| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345294 | A. BUILDING _____ B. WING _____ | C 02/09/2019 |

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| AUTUMN CARE OF SHALLOTTE | 237 MULBERRY STREET SHALLOTTE, NC 28459 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification/Complaint Investigation suvey was conducted on 02/04/19 through 2/09/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# OUD911. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification/complaint survey was conducted from 2/4/19 through 2/9/19 for Event ID #OUD911.<br><br>There were no deficiencies cited as a result of the complaint investigation survey on 2/9/19 for OUD911.<br><br>An amended Statement of Deficiencies was provided to the facility on 4/5/19 because the Informal Dispute Resolution (IDR) process deleted tags; F-580, F-600 and F-684 and information in tag F-0000 was changed to reflect the results of the IDR. Event# OUD911. | F 000 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 6 residents (Resident #12) | F 759 | F 759<br>1. Resident #12 received his metoprolol as soon as the issue was identified. Resident #12□s lactulose was discontinued on 2/27/18 by the physician due to repeated refusals. | 3/1/19 |

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

Electronically Signed | 03/01/2019

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| F 759 | Continued From page 1<br>observed during medication administration. Findings included:<br><br>During a medication administration observation on 02/06/19 at 9:15 AM Nurse #10 was observed passing medications to Resident #12. Nurse #10 removed baclofen 20 mg (milligrams), buspirone 10 mg, venlafaxine 75 mg, and a vitamin from the medication cart in preparation for administration to Resident #12. Nurse #10 provided the four medications to Resident #12 without incident.<br><br>During a medication reconciliation on 02/6/19 at 9:35 AM Resident #12's February 2019 Medication Administration Record (MAR) revealed an order for lactulose 10 grams in 15 ml (milliliters) give 30 ml scheduled to be administered at 9:30 AM for constipation. The medication had a checkmark signifying the medication had been administered. There was also an order for metoprolol 12.5 mg scheduled to be administered at 9:30 AM for hypertension. The medication had a checkmark signifying the medication had been administered and Resident #12's blood pressure reading was 146/84.<br><br>In an interview on 02/06/19 at 9:40 AM Nurse #10 verified she did not provide lactulose to Resident #12. She indicated that she signed it off because although it was ordered for 9:30 AM, it was always given at night. She indicated she should have notified the physician and requested an order to have the scheduled time changed but had not. Nurse #10 verified she had not provided metoprolol to Resident #12 after checking in the medication cart and realizing there was no metoprolol in the medication cart for Resident #12. Nurse #10 stated she thought she gave the metoprolol to Resident #12 but was nervous | F 759 | 2. To identify other residents that have the potential to be affected, the medication administration record will be compared to the contents of the medication cart to ensure all ordered medications are in the cart.<br><br>3. To prevent this from recurring, The Director of Nursing or licensed designee will reeducate licensed nurses concerning appropriate medication administration. They will also be educated concerning the processes to obtain medication that is not in the cart at the time that medication is due.<br><br>4. To monitor and maintain ongoing compliance, the Director of Nursing or licensed designee will observe medication administration by nurses for compliance with policy. This will be documented for 3 nurses per week for 12 weeks.<br>The Director of Nursing or licensed designee will review the documentation by the nurses of any medications to ensure that appropriate follow up occurred and to identify any trends in this issue.<br><br>MAR to cart audit will be completed for each cart weekly for 4 weeks and then monthly for 2 months.<br>The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.<br>5. Date of alleged compliance 3/1/2019 | |

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| F 759 | Continued From page 2<br>because she was being observed. She stated that all medications should be given as ordered.<br><br>In an interview on 02/08/19 at 2:54 PM the Director of Nursing (DON) stated he expected the medication error rate in the facility to be zero. He indicated that realistically, since we are human and do make mistakes, that the medication error rate should be less than 5%. | F 759 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to monitor dish machine temperature gauges which resulted in kitchenware not being sanitized when final rinse temperatures did not meet manufacturer specifications. The facility | F 812 | F 812<br><br>1. The opened bags of spaghetti and elbow macaroni pasta in the dry storage room were discarded on 2/4/19. The | 3/1/19 |

