STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record review, the facility failed to preserve dignity for 2 of 2 sampled dependent residents by not providing consistent grooming (Resident #68) and failing to discreetly label clothing (Resident #86). The findings are: 1. Resident # 68 was admitted to the facility with diagnoses which included macular degeneration, hearing loss, subdural hemorrhage, osteoporosis and Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 10/01/12 documented Resident #68 was highly impaired in hearing, required extensive assistance for toilet use and personal hygiene and was usually understood. Review of Resident #68's current care plan revealed the following: extensive assistance was needed for activities of daily living to include personal hygiene and toileting. An interview with a family member of Resident #68 on 12/03/12 at 10:30 AM revealed Resident #68 required a special size of brief for a fit that kept her outer garments dry. The family member stated they had consulted with the Admissions Staff Director about their concern of Resident #	F 241	***Disclaimer*** ***This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted to meet requirements established by state and federal law.*** It is the policy of Autumn Care of Saluda to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Autumn Care of Saluda provides briefs or protective adult underwear for the purpose of promoting privacy and dignity regarding a resident's incontinence. Briefs and protective underwear are obtained from Covidien. Briefs are available in sizes small through XX-large. Adult protective underwear is available in small/medium, large, XL and XXL sizes. Resident sizes are determined at the time of admission using measuring methods designed by Covidien, resident evaluation and resident preferences. Staff receive training in sizing residents. In addition, Covidien Incontinence Care Nurse Consultants visit the facility at least annually to determine that all residents are sized properly. Covidien staff are also available on an as needed basis to assist Autumn Care of Saluda in sizing and/or training issues. Example 1 No resident was harmed or negatively impacted.	

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

Glenn D. Pace | ADMINISTRATOR | 12-30-12

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.

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F 241	Continued From page 1 68 being wet due to inaccurate fit of the briefs used by the facility. The Admissions Director found a brief that would fit and the facility had been providing it but not consistently. The family member further stated on several occasions when they came to take Resident #68 for an outing or to visit she would smell of urine and her outer clothing would be wet. The family member noted on those occasions Resident #68 would be in the wrong size brief. The family member also confirmed they did her laundry and often found it wet with a urine odor. The family member stated Resident #68 always kept herself immaculate. Observation was made on 12/03/12 at 10:45 AM of Resident #68's laundry hamper. The clothes within smelled strongly of urine and appeared wet. The closet of Resident #68 contained briefs in the facility size of small/medium. A sign was observed posted inside the closet documenting the resident was to have size small briefs. Observation made on 12/04/12 at 9:30 AM of Resident #68's closet confirmed the facility size small/medium were in use. Interview on 12/04/12 at 9:35 AM with Nurse Aide (NA) #1, who provided incontinence care for Resident #68, confirmed the briefs in Resident #68's closet were the facility size small/medium. NA #1 confirmed the sign posted within the closet documented size small. NA #1 also stated the resident's garments stay dry with the smaller size. Interview on 12/04/12 at 10:50 AM with the staff member in charge of ordering supplies revealed the briefs in Resident #68's closet were the facility	F 241	Continued From page 1 Resident #68 had been sized according to facility policy and procedure using sizing techniques provided by Covidien. According to the Covidien Adult Protective Underwear Sizing procedure, the resident was determined to be a size small/medium. As noted by the surveyor, resident #68's closet contained protective underwear size small/medium, in accordance with facility policy and procedure. In addition, the surveyor noted that a sign indicating that the resident used size small/medium protective underwear was posted inside the resident's closet door, in accordance with facility procedure. To enhance currently compliant operations and under the direction of the Director of Nurses: 1) The Covidien Incontinence Care Nurse Consultant was contacted and a facility visit was scheduled for the first available opening which is January 8, 2013. As an interim step, the Covidien Consultant over nighted copies of all training and measuring supplies and instructions related to their incontinence products. 12-10-12 2) The resident was measured again by the Director of Nurses and found to be appropriate for small/medium size protective underwear based on the information provided by Covidien. 12-10-12 3) The Director of Nurses will contact the resident's responsible party and schedule a care plan meeting for the purpose of discussing incontinence care products and dignity issues. 12-28-12 4) Nurse Assistants will be in-serviced regarding measuring techniques for protective briefs and adult protective underwear. 12-10-12 Actions to determine if other residents were	

