEOLA CIRCLE SALUDA, NC</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 280</b>	<p><b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to invite one (1) of seventeen (17) residents to attend care plan meetings. (Resident # 80)</p> <p>The findings are:</p> <p>Resident #80 was admitted to facility in October of 2010 with diagnoses which included hemiplegia.</p> <p>Review of the annual Minimum Data Set (MDS) dated 10/17/11 assessed the resident as being independent in making daily decisions and as having no memory or cognitive problems.</p> <p>During an interview on 01/04/12 at 11:25 AM, Resident #80 stated he had never attended nor been invited to a care plan meeting since his admission in October of 2010.</p> <p>During a follow up interview on 01/06/12 at 1:20 PM the resident stated he did not know anything about care plan meetings and had never been invited to attend any meetings regarding his care. The resident stated he could make choices about daily care but had no knowledge regarding quarterly care plan meetings.</p> <p>During an interview on 01/06/12 at 2:30 PM, the Administrator stated residents and or family members were supposed to get a letter or a personal invitation to scheduled quarterly or annual care plan meetings. The Administrator further stated the former Social Worker had been responsible for scheduling care plan meetings and this information would then be posted in the resident's room with the date and time of the scheduled meeting. The Administrator stated he did not know if Resident #80 had ever been invited to attend a care plan meeting and could not verify whether the Resident had ever been invited or had attended a quarterly or annual care plan meeting since the former Social Worker was not available for interview.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN CARE OF SALUDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 ESSEOLA CIRCLE SALUDA, NC 28773</b>		
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F 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer the correct dosage of a non-steroidal anti-inflammatory (NSAID) gel medication for one (1) of twenty-one (21) sampled residents. (Resident #88)</p> <p>The findings are:</p> <p>1. Review of the medication manufacturer's instructions for the NSAID gel medication Voltaren Gel revealed the following: "Serious and potentially fatal cardiovascular (CV) thrombotic events, myocardial infarction, and stroke can occur with NSAID treatment. The lowest possible dose of Voltaren® Gel should be used in patients with known CV disease or risk factors for CV disease." The manufacturer's instructions also included a warning about hypertension: "NSAIDs, including Voltaren® Gel, can lead to the onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of cardiovascular events."</p> <p>The manufacturer's instructions also provided</p>	F 309	<p><i>The preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged, or of the correctness of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.</i></p>		
		F309	<p>Resident #88 had no negative outcomes. The attending physician provided orders to clarify the directions for the Voltaren Gel.</p> <p>For the residents with the potential to be affected, the following actions were implemented:</p> <ol style="list-style-type: none"> <li>1. A 100% audit of residents' medication administration records was done and no other residents were found with orders for Voltaren Gel.</li> <li>2. Licensed nurses and medication aides were in-serviced on administering Voltaren Gel according to the manufacturer's recommendation, and on how to use the administration grid</li> </ol>	01-04-12	01-12-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Handwritten Signature]*

**ADMINISTRATOR**

**FEB 01, 12**

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.

**FEB 13 2012**

*[Handwritten Signature]*

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F 309	<p>Continued From page 1</p> <p>guidance for dosing, including the following: "Total dose should not exceed 32 g per day, over all affected joints. Voltaren® Gel should be measured onto the enclosed dosing card to the appropriate 2 g or 4 g designation." Additionally, the instructions noted: "The proper amount of Voltaren® Gel should be measured using the dosing cards supplied in the drug product carton. One dosing card should be used for each application of drug product. The gel should be applied within the oblong area of the dosing card up to the 2 gram or 4 gram line (2 g for each elbow, wrist, or hand, and 4 g for each knee, ankle, or foot). The dosing card containing Voltaren® Gel can be used to apply the gel."</p> <p>Resident #88 was admitted to the facility with diagnoses including hypertension and peripheral vascular disease.</p> <p>The admission Minimum Data Set dated 10/11/11 revealed Resident #88 had moderately impaired cognition and required limited assistance with activities of daily living.</p> <p>Review of the physician's orders revealed the following order dated 12/05/11: "Voltaren gel 1% qid [four times daily]-apply to lumbar (pain)." Continued review of the physician's orders revealed no clarification of the order to specify a dose or amount for the medication. Review of the December 2011 Medication Administration Record (MAR) revealed initialed documentation which indicated the resident received the gel medication continuously beginning 12/07/11.</p> <p>During an interview on 01/04/12 at 2:55 PM, the Pharmacy Consultant said she was unaware</p>	F 309	<p>applicator provided by the manufacturer, and per physician orders.</p> <p>The Director of Nursing or the Assistant Director of Nursing will audit all physician orders written for Voltaren Gel to ensure it is correctly administered as per manufacturer's recommendation and physician orders, weekly for 3 months.</p> <p>The Director of Nursing is responsible for compliance. Findings of these audits will be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate</p>	<p>01-12-12</p> <p>01-31-12</p>	

