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 ______	C 03/07/2014

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event # H8VM11.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews with staff, resident and family the facility failed to honor food preferences noted on the tray card for 2 of 6 sampled residents. (Residents #51 and #83) The findings included: 1. Resident #83 was admitted to the facility 12/20/12 with diagnoses which included liver cirrhosis, liver cancer, diabetes and nutritional deficiency. Hospice services were initiated on 12/20/12 and have continued through the time of the survey. The latest Minimum Data Set (MDS) assessment dated 02/19/14 for Resident #83 assessed her with moderate cognitive impairment. The care plan last updated 02/19/14 included a problem area of Nutritional Needs-Determine food likes/dislikes, obtain nutritional consult as indicated, offer adequate fluid intake related to terminal diagnosis.	F 242	Disclaimer This Plan of Correction constitutes my written allegation of compliance for the deficiences cited. However, submission of this Plan of Correction is not an admission tat a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F242 Self Determination Right to Make Choices It is the policy of this facility to honor and provide for each resident's right to make choices. This has been accomplished for residents #83 and #51 by the following: The certified dietary manager and kitchen	3/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/31/2014

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 242	Continued From page 1 Receives ordered supplements, weigh per protocol, comfort care, honor food preferences as available, resident Hospice care, weights fluctuates related to edema, significant weight loss in 30 days, pressure ulcer to show signs/symptoms of improving/closing. A nurse's note in the medical record of Resident #83 included documentation on 02/02/14 that Resident #83 "requested fruit and cereal in the mornings." Documentation in the medical record of Resident #83 by the Food Service Director (FSD) on 02/21/14 noted, Spoke with resident sister today related to significant weight loss in 30 days. Informed sister that resident states she just doesn't have an appetite, and things don't taste good, also discussed supplement, encouraged protein, snacks, food related activities, food preferences honored, added to weekly weights. Observations of the tray card for Resident #83 on 03/04/14 at 9:11 AM noted instructions to "Send fruit at breakfast", "Send cold cereal at breakfast and dinner" and, "no black pepper". On 03/04/14 at 9:11 AM Resident #83 was observed eating breakfast in her room. A packet of pepper had been included with other condiments on the breakfast tray of Resident #83. Cold cereal and fruit had not been sent on the breakfast tray as indicated on the tray card. At the time of the observation Resident #83 stated she is allergic to pepper which is why it was listed as such on the tray card. Resident #83 stated because she is diabetic she liked to have cold cereal and fruit along with her breakfast meal per chance her blood sugar dropped mid morning. Resident #83 had an individual serving of pre-packaged canned fruit on the overbed table and indicated a family member brought these in for her when fruit was	F 242	supervisor reassessed each of the residents cited for this deficiency on 03/06/14 for food preferences. Resident #83 and #51□s food tray cards were updated to reflect current preferences on 03/06/14 by the certified dietary manager. Other ways this has been achieved for resident #83 and resident #51 is by periodic assessments for food preferences by the certified dietary manager, and periodic assessments/reviews by the consulting registered dietician. Black pepper was added to resident #83□s electronic records as a food allergy and a communication notice was forwarded to the dietary department to alert for pepper allergy 03/28/14. Dietary staff were in-serviced regarding the importance of reading resident tray cards and honoring preferences as stated on the tray care on 03/04/14 by the certified dietary manager. The nurse aides were in-serviced 03/26/14 by the director of nurses for reading meal tray cards and the importance of honoring resident preferences as documented on the tray cards. Because all residents have the potential to be affected by this cited deficiency, the certified dietary manager reviewed all tray cards, interviewed 10 additional residents for likes/dislikes, and food preferences, and is reviewing tray cards on the food service line 5 days per week to ensure staff are honoring food preferences and foods listed on the food tray cards are honored. Dietary staff were in-serviced by	

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F 242	Continued From page 2 not sent with the breakfast tray. On 03/05/14 at 8:42 AM the breakfast tray for Resident #83 was observed as it was delivered to the resident. Fruit was not included on the breakfast tray as indicated on the tray card. At the time of the observation Resident #83 stated she rarely received fruit with the breakfast meal. On 03/06/14 at 8:35 AM the breakfast tray for Resident #83 was observed on the tray delivery cart; prior to delivery to Resident #83. Fruit was not included on the breakfast tray for Resident #83 as indicated on the tray card. At the time of the observation the FSD was asked about the fruit for Resident #83. The FSD stated if fruit was listed on the tray card it should be sent. The FSD verified fruit had not been included with the breakfast meal for Resident #83 on 03/06/14 and could not explain why fruit had not been sent with the breakfast tray 03/06/14 or why the tray card had not been followed at the breakfast meal 03/04/14 and 03/05/14. 2. Resident #51 was admitted to the facility 6/10/10 with diagnoses which included B complex deficiency, dementia and abnormal loss of weight. The latest MDS for Resident #51 dated 02/19/14 assessed her with severe cognitive impairment. The current care plan for Resident #51 included a care plan for the problem area, Eating Needs. An approach to this problem area included, Cranberry juice on meal trays at breakfast, lunch and dinner. A progress note by the Food Service dated 02/13/14 noted, Resident continues to receive a regular diet, eats meals in dining room, and is eating 75% average of most meals. Receives cranberry juice on all meal trays per family request. Resident is alert, and able to voice likes and dislikes, but is deaf and uses a white board to communicate.	F 242	the certified dietary manager regarding the importance of reading resident tray cards and honoring preferences as stated on the tray card on 03/04/14. The CNAs were in-serviced for state and federal regulation and facility policy on 03/26/14 by the director of nurses for reading meal tray cards and importance of honoring resident preferences as documented on the tray cards. Effective 03/10/14 a QAPI program was implemented under the supervision of the certified dietary manager. The following systemic changes have been put in place: the certified dietary manager or kitchen supervisor reviews meal tray cards daily while trays are being prepared in the dietary kitchen to ensure resident preferences and choices are honored. The director of nurses or alternate administrative nurse monitors the delivery of 10 resident food trays, reviewing tray cards during 5 meals weekly for 3 months to ensure resident preferences are honored. Any concerns will be addressed on the spot with the dietary aides and/or nurse assistants by the certified dietary manager, kitchen supervisor, and/or director of nurses or alternate administrative nurse. The certified dietary manager is responsible for compliance and reports all concerns to the QAPI committee quarterly.	