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| F 812 | Continued From page 3<br>also failed to remove dust and dirt from 3 of 4 clean ceiling fans in the kitchen, and failed to monitor storage areas which resulted in thawing meats not having a "pull date" on them and opened food items being stored without labels and dates. Findings included:<br><br>1. A 01/02/19 dish machine service representative audit report documented the facility's dish machine was functioning correctly with the only adjustment necessary being titration of the release of the detergent into the dish machine.<br><br>Review of the dish machine temperature log on 02/06/19 at 9:20 AM revealed the final rinse temperature for kitchenware being washed after the breakfast meal had not been recorded yet for 02/06/19, but was documented as being 165 degrees Fahrenheit on 02/05/19.<br><br>During observation of the dish machine on 02/06/19 from 9:24 AM until 9:38 AM seven racks of kitchenware were run through the dish machine, and the final rinse temperatures ranged from 152 to 156 degrees Fahrenheit. Three dietary employees were involved in carrying out the dish machine process, but none of those employees were monitoring the dish machine temperature gauges.<br><br>On 02/06/19 at 9:42 AM strips were attached to several racks going through the dish machine. The temperature-sensing bar on these strips did not turn the bright orange color specified by the manufacturer of the strips which would have indicated that the temperature of the final rinse water met the minimum requirement for adequate sanitization of the kitchenware. | F 812 | unlabeled and dated open bags of raisin bran and toasted oats cereals, plastic storage container of grits were discarded. The shredded cheese and sliced ham that were in the walk-in refrigerator with no dates or labels were discarded. The hamburger that was thawing in the walk-in refrigerator without a pull date was corrected with a date and used same day. In the walk-in freezer opened bags of onion rings were discarded and green peas/carrot medley that were without labels were used on 2/4/19 same day as being opened.<br><br>The kitchen ceiling fans were cleaned on 2/6/2019.<br><br>The dish machine was identified as not working properly on 2/7/19. Paper products were used until 2/14/19.<br><br>2. To ensure that there were no other food at risk, the kitchen storage areas including dry storage, walk in refrigerator and walk in freezer were audited on 2/5/19 through 2/8/19 by the Regional Registered Dietitian and Dietary Manager to ensure there were no additional unlabeled items. No concerns were noted.<br>Ceiling fans throughout the facility were audited by the Maintenance Director on 2/20/19 for cleanliness. Those that needed to be cleaned were completed on 2/20/19 and 2/21/19. The dish machine was identified as not working properly on 2/7/19. Paper products were used until | |

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| F 812 | Continued From page 4<br><br>On 02/06/19 at 9:48 AM the Dietary Manager (DM) stated that when water pitchers were run through the dish machine earlier around 6:30 AM on 02/06/19 the final rinse gauge registered over 180 degrees Fahrenheit.<br><br>During a follow-up interview with the DM on 02/07/19 at 9:58 AM she stated that the dietary employee retrieving sanitized kitchenware from the dish machine was supposed to be watching the temperature gauges periodically. She reported the service representative from the dish machine company had educated the dietary employees that the machine's final rinse temperatures needed to be at least 180 degrees Fahrenheit. She commented that dietary employees were in-serviced to notify her if the final rinse gauge was registering below the 180 degrees so she could involve the Maintenance Manager and service representative if needed. According to the DM, final rinse temperatures below 180 degrees Fahrenheit were not effective in sanitizing the kitchenware, and germs and bacteria could be spread which had the potential for making residents sick. The DM stated she could not find the dish machine temperature log for January 2019, but a review of the logs for November and December 2018 revealed the final rinse temperatures were documented as being between 180 - 190 degrees Fahrenheit.<br><br>During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated she checked the dish machine gauges about every five minutes, and when the final rinse gauge registered below 180 degrees Fahrenheit she was supposed to let her DM know. | F 812 | 2/14/19.<br><br>3. To prevent this from recurring, dietary staff were educated on proper storage, labeling, and dating opened items by the dietary manager.<br><br>The facility□s Certified Dietary Manager provided education on the dish machine with the dietary department.<br>Maintenance Director was educated on a new cleaning schedule for the kitchen ceiling fans on 2/20/2019 by the Administrator.<br>4. To maintain ongoing compliance, audits on proper storage, labeling, and dating opened items will be conducted by the dietary manager or designee three days a week for twelve weeks with results brought to the facility QAPI meetings.<br><br>Audits will be conducted on fan cleanliness three days a week for twelve weeks by the maintenance director or designee with results brought to the facility QAPI meetings.<br><br>A dish machine audit will be conducted 5 days a week for twelve weeks by the dietary manager or designee with results brought to the facility QAPI meetings.<br><br>Audits will be reviewed weekly in the facility□s Risk Meeting and in the QAPI meeting for a period of 3 months. The facility□s decision to extend the audits will be based on the results of the audits.<br>5. Date of alleged compliance is | |