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F 309	<p>Continued From page 2</p> <p>Voltaren Gel should have dose specified and/or came with a dosing guide. After checking with an on-line pharmacy reference, the pharmacist called her pharmacy manager and was told they also were unaware of the information about the gel medication. The pharmacist said the pharmacy manager informed her they would no longer fill an order for Voltaren Gel if the order did not specify grams to be used and the order would need to be clarified by the physician.</p> <p>Interview on 01/04/12 at 3:10 PM with the resident's physician at the facility revealed he was unaware Voltaren Gel needed to be dispensed by gram dosing. The physician stated he would review the residents on the gel medication and make sure their orders reflected the correct dose to be used.</p> <p>During an interview on 01/5/12 at 5:30 PM, Licensed Nurse (LN) #1 revealed she had applied the gel medication to the resident "several times." The nurse said she was unaware of a dosing guide and stated, "I just put some on my gloved hand and applied it to his back." LN #1 said, "I was not aware there was a dosing to it" and said the doctor did not write any specific dosing in his order.</p> <p>Interview with Resident #88 on 01/06/12 at 10:35 AM revealed he had only been on the medication for a few weeks but thought the gel medication helped "some." During the interview, the resident stated he had suffered a stroke "probably two years ago." When asked if staff monitored his blood pressure, the resident said staff checked his blood pressure on a "pretty regular" basis and said he had no recent problems with his blood</p>	F 309			

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F 309	Continued From page 3 pressures.  During an interview on 01/06/12 at 10:50 AM, LN #2 stated she had applied the gel medication to the resident and had used the medication's dosing guide "but I didn't know how much to use." The nurse said she was actually using less than the smallest amount indicated on the dosing guide. LN#2 indicated she normally clarified orders she questioned and said the medication order should have been clarified. The nurse revealed she thought about asking the doctor but the resident had told her the doctor said to use a small amount to the lumbar area so she thought she "was doing the right thing by using a little bit on the dosing guide."  Interview with the Director of Nursing (DON) on 01/06/12 at 3:15 PM revealed she was unaware of dosing parameters for the Voltaren Gel until it was brought to her attention on 01/04/12. The DON also confirmed none of Resident #88's blood pressures that were taken since he began the gel medication needed or received medical attention.	F 309			
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, resident and staff	F 312	Resident #8 and #4 had no negative outcomes.  1. Resident #8's facial hairs were shaved and fingernails were trimmed and cleaned. 2. Resident #4's toenails were trimmed, by the Director of Nursing.  For residents with the potential to be	01-05-12  01-05-12	

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F 312	<p>Continued From page 4</p> <p>interviews and record review the facility failed to provide nail care for two (2) of four (4) sampled residents (Residents #4 and #8), and to remove facial hair for one (1) of ten (10) sampled residents (Resident #8) dependent on staff for personal care.</p> <p>The findings are:</p> <p>1. Resident #8 was admitted to the facility with diagnoses including Congestive Heart Failure, Diabetes Mellitus, and Osteoarthritis. A quarterly Minimum Data Set (MDS) dated 10/12/11 indicated Resident #8 had moderately impaired cognition and was able to make her needs known. In addition, Resident #8 required extensive assistance with personal hygiene and bathing. The quarterly MDS further noted rejection of care was not exhibited. Review of the shower schedule revealed Resident #8 was scheduled to receive showers every Wednesday and Saturday.</p> <p>The current care plan for personal hygiene stated Resident #8 required extensive assistance to meet her personal hygiene needs. The goal was for Resident #8 to have her personal hygiene needs met daily through the next review on 02/20/12.</p> <p>Resident #8's care guide dated 12/16/11, utilized by the nursing assistants, indicated the resident was to receive nail care on bath day. The care guide further stated the "diabetic" nurse was to provide nail care.</p> <p>Observations made during a resident interview on 01/04/12 at 11:42 AM revealed Resident #8's</p>	F 312	<p>affected, the following actions were implemented:</p> <ol style="list-style-type: none"> <li>100% audit of all residents was performed for facial hair, toenails and fingernails.</li> <li>No other residents were observed to be in need of facial hair or nail care.</li> </ol> <p>Resident fingernails and toenails are checked bi-weekly by the CNA at the time of their full bath. Licensed Nurses are responsible for monitoring this process.</p> <p>Facial hair is removed daily as needed by the CNA. Licensed Nurses are responsible for monitoring this process.</p> <p>All nursing staff members were re-in-serviced regarding fingernail and toenail care and removal of unwanted facial hair for residents who require assistance.</p> <p>The Director of Nursing or Assistant Director of Nursing will visually audit 5 residents weekly for 4 weeks, then, 5 residents every 2 weeks for 2 months for nail care and facial hair needs.</p> <p>The Director of Nursing is responsible for compliance. Audit reports will be submitted to the Quality Assurance Committee monthly for three months.</p>	01-12-12  01-12-12  01-12-12  01-31-12