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F 242	Continued From page 3	F 242		

Review of the tray card of Resident #51 noted to include cranberry juice and ice cream with the lunch meal. On 03/03/14 from 11:45 AM-1:11 PM observations were made of Resident #51 in the dining room for the lunch meal. The open cart of trays for residents eating in this dining room included only the plated hot food. An assortment of beverages and basket of bread were delivered on a separate cart to the dining room. Resident #51 was served ice tea with her meal. Cranberry juice was not offered to Resident #51 (as indicated on the tray card) and was not observed on the separate cart containing beverages. During the course of the meal Resident #51 requested ice cream. Staff working in the dining room notified the kitchen and a tray with ice cream and canned pears (the planned dessert for the lunch meal) was delivered to the dining room. The ice cream was not provided to Resident #51 after it was brought to the dining room. Resident #51 ate very little and was assisted out of the dining room without ever receiving the ice cream. Nurse aide #2 working in the dining room reported Resident #51 typically ate well at breakfast and poorly at lunch and supper.

On 03/5/14 from 12:14 PM-12:30 PM Resident #51 was observed in the dining room for the lunch meal. Cranberry juice was not served to Resident #51 (as indicated on the tray card) and was not observed on the separate cart containing beverages.

On 03/06/14 at 12:15 PM Resident #51 was observed in the dining room for the lunch meal. Cranberry juice was not served to Resident #51 (as indicated on the tray card) and was not

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	345351	A. BUILDING ______ B. WING ______	C 03/07/2014

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F 242	Continued From page 4 observed on the separate cart containing beverages. A family member was present beside Resident #51 and reported the cranberry juice was rarely served to Resident #51 as requested and indicated on the tray card. The family member stated the physician of Resident #51 had recommended cranberry juice at every meal due to frequent urinary tract infections. The family member also confirmed Resident #51 liked ice cream every day and would ask for it if it was not served because the physician had encouraged Resident #51 to eat ice cream every day. At the time of the observation Nurse Aide #2 was asked about the provision of beverages to residents eating in the dining room. Nurse Aide #2 stated she was familiar with what residents eating in the dining room liked to drink. When asked about the cranberry juice for Resident #51, Nurse Aide #2 stated there was not cranberry juice on the beverage cart to give to Resident #51. On 03/06/14 at 12:25 PM the facility consultant dietitian stated any items listed on the tray card should be provided to residents. The consultant dietitian stated if the item was not sent from the kitchen the nurse aides should call the kitchen for any additional needs. On 03/06/14 at 12:35 PM the food service director (FSD) stated dietary staff typically look at the tray cards to ensure all beverages that residents request are on the service beverage cart. The FSD stated if Resident #51 had cranberry juice listed on the tray card it should have been provided with the meal. The FSD stated she wasn't aware the cranberry juice wasn't being included on the service beverage cart sent to the dining room where Resident #51 ate lunch. The FSD stated ice cream is always sent along with the planned dessert and should have been provided to Resident #51, especially if requested.	F 242		

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F 242	Continued From page 5 On 03/06/14 at 5:20 PM the Director of Nursing stated she expected staff working in the dining rooms to look at the tray cards when serving residents to ensure all food and beverages were served consistent with the individual residents preference.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain painting and broken wallboard, repair door frames, repair doors with chipped, splintered veneer, clean stained bathroom floors and grout, repair broken tiles in bathrooms, shower rooms and common areas, and replace flashing light fixture, for 4 of 5 halls (Halls B, C, D, and E). The findings are: 1. Wallboards broken and plaster requiring painting: a) On 03/03/14 at 09:45 AM observation of Room D8 revealed the wall behind the bed with a large rough patched area of drywall with deep scratches into the drywall. b) On 03/03/14 at 09:45 AM observation of room C8 revealed the corner of the wall to the	F 253	F253 It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable home like interior: To achieve this cited deficiency an audit list was created to review each room sited in the 2567 for broken wallboards and plaster requiring painting; door frames with broken trim and chipped paint; doors with chipped and/or splintered veneer; bathroom floor tiles and grout that needs attention; repairs of tiles in bathrooms, shower rooms and common areas; and, flashing light fixtures in hallways. The specific repair deficiencies cited in the 2567 will be corrected by 06/07/2014. The light fixture noted to be blinking in the hallway was corrected on 03/07/2014.	4/5/14

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F 253	Continued From page 6 bathroom door had a corner strip protector missing with a 4 foot section from the floor up 4 feet with missing plaster and a metal strip showing with rough edges. c) On 03/03/14 at 11:48 AM observation of Room C6 revealed wall beside bed with chipped scarred plaster board without paint where resident rests against wall while in bed and the vent beside the bathroom door with chipped flaking paint. d) On 03/03/14 at 02:43 PM observation of Room E4 revealed the walls with two broken patched areas, and walls near the floor level with scuffs and scrapes in the drywall. e) On 03/03/14 at 03:08 PM observation of room D5 revealed the walls with large rough patched areas of drywall with scrapes into the drywall in the resident room and in the bathroom. f) On 03/03/14 at 04:18 PM observation of room E8 revealed the wall behind the bed with patched rough areas that were chipped and flaky and multiple scrapes and black marks on the walls. g) On 03/03/14 at 04:18 PM observation of E8 bathroom walls with scraped areas on the drywall. h) On 03/03/14 at 04:39 PM observation of room C8 revealed a large piece of torn plaster board beside the bathroom door of the resident's room and large area of peeled torn wallboard with chipped and scarred plaster on the wall behind the head of the bed. i) On 3/3/14 at 4:48 PM observation of room C1	F 253	A 100% percent audit will be completed by the Administrator by 04/05/2014. A list of additional needed repairs will be compiled. One room with identified concerns will be completed weekly until each room identified has been repaired. The maintenance supervisor or a contracted repair person will be responsible for repairs to the facility as identified via rounds, and staff and resident concerns. The maintenance supervisor will maintain an ongoing list of areas needing repair as identified through weekly and prn facility environmental rounds and as reported by staff, residents, and families. The administrator makes housekeeping and environmental rounds weekly and prn to assess facility repair needs. The administrator is responsible for monitoring of the facility environment on a daily basis and as needed and addresses concerns immediately with the housekeeping and or maintenance supervisor for compliance. The administrator will report areas that need repair to the QAPI committee monthly for the next three months and quarterly for two quarters.	