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F 241	Continued From page 2 size small/medium and that the sign inside the closet documented the resident was to have a small size. The staff member noted staff had been buying the size small briefs when told they were needed for Resident #68. She confirmed there was no system in place to ensure the size small were available for use by the resident and expected NAs or family members to tell central supply when they needed to go purchase more. Interview on 12/05/12 at 9:00 AM with the Admissions Director revealed Resident #68's family had consulted with her on the issue of keeping the Resident well groomed by providing a best fit brief. She confirmed she had been purchasing them when told by NAs or family that more were needed but there was no current system in place to ensure the correct size briefs were available for use by Resident #68. Interview on 12/06/12 at 9:30 AM with the Director of Nurses (DON) revealed her expectations were for the staff to assist Resident #68's to be well groomed and without odors. The DON confirmed she would expect the resident to be supplied with her needed size of briefs. 2. Resident #86 was admitted to the facility with diagnoses which included dementia with behavioral disturbances and atrial fibrillation. The most recent annual Minimum Data Set (MDS) dated 08/09/12 documented Resident #86 as sometimes understanding others and sometimes being understood with severely impaired cognition. Resident #86 required extensive assistance with dressing with one person physical assistance. A review of her current care plan revealed Resident #86 was to have extensive	F 241	Continued From page 2 affected include: 1) The Director of Nurses or designee will audit all residents to determine if they have the correct type and size of incontinent product designated for that resident. 2) The Covidien Incontinence Care Nurse Consultants will do a full sizing audit of all residents on 01-08-13. 3) The Director of Nurses will contact any resident and/or responsible party determined to need a size or style other than currently being used to discuss dignity issues related to proper incontinence protection issues. The following monitoring activities will be put into place: 1) The Director of Nurses or designee will review the results of the Nurse Consultant's measurements to be done on January 8, 2013 for discrepancies in sizes. 2) The Director of Nurses or designee will review all new resident's for proper sizing for 30 days and then once monthly for three months. Findings will be submitted to the Quality Assurance Committee for review. Example 2 No resident was harmed or negatively impacted by this example It is the policy of Autumn Care of Saluda to maintain or enhance each resident's dignity and respect in full recognition of his or her individuality. This includes encouraging and assisting residents to dress in their own clothes appropriate to the time of day and individual preferences and in labeling each resident's clothing in a way that respects his or her dignity. Autumn Care of Saluda provides a clothing labeling system that uses printed name	12-07-12 12-07-12 12-07-12 12-07-12 12-06-12

