| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 345567 | A. BUILDING: _____ B. WING _____ | 1/7/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF CORNELIUS | 19530 MOUNT ZION PARKWAY CORNELIUS, NC |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 655 | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with staff the facility failed to develop a person-centered baseline care plan to address the use of a continuous positive airway pressure (CPAP) device within 48 hours of admission and failed to provide a summary of the baseline care plan to the resident and Responsible Party (RP) for 1 of 2 residents reviewed for oxygen (Resident #251).<br><br>The findings included:<br><br>Review of the hospital discharge summary revealed Resident #251 was admitted on 05/03/22 with an active list of problems and diagnoses that included moderate obstructive sleep apnea. The hospital discharge summarized Resident #251's medical history and listed obstructive sleep apnea with the use of a CPAP as |

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| **AUTUMN CARE OF CORNELIUS** | **19530 MOUNT ZION PARKWAY CORNELIUS, NC** |

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| **F 655** | Continued From Page 1 |

treatment. Resident #251 was discharge from the hospital on 05/10/22.

Resident #251 was admitted to the facility on 05/10/22 with diagnoses including heart failure and chronic obstructive pulmonary disease (a chronic inflammatory lung disease obstructing airflow).

Review of the admission Minimum Data Set (MDS) dated 05/12/22 assessed Resident #251 as being cognitively intact and indicated the use of oxygen and a CPAP occurred while a resident at the facility.

Review of Resident #251's medical records revealed there was no baseline care plan initiated for the use of a CPAP for a diagnosis of obstructive sleep apnea or evidence a summary of the baseline care plan was provided to the resident or RP within 48 hours of admission.

Review of the comprehensive care plan revealed a focus for the use of a CPAP was initiated on 05/23/22 and included the intervention for nursing staff to put the CPAP on Resident #251 at bedtime and remove in the morning per Medical Doctor (MD) orders.

During an interview on 01/05/23 at 2:27 PM Nurse #1 confirmed she completed the admission assessment but didn't recall Resident #251 or the use of a CPAP. Nurse #1 revealed she didn't provide the baseline written summary to the resident or RP. Nurse #1 stated it was the responsibility of the MDS Coordinator to complete the baseline care plan.

During an interview on 01/06/23 at 11:09 AM the MDS Coordinator confirmed the admission MDS dated 05/12/22 indicated Resident #251 used a CPAP when admitted to the facility. The MDS Coordinator revealed she reviewed the hospital records when a resident was admitted and if Resident #251's discharge summary discussed the use of a CPAP for the diagnosis of obstructive sleep apnea it should have been included on the baseline care plan and initiated on admission to the facility. The MDS Nurse revealed members of the Interdisciplinary Team met with residents and invited their RP to go over the care plan within 48 hours of admission and a copy of the baseline care plan was provided at that time and maintained in the resident's medical record. The MDS Coordinator confirmed there was no documentation in Resident #251's medical records to indicate a baseline care plan written summary was provided within 48 hours after admission and thought it was overlooked.

An interview was conducted on 01/06/23 at 2:54 PM with Director of Nursing (DON). The DON stated she would expect a CPAP was initiated on admission and included on Resident #251's care plan when in use while a resident. The DON revealed she would expect the baseline care plan summary was provided to the resident and RP within the 48 hour timeframe.

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| AUTUMN CARE OF CORNELIUS | 19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 01/03/23 through 01/17/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V36Z11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint investigation were conducted on 01/03/23 through 01/07/23. Event ID #V36Z11. The following intakes were investigated: NC00188334, NC00189157, NC00189656, NC00189746, NC00192176, NC00193021, NC00193366, NC00193570, NC00193584, NC00193591, NC00194550, NC00194658, NC00196048, NC00196504.<br><br>6 of the 41 complaint allegations were substantiated and resulted in citations F561, F655, F658, and F695. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. | F 561 | | 2/2/23 |