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	345351	A. BUILDING ______ B. WING ______	C 03/07/2014

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F 253	Continued From page 7 revealed the wall at level of mattresses scarred with chipped scarred plaster board without paint where resident rests against wall while in bed. j) On 03/04/14 at 8:33 AM revealed D hallway walls had multiple scuffmarks and scratched paint from handrail down and on the vinyl side boards. k) On 03/04/14 at 8:33 AM revealed E hallway walls had multiple scuffmarks and scratched paint from handrail down and on the vinyl side boards. l) On 03/04/14 at 8:43 AM observation of room D7 revealed the room had multiple scuffmarks and scratched paint. m) On 03/04/14 at 9:09 AM observation of room E7 revealed walls in bathroom on left when entering had chipped broken plaster near the edge of the baseboard. n) On 03/04/14 at 9:26 AM observation of C hallway walls had multiple scuffmarks and scratched paint from handrail down and on the vinyl side boards. o) On 03/04/14 at 9:26 AM observation of room C5 revealed door with chipped paint on the door below door handle. p) On 03/04/14 at 09:34 AM observation of room D9 revealed the walls near to bed with rough nicked plaster areas at mattress level. q) On 03/04/14 at 09:34 AM observation of room D9 bathroom walls with multiple scraps and black marks and flaky spackling under the sink. r) On 03/04/14 at 10:30 AM observation of	F 253		

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	345351	A. BUILDING ______ B. WING ______	C 03/07/2014

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AUTUMN CARE OF SALUDA	**501 ESSEOLA CIRCLE SALUDA, NC 28773**

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F 253	Continued From page 8	F 253		

room D11 revealed walls around the bed have multiple areas of chipped spackling and multiple patches of white paint on 2 colored painted walls.

s) On 03/04/14 at 10:30 AM observation of D12 revealed walls with scuff marks and chips, and the corner of the wall near TV and had chipped drywall with rough edges and scuffed black marks on multiple areas of the baseboards.

t) On 03/04/14 at 12:53 PM observation of room C10 revealed 2 large areas with torn and peeling drywall and chipped scratched plaster on the walls behind the beds.

2. Door frames with broken trim and chipped paint:

a) On 03/03/14 at 04:48 PM observation of room C10 revealed the door frame guard on the outside right side of the door was broken off and had chipped paint on the bottom half of the door frame.

b) On 03/04/14 at 8:33 AM observation of the D hall shower room revealed the door frames were scratched and chipped paint. Observation also revealed D and E hallway doorways with multiple door frames with chipped and scuffed paint.

c) On 03/04/14 at 8:43 AM observation of room D7 revealed the door to room frame with chipped and scuffed paint.

d) On 03/04/14 at 9:05 AM observation of the main dining room on C hall revealed doors to dining room with nicked paint and door frames with multiple chipped and scraped areas from waist down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 9 e) On 03/04/14 at 9:28 AM observation of room C8 bathroom revealed the door frames with chipped and scuffed paint. f) On 03/04/14 at 9:28 AM observation of room E4 revealed door and door frames scuffed and chipped paint. g) On 03/04/14 at 10:30 AM observation of the door of the dining room on D hall revealed trim around the view window was observed with a bowed trim frame with a gap of approximately 1 inch from the main frame. The trim around the door frame at the bottom right side of the door from the floor was loose approximately 10 inches. h) On 03/04/14 at 10:30 AM observation of outside the D hall dining room revealed at the entrance a 6 inch long piece of vinyl floor trim was observed loose from the wall. i) On 03/04/14 at 10:30 AM observation of room D11 revealed the door frame guard on right hand side of door was loose from the frame from floor up about 8 inches up. j) On 03/04/14 at 11:19 AM observation of the doorway exit to the smoking patio revealed the door frame edges with blackened scarred marks and chipped paint on the bottom half of the door and the door frame. k) On 03/04/14 at 2:10 PM observation of the soiled utility room next to nurse's station near C hall revealed broken missing door edge frame and missing vinyl baseboard. 3. Doors with chipped splintered veneer:	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 10 a) On 03/04/14 at 8:33 AM observation of the D hall shower room revealed door with chipped splintered veneer. b) On 03/04/14 at 8:43 AM observation of room D7 revealed door to room with chipped veneer. c) On 03/04/14 at 8:43 AM observation of room D12 revealed bathroom door and room door with chipped veneer. d) On 03/04/14 at 9:09 AM observation of room E7 revealed the bathroom and bedroom doors with splintered chipped veneer to door edges at ankle height. e) On 03/04/14 at 9:28 AM observation of room E4 revealed the bathroom and bedroom doors with chipped veneer at ankle level and on edges below the door knob. f) On 03/04/14 at 10:30 AM observation of room D11 revealed the entrance door to room with one foot long area on edge of door with flaked splintered veneer between the door knob and the kick plate. g) On 03/04/14 at 10:37 AM observation of the door of the dining room on D hall revealed splintered veneer. h) On 03/04/14 at 10:42 AM observation of room C10 revealed the door with splintered veneer. i) On 03/04/14 at 12:53 PM observation of room C8 revealed the door to the room with a large splintered veneer on edge of door between	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 11	F 253		

door knob and kick plate.

j) On 03/04/14 at 12:53 PM observation of room C8 bathroom door with a large chipped and splintered veneer area below the door knob.

k) On 03/04/14 at 1:21 PM observation of room D4 revealed the door to the room with splintered veneer on edges of the door.

l) On 03/04/14 at 1:26 PM observation of room D1 revealed the entrance door to the room with splintered edges.

m) On 03/04/14 at 04:48 PM observation of room C10 revealed the door to the bathroom had splintered wood veneer on the edges of the door.

n) On 03/04/14 at 04:48 PM observation of room D2 revealed the door to the bathroom had splintered wood veneer on the edges of the door.