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F 241	Continued From page 3 assistance for dressing. Observation on 12/04/12 at 10:14 AM was made of Resident #86 in the resident lounge area by the front door of the facility. The Resident was observerd asleep in a wheelchair and her right pant leg gathered up in the chair up to her right knee and her left pant leg gathered up to the middle of her left calf . Her last name was noted in permanent black ink in approximately 3 inch tall letters up the front and length of her knee high compression hose along both of her shins. Observation on 12/05/12 at 11:55 AM was made of Resident #86 sitting in a wheelchair at the nursing station for the A and B corridors, awake and responsive. Resident #86 had her right leg crossed over her left leg which gathered her pants leg at her knee and revealed her last name in permanent black ink in approximately 3 inch tall letters up the front and length of her knee high compression hose along her shin. The last few letters of her name were visible on the compression hose at the cuff of her left pant leg. Observation on 12/05/12 at 2:44 PM was made of Resident #86 in a wheelchair in the dining room off the D corridor watching television with two other residents, awake and responsive. The last letters of her name were noted in permanent black ink in approximately 3 inch tall letters on compression hose at the cuffs of her pants legs. Observation on 12/06/12 at 9:15 AM revealed Resident #86 sitting in a wheelchair in the resident lounge are by the front door of the facility, awake and responsive. Resident #86 was wearing light blue leisure slacks which covered	F 241	Continued From page 3 labels which are then pressed to the inside of resident's clothing using a commercial heat printing process. Residents and/or their responsible parties are informed at admission that the facility will assist with labeling a resident's clothing if they so desire. Residents and/or responsible parties are also informed that any labeling done by family members, etc., should be done in such a manner that it is permanent, but not visible to other residents, family or visitors, as a means of preserving the resident's dignity. To enhance currently compliant operations, and under the direction of the Director of Nursing: 1) The TED hose referred to in the example were removed and new TED hose were supplied. 2) The Director of Nurses contacted the resident's responsible party regarding the facility policy for marking resident clothing and discussed the issue raised by the surveyor. The responsible party stated that she had placed her mother's name on the outside of her mother's holiday vest and a variety of other clothing items and that she preferred her mother's clothing be marked on the outside where it was visible. The responsible party indicated that she would like the clothing currently in circulation to continue to be used. She also stated that in the future she would comply with facility policy regarding the marking of personal clothing. For residents with the potential to be affected, the following action was taken: 1) Nursing staff were in-serviced on new	12-06-12 12-06-12 12-10-12

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F 241	Continued From page 4 white compression hose stockings, with only the ankle and tops of her feet exposed with no name labeling visible. Resident #86 was wearing a sleeveless light blue holiday vest with stitched snowmen, with her first and last name marked in permanent black ink in approximately 1 inch tall letters on the front of her vest at her right shoulder. Interview on 12/06/12 at 12:40 PM with Nurse Aide (NA) #2 revealed she was assigned that day to care for Resident #86. NA #2 stated all resident clothing was labeled with their names to prevent it from getting mixed up in the laundry with the only exception for clothing that families had indicated they would launder at home. NA #2 stated clothing was normally labeled inside the collar or inside the waistband of pants and socks were usually labeled on the soles. NA #2 stated Resident #86 was wearing a light blue holiday vest with her name in permanent black ink visible on front of the resident's right shoulder and she did not know who put the name label in that location. Interview on 12/06/12 at 3:44 PM with the Director of Nursing (DON) revealed her expectation was to encourage placement of name labels on resident clothing regardless if laundered by the facility or the family. The DON stated that name labels should be placed on the inside of collars and pants' waistbands and on compression hose around the top band. The DON stated it is not appropriate for name labels to be visible on clothing to other residents, family and visitors. If staff saw clothing with readily visible name label she expected these clothing items would be set aside and brought to family	F 241	Continued From page 4 measures put in place regarding the handling of improperly labeled or torn resident clothing. 2) Laundry Staff were in serviced on new measures put in place regarding improperly labeled or torn resident clothing. 3) Nursing staff will inspect clothing when dressing and undressing a resident. If the clothing is inappropriately labeled and/or torn, it will not be placed on the resident. Such clothing will be taken to the Laundry and put in a designated location. 4) Laundry personnel will inspect all clothing when removed from the dryer. Clothing that is damaged or inappropriately labeled will be placed in a designated location. 5) The Housekeeping/Laundry Supervisor or designee will inspect the damaged clothing and contact the resident/responsible party regarding its disposition. The following actions will be used to monitor the plan. 1) The Housekeeping/Laundry Supervisor or designee will monitor clothing leaving the Laundry two times a week for six weeks and then one time a week for 3 months. Findings will be reported to the Quality Assurance Committee for their review. 2) The Director of Nurses or designee will monitor clothing on two residents two times weekly for six weeks and then two residents one time weekly for three months. Findings will be reported to the Quality Assurance Committee.	12-10-12 12-10-12 12-10-12 12-17-12 12-17-12 12-17-12

