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 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

(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 survey was conducted on 2/28/22 through 3/3/22. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID#56C311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/28/22 through 3/3/22. Event ID# 56C311. 1 of the 1 complaint allegation was substantiated resulting in a deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/22/2022

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 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to promote a homelike dining experience for dependent residents during 3 of 3 meals observed by serving meals on trays in the Mulberry dining room. Findings included: a. During an observation on 2/28/22 at 12:02 PM of the Mulberry (assist) dining room, 13 of 13 residents were observed with the meal tray on table during dining experience. b. During an observation on 3/01/22 at 12:19 PM of the Mulberry dining room 11 of 11 residents were observed with the meal tray on table during dining experience. c. During an observation on 3/02/22 at 12:25 PM of the Mulberry dining room 14 of 14 residents	F 584	F 584 1.Each resident (#s 7, 61,51,43,18,67,4) was served with their food removed from their trays while eating in the dining room for the next meal after the issue was identified. 2. To identify other residents that have the potential to be affected, an audit of residents who eat in the dining room was completed by the Director of Social Services to validate that they prefer to have items let on the tray during dining. There were no negative findings. The audit was completed on 3/17/2022. 3. To prevent this from recurring, nursing and dietary staff have been reeducated that food served in the dining room will be removed from the serving tray and set up	

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F 584	Continued From page 2 observed with the meal tray on table during dining experience. During an interview on 3/02/22 at 12:25 PM the Activities Assistant revealed the staff did not remove the food plates and drinks from the tray in the dining room because the residents were dependent on staff for eating and were not oriented. She stated the food plates were removed from the independent dining when the other dining room was open because those residents were oriented. Record review of the Mulberry Dining Location Assignment dated 3/03/22 revealed the following residents were assigned to the assist dining room: Resident #45 Resident #36 Resident #71 Resident #7 Resident #48 Resident #61 Resident #19 Resident #66 Resident #51 Resident #54 Resident #18 Resident #67 Resident #26 Resident #4 Resident #34 Resident #10 During an interview on 3/03/22 at 8:38 AM the Director of Nursing (DON) revealed based off her previous observations the plates were not removed from the meal tray for the residents in	F 584	in a homelike fashion for the resident. This education will be completed by the Director of Nursing, Dietary Manager, or designee on 3/22/2022. Any nursing or dietary staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency nursing staff and newly hired nursing staff will have this education during their orientation. 4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will observe meals in the dining room to ensure that the food is removed from the serving tray and presented in front of the resident in a homelike manner. This will be documented 5 days a week for one meal a day for 3 weeks. Then, 1 day a week for 1 meal weekly for 8 weeks. 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. 5. Corrective action will be 3/29/2022.	

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F 584	Continued From page 3	F 584		

the assist dining room because they are not oriented and were assisted with eating. The DON stated the trays were used to provide a visual barrier for their food. The DON stated the food plates and cups when removed from the delivery tray would provide the resident with the experience of not eating in a cafeteria every day.

During an interview on 3/03/22 at 9:01 AM the Unit Manger (UM) revealed that most of the residents in the Mulberry dining room were not oriented, needed to be fed by staff, or cued to eat so we have always left the food plates on the meal tray. The UM stated there was not a difference between those residents that needed cueing or fed versus those that were oriented and both deserved the same dining experience.

During an interview on 3/03/22 at 1:03 PM the RN Supervisor revealed the staff have always left the food on the delivery tray in the Mulberry dining room. She stated in the Pineapple (independent)dining room the residents were asked but in the Mulberry dining room the food remained on the tray.

During an interview on 3/03/22 at 4:06 PM the Activities Director revealed that the residents used to have their plate removed from the tray to make it a more home like environment and not an institutional setting. The Activities Director stated all residents deserve a dignified dining experience.