4. Bathrooms were not clean and orderly:

a) On 03/04/14 at 8:33 AM observation of the D hall shower room revealed the shower floor with black brown debris in grout covering multiple tiles in the area of the stall 4' x 4'.

b) On 03/04/14 at 8:43 AM observation of room D2 revealed the bathroom tiles stained and dirty around the toilet and under the sink.

c) On 03/04/14 at 8:43 AM observation of room D9 revealed tiles stained and dirty around the toilet and the sink, and the putty around the toilet with black substance tearing away from toilet.

d) On 03/04/14 at 8:43 AM observation of room

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 ______	C 03/07/2014

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 253	Continued From page 12 D11 revealed the bathroom tile around the toilet broken and sunken and the tiles were stained around the toilet. e) On 03/04/14 at 8:43 AM observation of room D12 revealed the tiles in the bathroom stained with brown black substance around the toilet where the grouting was missing. f) On 03/04/14 at 8:43 AM observation of room D7 revealed the bathroom tiles stained around the toilet. g) On 03/04/14 at 9:28 AM observation of room E4 bathroom revealed the tiles were stained and dirty and grout around the toilet was chipped and stained with a black substance. h) On 03/04/14 at 9:28 AM observation of room C8 bathroom revealed stained tiles around the toilet. i) On 03/04/14 at 09:45 AM observation of room D8 bathroom revealed the floor tiles and baseboard not clean and small section of baseboard missing. j) On 03/04/14 at 11:37 AM observation of C hall shower room revealed a black brown substance between the tile grout of the floor tiles. k) On 03/04/14 at 01:05 PM observation of room D7 revealed the bathroom floor tiles and grout stained. l) On 03/04/14 at 03:08 PM observation of room D5 revealed the bathroom floor tiles stained.	F 253		

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 ______	C 03/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 13 5. Repairs of tiles in bathrooms, shower rooms and common areas: a) On 03/03/14 at 9:36 AM observation of C hall shower room revealed 5 floor tiles missing and cracked around the drain, broken chipped tile work about 4 inches long with ragged edges on the privacy shower wall at ankle height. b) On 03/03/14 at 2:10 PM observation of C hall shower room revealed shower room toilet stall had a missing tile near the edge of toilet on the floor. c) On 03/04/14 at 8:33 AM observation of D hall shower room revealed the shower stall with 3 cracked missing tiles on privacy wall at ankle height, and tile broken and chipped on corner wall by hand washing sink fifth tile up from the floor at knee height. d) On 03/04/14 at 8:43 AM observation of room D11 revealed the bathroom tile around toilet broken and sunken. e) On 03/04/14 at 8:43 AM observation of room D12 revealed tiles at the door entrance were cracked. f) On 03/04/14 at 9:05 AM observation of the main dining room on C hall revealed multiple tiles that were peeled all over the whole dining room. Walls were scraped and scuffed; multiple tiles under most all of tables were torn, chipped, and peeling linoleum tiles. g) On 03/04/14 at 9:28 AM observation of room C8 bathroom revealed a broken tile at corner of wall near the toilet.	F 253		

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 ______	C 03/07/2014

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

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F 253	Continued From page 14 h) On 03/04/14 at 9:28 AM observation of room E4 revealed the bathroom sink broken at hand level with broken, chipped, and stained porcelain. i) On 03/04/14 at 11:19 AM observation of the doorway exit to the smoking patio revealed broken floor tiles the width of the doorway. 6. Replace flashing light fixtures in hallway: a. On 03/03/14 at 9:36 AM observation of the overhead hallway light fixture on B hallway revealed flashed off and on. Multiple Observations revealed the overhead light remained the same flashing on and off throughout the days of the investigation. On 03/04/14, 03/5/14, 03/06/14, and on 03/07/14 during multiple observations these rooms and maintenance areas remained the same with no changes. On 03/06/14 at 9:23 AM an interview was conducted with the Maintenance Supervisor (MS). The MS revealed monthly rooms check off list which he completed showing repairs checked off as completed. He further revealed there were a lot repair problems in the building and there was not a comprehensive list of repairs which needed to be done. The MS stated the repairs to the resident rooms are an unending work in progress. The MS further stated there was no written plan for repairs that were needed. The MS revealed his system was to prioritize the most important repairs by safety factors and that he started with electrical, water and kitchen repairs each day and then moved onto resident room repairs	F 253		

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 ______	C 03/07/2014

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

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F 253	Continued From page 15 On 03/06/14 at 3:50 PM an interview and tour of the building and rooms was conducted with the Administrator. He stated this past year the focus was on remodeling the resident rooms and bathrooms. The Administrator further stated the repairs to the building and the rooms were a work in progress. He further stated they had planned to place bumpers on the walls in the rooms to protect plaster being broken from the beds and had placed these bumpers in 6 rooms since September of last year. The Administrator revealed there was no written plan for the repairs that were needed but that they were working on one room at a time correcting the most important repairs that were of a safety concern to residents. During the tour of the building the Administrator confirmed there were many repairs needed to walls, bathrooms and showers and tile work.	F 253		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		3/31/14