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F 241	Continued From page 5 attention.			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain wall and ceiling surfaces in Rooms A12, B4, D1, D10 and D11. The findings are: 1. On 12/03/12 at 9:00 AM an observation of room A12 revealed an approximately 4 inch section of crushed drywall below the headboard of bed #2. In this same room on the wall alongside bed #1 were observed deep scrapes into the gypsum layer of the drywall across an area measuring approximately 6 inches by 12 inches. 2. On 12/03/12 at 1:13 PM an observation of room D10 revealed numerous drywall nails with rusted nail heads popping out of the drywall from the ceiling in the shared bathroom. 3. On 12/04/12 at 9:30 AM an observation of room D11 revealed an approximately 4 inch section of crushed drywall behind bed #1. 4. On 12/04/12 at 11:16 AM an observation of room D1 revealed an approximately 5 foot long section of vinyl baseboard missing behind the	F 253	It is the policy of Autumn Care of Saluda to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior. Autumn Care of Saluda has a full time maintenance employee whose primary responsibility is the repair and painting of wall and ceiling damage in the facility. The policy is to report room damage to the Maintenance Supervisor who then updates the priority list. Rooms are also repaired and painted at the time that a resident is relocated or discharged. In a discussion with the surveyor on 12/06/12, the administrator informed the surveyor of this policy and procedure. He also noted that the Maintenance Supervisor had been out of work due to a work related injury since 05/08/12. This had required the facility to move the employee designated for room repair and painting into the maintenance position. Due to this change, the facility had a backlog of wall repair needs. The surveyor indicated that her main concern was the lack of a written priority list of walls needing to be repaired. Example (See room numbers in citation) No resident was harmed or negatively impacted by these examples. Corrective action taken to address the examples noted in the citation includes: 1) Rooms A12, B4, D1, and D11 were repaired. 2) An audit of all resident rooms was done and a written priority list of all rooms needing repair was developed. The priority list will be maintained by the Maintenance Supervisor and updated as needed.	01-04-13 12-10-12

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F 253	Continued From page 6 headboard of bed #2. In this same area of missing vinyl baseboard was observed an approximately one half to 1 inch gap from the bottom of the drywall to its junction at the floor. An approximately 4 inch diameter hole was observed in the drywall behind the headboard to bed #1. 5. On 12/04/12 at 9:30 AM an observation of room B4 revealed deep scrapes into the gypsum layer of the drywall across an area measuring approximately 6 inches by 12 inches on the wall alongside bed #2. On 12/06/12 at 9:15 AM the Administrator and Maintenance Director were interviewed during a tour of Rooms A12, B4, D1, D10 and D11 and acknowledged the drywall conditions in these rooms. The Administrator stated he expected drywall should be intact without deep scrapes or holes. The Maintenance Director stated he expected facility staff should report to his department any scraped or broken drywall for repair.	F 253	Continued From page 6 To enhance currently compliant operations and under the direction of the Maintenance Supervisor: 1) The Maintenance Supervisor in-serviced Nursing and Housekeeping employees on the facilities policy of reporting wall/ceiling damage in the Maintenance Repair Request Book located at each nursing unit. 01-04-13 2) The Maintenance Supervisor will review the Maintenance Repair Request Book on a daily basis. Reported room damage will be repaired within 5-10 working days. 01-04-13 The following actions will be used to monitor the plan: 1) The Maintenance Supervisor will audit resident rooms for damage one time weekly for six weeks and then one time monthly for six months. 01-04-13 2) The Maintenance Supervisor will review the priority list with the Administrator for six months. 01-04-13 3) Results of the room audits will be reported to the QA Committee for their review and need for any additional action. 01-04-13
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, family and staff interviews and record review, the facility failed to	F 312	It is the policy of Autumn Care of Saluda to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Autumn Care of Saluda provides briefs or protective adult underwear for the purpose of promoting privacy and dignity regarding a resident's incontinence. Briefs and protective underwear are obtained from Covidien. Briefs are available in sizes small through XX-large. Adult protective underwear is available in small/medium,	