During an interview on 3/03/22 at 4:32 PM the Administrator revealed the tray would be removed based on if they needed the plates removed or left on to create a border or guideline for their food. She stated the UM and the RN Supervisor

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F 584	Continued From page 4 were responsible for the dining room, and they made the decision based on resident needs.	F 584		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow a renal diet for 1 of 1 resident reviewed for dialysis (Resident #129). The findings included: Resident #129 was admitted to the facility on 12/15/22 after surgical amputation of the lower extremity and had a diagnosis of end stage renal	F 692	F692 1. Resident #129 is no longer at the facility. 2. To identify other residents that have the potential to be affected, an audit of residents who are ordered a renal diet has been completed by the Registered Dietician/designee on 3/18/2022 with no negative findings.	3/29/22

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F 692	Continued From page 5 disease that required dialysis, diabetes mellitus and a stage 2 pressure ulcer. The Admission Minimum Data Set (MDS) Assessment dated 2/22/22 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living with the exception he required cueing and supervision with eating after tray set-up. The MDS noted the resident received a therapeutic diet and was on dialysis. The initial care plan for Resident #129 dated 2/15/22 revealed the resident was at nutritional risk with the potential for alteration in nutrition and hydration. The interventions included to provide diet as ordered. The care plan noted the resident had renal insufficiency and was on dialysis. The interventions included to provide the diet as ordered. The Care Plan noted the resident had actual skin breakdown and to monitor the resident's nutritional status. Review of the physician's current orders revealed an order for a renal/low concentrated sweets (LCS) diet. There was also an order for the resident to take a bagged lunch with him to dialysis. A dietary note dated 2/17/22 revealed the resident's appetite was good with no diet restrictions at home and no food supplements taken at home. The note revealed the resident had no food dislikes and was on a renal/LCS diet. A note by the facility's Registered Dietician (RD) dated 2/21/22 revealed the resident's meal intake was 50-100 percent of 3 meals and the intake did not meet the resident's needs. The note revealed	F 692	3.To prevent this from recurring, the Registered Dietician/designee has reeducated the dietary staff concerning what foods are recommended for a renal diet. This education will be completed by the Registered Dietician/designee by 3/21/2022. Any dietary staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Newly hired dietary staff will have this education during their orientation. 4. To monitor and maintain ongoing compliance, the Dietary Manager/designee will validate that the renal diet meals and pre prepared lunches for dialysis contain only food that is recommended for the renal diet. Audits will be done 3 x week for 12 weeks. The Dietary Manager 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. 5. Corrective action will be 3/29/2022.	

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F 692	Continued From page 6	F 692		

the resident needed increased calories and protein for wound healing and dialysis. The interventions included a Renal/LCS diet and NovaSource Renal twice a day. NovaSource is a nutritional drink that provides additional calories, vitamins and minerals for a person with renal insufficiency.

On 3/2/22 at 12:45 PM Resident #129 was observed sitting on the side of the bed eating lunch. There was a plastic bag in the room that contained a peanut butter and jelly sandwich, 2 packs of cheese/peanut butter crackers, 1 pack of saltine crackers and a bag of cheese puffs. None of the packaging on the food items identified the items as low sodium. A family member of the resident stated he was not supposed to eat any of that. The resident stated these items were sent with him to dialysis this morning.

Review of the facility's Renal Diet (Liberal), recommended foods or foods to avoid, did not include any of the items sent with the resident to dialysis with the exception that unsalted (low sodium) crackers were recommended.

On 3/2/22 at 2:38 PM an interview was conducted with the facility's Registered Dietician (RD) who stated Resident #129 was having difficulty meeting his protein needs and he would eat peanut butter. The RD further stated the peanut butter had increased potassium, but they were trying to meet his protein needs. The RD stated the cheese crackers with peanut butter and cheese puffs were probably not a good idea and the content of the sodium in these foods would outweigh the benefit for this resident.

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F 692	Continued From page 7 On 3/2/22 at 5:20 PM an interview was conducted with the Dietary Manager (DM) who stated the resident had not been eating much and asked for a peanut butter and jelly sandwich. The DM further stated she would have hoped he would eat the cheese/peanut butter crackers for the extra protein. The DM stated the resident should not have received the cheese puffs.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews, the facility failed to obtain doctor's orders for oxygen therapy for 1 of 4 residents reviewed for oxygen therapy (Resident #47). The facility also failed to obtain orders for continuous positive airway pressure (CPAP) for 1 of 2 residents reviewed for respiratory treatments (Resident #11). The findings included: The facility policy titled Oxygen Administration (all routes) Policy last revised on 12/16/19 under Policy read: "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider."	F 695	F695 1. Resident # 47 no longer resides at the facility. Resident #11 had orders written for the use of the CPAP with correct setting information on 3/3/2022. 2. A. To identify other residents that have the potential to be affected, an audit of residents who are receiving oxygen was compared to an audit of orders written for oxygen by the Director of nursing or designee. Any inconsistency was addressed at the time of the audits. These audits were completed on	3/29/22