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 ______	C 03/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 16 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to accurately assess 4 of 24 sampled residents utilizing the Minimum Data Set (MDS) tool in the area of dental (Residents #50, #84), pressure sores (Resident #117) and medication administration (Resident #83). (Residents #50, #83, #84 and #117). The findings included: 1. Resident #117 was admitted to the facility 02/04/14 with diagnoses which included a pressure ulcer on the buttock. The admission MDS dated 02/16/14 for Resident #117 under section M/Skin conditions noted Resident #117 was at risk of developing pressure ulcers but did not have a stage 1 or higher unhealed pressure sore. Review of an admission nursing note in the medical record of Resident #117 dated 02/04/14 noted, Resident admitted with stage 1 non blanchable red area on right buttocks. Subsequent nurses notes in the medical record of Resident #117 included:	F 278	F 278 It is the policy of this facility that section M of the MDS assessment accurately reflects the resident□s skin conditions. This has been achieved by completing a MDS modification on 03-26-14 that reflects the resident□s accurate skin condition. Some of the other ways this had been achieved for resident #117 is a licensed nurse assessing her skin on admission with a noted stage 1 ulcer, immediate interventions such as: pressure relief cushion for wheel chair, dietary assessment, and MD assessment for diabetes control. Weekly skin checks were completed by a licensed nurse, immediate care planning of resident□s potential for wounds, timely treatment of resident□s wound, weekly wound assessments by a licensed nurse, periodic assessments by certified dietician, periodic assessments by a certified dietary manager and periodic review by the attending physician. This	

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 ______	C 03/07/2014

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 278

Continued From page 17

02/12/14-Nurses noted open area on coccyx. Area is pink and is blanchable. No open skin noted at this time.
02/17/14-Resident noted to have a reopened area (1 centimeter in diameter) to her right inner buttocks.
Wound Assessments in the medical record of Resident #117 after admission noted:
02/07/14-Stage 2, less than 4 centimeters, partial thickness skin loss involving epidermis and/or dermis.
02/11/14-Stage 2, less than 4 centimeters, partial thickness skin loss involving epidermis and/or dermis.
02/19/14-Stage 2, less than 4 centimeters, partial thickness skin loss involving epidermis and/or dermis

On 03/06/14 at 11:30 AM Nurse #3 that completed the 02/16/14 MDS for Resident #117 stated she reviewed the Wound Assessment reports when completing section M/Skin conditions and overlooked the Stage 2 pressure sore at the time of the assessment.

2. Resident #83 was admitted to the facility 12/20/12 with diagnoses which included ascites, liver cirrhosis and hypopotassemia. The annual MDS dated 11/26/13 for Resident #83 under section N/Medications noted Resident #83 did not receive a diuretic during the 7 days prior to the assessment date. Review of physician orders in the medical record of Resident #83 and the November 2013 Medication Administration Record (MAR) noted Resident #83 received 40 milligrams of Lasix (a diuretic) during the month of November.

F 278

resident experienced no negative outcomes. In this case, after the surveyor reported the inconsistent assessment, the resident□s care plan was immediately reviewed on 03-06-14 and found to be accurate. Resident #117 experienced no negative outcomes related to the inconsistent assessment. Resident #117□s wound healed as of 03-18-14. MDS nurse # 3 was re-in-serviced for accurate documentation for section M of the MDS on 03/11/14.

Because all residents have the potential to be affected by the cited deficiency the following audits have been put into place. The director of nurses will review sections M/skin conditions, section N/medications and section L/oral dental status for 100% of residents that had an admission and/or an annual MDS completed from 02-26-14 till 03-26-14, by 03-31-14.

To enhance currently compliant operations and under the direction of the director of nurses, on 03-11-14 all registered MDS nurses received in-service training regarding state and federal requirements for accurately completing and certifying the accuracy of the MDS assessment. The training emphasized the importance of accurately assessing and accurately documenting resident□s skin condition as instructed in the RAI manual.

Effective 03-31-14, a QAPI program was implemented under the supervision of the director of nurses to monitor accuracy of

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 ______	C 03/07/2014

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 278

Continued From page 18

On 03/06/14 at 11:30 AM Nurse #3 that completed the 11/26/13 MDS for Resident #83 stated she reviewed the electronic MAR for Resident #83 prior to completing section N/Medications of the MDS. Nurse #3 stated she overlooked the administration of a diuretic in the 7 day period prior to the 11/26/13 assessment for Resident #83.

3. Resident #84 was admitted to the facility 01/02/13 with diagnoses which included dysphagia. The annual MDS dated 01/21/14 for Resident #84 under section L/Oral/Dental Status noted Resident #84 had no issues.

Observations of Resident #84 on 03/04/14 at 10:00 AM and 03/06/14 at 8:33 AM noted teeth in very poor condition with multiple missing teeth on both the top and bottom, broken teeth and teeth that appeared badly decayed.

On 03/06/14 at 5:20 PM Nurse #4 assessed the condition of Resident #84's teeth and noted a total of 7 upper teeth with 2 of the 7 broken off at the gum line; as well as decay. Nurse #4 stated Resident #84 had a total of 3 teeth on the bottom; all on the left hand side.

On 03/06/14 at 11:30 AM Nurse #3 that completed the 01/21/14 MDS for Resident #84 stated the assessment was based on a visual inspection of residents teeth. Nurse #3 stated section L/Oral/Dental Status should have been checked for, Obvious or likely cavity or broken natural teeth. Nurse #3 stated she couldn't explain how she overlooked the condition of Resident #84's teeth when doing the 01/21/14 assessment.

F 278

sections M/skin condition, N/medications, and L/oral/dental status of admission and annual MDS□. The director of nurses or designated QAPI representative will perform the following systematic changes: weekly 100% checks of sections M/skin condition, N/medications, and L/oral/dental status on all admission and annual MDS□ for 1 month. Then, bi-weekly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Then, monthly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Any concerns identified will be corrected on the spot and the findings will be documented and submitted at the quarterly QAPI committee meeting for further review or corrective action. The director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports to the QAPI committee quarterly.