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F 312	Continued From page 7 provide the correct size incontinence product for 1 of 2 dependent residents (Resident #68), and failed to ensure clothing to be in good repair for 1 of 2 dependent residents reviewed for activities of daily living. (Resident #63) The findings are: 1. Resident #68 was admitted to the facility with diagnoses which included macular degeneration, hearing loss, subdural hemorrhage, osteoporosis and Alzheimers. The most recent Minimum Data Set (MDS) dated 10/01/12 documented Resident #68 was highly impaired in hearing, required extensive assistance for toilet use and personal hygiene and was usually understood. Review of Resident #68's current care plan revealed the following: extensive assistance was needed for activities of daily living to include personal hygiene and toileting. An interview with a family member of Resident #68 on 12/03/12 at 10:30 AM revealed Resident #68 required a special size of brief for a fit that kept her outer garments dry. The family member stated they had consulted with the Admissions Staff Director about their concern of Resident #68 being wet due to inaccurate fit of the briefs used by the facility. The Admissions Director found a brief that would fit and the facility had been providing it but not consistently. The family member further stated on several occasions when they came to take Resident #68 for an outing or to visit she would smell of urine and her outer clothing would be wet. The family member noted on those occasions Resident #68 would be in the wrong size brief. The family member also confirmed they did her laundry and often found it wet with urine odor. Observation was made on 12/03/12 at 10:45 AM	F 312	Continued From page 7 large, XL and XXL sizes. Resident sizes are determined at the time of admission using measuring methods designed by Covidien, resident evaluation and resident preferences. Staff receive training in sizing residents. In addition, Covidien Incontinence Care Nurse Consultants visit the facility at least annually to determine that all residents are sized properly. Covidien staff are also available on an as needed basis to assist Autumn Care of Saluda in sizing and/or training issues.No resident was harmed or negatively impacted. Resident #68 had been sized according to facility policy and procedure using sizing techniques provided by Covidien. According to the Covidien Adult Protective Underwear Sizing procedure, the resident was determined to be a size small/medium. As noted by the surveyor, resident #68's closet contained protective underwear size small/medium, in accordance with facility policy and procedure. In addition, the surveyor noted that a sign indicating that the resident used size small/medium protective underwear was posted inside the resident's closet door, in accordance with facility procedure. To enhance currently compliant operations and under the direction of the Director of Nurses: 1) The Covidien Incontinence Care Nurse Consultant was contacted and a facility visit was scheduled for the first available opening which is January 8, 2013. As an interim step, the Covidien Consultant over nighted copies of all training and measuring supplies and instructions related to their incontinence products. 2) The resident was measured again by	12-06-12 12-07-12