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F 312	<p>Continued From page 5</p> <p>finger nails were long with brown debris noted under all ten finger nails and multiple facial hairs were approximately 1/4 of an inch in length. Resident #8 stated the nursing assistants "sometimes" provided nail care and removed facial hair with her shower. Resident #8 further stated she would like to have her finger nails cleaned/trimmed and her facial hair removed. A subsequent observation on 01/05/12 at 1:15 PM revealed Resident #8 holding cookie in her left hand and taking a bite. All ten finger nails were long with brown debris noted and multiple facial hairs were approximately 1/4 of an inch in length. Resident #8 stated she had received a shower on 01/04/12 but nail care was not provided and her facial hairs had not been removed. An observation on 01/06/12 at 12:40 PM revealed Resident #8's finger nails were long with brown debris noted under all ten finger nails and multiple facial hairs were approximately 1/4 of an inch in length.</p> <p>During an interview on 01/06/12 at 1:35 PM nursing assistant (NA) #1 confirmed she had showered Resident #8 on 01/04/12. NA #1 stated she usually cleaned under residents finger nails and removed facial hair with their shower. NA #1 indicated NAs were not allowed to trim diabetic residents nails. The interview further revealed NA #1 could not recall if she cleaned under Resident #8's finger nails or removed her facial hair during her shower on 01/04/12.</p> <p>An interview was conducted with the Director of Nursing (DON) on 01/06/12 at 1:45 PM. During the interview the DON stated she expected NAs to clean under residents finger nails and remove facial hair with showers. The DON further stated</p>	F 312	The Committee will initiate further recommendations if appropriate.		

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F 312	<p>Continued From page 6</p> <p>NAs could file diabetic residents nails but expected licensed nursing staff to monitor and trim diabetic residents fingernails.</p> <p>During a follow up interview on 01/06/12 at 2:30 PM the DON observed Resident #8's finger nails and facial hair. The DON asked Resident #8 if she liked her finger nails long and Resident #8 replied, "Not that long." The DON indicated to Resident #8 a staff member would provide nail care and remove her facial hair.</p> <p>2. Resident #4 was admitted to the facility with diagnoses including Diabetes Mellitus, Chronic Kidney Disease and Osteoporosis. An admission Minimum Data Set (MDS) dated 09/21/11 indicated Resident #4 was cognitively intact and able to make his needs known. In addition, Resident #4 was totally dependent on two (2) or more staff for personal hygiene and bathing.</p> <p>The most recent care plan for personal hygiene stated Resident #4 required extensive assistance to meet his personal hygiene needs. The interventions stated his hygiene needs would be met daily by staff.</p> <p>During a resident interview on 01/03/12 at 12:33 PM Resident #4 wriggled his feet out of his shoes and asked surveyor to look at his toenails. Resident #4 stated he has asked numerous staff members to trim his toenails over the past three months and they still haven't been trimmed. The toenails on both great toes extended approximately 1/2 of an inch beyond the end of the toes and the other eight toenails were long and jagged. None of the toenails were unusually thick.</p>	F 312			



