STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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
E 000	Initial Comments An unannounced Recertification and Complaint Investigation Survey was conducted 05/10/21 through 05/13/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# K1IB11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint Investigation Survey was conducted 05/10/21 through 05/13/21. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One of the five allegations was substantiated. Event ID# K1IB11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		5/27/21

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

Electronically Signed | 06/07/2021

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate Advanced Directives throughout the Resident's (Resident #38) medical record for 1 of 19 residents reviewed for Advanced Directives. The finding included: Resident #38 was admitted to the facility on 04/02/20 with diagnoses that included atrial fibrillation and heart failure. On 05/10/21 at 4:11 PM a review of Resident #38's electronic medical record (EMR) revealed an Advanced Directive order dated 05/03/21 for	F 578	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BU THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATES ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENT UNDER STATE AND FEDERAL LAU. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:	

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F 578	Continued From page 2 Resident to be a DNR (do not resuscitate). A review of the Code Status notebook revealed there was no information in the notebook that indicated an Advanced Directive for Resident #38. An interview with Nurse #1 on 05/12/21 at 3:18 PM revealed Nurse #1 explained that the residents' Advanced Directive status was in the EMR as well as in the Code Status notebook that was kept at the nursing desk. An observation was made with Nurse #1 of the Code Status notebook which revealed Resident #1's Advanced Directive was not in the Code Status notebook. An interview was conducted with the Social Worker (SW) on 05/12/21 at 3:31 PM. The SW explained that she was responsible for the residents' Advanced Directives in that she had to ensure the residents' Advanced Directive in their EMR, and the Code Status notebook matched. The SW stated she conducted an audit of the Advanced Directive every six months and completed the most recent audit last week and all the residents' Advanced Directives matched perfectly. An observation was made of Resident #38's EMR and the Code Status notebooks at both nurses' stations with the SW. The SW noted Resident #38's Advanced Directive was not in the Code Status notebooks and stated she had no explanation as to why, but she would follow up with the correction. On 05/13/21 at 1:48 PM an interview with the Administrator revealed, the Administrator stated she understood the importance of making sure the two places for the residents' Advanced Directive information matched (EMR and Code Status notebook) and that it was her expectation	F 578	On 5/14/2021 Resident #38 Advanced Directive Medical Record was reviewed to ensure accuracy with Code Status, Care Plan, Order, and Advance Directive Book at nurses station. This was completed on 5/14/2021. OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTIONS TAKEN: Beginning on 5/14/21 a review of current residents Advance Directive/Medical Records/Code Status was reviewed by Social Worker to include orders, consents, care plans and advance directives in note book at nurses station. No additional residents were found to have inaccurate advance directive through out residents medical records. This was completed on 5/14/2021 Systematic Change Implemented: Beginning 5/14/2021 Facility social worker was educated by Regional Director of Clinical Services on policy for Advance Directives and maintaining accurate code status throughout medical record. Beginning 5/14/2021 current nursing staff, physician, nurse practitioner's was educated on code status maintain throughout residents medical records. All new hires will be educated on residents code status policy. This is added to agency orientation Completed on 5/16/2021. Monitoring:	

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F 578	Continued From page 3 that the two places matched.	F 578	Beginning 5/14/2021 facility social worker/designee will monitor monitor code status/advance directives weekly x 12 weeks to ensure code status maintained accurately in each residents medical record.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and facility staff interviews, the facility failed to initiate a PASARR review for a resident who had a new mental health diagnosis for 1 of 1 resident reviewed for PASARR (Resident #45). The Findings Included:	F 644	THE PREPARATION AND SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATED ON THIS STATEMENT OF DEFICIENCIES.	5/27/21

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F 644	Continued From page 4 Resident #45 was most recently admitted to the facility on 03/26/21 with diagnoses that included Parkinson's disease, dementia, and schizoaffective disorder. A review of Resident #45's admission Minimum Data Set Assessment dated 04/01/21 revealed she was severely impaired for daily decision making with no documented psychosis or behaviors. Resident #45 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. She was totally dependent on others for bathing. Resident was coded as having a diagnosis of Schizoaffective disorder. A review of Resident #45's electronic documents revealed when she admitted to the facility, it was with a PASARR that was completed in May of 2017. Review of Resident #45's medical records during that time it was revealed that she did not have a diagnosis of schizoaffective disorder while admitted and was diagnosed with schizoaffective disorder before her admission to the facility on 03/26/21. During an interview with the facility's Social Worker (SW) on 05/13/21 at 11:08 AM, she reported she was responsible for ensuring all residents that admitted to the facility had an appropriate PASARR number. She reported she was unaware that she was required to request a PASARR review for any resident what was diagnosed with a new mental health condition. She reported when Resident #45 admitted to the facility she verified that she had a PASARR initiated in May of 2017 but was unaware she needed to request a review since Resident #45	F 644	THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW. CORRECTION ACTION FOR THE AFFECTED RESIDENT: Resident #45 PASRR was corrected to include the new Mental Health diagnosis. OTHER RESDIENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN: Beginning on 5/14/2021 all current residents were reviewed to ensure PASRR#'s are with current diagnosis. This was completed on 5/14/2021. SYSTEMATIC CHANGES IMPLEMENTED: Beginning on 5/14/2021 facility's social worker was educated on PASARR company policy and, and initiation of PASRR's with new mental health diagnosis. This was completed on 5/14/2021 MONITORING: Beginning on 5/14/2021 Facility Social Worker/designee will complete an ongoing audit that consist of Residents name; Admit date; PASSR List Number with effective date; PASSR if short term approval list in column is 7 day, 30 day, 60 day with date; Level 2 screening; If short	