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F 312	Continued From page 8 of Resident #68's laundry hamper. The clothes within smelled strongly of urine and appeared wet. The closet of Resident #68 contained briefs in the facility size of small/medium. A sign was observed posted inside the closet documenting the resident was to have size small briefs. Observation made on 12/04/12 at 9:30 AM of Resident #68's closet confirmed the facility size small/medium were in use. Interview on 12/04/12 at 9:35 AM with Nurse Aide (NA) #1, who provided incontinence care for Resident #68, confirmed the briefs in Resident #68's closet were the facility size small/medium. NA #1 confirmed the sign posted within the closet documented size small. NA #1 also stated the resident's garments stay dry with the smaller size. Interview on 12/04/12 at 10:50 AM with the staff member in charge of ordering supplies revealed the briefs in Resident #68's closet were the facility size small/medium and that the sign inside the closet documented the resident was to have a small size. The staff member noted staff had been buying the size small briefs when told they were needed for Resident #68. She confirmed there was no system in place to ensure the size small were available for use by the resident and expected NA's or family members to tell central supply when they needed to go purchase more. Interview on 12/05/12 at 9:00 AM with the Admissions Director revealed	F 312	Continued From page 8 the Director of Nurses and found to be appropriate for small/medium size protective underwear based on the information provided by Covidien. 3) The Director of Nurses will contact the resident's responsible party and schedule a care plan meeting for the purpose of discussing incontinence care products and dignity issues. 4) Nurse Assistants will be in-serviced regarding measuring techniques for protective briefs and adult protective underwear. Actions to determine if other residents were affected include: 1) The Director of Nurses or designee will audit all residents to determine if they have the correct type and size of incontinent product designated for that resident. 2) The Covidien Incontinence Care Nurse Consultants will do a full sizing audit of all residents on 01-08-13. 3) The Director of Nurses will contact any resident and/or responsible party determined to need a size or style other than currently being used to discuss dignity issues related to proper incontinence protection issues. The following monitoring activities will be put into place: 1) The Director of Nurses or designee will review the results of the Nurse Consultant's measurements to be done on January 8, 2013 for discrepancies in sizes. 2) The Director of Nurses or designee will review all new resident's for proper sizing for 30 days and then once monthly for three months. Findings will be submitted to the Quality Assurance Committee for review.	12-07-12 12-10-12 12-17-12 12-07-12 12-06-12 12-06-12 12-07-12

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	345351	A. BUILDING _____ B. WING _____	12/06/2012

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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F 312	Continued From page 9 Resident #68's family had consulted with her on the issue of keeping the Resident well groomed by providing a best fit brief. She confirmed she had been purchasing them when told by NA's or family that more were needed but there was no current system in place to ensure the correct size briefs were available for use by Resident #68. Interview on 12/06/12 at 9:30 AM with the Director of Nurses (DON) revealed her expectations were for the staff to assist Resident #68 to be well groomed and without odors. The DON confirmed she would expect the resident to be supplied with her needed size of briefs.			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to prevent a significant medication error for 1 of 14 residents observed for medication administration by crushing the contents of an extended release medication capsule. (Resident #91). The findings are: A review of a facility "Do Not Crush" list of medicatic revealed the medication aspirin/extended release dipyridamole (Aggrenox) was listed as a medication that should not be crushed. Aggrenox is a time relea medication used to decrease the risk of a stroke. A review of the blister package containing the	F 333	It is the policy of Autumn Care of Saluda that residents are free of any significant medication errors. Autumn Care of Saluda retains a Pharmacy Consultant to assist with ensuring the accepted professional standards and principles which apply to professionals providing services. The Pharmacy Consultant visits the facility monthly and/or as needed to review resident related medication regimens. The Pharmacy Consultant as part of her duties, the Consultant provides regular observations of medication passes, as well as in-services on administration. In addition, the Director of Nurses and/or her designee observe medication passes on at least a monthly basis. Example—Resident #91 No resident was harmed or negatively impacted. The actions taken upon notification of the medication error were:	