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F 312	Continued From page 7 Observation of Resident #4's toenails on 01/05/12 at 4:50 PM with the Director of Nursing (DON) revealed the toenails on both great toes extended approximately 1/2 of an inch beyond the end of the toes and the other eight toenails were long and jagged. None of the toenails were unusually thick. Resident #4 stated they felt like they stuck against the end of his bedroom slippers.  Observation of Resident #4's toenails on 01/06/12 at 9:10 AM with the DON revealed the toenails had been trimmed and had even, regular edges. The resident stated: "they feel so much better."  An interview was conducted with the Director of Nursing (DON) on 01/05/12 at 2:00 PM. During the interview the DON stated she preferred for the podiatrist to cut the toenails of residents with diabetes. She further stated staff had not reported any concerns to her about problems with his toenails.  During a follow up interview on 01/05/12 at 5:00 PM the DON stated she thought a nurse could trim Resident #4's toenails. The DON further stated she would ensure his toenails were trimmed right away.  During an interview on 01/06/12 at 2:04 PM nursing assistant (NA #2) stated she has provided care for Resident #4 for about two months. NA #2 stated she doesn't cut his toenails because he has diabetes. She stated Resident #4 asked to have his toenails cut about two weeks ago and she told the nurse. She stated today is the first day she's been assigned to provide care for him since that time.	F 312		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=E	<p>Continued From page 8</p> <p><b>PREVENT/HEAL PRESSURE SORES</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to identify or initiate treatment of a facility acquired pressure ulcer until necrotic tissue had developed in the wound for one (1) of three (3) sampled residents. (Resident #85)</p> <p>The findings are:</p> <p>Resident #85 was admitted to the facility on 06/27/11 with diagnoses including; Alzheimer's Disease, Peripheral Vascular Disease, Venous Insufficiency, Kidney Disease and Failure to Thrive. Review of the resident's 06/27/11 skin risk assessment revealed she did not have any skin break down, but was assessed as being at high risk for pressure ulcers.</p> <p>Review of the resident's Minimum Data Set (MDS) dated 07/04/11 revealed she did not have pressure ulcers present, had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required</p>	F 314	<p>Resident #85's pressure ulcer was identified on 09/10/2011 and treatment was immediately initiated, and physician order's for treatment were obtained.</p> <p>For residents with the potential to be affected:</p> <ol style="list-style-type: none"> <li>1. Each resident is assessed at admission for skin breakdown risks and reassessed weekly thereafter for a total of 4 weeks.</li> <li>2. Residents identified as being at risk have documented care plans with appropriate interventions which are updated as needed.</li> <li>3. Weekly visual skin checks are completed by the licensed nurse.</li> <li>4. Nurse aides check skin concerns during showers, incontinence care, turn and repositioning, and communicate concerns to the licensed nurse. Licensed nurses perform weekly skin assessments on each resident as assigned.</li> <li>5. All nursing staff members are in-serviced annually regarding skin observation.</li> </ol> <p>All nursing staff members were re-in-serviced on the facilities procedures listed</p>	09-11-11	

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F 314	<p>Continued From page 9</p> <p>staff assistance with activities of daily living (ADLs) including; bed mobility, transfers, personal hygiene and toilet use.</p> <p>Review of Resident #85's "Pressure Ulcers" Care Area Assessment (CAA) of 07/08/11 specified; "CAA triggered d/t (due to) assistance needed with ADL's and incontinence. Resident has no pressure areas at this time. Incontinence care provided by staff. Assist needed with all ADL's. Pressure reducing mattress in place. Up in geri chair when OOB (out of bed)." The CAA also specified that a care plan would be developed because the resident was "At risk for breakdown".</p> <p>Review of Resident #85's care plan revealed a "Focus", initiated on 07/06/11, which addressed the resident's skin integrity needs. The care plan specified, "Skin Integrity needs- Monitor skin during a.m. &amp; p.m. care, R/T (related to): Cognitive Impairment, Uses adult briefs/pads." There were no goals or evaluation dates noted for this focus care plan area. Care plan interventions included; Turn and reposition in bed on care rounds and as needed, check/change and provide peri-care with each incontinent episode, observe skin daily during care and report findings to nurse.</p> <p>Review of direct care documentation from 09/08/11 to 09/10/11 revealed Resident #85 was incontinent of bowel and bladder and dependent on staff for transfers.</p> <p>Review of a 09/10/11 nursing skin integrity progress note for Resident #85 revealed the following: "Resident has developed an open wound on coccyx approximately 1.3 cm wide and</p>	F 314	<p>above.</p> <p>The Director of Nursing or Assistant Director of Nursing will perform complete skin assessments on 3 dependent residents weekly for 4 weeks, then 3 residents every other week for 4 weeks.</p> <p>The Director of Nursing is responsible for compliance. Findings of these audits will be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate.</p>	<p>01-12-12</p> <p>01-31-12</p>	