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F 695 Continued From page 8

The section titled Cleaning read: "Change tubing and cannula weekly and document according to facility policy.

1. Resident #47 was admitted to the facility on 12/24/21 and had a diagnosis of chronic obstructive pulmonary disease (COPD).

Review of a hospital discharge summary dated 1/20/22 read: "Occasionally uses O2 (oxygen) due to underlying COPD which may be required upon leaving." The discharge orders did not include an order for oxygen therapy.

The care Plan for Resident #47 was updated on 1/21/22 and noted the resident had a respiratory infection. The interventions included oxygen as ordered.

The 5-day Minimum Data Set (MDS) Assessment dated 1/27/22 noted the resident was cognitively intact, required extensive assistance with activities of daily living and received oxygen therapy.

Review of the medical record for Resident #47 revealed no physician's order for oxygen therapy.

On 2/28/22 at 11:00 AM Resident #47 was observed lying in bed with nasal oxygen at 2 liters per minute delivered by nasal cannula.

On 3/2/22 at 12:18 PM Resident #47 was observed sitting on the edge of the bed with a nasal cannula lying on the bed. The oxygen concentrator was running and was set to deliver 2 liters of oxygen per minute. The Resident stated she used her oxygen in the afternoon when she took a nap and used the oxygen at night.

F 695

3/21/2022 with no negative findings.
To identify other residents that have the potential to be affected, an audit of residents using CPAP machines will be compared to an audit of orders written for CPAP use. CPAP orders written will have the settings in the order.
Any discrepancies will be resolved at the time of identification.
The audit was completed on 3/21/2022 by the Director of Nursing/designee.

3. To prevent this from recurring, licensed nurses have been reeducated to ensure that oxygen is only delivered when there is an order written.
This education will be completed by the Director of Nursing/designee on 3/21/2022
Any licensed staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation.
Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. To prevent this from recurring, licensed nurses will be reeducated to look for orders for any resident who has brought a CPAP from home. This includes what should be in the order in reference to the settings.

The education will be completed on 3/21/2022 by the Director of Nursing/designee.

Any licensed staff that cannot be reached within the initial reeducation time frame,

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F 695	Continued From page 9	F 695		

On 3/3/22 at 12:56 PM an interview was conducted with the Director of Nursing (DON) and the Corporate Nurse. The Corporate Nurse stated Resident #47 went to the hospital shortly after admission and he thought when she was re-admitted to the facility the oxygen order was not re-written. The DON stated an order for oxygen had been written and provided a copy of the order dated 3/3/22 that read: "Oxygen 2 liters per minute via nasal cannula as needed to keep oxygen saturation above 90 percent."

2. Record review of the hospital discharge summary dated 12/10/22 revealed Resident #11 was to continue with continuous positive airway pressure (CPAP) machine with sleep and as needed.

Resident #11 was admitted to the facility on 12/10/21 with a diagnosis of obstructive sleep apnea.

Record review of the Admission Nursing Assessment and admission nursing note dated 12/10/21 by Nurse #5 did not have information regarding CPAP use for Resident #11.

Attempts to contact Nurse #5 were unsuccessful.

Record review of the Nurse Practitioner (NP) History and Physical dated 12/14/22 revealed Resident #11 had a history of obstructive sleep apnea and was to continue with home CPAP machine in facility.

Record review of the Minimum Data Set (MDS)

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will not take an assignment until they have received this reeducation.

Agency licensed nurses and newly hired licensed nurses will have this education during their orientation.