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

Electronically Signed | 01/27/2023

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| F 561 | Continued From page 1<br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to honor a resident choice to get out of bed everyday for 1 of 3 residents reviewed for choices (Resident #44).<br><br>The findings included:<br><br>Resident #44 was admitted to the facility on 05/07/19 with diagnoses that included neuromuscular dysfunction.<br><br>Review of a care plan updated on 07/12/22 read in part, Resident #44 had deficits in activities of daily living. The goal read, Resident #44 will maintain current level of function through the next review period. The interventions included transfer with total body lift with two-person assistance.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 12/20/22 indicated that Resident #44 was cognitively intact and required extensive assistance of two staff members with transfers. The MDS further revealed no rejection of care | F 561 | Resident #44 was out of bed at the time the complaint was discovered by facility staff. There was no negative outcome due to the resident not getting out of bed.<br><br>All residents have the potential to be affected therefore on 1/17/2023, a review of all residents rights requests were made. On 1/7/2023 an audit was conducted to ensure the facility had the proper amount of slings was available. No other findings were observed.<br><br>On 1/26/23, the Director of Nursing educated all staff on the facility policy for honoring resident rights, specifically honoring residents request to get out of bed when the request is made regardless of method required, 2 person assistance with Hoyer Lifts and the location of Hoyer lift slings. New staff will be educated upon hire. | |

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| F 561 | Continued From page 2<br>was noted during the assessment reference period.<br><br>Resident #44 was interviewed on 01/03/23 at 2:09 PM and revealed that last Saturday and Sunday (12/31/22 and 01/01/23) she was not able to get out of bed because "there was no sling to use." Resident #44 explained that the Nurse Aides (NA) has been reporting to her that if the lift sling pad was soiled the staff were throwing it away instead of washing it. She further explained that when she asked why she was not able to get out of bed the NAs reported that there was not enough staff, there were not enough sling pads, or the lifts were not working correctly so she was not sure what the real reason why she could not get up those days. Resident #44 stated that she tried to accommodate the staff by not getting up by watching television, but added she liked to practice the piano and "I can not do that from my bed." Resident #44 stated that she believed NA #1 was caring for her on Saturday and Sunday when she could not get out of bed.<br><br>An observation of Resident #44 was made on 01/06/23 at 2:33 PM. Resident #44 was noted to be in the mechanical lift and was being transferred from her recliner chair to her bed by NA #1.<br><br>An interview with NA #1 was conducted on 01/06/23 at 2:43 PM who confirmed that she cared for Resident #44 on 12/31/22 and 01/01/23 and that she was not able to get her out of bed because she could not find the appropriate lift sling pad for her. She explained that Resident #44 got up every day for a short period of time and usually her lift pad remained in her room. She stated that on 12/31/22 the lift pad was not in | F 561 | The Director of Nursing or designee will interview 5 residents weekly for 12 weeks to ensure all residents are out of bed per their request.<br><br>The Administrator or designee will audit lift slings weekly for 12 weeks to ensure slings are available and easily accessible.<br><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. The Administrator is responsible for compliance. Compliance date is 2/2/2023. | |

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| F 561 | Continued From page 3 | F 561 | | |

her room, so she had gone to the laundry to look for a sling and was unable to locate one. NA #1 stated that she had gone several times to laundry and could not locate a sling to use on Resident #44. On Monday 01/02/23 when the housekeeper came to collect Resident #44's laundry, NA #1 stated she discovered her sling pad in the bottom of her laundry basket, but she did not know that it was there until after the weekend. NA #1 stated she reported to Nurse #2 that they could not find a lift pad to get Resident #44 out of bed who found a sling pad in a resident's room that was empty because the resident had gone to the hospital earlier that day but because that resident was COVID positive Nurse #2 would not allow me to use the sling pad on Resident #44.

An observation of the laundry room was made with NA #1 on 01/06/23 at 2:50 PM. The laundry room was observed to have a very large bin on wheels that was covered. NA #1 pulled back the cover and the bin was observed to be full to the top with different sling pads. NA #1 stated that the bin was full on 12/31/22 and 01/01/23 but the lift pad that Resident #44 required was not in the bin and she could not use one that was not the right size or shape for Resident #44.

A follow up interview and observation with Resident #44 was made on 01/06/23 at 2:57 PM. Resident #44 was resting in bed. There was a large box behind her bed and laying on top of the open box was a sling pad. She stated that her lift pad was kept in that box because "we try to hide it" so we always have one available.