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F 314	<p>Continued From page 10</p> <p>1.5 cm long. Wound has some necrotic tissue on the surrounding edges and a thin layer of slough over the center. Area around wound is darkened in color. Wound was cleaned with NS (normal saline) and antibiotic ointment was applied. Wound was covered with biatain."</p> <p>On 09/10/11 a physician's order was written to initiate treatment to an open area on Resident #85's coccyx area.</p> <p>On 01/06/12 at 9:25 AM Resident #85's coccyx pressure ulcer was observed as staff performed a treatment to the ulcer. The resident's coccyx pressure ulcer was observed to be four (4) centimeters in size with no necrosis present. After this observation the facility's treatment nurse stated that Resident #85's coccyx ulcer had a lot of necrosis when treatments were initiated in September 2011, but was now healing well.</p> <p>On 01/06/12 at 9:27 AM the facility's Director of Nursing (DON) was interviewed. The DON stated that Resident #85's coccyx pressure ulcer was facility acquired and was discovered by staff on 09/10/11.</p> <p>Further interview with the DON on 01/06/12 at 10:00 AM revealed that she expected direct care staff to report any changes in a resident's skin condition to a nurse for assessment. The DON confirmed that Resident #85 was dependent on staff for care and would have expected nursing staff to have identified and reported that the resident's coccyx area had signs of breakdown before it progressed to an opened area which measured 1.3 cm by 1.5 cm with necrotic tissue present as first documented by nursing staff on</p>	F 314			

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F 314	Continued From page 11 09/10/11.	F 314			
F 371 SS=F	<p>On 01/06/12 at 3:35 PM Nursing Assistant (NA) #3, who regularly provided care to Resident #85 during the previous four (4) months, was interviewed. NA #3 stated that Resident #85 required total care including; turning, repositioning and incontinence care. The NA stated that he checked on Resident #85 every two hours and provided care as needed. NA #3 further explained that nursing assistants were expected to report any changes in a resident's skin condition to a nurse as soon as possible for follow-up.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove foods with expired manufacturer's expiration dates from storage, properly store refrigerated foods and ensure that food preparation and service equipment was clean and dry when stored.</p> <p>The findings are:</p>	F 371	<p>1. No resident had a negative outcome.</p> <p>a. The kitchen's walk-in refrigerator was audited and all expired products (milk, buttermilk, cream cheese) were discarded immediately. 01-03-12</p> <p>b. See (a.) above. 01-03-12</p> <p>c. The margarine noted to be on the tray line at 10:12 am on 01-05-12, was discarded immediately. 01-05-12</p> <p>2. No resident had a negative outcome.</p> <p>a. The six pans with minor moisture droplets were immediately re-washed and air dried. 01-05-12</p> <p>b. The refrigerator and microwave in the C Hall employee lounge were</p>		



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F 371	<p>Continued From page 13</p> <p>kitchen's tray line area revealed a container which contained more than twenty (20) individual packages of margarine was stored on a counter top at room temperature. Review of information on the label of these margarine packages specified to "Keep refrigerated". Temperature monitoring of one (1) of these packages of margarine revealed that it had an internal temperature of sixty-five (65) degrees Fahrenheit.</p> <p>Interview on 01/05/12 at 10:12 AM, with the kitchen's morning cook, revealed the margarine in the container was used during the 01/05/12 breakfast tray line service and had remained out at room temperature since the tray line concluded at around 8:35 AM.</p> <p>Interview with the facility's Dietary Manager (DM) on 01/05/12 at 10:15 AM revealed the margarine should be refrigerated in order to keep its internal temperature at forty-one (41) degrees Fahrenheit or below.</p> <p>2. Observations of food preparation and storage equipment in the facility's kitchen and in the facility's C-Hall nourishment room revealed the following equipment was not dry or not clean when stored for use:</p> <p>a. Observations of the kitchen's food preparation and service equipment on 01/05/12 at 10:00 AM revealed that six (6) of ten (10) pans, that were checked for cleanliness, contained moisture and were not dry. These wet pans were observed stacked onto other preparation pans and were stored ready for use.</p> <p>Interview with the facility's Dietary Manager (DM)</p>	F 371	<p>be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate.</p> <p>4. Housekeeping staff members were in-serviced by the Housekeeping Supervisor. The in-service covered the topics of proper sanitation/cleaning of nourishment room equipment (refrigerator, microwave).</p> <p>5. The Housekeeping Supervisor will audit the nourishment room equipment twice a week for four weeks and then once a week for two months.</p> <p>The Housekeeping Supervisor is responsible for compliance. Findings of these audits will be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate.</p>	01-09-12	01-31-12