4.To monitor and maintain ongoing compliance, the Director of Nursing or designee will make rounds to identify which residents are receiving oxygen and validate that there are orders present for each resident. This will be documented daily for 7 days and then weekly for 11 weeks.
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.
To monitor and maintain ongoing compliance, the Director of Nursing or designee will make rounds to identify residents who are using CPAP machines and ensure that the orders are complete and in place for each resident.

This will be documented daily for 7 days and then weekly for 11 weeks.
The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of

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F 695	Continued From page 10 Admission Assessment dated 12/17/21 revealed Resident #11 was cognitively intact and was not coded for use of CPAP machine. Record review of physician orders revealed Resident #11 did not have a physician order for CPAP. Record review of Resident #11 ' s care plan dated 2/27/22 revealed he had altered respiratory status related to sleep apnea and use of CPAP with an intervention which included CPAP settings per physician orders. During an interview on 2/28/22 at 11:25 AM Resident #11 revealed he brought his CPAP from home to use in the facility. He stated he was able to put the mask on independently and he used the CPAP at bedtime. During an interview on 3/01/22 at 2:16 PM Nurse #3 revealed Resident #11 used his CPAP machine at night and that it was his personal CPAP from home. She stated a physician order with the settings was required and the nurse that obtained the physician order would be responsible to enter it in the electronic medical record. Nurse #3 reported Resident #11 did not use the CPAP during her shift but stated the CPAP settings were confirmed with the physician order when the machine was placed on at night. During an interview on 3/01/22 at 2:27 PM the Director of Nursing (DON) revealed a physician order was required for use of CPAP and Resident #11 was able to use his personal CPAP from home while at the facility. She stated when the CPAP was brought from home the facility was responsible to verify the CPAP settings from the	F 695	the monitoring period or as it is amended by the committee 5. Corrective action will be 3/29/2022.	

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F 695	Continued From page 11 community prescribing physician and then would enter the order in the electronic medical record. She reported the nurse working on floor and the RN Supervisor were responsible to confirm an order was in place for Resident #11 ' s CPAP. The DON was unable to locate the setting information for the CPAP in medical record or hospital discharge summary for Resident #11. During an interview on 3/02/22 at 12:55 PM the Nurse Practitioner (NP) revealed that he assumed the CPAP settings information would come from the hospital, so he documented to continue use of home CPAP for Resident #11. During an interview on 3/02/22 at 1:01 PM the RN Supervisor revealed the night shift nurses were required to complete chart checks to ensure orders were in place. She stated the nurses should have asked questions about an order for CPAP for Resident #11. During an interview on 3/03/22 at 8:21 AM Nurse #4 revealed Resident #11 used his CPAP during night shift and that he turned on the CPAP and placed on his mask independently during her shift. She stated he used his machine on his home settings. Nurse #4 reported the CPAP required a physician order and was required to be confirmed that the settings were correct, and it was in use by the nurse. She was not able to state why the physician order for Resident #11 ' s CPAP was not in place. During an interview on 3/03/22 at 10:18 AM the Administrator revealed the nursing team was responsible to ensure a physician order was in place for the CPAP for Resident #11.	F 695		

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 12	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews with the facility's consulting Registered Dietician (RD) and the dialysis Registered Dietician, the facility failed to clarify fluid restriction recommendations from dialysis and failed to coordinate with dialysis the resident's dietary requirements for 1 of 1 resident reviewed for dialysis (Resident # 129). The findings included: Resident #129 was admitted to the facility on 2/15/22 for orthopedic care following surgical amputation of a lower extremity. The resident had a diagnosis of end stage renal disease that required dialysis, diabetes mellitus, protein-calorie malnutrition, anemia of chronic disease, chronic obstructive pulmonary disease with a dependence on supplemental oxygen and a stage 2 pressure sore. The Admission Minimum Data Set (MDS) Assessment dated 2/22/22 revealed the resident was cognitively intact had no behaviors and required extensive to total assistance with activities of daily living except he required oversight and encouragement and tray set up with eating. The MDS revealed the resident was	F 698	F698 1. Resident #129 is no longer at the facility. 2. To identify other residents that have the potential to be affected, an audit of current residents receiving dialysis are at risk for this issue. This audit will be completed by the Director of Nursing or designee to identify these residents and ensure that there is up to date information from the last visit to dialysis present in their chart and that any recommendations or orders have been reviewed with the medical provider and transcribed into the resident medical record. This will be completed by 3/21/2022. 3. To prevent this from recurring, the Administrator will provide education to the Registered Dietician of the expectation to clarify any fluid restriction and coordinate any dietary requirements with the dietician at the dialysis center. This education will be completed by 3/18/2022.	3/29/22