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F 333	Continued From page 10 Aggrenox capsule revealed a blue sticker labeled "may pull apart/do not crush contents." A medical record was review revealed Resident # 91 was admitted to the facility with diagnoses including cerebral vascular disease and diabetes among others. Review of an annual Minimum Data Set (MDS) assessment dated 10/30/12 revealed Resident #91 was unable to make her needs known and was completely dependent on staff to perform all activities of daily living. The medical record further revealed Resident #91 received nourishment through a gastrostomy tube. On 12/04/12 at 4:10 PM an observation was made of Nurse #1 preparing medications to administer to Resident #91. Nurse #1 opened the Aggrenox capsule and placed the contents into a plastic pouch, placed the pouch into a device used to crush pills and crushed the contents of the capsule. Nurse #1 placed the medication in a cup of water and administered the medication through the gastrostomy tube using correct technique. On 12/05/12 at 4:11 PM, Nurse #1 was interviewed and revealed she had crushed the medication, confirmed it was her normal practice to crush the Aggrenox, and indicated crushing medications was the only way to get the medication through Resident # 91's gastrostomy tube. After reviewing the "do not crush" medication list at the time of the interview, Nurse #1 indicated the Aggrenox should not have been crushed. An interview with the Director of Nursing (DON)		1) The resident's attending physician was notified immediately of the incident. The physician indicated that there was no harm to the resident and no new orders were given. 2) The Director of Nurses reviewed the resident's medical record to ensure that all physician orders contained the proper administration information. All orders were correct. 3) The Director of Nurses audited the resident's medication cards to ensure "DO NOT CRUSH" instructions were on the cards. The cards were properly marked. 4) Nurse #1 was in-serviced on the proper administration of Aggrenox via a peg tube. To enhance currently compliant operations and under the direction of the Director of Nurses: 1) All licensed nursing staff were in-serviced on the administration of medications via peg tubes. 2) All licensed staff were in-serviced on procedures regarding medications marked, "Do Not Crush." Actions to determine if other residents were affected include: 1) An audit of all residents was completed to identify residents with peg tubes. 2) All medications of residents identified as having peg tubes were reviewed for "Do Not Crush" directions. None were found. The following monitoring activities will be put in place: The Director of Nurses and/or her designee will audit the administration of medications	12-04-12 12-04-12 12-04-12 12-04-12 12-10-12 12-10-12 12-06-12 12-06-12 12-28-12

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F 333	Continued From page 11 on 12/06/12 at 9:21 AM revealed the Aggrenox was time released and therefore should not be crushed prior to administration. An interview wit the facility pharmacist on 12/06/12 at 3:55 PM revealed the time release component of the capsule should not be crushed prior to administration. The pharmacist further revealed she was unable to determine if there have been any adverse consequences to Resident #91 from crushing the Aggrenox.	F 333	via peg tube on 2 residents a week for 3 weeks, then 2 residents every other week for 3 months. Audit results will be provided to the Quality Assurance Committee for their review.	
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 observations and staff interviews, the facility failed to maintain cleanliness of a fan, air condition units and ventilation cover in the kitchen. The findings are: 1. On 12/03/12 at 9:30 AM observation of the dish washing area revealed dust on the front wire grill of an oscillating fan, mounted to the wall and angled down over racks of clean bowls and cups;	F 371	It is the policy of Autumn Care of Saluda for the facility to store, prepare, distribute and serve food under sanitary conditions. The facility policy has all equipment either on a preventive maintenance schedule or a cleaning schedule maintained by the Maintenance Supervisor and/or the Dietary Department. No specific resident was affected by the examples given in this citation. To enhance currently compliant operations and under the direction of the Director of Nutritional Services: 1) Dietary staff were in-serviced regarding state and federal regulations related to the cleaning of kitchen equipment. 2) The oscillating fan noted in the example was removed from the wall, dismantled, cleaned and reinstalled in the dish room. The fan was placed on the dietary department's cleaning schedule, to be cleaned monthly or as needed. 3) All vents and air conditioning grills were removed, pressure washed and repainted. Vents and air conditioning grills are on the dietary department cleaning schedule and/or the Maintenance	12-04-12 12-04-12 12-04-12