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F 371	Continued From page 14 on 01/05/12 at 10:00 AM revealed staff should make sure that food preparation and service pans are dry prior to storing them for use.  b. Observations on 01/06/12 at 3:35 PM of the resident refrigerator in the facility's C-Hall Nourishment room revealed it was unclean with dried substances on shelves and its door compartment. Observations of the microwave in this nourishment room revealed it was unclean with dried substances on its inner cooking compartment.  Interview with the Nursing Assistant (NA) #4 on 01/06/12 at 3:40 PM revealed the microwave in the C-Hall Nourishment room was utilized to reheat resident foods when needed.  Interview with the facility's Director of Nursing (DON) on 01/06/12 at 4:15 PM revealed that the facility's housekeeping staff was responsible for cleaning the refrigerator and microwave in the C-Hall nourishment room.	F 371			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412	Resident #82 had no negative outcome and was transported to the Dentist on 01-10-12 for adjustment of his dentures.  For residents with the potential to be affected the following actions were implemented:  1. A 100% audit of all orders from 11-29-11 till 01-06-12 was completed, finding no other	01-10-12	



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F 412	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review the facility failed to provide dental services as ordered for one (1) of three (3) residents reviewed for dental care. (Resident #82).</p> <p>The findings are:</p> <p>Resident #82 was admitted to the facility on 10/22/10 with a diagnosis of Cerebral Vascular Accident (CVA) with hemiplegia. Review of the resident's medical record revealed his most recent dental consult was performed on 06/16/11. The resident was assessed on his Annual Minimum Data Set (MDS) of 10/20/11 as having no cognitive deficits and having no facial pain, discomfort or difficulty with chewing.</p> <p>A physician's note dated 11/29/11 specified that Resident #82 had mouth soreness due to ulcers in his mouth that were caused by his lower dentures. The note specified that the resident to go without his lower denture for a week and then was to have a dental consult for relining of the denture.</p> <p>On 11/29/11 a physician's order was written for Resident #82 to keep his teeth out of his mouth for one week and to review with dentist as soon as possible.</p> <p>Interview with Resident #82 on 01/04/12 at 9:20 AM revealed that he experienced discomfort in his mouth due to his dentures not fitting correctly during the past couple months. The resident stated that staff was aware of his need to see a</p>	F 412	<p>dental consults ordered.</p> <p>2. Licensed nurses were in-serviced regarding follow through of physician consult order process.</p> <p>The following measures/systemic changes were implemented:</p> <ol style="list-style-type: none"> <li>1. The facility's physician consult order process was revised to include an additional review of consult orders by the designated Unit MDS Nurse.</li> <li>2. All licensed nurses were in-serviced on the revised procedure.</li> </ol> <p>The Director of Nursing or Assistant Director of Nursing will audit 100% of physician orders weekly times 4 weeks for consult referrals, then every other week for 4 weeks then, monthly for 2 months.</p> <p>The Director of Nursing is responsible for compliance. Findings of these audits will be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate.</p>	01-06-12	01-10-12
				01-12-12	01-12-12
					01-31-12