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 698	Continued From page 13 on a therapeutic diet and had one stage 2 pressure ulcer on admission. The MDS revealed the resident received pressure ulcer care and surgical wound care. The MDS noted the resident received insulin for 7 days during the lookback period and received oxygen therapy and dialysis. The initial care plan dated 2/15/22 revealed the resident was at risk for alteration in nutrition and hydration. The interventions included to provide diet, medications and to monitor laboratory tests as ordered and to provide supplements as ordered. The care plan dated 2/16/22 noted the resident was at risk for impaired skin integrity related to edema, poor nutrition, surgical incision due to bilateral above the knee amputation, impaired mobility and underlying disease. The interventions included pillows for positioning and treatments as ordered. The care plan noted the resident had actual skin breakdown and actual skin integrity related to mobility. The interventions included to monitor the resident's nutritional status and weight variations with dietary consult as needed. The care plan revealed the resident received dialysis three times a week and required oxygen related to the disease process. The care plan noted the resident received dialysis three times a week and to maintain communication with the dialysis staff and the physician per routine. The Care Area Assessment (CAA) for Nutrition dated 2/22/22 revealed the resident had increased protein needs to promote wound healing for bilateral below the knee amputation, stage 2 pressure ulcer and to replenish losses from hemodialysis. Review of the current physician's orders revealed the following orders: Dialysis on Monday,	F 698	4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor progress notes in the medical record to validate communication from the facility RD with the dialysis center RD. This will be done during the clinical morning meeting. Monitoring will be done 3 x weekly for 12 weeks. 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. 5. Correction action will be 3/29/2022.	

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F 698	Continued From page 14	F 698		

Wednesday and Friday. Send packed lunch to dialysis with the resident. NovaSource renal twice a day for wound healing. Renal/Low Concentrated Sweets (LCS) diet. NovaSource renal is a nutritionally complete formula high in calories, protein, vitamins and minerals to meet the needs of people with chronic kidney disease on dialysis.

A note by the Dietary Manager dated 2/17/22 revealed the resident's usual weight was 177 pounds. Current appetite is good. No diet restrictions at home. No food supplements taken at home. No food dislikes. Resident on Renal/LCS diet. No chewing or dental concerns.

A note by the facility's consulting Registered Dietician (RD) dated 2/21/22 revealed the resident consumed 50-100 percent of 3 meals per day and 1500 milliliters (50 ounces) of fluids. Intake does not meet the resident's needs. Needs increased for calories and protein for wound healing and dialysis. No significant weight changes. Interventions were for Renal/LCS diet and Nova Source Renal twice a day.

On 3/2/22 at 12:45 PM Resident #129 was observed sitting on the side of the bed eating lunch. A family member was in the room and provided a bag with a peanut butter/jelly sandwich, 2 packs of cheese and peanut butter crackers, 1 package of saltine crackers and a bag of cheese puffs. Resident #129 stated this was a bag lunch that was sent with him this morning to dialysis.

On 3/2/22 at 2:44 PM an interview was conducted with the facility's consulting Registered Dietician (RD). The RD stated they were having trouble

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

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F 698	Continued From page 15	F 698		

meeting the resident's protein needs and he liked peanut butter and jelly sandwiches, so they decided to give him this to increase his protein. The RD stated she was making allowances to meet the resident's nutritional needs. The RD further stated the cheese crackers and cheese puffs were high in sodium and not a good idea and that the sodium content outweighed the benefit.

On 3/2/33 at 3:12 PM an interview was conducted with the Registered Dietician (RD) at the dialysis center where Resident #129 received dialysis. The RD stated the resident should not have foods high in phosphorus and salt and his phosphorus level had been running high. The RD further stated the resident should avoid foods high in phosphorus like peanut butter. The RD stated the resident was supposed to be on a 32 ounce fluid restriction daily and should be getting double meats/double protein and Nova Source twice a day. The RD stated he did not know if the dialysis communication form gave any orders for fluid restriction or diet.