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| F 812 | Continued From page 5 | F 812 | 3/1/2019 | |

On 02/08/19 at 10:28 AM the DM stated even though service representatives had replaced wires, valves, and thermostats, and were currently working on the dish machine diaphragm, the dish machine was still not able to sustain final rinse temperatures of 180 degrees Fahrenheit.

During an interview with the Director of Nursing on 02/09/19 at 9:12 AM he stated the nursing home had no residents who were diagnosed with foodborne illness. He reported it was his expectation that the residents in the nursing home be protected against foodborne illness by a dish machine which was able to sustain final rinse temperatures which the manufacturer documented as being effective in sanitizing kitchenware.

2. During an initial tour of the kitchen on 02/04/19, beginning at 11:18 AM, strands of dust were hanging from the blades and accumulations of dust and dirt could be seen on the blades of 2 of 4 ceiling fans in the kitchen. The fan above the steam table was not running, but the fan near a food preparation counter was running although no food preparation tasks were being completed at the time.

During a follow-up tour of the kitchen on 02/06/19, beginning at 9:20 AM, there were still strands and clumps of dust on the blades of the ceiling fan above the steam table which was not running. Sandwiches were being assembled on a preparation counter, and the ceiling fan near them was running. There were also strands and clumps of dust on the blades of this ceiling fan. Upon closer inspection there were clumps of dust and dirt on a third ceiling fan which was running near a storage rack housing sanitized pitchers.

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| F 812 | Continued From page 6 | F 812 | | |

During an interview with the Maintenance Manager (MM) on 02/06/19 at 10:08 AM he stated maintenance and dietary worked together to make sure vents and ceiling fans in the kitchen remained clean. He reported he thought the ceiling fan above the steam table got overlooked because it was non-operational at present, and needed to be replaced. However, he commented he was unable to explain why the other two ceiling fans had not been cleaned.

During an interview with the Dietary Manager (DM) on 02/06/19 at 10:13 AM she stated the ceiling fans were on the monthly cleaning schedule, and starting in December 2018 she now had a dietary employee who was available to clean the fans as opposed to holding maintenance responsible for carrying out the task.

During a follow-up interview with the DM on 02/07/19 at 9:58 AM she stated the dust and dirt from the ceiling fans in the kitchen could fall into the food being prepared for the residents and cause cross-contamination, and had the potential for making residents sick.

During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated the ceiling fans in the kitchen should be kept free from dust and dirt, and not doing so, increased the chance that the food being served to the residents could make them sick.

3. During an initial tour of the kitchen on 02/04/19, beginning at 11:18 AM, there were no labels and dates on opened bags of raisin bran and toasted oat cereals, a plastic storage

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| F 812 | Continued From page 7 | F 812 | | |

container of grits, and opened bags of spaghetti and elbow macaroni pasta in the dry storage room. In the walk-in refrigerator there were opened bags containing shredded cheese and sliced ham which were without labels and dates. Also in the walk-in refrigerator there were three rolls/tubes of thawing hamburger which were without "pull dates" to indicate when the thawing process began. The hamburger meat was still pink, and there were no signs of spoilage. However, at this time the Dietary Manager (DM) stated "pull dates" were necessary to make sure the meat was still fresh and safe to use. In the walk-in freezer opened bags of onion rings and green peas/carrot medley were without labels and dates.

During an interview with the DM on 02/07/19 at 9:58 AM she stated all opened food items should be labeled and dated to ensure that residents were served the freshest food possible.

During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated she was trained that any dietary employee who opened food items was supposed to place labels and dates on the packaging if the items were not all used up. She reported she was not sure if any one employee was in charge of monitoring the storage areas on a regular basis.