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F 412	<p>Continued From page 16</p> <p>dentist to have his dentures adjusted, but nothing had been done yet. The resident specified that he was last seen by a dentist about four to five months ago. The resident stated at times he was unable to chew the foods that he was served at meals due to his mouth pain and would request to be served a soft sandwich that he was able to eat without experiencing discomfort.</p> <p>Observations on 01/04/12 at 9:24 AM revealed Resident #82 had his lower denture in place and pointed to the right side of his mouth where his lower denture was causing him discomfort.</p> <p>On 01/6/12 at 1:10 PM the facility's Director of Nursing (DON) was interviewed. The DON stated that Resident #82 had not been seen by a dentist since June 2011. The DON explained that staff had not followed up with a dentist, as ordered by the physician on 11/28/11, to address the resident's dentures not fitting properly. The DON stated that the dentist did not come to the facility as scheduled during the month of December 2011 and staff had not made Resident #82 an appointment to be seen by a dentist. The DON further stated that Resident #82's payment source was Medicaid and staff would schedule an appointment for him to be seen by a dentist as soon as possible.</p> <p>Interview with Licensed Nurse (LN) #4 on 01/06/12 at 3:58 PM revealed that Resident #82 had previously voiced concerns to her regarding his dentures and having mouth discomfort, but the resident had not been seen by a dentist since the physician's order was written on 11/29/11.</p>	F 412			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			



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F 431	<p>Continued From page 18</p> <p>interviews, the facility failed to remove two expired bottles of medication from two of four medication carts and one vial of Tuberculin test agent from one of two medication rooms. In addition, the facility failed to provide accurate labeling to facilitate consideration of precautions and safe administration for one of one residents using Voltaren Gel. (Resident #88)</p> <p>The findings are:</p> <p>1. Review of the manufacturer's instructions for Novolog insulin revealed the following: "After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight."</p> <p>Observation of the A-hall medication cart on 01/04/12 at 10:40 AM with the Director of Nursing (DON) present revealed one vial of Novolog insulin opened 11/25/11.</p> <p>Interview with the Director of Nursing (DON) on 01/04/12 at 1:40 PM revealed the medication rooms and medication carts were normally checked during the first week of every month to coincide with the consultant pharmacist's monthly visits.</p> <p>2. Observation of the B-hall medication cart on 01/04/12 at 1:30 PM revealed:</p> <p>*One opened bottle of Calcium with Vitamin D, 60 tablet count, with a manufacturer's expiration date of 07/11. The bottle was dated with a hand-written 01/03/12 and there were 57 tablets inside.</p> <p>*One unboxed tube of Voltaren Gel in a plastic</p>	F 431	<p>expiration dates of insulin and Tubersol prior to withdrawal and administration of the medication. In addition, licensed nurses and medication aides were in-serviced on administering Voltaren Gel according to the manufacturer's recommendation, and on how to use the administration grid applicator provided by the manufacturer, and per physician orders.</p> <p>2. The 11-7 nurses will audit Medication Carts and medication refrigerators 5 days a week for 3 weeks for expired medications.</p> <p>The Director of Nursing or Assistant Director of Nursing will audit all medication carts and medication refrigerators weekly for 4 weeks, then every 2 weeks for 2 months.</p> <p>The Director of Nursing is responsible for compliance. Findings of these audits will be submitted to the Quality Assurance Committee monthly for three months. The Committee will initiate further recommendations if appropriate.</p>	01-12-12 01-31-12 01-31-12	

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F 431	<p>Continued From page 19</p> <p>bag. There was no dosing guide included in the bag with the medication. The Voltaren Gel (a non-steroidal anti-inflammatory topical medication) was labeled by the pharmacy with the following directions: "Apply to lumbar for pain four times a day."</p> <p>During an interview on 01/04/12 at 2:51 PM Licensed Nurse (LN) #2 stated she normally checked expiration dates before she gave medications and said she had given calcium to one resident. The nurse stated, "I didn't check because I kind of assumed since it was in there [the medication cart] it was ok."</p> <p>Interview on 01/04/12 at 2:55 PM revealed the Pharmacy Consultant was unaware Voltaren gel should have a dose specified and/or came with a dosing guide. After checking with an on-line pharmacy reference, the pharmacist called her pharmacy manager and was told they were also unaware of the information about the gel medication. The pharmacist said the pharmacy manager informed her they would no longer fill an order for Voltaren Gel if the order did not specify grams to be used and the order would need to be clarified by the physician.</p> <p>3. Review of the manufacturer's instructions for Tubersol revealed the following: "A vial of Tubersol which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency." The instructions further stated: "Failure to store and handle TUBERSOL as recommended will result in a loss of potency and inaccurate test results."</p>	F 431			