On 3/2/22 at 5:20 PM an interview was conducted with the facility's Dietary Manager (DM) regarding the food sent to dialysis with the resident. The DM stated Resident #129 had not been eating much and had asked for the peanut butter and jelly sandwich. The DM further stated the resident was getting NovaSource twice a day. The DM stated the resident should not have received the cheese puffs and would hope he ate the cheese and peanut butter crackers for the added protein. The DM stated she was not aware of any fluid restrictions and dialysis had not communicated to her any fluid restrictions for the resident.

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F 698	Continued From page 16 On 3/2/33 at 5:50 PM the Director of Nursing (DON) provided dialysis communication forms. The dialysis communication form dated 2/18/22 noted there were no fluid restrictions. A dialysis communication form dated 2/23/22 noted fluid restrictions of 32 ounces per day. At the bottom of the form there were orders to discontinue some medications due to low blood pressure. There was no clarification of the fluid restrictions. The DON stated the fluid restrictions should have been clarified with dialysis and if this was a recommendation, the Nurse Practitioner should have been called. The DON provided a dialysis communication form dated 2/25/22 that had no fluid restrictions marked on the form. The DON stated the fluid restrictions had not been put into place and that dialysis was now closed and she was waiting for the Nurse Practitioner to return her call. On 3/3/22 at 4:45 PM an interview was conducted with the Director of Nursing (DON), the Administrator and the Corporate Nurse. The DON stated the fluid restriction on one day was due to the dry weight of the resident. The dry weight is the weight of a person without the excess fluid that builds up between dialysis treatments. The DON stated she called dialysis today, but they have not called her back regarding the fluid restrictions. The Administrator stated they use the communication form to communicate back and forth, and dialysis had not called them with any concerns.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		3/29/22

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 726	Continued From page 17 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to train the nursing staff in the care of a LifeVest wearable defibrillator for 1 of 1 resident with a LifeVest wearable defibrillator (Resident #129). The findings included: A LifeVest is a personal defibrillator worn by a	F 726	F726 1. Resident #129 is no longer at the facility. 2. There are no current residents with a life vest at the facility. 3. To prevent this from recurring, the licensed staff have been educated concerning the use and processes for care of a Life Vest.	

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 726 Continued From page 18

patient at risk for sudden cardiac arrest. The device continuously monitors the patient's heart and if the patient goes into a life-threatening rhythm, the LifeVest delivers a shock treatment to restore the patient's heart to normal rhythm.

Resident #129 was admitted to the facility on 2/15/22 and had a diagnosis of congestive heart failure and coronary artery disease and had a LifeVest wearable cardiac defibrillator.

The Admission Minimum Data Set (MDS) Assessment dated 2/22/22 revealed the resident was cognitively intact and required extensive assistance with activities of daily living with the exception of cueing and supervision with eating after tray set-up.

There was a physician's order dated 2/20/22 for a LifeVest in place (batteries to be changed every morning).
The care plan for Resident #129 dated 2/23/22 noted the resident had cardiac symptoms related to coronary artery disease, hypertension, congestive heart failure, hyperlipidemia, anemia and hyperkalemia and had a LifeVest. The intervention for the LifeVest was for the device to be in place at all times.

On 3/1/22 at 10:15 AM, Resident #129 was observed to change the batteries in the battery pack of the LifeVest while a staff member held the battery pack.

On 3/3/22 at 10:13 AM an interview was conducted with the Staff Development Coordinator (SDC) who stated when Resident #129 was admitted to the facility she questioned the Admissions Coordinator regarding in-services

F 726

The education will be completed by the Director of Nursing/designee on 3/25/2022.
Any licensed staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation.
Agency licensed nurses and newly hired licensed nurses will have this education during their orientation.
4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor any new orders for life vests. If a new order is received the Director of Nursing/designee will validate competency with the licensed nurse.

Monitoring will occur 5x week for 12 weeks.

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.
5. Corrective action will be 3/29/2022.