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F 371	the fan was on. On 12/04/12 at 2:35 PM with the Dietary Manager and Assistant Dietary Manager present, observation of the dish washing area revealed dust on the wire grill of an oscillating fan mounted to the wall and angled down over racks of clean bowls and cups. The fan was observed on. With the Dietary Manager's permission, the fan was shut off which revealed a black substance along approximately one half inch of the curved portion of the fan blades and dust on the back wire grill against the wall. The Dietary Manager directed a dietary aide to remove the fan for cleaning. On 12/04/12 at 2:35 PM, the Dietary Manger was interviewed and stated the oscillating fan was cleaned as needed and should not be dirty and blowing on clean dishes. 2. On 12/04/12 at 2:45 PM with the Dietary Manager present, dust was observed on the corner of a ceiling mounted rectangular light fixture over a food preparation counter next to the steam table. Next to this light fixture, a metal ceiling ventilation grill was observed covered in dust and a dark grey substance with most of the metal fins of the ventilation grill covered in rust and without paint. Two air conditioning units mounted at the juncture of a wall and the ceiling over a food preparation counter and clean utensils were observed with metal grills covered in a black substance. Inside these grills were observed fiberglass filters blackened along the periphery with an approximately 4 inch diameter spot of clean white filter in the center. The metal grill on the air conditioning unit to the right was observed to have an approximately 1 inch by 6	F 371	Continued From page 12 Department Preventive Maintenance list to be cleaned monthly or as needed. The following actions will be used to monitor the plan: 1) The Director of Nutritional Services or her designee will monitor for cleanliness of the fan weekly for 12 weeks, then monthly to ensure the cleaning schedule is followed. A Quality Assurance tracking tool will be used to document any findings with the information reported to the Quality Assurance Committee for their review. 2) The Director of Nutritional Services or her designee will monitor vents and grills for signs of rust and/or dust weekly for 12 weeks, an then monthly. The results of the audits will be reported to the Quality Assurance Committee.	12-06-12 12-10-12

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F 371	Continued From page 13 inch area with peeling paint. On 12/04/12 at 2:45 PM the Dietary Manger was interviewed. She stated her expectation was ventilation grills and fixtures in food preparation areas should be free of grease and dust and cleaned on a regular schedule. On 12/04/12 at 4:20 PM the Registered Dietician and Administrator were interviewed and stated the metal ceiling ventilation grill and air conditioning unit metal grills were removed for power washing and painting.			
F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on staff interviews and observations, the facility failed to properly cover a barrel containing used grease. The findings are: On 12/04/12 at 2:40 PM with the Dietary Manager and Assistant Dietary Manager present, two blue 55 gallon drums for grease disposal were observed next to a dumpster and on a concrete pad outside the rear entrance to the kitchen. One of the drums was observed covered with a tight fitting metal lid and the other was uncovered and filled to within approximately two inches of the rim with a dark black liquid.	F372	It is the policy of Autumn Care of Saluda to dispose of garbage and refuse properly. Autumn Care maintains contracts for dumpsters and containers for the purpose of appropriate disposal of garbage and refuse. Dumpsters and containers are emptied on a regular schedule or as needed basis. No specific resident was affected regarding this citation. To enhance currently compliant operations and under the direction of the Director of Nutritional Services: 1) A missing lid was replaced on one of two grease barrels. 2) The grease removal company was called for immediate service. The following action will be used to monitor the plan: The Director of Nutritional Services and/or her design will monitor the grease barrels for proper lids weekly for six weeks and	12-06-12 12-06-12 12-06-12

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F 372	Continued From page 14 On 12/04/12 at 2:40 PM the Dietary Manager was interviewed She stated her expectation was the grease barrels should be kept covered at all time. On 12/05/12 at 11:15 AM with the Dietary Manager present, two blue 55 gallon drums for grease disposal were observed next to a dumpster and on a concrete pad outside the rear entrance to the kitchen. One of the drums was observed covered with a metal lid and the other was covered with a piece of plywood. The concrete pad under the dumpster and barrels was observed being power washed by a facility staff member. On 12/05/12 at 11:15 AM the Dietary Manager was interviewed and stated the company contracted for grease removal should empty the grease barrels and provide a new tight fitting lid.		then monthly for three months. A Quality Assurance tracking form will be used, with the findings submitted to the Quality Assurance Committee for review.	