F278
It is the policy of this facility that section N of the MDS assessment accurately reflects the medications the resident has received. This has been achieved by completing a MDS modification on 03-26-14 that accurately reflects the resident□s received medications as of 11-26-13. Some of the other ways this has been accomplished for resident #83 is Resident #83□s most current MDS dated 02-19-14 is correctly noted, monthly medication

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 ______	C 03/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 19 4. Resident #50 was admitted to the facility on 01/23/14 with diagnoses that included, but were not limited to renal failure, nutritional deficiency, adult failure to thrive, and dental caries. Review of the admission MDS revealed Resident #50 was cognitively intact and required assistance with personal hygiene. Under section L of the MDS entitled Oral/Dental Status; he was indicated to have no issues present with his teeth; which included broken, missing, or chipped teeth. Observations of Resident #50 on 03/04/14 at approximately 9:00 AM revealed he had a number of missing and broken teeth, with teeth that appeared decayed. Resident #50 indicated he only had eight teeth left in his mouth. Review of the nurses' notes dated 01/23/14 by Nurse #5, indicated Resident #50 had teeth missing and dental caries. On 03/05/14 at 3:05 PM an interview was conducted with Nurse #5. She acknowledged she knew Resident #50 had missing teeth because it was noticeable when he spoke. On 03/05/14 at 3:30 PM an interview was conducted with Nurse #3, MDS Nurse. She stated the dental section of the MDS, section L, indicated Resident #50 had no dental issues. She revealed she did the dental assessment, made a mistake, and did not include Resident #50's missing and broken teeth on the assessment. On 03/06/14 at 5:00 PM an interview was conducted with the Director of Nursing. She indicated she was aware of the issue of the incorrect documentation on Resident #50's MDS concerning his dental issues. She acknowledged	F 278	review by a licensed pharmacist, periodic review by the attending physician, weekly assessments by a Hospice nurse, periodic review by a Hospice doctor, periodic lab studies and every shift evaluation of pedal edema by licensed nurses. In this case, after the surveyor reported this inconsistent assessment, Resident #83□s care plan was immediately reviewed on 03-07-14. Concerns identified during this audit will be corrected on the spot. Resident #83 has experienced no negative outcomes related to the inconsistent assessment. All residents are potentially affected by the cited deficiency because all residents require an admission and an annual MDS. The director of nurses will review sections M/skin conditions, section N/medications and section L/oral dental status for 100% of residents that had an admission and/or an annual MDS completed from 02-26-14 till 03-26-14, by 03-31-14. Concerns identified during this audit will be corrected. To enhance currently compliant operations and under the direction of the director of nurses, on 03-11-14 all registered MDS nurses received in-service training regarding state and federal requirements for accurately completing and certifying the accuracy of the MDS assessment. The training emphasized the importance of accurately assessing and accurately documenting resident□s current medication regime.	

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 ______	C 03/07/2014

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 278	Continued From page 20 the failure to document his missing and broken teeth, and stated it would be corrected on his next MDS assessment.	F 278	Effective 03-31-14, a QAPI program was implemented under the supervision of the director of nurses to monitor accuracy of sections M/skin condition, N/medications, and L/oral/dental status of admission and annual MDS□. The director of nurses or designated QAPI representative will perform the following systematic changes: weekly 100% checks of sections M/skin condition, N/medications, and L/oral/dental status on all admission and annual MDS□ for 1 month. Then, bi-weekly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Then, monthly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Any concerns will be corrected on the spot and the findings will be documented and submitted at the quarterly QAPI committee meeting for further review or corrective action. The director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports findings to the QAPI committee quarterly. F278 It is the policy of this facility that section L of the MDS assessment accurately reflects the resident□s oral/dental status. This has been achieved by completing a MDS modification on 03-26-14 that accurately reflects Resident #84□s oral/dental status. Some of the other	

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 ______	C 03/07/2014

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 278	Continued From page 21	F 278	ways this has been accomplished for resident #84 is by periodic assessment by the attending physician, periodic assessment by certified dietary manager, periodic assessment by a licensed dietician, has been assessed for and receives a mechanical soft diet, pain assessments every shift by licensed nurses, and periodically seen by a dentist. Resident exhibits no difficulty while eating, nor pain while eating. In this case, after the surveyor reported the inconsistent assessment Resident #84s care plan was reviewed on 03-06-14 and found to be accurate. Resident #84 has experienced no negative outcomes related to the inconsistent assessment. All residents are potentially affected by the cited deficiency because all residents require an admission and an annual MDS. The director of nurses will review sections M/skin conditions, section N/medications and section L/oral dental status for 100% of residents that had an admission and/or an annual MDS completed from 02-26-14 till 03-26-14, by 03-31-14. Concerns identified during this audit will be corrected. To enhance currently compliant operations and under the direction of the director of nurses, on 03-11-14 all registered MDS nurses received in-service training regarding state and federal requirements for accurately completing and certifying the accuracy of the MDS assessment. The training emphasized the importance of accurately	

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 ______	C 03/07/2014

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 278	Continued From page 22	F 278	assessing and accurately documenting resident□s oral/dental status. Effective 03-31-14, a QAPI program was implemented, under the supervision of the director of nurses, to monitor accuracy of sections M/skin condition, N/medications, and L/oral/dental status of admission and annual MDS. The director of nurses or designated QAPI representative will perform the following systematic changes: weekly 100% checks of sections M/skin condition, N/medications, and L/oral/dental status on all admission and annual MDS□ for 1 month. Then, bi-weekly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Then, monthly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Any concerns will be corrected on the spot and the findings will be documented and submitted at the quarterly QAPI committee meeting for further review or corrective action. The director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports findings to the QAPI committee quarterly. F278 It is the policy of the facility that section L of the MDS assessment accurately reflects the resident□s oral/dental status. This has been achieved by completing a MDS modification on 03-26-14 that	