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F 726	Continued From page 19 for the staff on the LifeVest and was told that the resident was able to manage the device himself and the only thing they had to do was to change the batteries before dialysis. The SDC further stated the resident had a family member that visited during the day who knew how to take care of the LifeVest. The SDC stated they kept a spare set of batteries in the room on the charger and the LifeVest would beep when the battery was low. The SDC stated she did not speak with the Director of Nursing regarding education for the staff regarding the LifeVest. On 3/3/22 at 11:15 AM an interview was conducted with Nurse #1 who was assigned to Resident #129 on the day shift on 3/3/22. Nurse #1 stated that she had received no training on the LifeVest and was told that the resident knew how to take care of the LifeVest. On 3/3/22 at 11:20 AM an interview was conducted with Nurse #2 who worked on the 3 PM to 11 PM shift on 3/2/22 and was assigned to Resident #129. Nurse #2 was asked if she had received training on the LifeVest for Resident #129 and the Nurse stated: "No one here knows anything about it and the only reason they took him was because he knew how to take care of it." The Nurse further stated she had received no training on the LifeVest. On 3/3/22 at 4:54 PM an interview was conducted with the Director of Nursing, the Administrator and the Corporate Nurse. The Corporate Nurse stated the staff should have been educated on the LifeVest.	F 726		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/29/22

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 880	Continued From page 20	F 880		

Continued From page 20

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 880	Continued From page 21 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility staff failed to sanitize their hands between residents when serving lunch trays for 1 of 6 halls observed during lunch (600 Hall) and the facility failed to prevent cross contamination by pushing the treatment cart in 3 of 3 resident's rooms during wound care (Room #502, #606 and #602). The findings included:	F 880	F 880 1.Resident #129, #6, #72 suffered no harm as a result of the treatment cart in the rooms. No specific resident was identified with the lunch trays. Resident #129 is no longer at the facility. 2. Current residents receiving treatments or meals are at risk for this issue.	

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	345294	A. BUILDING ______ B. WING ______	C 03/03/2022

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F 880	Continued From page 22 1. The facility policy titled Hand Hygiene/Handwashing Policy revised on 7/14/21 read: "Proper handwashing is the most important component for preventing the spread of infection." Procedure #3a read: Perform hand hygiene before and after having direct contact with residents." An observation of staff delivering meal trays to residents on the 500 and 600 Halls was made on 2/28/22 from 12:26 PM to 12:45 PM. Nursing Assistant (NA) #1 was observed to deliver a lunch tray to room number 505. NA #1 exited the room without sanitizing her hands and Resident #128 was sitting in the hall in a wheelchair near room 505. The NA went to the resident and put her hand on the Resident's arm and rolled the resident to room 606. Another staff member delivered the meal tray to room 606 and NA #1 set up the meal tray for the resident. The NA exited the room without sanitizing her hands and was requested to assist with pulling the resident in room 602 up in the bed. The NA used the draw sheet on the bed to assist another NA to pull the resident up in the bed. The NA exited the room and walked to the nurse's station. During the observation, NA #1 did not wash or sanitize her hands between residents. On 2/28/22 at 12:48 PM NA #1 stated she did not sanitize her hands between residents because it slipped her mind. NA #1 further stated she was focused on getting the lunch trays out. On 3/3/22 at 5:30 PM, the Director of Nursing stated in an interview that she expected the staff to perform hand hygiene before entering a	F 880	3. To prevent this from recurring, the licensed staff have been reeducated that a treatment cart cannot be taken into any resident room. Current nursing staff have been reeducated that hand hygiene must be performed prior to and after direct contact with residents. The education will be completed by the Director of Nursing/designee on 3/21/2022. Any licensed or nursing staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses or nursing staff and newly hired licensed nurses or nursing staff will have this education during their orientation. 4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will observe nurses doing treatments to ensure that the treatment cart is never taken across the threshold of a resident room and is secured outside the resident room when a treatment is performed. Director of Nursing or designee will observe for hand hygiene between resident care for nursing staff. The treatment cart observations will be documented 5 days a week for 4 weeks (of 1 tx) and then weekly for 8 weeks (of 1 tx). The hand hygiene observations will be documented for 5 direct care nursing staff members a day, 5 days a week for 4 weeks and then weekly for 8 weeks	