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F 644	Continued From page 5 had a new diagnosis of schizoaffective disorder. She stated she would request a review immediately. An interview with the Director of Nursing (DON) on 05/13/21 at 11:42AM revealed she expected PASARR reviews to be completed for any residents that return or readmit to the facility with a new mental health diagnosis and for residents who are admitted and receive a new mental health diagnosis. She stated she would ensure that the facility's social worker was trained on the facility's process for requesting PASARR reviews.	F 644	term PASSR approval; New PASSR completed with date completed; FL2 received if applicable, date applied; Were any significant PASSR's needed? If yes, add date completed; List any time specific PASSR with date and roll over from prior month; Date of weekly meeting, list those in attendance. This information will be audited weekly x 12 weeks to ensure up to date and any new mental diagnosis added.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		5/27/21

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F 761	Continued From page 6 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (Cart 200 and Cart 400/500/600) reviewed for expired medications. The findings included: a. An observation of Cart 200 was made on 05/12/21 at 4:43 PM along with Nurse #2. The observation revealed the following expired medication that were on the medication cart and available for use: 1 card of Reglan (Antiemetic) 10 milligrams that contained 30 pills that expired 02/28/21. 1 card of Lexapro (antidepressant) 20 milligrams that contained 21 pills that expired on 03/31/21. An interview was conducted with Nurse #2 on 05/12/21 at 4:44 PM. Nurse #2 stated she worked at the facility through an agency and was not familiar with the policy and procedures on medication carts. She stated she was not sure who was responsible for checking the medication cart. She added that she had gone through the over the counter medication and made sure all the insulin pens were dated but that was it. Nurse #2 stated if she discovered expired medication, she would put them in the medication room and send it back to the pharmacy. b. An observation of Cart 400/500/600 was made on 05/12/21 at 3:52 PM along with Nurse #3. The observation revealed the following medication	F 761	THE PREPARATION AND SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTSALLEGED OR OF THE CONCLUSION STATED ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: On 5/13/21, all expired medication have been removed from all medication carts 200 and 400/500/600. OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN: Beginning on 5/14/2021 each medication cart was reviewed for any expired medications, any medication that had an expired date have been removed and sent back to the facility's pharmacy or otherwise destroyed. This was completed on 5/14/2021 SYSTEMATIC CHANGES IMPLEMENTED:	

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F 761	Continued From page 7 expired and on the medication cart available for use: 1 card of Sinemet (used to treat Parkinson's disease) 50 milligrams/200 milligram that contained 20 pills that expired on 04/30/21. 1 card of Depakote (used to treat seizures) 500 milligrams that contained 30 pills that expired on 04/30/21. 1 card of Aldactone (diuretic) 100 milligrams 15 pills that expired on 04/21. An interview was conducted with Nurse #3 on 05/12/21 at 3:57 PM. Nurse #3 stated she thought the Unit Manager (UM) checked the medication carts for expired medication. She stated she had not checked the medication cart for expired medication today and added she was an agency nurse that usually worked at the facility 3 days a week. Nurse #3 stated she would give the expired medication to the UM to handle. An interview was conducted with the UM on 05/12/21 at 4:02 PM. The UM stated that she just took over the UM position a few days ago and was instructed to go through the medication carts. I assumed they were just referring to the over the counter medications and the insulin pens because night shift staff was responsible for checking the medication carts for expired medications. She added the hall nurses should also be going through the carts before they administer medications. The UM stated that the expired medication should be removed from the medication cart and returned to the pharmacy. An interview was conducted with the Director of Nursing (DON) on 05/13/21 at 12:40 PM. The DON stated that the UM should be going through	F 761	Beginning on 5/14/2021 current nurses have been educated on policy for expired medications. New hires will be educated on policy for expired medication. Agency nurse packets for orientation will include education on expired medication policy. MONITORING: Beginning on 5/16/2021 Unit Manager/Designee will audit medication carts for expired medications 2x a week for 4 weeks then weekly x8 weeks. Director of Nursing will review all audits.	

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F 761	Continued From page 8 the medication carts at least weekly if not twice a week. She stated that sometimes the UM would have the hall nurses go through them first and then they would follow up behind and make sure nothing was missed. The DON stated if the UM was not available the Assistant Director of Nursing (ADON) could help out with the process. She indicated the expired medication should be removed from the medication cart and returned to the pharmacy for destruction.	F 761		