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 ______	C 03/07/2014

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

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F 278	Continued From page 23	F 278	accurately reflects Resident #50s oral/dental status. Some of the other ways in which this has been accomplished for resident #50 is by periodic assessment by the attending physician, 3 times a week assessment by dialysis, periodic assessment by certified dietary manager, periodic review by a registered dietician and pain assessment every shift by a licensed nurse. Resident has no problem eating a regular diet and has no mouth pain. In this case, after the surveyor reported this inconsistent assessment Resident #84s care plan was reviewed on 03-06-14 and found to be accurate. Residents dietary assessment had noted missing/broken teeth and that resident #50 eats a regular diet without pain or difficulty. Resident #50 has experienced no negative outcomes related to the inconsistent assessment. All residents are potentially affected by the cited deficiency because all residents require an admission and an annual MDS. The director of nurses will review sections M/skin conditions, section N/medications and section L/oral dental status for 100% of residents that had an admission and/or an annual MDS completed from 02-26-14 till 03-26-14, by 03-31-14. Concerns identified during this audit will be corrected. To enhance currently compliant operations and under the direction of the director of nurses, on 03-11-14 all registered MDS nurses received in-service training regarding state and	

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F 278	Continued From page 24	F 278	federal requirements for accurately completing and certifying the accuracy of the MDS assessment. The training emphasized the importance of accurately assessing and accurately documenting resident□s oral/dental status. Effective 03-31-14, a QAPI program was implemented under the supervision of the director of nurses to monitor accuracy of sections M/skin condition, N/medications, and L/oral/dental status of admission and annual MDS□. The director of nurses or designated QAPI representative will perform the following systematic changes: weekly 100% checks of sections M/skin condition, N/medications, and L/oral/dental status on all admission and annual MDS□ for 1 month. Then, bi-weekly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Then, monthly checks of sections M/skin condition, N/medications and L/oral/dental status on 5 residents with admission and annual MDS□ for 3 months. Any concerns will be corrected on the spot and the findings will be documented and submitted at the quarterly QAPI committee meeting for further review or corrective action. The director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports findings to the QAPI committee quarterly.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		3/31/14

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F 309 SS=D	Continued From page 25 HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observations staff and resident interviews and record reviews the facility failed to provide a dressing change to an IV site for 1 of 1 residents (Resident #121) and failed to provide supervision for restorative dining for 1 of 1 residents (Resident # 3). The findings included: 1. Resident #121 was admitted to the facility on 02/14/14 with diagnoses which included open wound to foot, post op infection, surgical convalescence, local skin infections, and amputation of toes to right foot, diabetes, neuropathy, and anxiety. Resident # 121's Admission Minimum Data Set (MDS) dated 02/14/14 indicated she was cognitively intact for daily decision making skills. Further review of the MDS revealed Resident #121 required extensive assistance with all activities of daily living (ADL)s. Review of Resident #121's care plan dated 02/14/14 for intravenous (IV) therapy for indwelling IV medications revealed dressing changes were ordered once weekly. A review of the monthly treatment administration record	F 309	F 309 It is the policy of this facility to provide a dressing change every week and prn for a transparent dressing covering a PICC line site. This has been achieved for resident #121 by changing the transparent PICC line dressing on 03-05-14. Resident #121 experienced no negative outcomes. Other ways that this has been achieved for resident #121 is that the transparent PICC line dressing was re-scheduled in treatments in the Electronic health care record for every 7 days. The nurse responsible for the transparent dressing change was re-in serviced for the facility□s protocol to change a transparent dressing covering a PICC line site every 7 days and prn. The PICC line was discontinued on 03-12-14 per MD order. A 100% review of all residents done by the Director of Nurses on 03/05/14 revealed no other resident in the facility had a PICC line at the time of the survey. However, because all residents that require a PICC line will also require a	

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F 309 Continued From page 26

(TAR) revealed the dressing was last changed on 02/28/14. A review of the physician orders dated 02/14/14 reveled an order for IV dressing change on admission and then once weekly.

An observation was made on 03/03/14 at 11:50 AM revealed the dressing on Resident #121's left arm was dated 02/23/14. An observation was made on 03/05/14 at 10:43 AM revealed the same dressing was noted to be in place on Resident #121's left arm.

During an interview on 03/03/14 at 11:50 AM Resident #121 stated this dressing on my IV site was dated 02/23/14 and has not been changed in nine days and it is supposed was changed weekly.

During an interview on 03/05/14 at 3:05 PM the Director of Nursing (DON) observed the dressing on Resident #121's left arm dated 02/23/14. The DON reviewed the TAR and verified the dressing should have been changed on 02/28/14. The DON confirmed the dressing on Resident #121's IV site was past due for changing. The DON stated her expectation was for the nurses to change the IV dressing as per the doctors orders which was once weekly.

2. Resident #3 was admitted to the facility on 05/29/12 with diagnoses which included Alzheimer's, diabetes, depression, dementia with behaviors, malnutrition, and debility. Resident #3's most recent quarterly minimum data set (MDS) dated 12/02/12 indicated he was severely cognitively impaired for daily decision making skills with short and long term memory problems. Further review of the MDS revealed Resident #3 required maximum assistance with activities of

F 309

transparent dressing change are potentially affected by the cited deficiency, all licensed nurses were in-serviced on the facility protocol for changing a transparent PICC line dressing on 03-26-14 by the director of nurses. Facility protocol reveals transparent dressings covering PICC lines are changed every 7 days and prn.

To enhance currently compliant operations and under the direction of the director of nurses, on 03-26-14 all licensed nurses received in-service training regarding state and federal requirements for providing care/services for residents highest wellbeing. The training emphasized the importance of changing a transparent dressing covering a PICC line site every week and prn as stated in the facility protocol and current standard of practice for changing PICC line dressing.

Effective 03-27-14, a QAPI program was implemented under the supervision of the director of nurses and the following systematic changes were placed: weekly checks of residents who require a weekly transparent PICC line dressing change for 3 months. Then, bi-weekly checks of residents who require a weekly transparent PICC line dressing change for 3 months. Then, monthly checks on residents who require a weekly transparent PICC line dressing change for 3 months. Any concerns identified during this audit will be corrected on the spot by re-training the nurses observed. The

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F 309

Continued From page 27

daily living (ADL)s limited assistance for eating which included set up and supervision during meals.