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 880	Continued From page 23 resident's room and after setting up the meal trays for each resident. 2a. On 3/2/22 at 3:40 PM, the Treatment Nurse and the RN (Registered Nurse) Supervisor were observed to provide wound care for Resident #6. The Treatment Nurse was observed to roll the treatment cart into the resident's room. The RN Supervisor placed a towel over the resident's over bed table and the Treatment Nurse removed the supplies needed for the treatment from the cart and placed on the towel on the over bed table. b. On 3/2/22 at 3:55 PM, the Treatment Nurse and RN (Registered Nurse) Supervisor were observed to provide wound care for Resident #72. The Treatment Nurse was observed to roll the treatment cart into the resident's room. The RN was observed to place a towel on the resident's over bed table and the Treatment Nurse removed supplies needed for the treatment from the treatment cart and placed on the towel on the over bed table. c. On 3/2/22 at 4:35 PM, the Treatment Nurse and RN (Registered Nurse) Supervisor were observed to provide wound care for Resident #129. The Treatment Nurse was observed to roll the treatment cart into the resident's room. The RN Supervisor was observed to place a towel on the resident's over bed table and the Treatment Nurse removed the supplied needed for the treatment from the treatment cart and placed on the towel on the over bed table. d. On 3/2/22 at 5:00 PM the Treatment Nurse was observed to roll the treatment cart into Resident #47's room. The Treatment Nurse	F 880	5. Correction action will be 3/29/2022	

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 03/03/2022

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F 880	Continued From page 24 observed the resident's buttocks and stated the wound had healed and no treatment was necessary at this time. The Treatment Nurse rolled the treatment cart out of the room. On 3/2/22 at 5:04 PM the Director of Nursing (DON) stated in an interview that if there was space in the resident's room, she would take the treatment cart in the room to get it out of the hall so it would not be in the way. On 3/2/22 at 5:10 PM the Corporate Nurse stated in an interview that he probably would not take the treatment cart in a resident's room but did not think it was wrong to do this. The Corporate Nurse further stated they did not have a policy related to taking the treatment cart in a resident's room, but they usually removed the supplies from the cart and took them in the room and left the treatment cart in the hall.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the manufacturer's instructions, the facility failed to clean the laundry dryer lint filter according to the manufacturer's specifications for 2 of 3 dryers. The findings included: Review of the User's Guide for Dryers dated May 2020 from Alliance Laundry Systems read:	F 908	F 908 1. No residents were identified with this issue. The lint filters were clean when this observation occurred. 2. All residents have the potential to be affected by this practice. 3. To prevent this from recurring, the	3/29/22

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F 908	Continued From page 25 "ALWAYS clean the lint filter after every load." On 3/3/22 at 12:00 PM an observation of the laundry with the Laundry Employee #1 that was working in the laundry. Two of 3 dryers contained linens or clothing and were operational. Laundry Employee #1 stated she worked 7:30 AM to 3:30 PM and another employee worked from 2 PM to 10 PM and the laundry was staffed 7 days a week. Laundry Employee #1 stated she cleaned the dryer lint filters twice during her shift and the person that worked 2 PM to 10 PM cleaned the dryer lint filters twice during that shift. The Employee provided a log that showed documentation that the dryer lint filter was cleaned twice a day. An observation of the laundry filter revealed approximately 1/4 inch of lint build up. On 3/3/22 at 1:10 PM the Administrator stated she looked up the dryer manufacturer's instructions and the instructions were to clean the lint filter after each load. The Administrator further stated they had cleaned the filter twice a shift for years and did not know when the practice began.	F 908	Director of Maintenance reeducated the Director of Housekeeping and laundry staff on the manufactures recommendations that the lint filters must be cleaned after every use. The education will be completed by 3/21/2022. 4. To monitor and maintain ongoing compliance, the Director of Maintenance will monitor dryer logs to validate they have been cleaned per the manufactures recommendations. Monitoring will be done 5x weekly for 12 weeks The Director of Maintenance 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. 5.Corrective action is 3/29/2022.	