Nurse #2 was interviewed on 01/06/23 at 3:01 PM. Nurse #2 confirmed that she worked on

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| F 561 | Continued From page 4<br>12/31/22 and 01/01/23 and that the staff had reported that they could not find a lift pad to get Resident #44 out of bed. Nurse #2 stated that NA #1 had gone several times to laundry and could not locate the correct sling to use on Resident #44. Nurse #2 explained that she had another resident who was very sick, and she had tested positive for COVID, and they had sent that resident to the hospital earlier and in her room, they found a sling pad that could be used on Resident #44 but because the resident had been COVID positive she would not allow NA #1 to use the sling on Resident #44 until it could be washed appropriately. She confirmed that Resident #44 got out of bed every day for a short period of time and would practice her piano a few times a week during the times that she was out of bed.<br><br>The Director of Nursing (DON) was interviewed on 01/06/23 at 4:41 PM. The DON explained she had only been working at the facility since 12/30/22 and was unaware that they could not find a sling pad to get Resident #44 out of bed. The DON stated that she expected the staff to honor Resident #44's request to get of bed when she wanted to.<br><br>The Administrator was interviewed on 01/06/23 at 5:35 PM. The Administrator stated that there should be sling pads available to get the residents out of bed. He stated that they have extra slings in the storage rooms. The problem is that often time the slings were not returned to the supply room. The Administrator stated that if the sling was soiled it should have been sent to the laundry and an extra sling pad obtain and used until the other sling was clean. | F 561 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation | F 610 | | 2/2/23 |

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| F 610 | Continued From page 5<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and policy review the facility failed to thoroughly investigate alleged abuse and protect residents from further abuse and failed to implement their abuse policy and procedure in the area of reporting to the State Survey Agency when they received an allegation of staff to resident abuse for 1 of 3 residents (Resident #57) reviewed for abuse.<br><br>Findings included:<br><br>Review of the facility's policy titled "Abuse, Neglect, and Exploitation" last revised 10/03/22 read in part as follows, "It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, | F 610 | The abuse allegation for resident #57 started on 1/7/23 and ended on 1/13/23.<br><br>All residents are at risk for this same deficient practice, therefore on 1/9/23, a review of all allegations were reviewed to ensure proper investigation. No other findings were observed.<br><br>On 1/6/23, the Regional Director of Clinical Services educated the Administrator on abuse policies and procedures, specifically investigation and reporting requirements. New Administrators will be educated upon hire.<br><br>The Social Service Director or designee | |

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| F 610 | Continued From page 6<br>exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy". Further review of the policy read in part as follows:<br>"Section 4<br>If a staff member is accused or suspected of abuse, neglect, mistreatment, exploitation, involuntary seclusion, and/or misappropriation of property the facility immediately removes the staff member from the resident care are and requests a written statement from the accused staff member. The accused staff member will remain under direct supervision until statement is complete and/or law enforcement arrives if applicable. The accused staff member will then be removed from the facility and the schedule pending the outcome of the investigation.<br>Section 7<br>Once the Administrator and Director of Nursing (DON) are notified an investigation of the allegation or suspicion will be conducted. The investigation must be completed within five working days from the alleged occurrence.<br>Section 9<br>Final report will be submitted to applicable State Agency after the investigation is completed but no later than five working days from the alleged occurrence".<br><br>An interview with Resident #37 on 01/04/23 at 02:51 PM revealed she reported seeing through the room divider curtain in August 2022 (she could not recall the exact date) Nurse Aide (NA) | F 610 | will interview 5 random residents weekly for 12 weeks to ensure there are no abuse allegations.<br><br>The Administrator or designee will review all outstanding allegations weekly for 12 weeks to ensure proper investigation requirements are met.<br><br>The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023. | |

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#3 hit Resident #57 on the upper body while providing care. Resident #37 said she reported the incident to Nurse #5 the same day it occurred.

During an interview with the Administrator on 01/04/23 at 05:14 PM he confirmed he was the Abuse Coordinator. He stated he was notified by Nurse #5 on 08/21/22 that Resident #37 needed to speak to him regarding an allegation of abuse. The Administrator stated he spoke with Resident #37 on 08/21/22 and she reported that she saw through the room divider curtain NA #3 hit Resident #57 while providing care. He explained he felt it was not possible to see through a room divider curtain and he already had 3 abuse investigations in progress that involved random weekly skin checks and random abuse questionnaires. The Administrator stated a skin check was done on Resident #57 on 08/21/22 and no skin abnormalities were noted and he interviewed NA #3 and NA #4 who were assigned to care for Resident #57 and they denied Resident #57 was struck by NA #3 when care was provided. He confirmed he did not suspend NA #3 or obtain a written statement from her after the allegation of abuse was reported. The Administrator stated he did not complete a 24 hour/5-day investigation and looking back he "probably should have".