A review of the care plan dated 02/14/14 with the identified focus for eating needs indicated Resident #3 required meal set up, supervision, oversight, and adaptive utensils due to the diagnose of Alzheimer's and dementia with behaviors. A care plan dated 02/24/14 with the identified focus for behavior with moods indicated Resident #3 had the tendency to rummage and grab items and place items in his mouth with the intervention to monitor and redirect behaviors.

A review of a dietary communication dated 09/06/12 indicated Resident #3 required no straws with his meals. A review of the dietary assessment dated 02/19/14 indicated Resident #3 was alert and always confused, required a mechanically altered diet, and required adaptive eating equipment for all meals.

During an observation on 03/04/14 at 8:50 AM Resident #3 was observed in the dining room eating his breakfast. Resident #3 was served his meal in a 3 compartment divided plate, with an adaptive spoon. Resident # 3 was served milk, juice and water. Resident #3 was observed drinking water through a straw from a plastic cup. The tray card on the table on Resident #3's tray indicated he was to receive a pureed diet served on a 3 compartment plate, an adaptive spoon, and no straws.

During an observation on 03/06/2014 at 8:29 AM Resident #3 was observed sitting in the dining room while breakfast being served. Resident #3 was observed taking a plastic butter condiment

F 309

director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports the findings to the QAPI Committee quarterly.

F309
It is the policy of the facility to provide supervision for residents in restorative dining. Staff, per surveyor interviews, had knowledge of resident #3s behaviors and ensured that resident #3 did not have non- food items on his meal tray. Some of the other ways this has been achieved for resident #3 is by periodically assessing residents level of supervision needed and residents ability to feed himself, providing a maroon spoon so the resident doesnt place too much food in his mouth, providing a divided plate to allow resident to better feed himself and staff knowledge of residents behavior and their knowledge to not leave non-food items including a straw for this resident. In this case, after the surveyor reported that resident #3 put a non-food item in his mouth and had taken a straw from another resident, the nurse aide immediately removed the item from his mouth and removed the straw from his possession. On 03-06-14, Resident #3s seating arrangement was also re-evaluated and changed to allow resident to be supervised and to not have non-food items within reach. Resident #3 experienced no negative outcomes.

Because all residents in restorative dining requiring supervision/oversight are potentially affected by the cited deficiency,

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F 309	Continued From page 28 container from another resident's tray at the table and placed it in his mouth and started to chew. Nursing Assistant (NA) #1 was immediately notified and was observed encouraging Resident #3 to spit the plastic out of his mouth. The NA then served Resident #3 his breakfast and assisted with set up of food and drinks. The tray card was again observed on the tray which indicated no straws. No straw was observed at his time. At 8:45 AM observed Resident #3 again during the breakfast meal drinking from a straw in a plastic cup of water. NA #1 removed the water with the straw and provided Resident #3 another drink without a straw. During an interview on 03/06/2014 at 8:55 AM NA #1 revealed she had set up Resident #3's meal and did not provided him a straw. She further revealed that Resident #3 often takes items and food from other resident's trays. NA #3 stated that she works in the restorative dining area assisting residents with tray set up, encouraging and supervising their meals and feeding residents. NA #1 further stated that she was aware that Resident #3 was not to be given a straw in his drinks and needed to be supervised because of his behaviors of taking things from other residents trays. NA #1 revealed that she observed the nurse administering medications to the resident at the table with Resident #3 and left a plastic cup of water with a straw in it with that resident. During an interview on 03/06/2014 at 9:05 AM Nurse #1 confirmed that she had administered medications to the resident at the table seated with Resident #3 and that she had left a plastic cup of water with a straw in it with him. Nurse #1 revealed that she knows that Resident #3 does	F 309	on 03-07-14, the director of nurses assessed 100% of residents in restorative dining to ensure proper supervision and any special needs were being met. 100% of the residents were properly supervised and all special needs were being met. No other residents were affected. Direct care nurse aides who work in dining rooms were in-serviced for oversight/supervision to residents in order to help resident□s maintain highest well being by the director of nurses on 03-07-14. To enhance currently compliant operations and under the direction of the director of nurses, on 03-26-14 all licensed nurses and cna□s received in-service training regarding state and federal requirements for providing care/services for residents highest wellbeing. The training emphasized the importance of providing supervision for restorative dining, including following any special instructions on resident□s tray cards and removal of non edible items form trays for residents who are identified to place no edible items in their mouths. Effective 03-27-14, a QAPI program was implemented under the supervision of the director of nurses to monitor supervision of residents in restorative dining. The director of nurses or designated QAPI representative will perform the following systemic changes: weekly checks of residents who require supervision in restorative dining for 3 months, then, bi-weekly checks of residents who require supervision in restorative dining for 3	

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F 309	Continued From page 29 not get straws in his drinks and that she does not give him straws. Nurse #1 further revealed that Resident #3 has the behavior of taking things from other resident's trays. Nurse #1 confirmed that Resident #3 was in restorative dining to provide assistance, encouragement, and supervision as needed with his meals. During an interview on 03/06/14 at 3:05 PM the Director of Nursing (DON) stated residents who were dependent on staff for Activities of daily living and required assistance with meals were placed in the restorative dining program. The DON further stated it was her expectation that residents in the restorative dining program were provided assistance, encouragement, and supervision as needed with their meals by the staff. The DON confirmed that it was her understanding that Resident #3 was in the restorative dining program for assistance with meal set up, cueing and supervision.	F 309	months, then, monthly checks on the residents who require supervision in restorative dining for 3 months. Any concerns will be corrected on the spot by immediate intervention and retraining by the director of nurses or other administrative nurse. The findings will be documented and submitted at the quarterly QAPI committee meeting for further review or corrective action. The director of nurses is responsible to monitor compliance and effectiveness of the interventions and reports findings to the QAPI committee quarterly.	