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F 431	Continued From page 20 Observation of the B-hall medication refrigerator on 01/05/12 at 9:35 AM revealed one of five vials of Tubersol (Tuberculin protein purified derivative) was opened but undated.  During an interview on 01/05/12 at 10:20 AM, Licensed Nurse (LN) #3 confirmed the vial was undated and said the medication was supposed to be dated when opened.  Interview with the Director of Nursing (DON) on 01/05/12 at 10:21 AM revealed nurses were expected to date the vials when opened. The DON also stated if nurses found a vial opened but undated they should discard it and get a new one.  Further interview with the DON on 01/06/12 at 3:00 PM revealed nurses were expected to check expiration dates when opening and giving medications. During continued interview, at 3:15 PM the DON revealed she was unaware of the dosing parameters for the Voltaren Gel until it was brought to her attention during the survey.	F 431			
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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 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,	F 441	No resident had negative outcomes.  For residents with the potential to have been affected the following actions were implemented:  1. All licensed nurses were re-in-serviced regarding the cleaning and disinfecting of glucometers according to the manufacturer's recommendations.  2. Individual resident glucometers were ordered and placed in the resident's	01-04-12	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345351</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN CARE OF SALUDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 ESSEOLA CIRCLE SALUDA, NC 28773</b>		
(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 441	<p>Continued From page 22</p> <p>Sampling-Capillary (Finger Sticks)" revised April 2010 included directions to clean and disinfect glucometers after each use according to manufacturer's instructions.</p> <p>Review of the facility's glucometer manufacturer's directions for disinfecting the glucometer, included: To disinfect the meter, dilute 1 milliliter (ml) of household bleach (5%-6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution.</p> <p>Review of the facility's adopted protocol (undated) used during Blood Borne Pathogen in- service training revealed the following recommendation: "Disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim, or a dilute bleach of solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration."</p> <p>On 01/04/12 from 5:10 PM to 5:40 PM, Licensed Nurse (LN) #1 was continuously observed during medication administration. At 5:13 PM, after completing a finger stick blood sugar on Resident # 59, LN #1 exited the resident's room and placed the glucometer on top of the medication cart without disinfecting the unit. LN #1 removed her gloves, washed her hands, and proceeded to administer several oral medications and provided other services for Resident #59.</p> <p>On 01/04/12 at 5:40 PM, LN #1 prepared to obtain a FSBS for Resident #74. LN #1 picked up the glucometer from the top of the medication cart, wiped it with an alcohol wipe, inserted a test</p>	F 441			



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NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF SALUDA		STREET ADDRESS, CITY, STATE, ZIP CODE 501 ESSEOLA CIRCLE SALUDA, NC 28773		
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F 441	<p>Continued From page 23</p> <p>strip into the glucometer, picked up a lancet, turned away from the medication cart, knocked on Resident # 74's door and started to the room to obtain a finger stick blood sugar. LN #1 was stopped prior to utilizing the contaminated glucometer.</p> <p>On 01/04/12 at 5:43 PM an interview was conducted with LN #1 who confirmed the glucometer intended for use on Resident #74 was not disinfected after use on Resident #59. LN #1 stated she normally disinfected the glucometer at the end of her shift and would wipe it down at that time with a germicidal wipe. LN #1 stated she was thought wiping it with alcohol was acceptable between residents. LN #1 stated that her usual practice was to disinfect the glucometer and the entire medication cart at the end of her shift.</p> <p>During an interview on 01/04/12 at 5:45 PM, the Director of Nursing (DON) stated all LN staff were trained and required to disinfect the glucometer before/after use on each resident. The DON stated disinfectant wipes were kept on the medication cart and proceeded to look in the cart but no disinfectant wipes were found on the cart. At this time LN #1 stated the wipes were at the nurse's station.</p> <p>During a follow up interview on 01/04/12 at 6:15 PM, the DON stated that nurses were expected to disinfect the glucometers between each resident. The DON stated cleaning glucometers was included in infection control training as part of orientation.</p> <p>During an interview on 01/06/12 at 8:50 AM, the SDC (Staff Development Coordinator) stated all</p>	F 441		

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F 441	Continued From page 24 new personnel had to watch a video on BBP (Blood Borne Pathogens) and were re-inserviced once a year. The SDC further stated she expected staff to disinfect glucometers with specified germicidal wipes at the beginning of their shift and allow them to dry 3-5 minutes and then repeat the disinfection process between each resident.	F 441		