An interview with NA #3 on 01/04/23 at 09:57 PM revealed she was aware of an allegation in August 2022 by Resident #37 that she struck Resident #57 while providing care to her. She stated she did not become aware of the allegation until several days after the incident when the former Director of Nursing (DON) told her Resident #37 stated she hit Resident #57. NA #3 stated the DON did not interview her regarding

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the incident. She stated the Administrator interviewed her the same day the DON made her aware of the allegation, but she never heard anything else about the incident. NA #3 stated on the day in question she and NA #4 provided incontinence care for Resident #57 and Resident #57 was combative during care, but they were able to complete the care with no problems. She stated she did not hit Resident #57 in August 2022 or any other time.

An interview with NA #4 on 01/05/22 at 11:32 PM revealed she was aware of an allegation in August 2022 by Resident #37 that NA #3 struck Resident #57 while providing care to her. She stated she did not become aware of the allegation until several days after the incident was said to have occurred. NA #4 stated the former DON asked her to write a statement regarding the reported incident and she did not hear anything else about the incident. She stated she never discussed the incident with the Administrator. NA #4 stated when she and NA #3 provided care to Resident #57 on the day in question the resident was swatting at the air, but she talked with Resident #57 and she calmed down and they completed care with no difficulty. NA #4 stated she was in the room with NA #3 the entire time care was provided to Resident #57 and NA #3 did not strike Resident #57.

An interview with Nurse #5 on 01/05/23 at 01:09 PM revealed Resident #37 reported to her one day in August 2022 (she could not recall the exact date) that the resident witnessed through a pulled room divider curtain NA #3 strike Resident #57 while NA #3 was providing care. Nurse #5 stated when Resident #37 reported the allegation of NA #3 striking Resident #57 she understood the

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| F 610 | Continued From page 9<br>incident had occurred a few days prior to Resident #57 reporting the incident to her but she notified the Administrator immediately of the report of abuse. Nurse #5 stated she asked Resident #37 to write a statement of what she witnessed between NA #3 and Resident #57, and she wrote a statement of what Resident #37 reported to her and placed both statements in the Administrator's mailbox at the end of her shift. She stated the Administrator or Director of Nursing (DON) employed at the facility in August 2022 did not interview her regarding what Resident #37 reported to her regarding alleged abuse.<br><br>In a follow-up interview with Resident #37 on 01/06/22 at 04:51 PM she stated the Administrator did not speak with her regarding her report of seeing NA #3 hit Resident #57 through the room divider curtain for "over a week" after she reported the incident to Nurse #5. Resident #37 stated the day she reported the incident to Nurse #5, Nurse #5 asked her to write a statement regarding what she observed and wrote a statement and gave it to Nurse #5.<br><br>An interview with the former DON revealed she did not recall any allegation by Resident #37 that NA #3 struck Resident #57 when care was provided. | F 610 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by: | F 641 | | 2/2/23 |

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| F 641 | Continued From page 10<br>Based on record review and facility staff interviews, the facility failed to accurately code a Minimum Data Set Assessment for the use of antipsychotics for 1 of 5 residents reviewed for unnecessary medications (Resident #12), failed to accurately code a level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR (Resident #9), and failed to accurately code a discharge location for 1 of 3 residents reviewed for discharges. (Residents #90).<br><br>The findings included:<br><br>1. Resident #12 was admitted to the facility on 06/23/19 with diagnoses that included major depressive disorder, and mood disorder.<br><br>A review of Resident #12's quarterly Minimum Data Set Assessment (MDS) dated 11/12/22 revealed she received antipsychotic medications 7 of 7 days during the assessment period. Resident #12 was coded as not receiving antipsychotics on a scheduled or routine basis.<br><br>A review of Resident #12's physician orders revealed an order dated 03/02/22 for Aripiprazole tablet 2 milligrams - give 1 tablet by mouth one time a day for mood disorder.<br><br>During an interview with MDS Nurse #1 on 01/05/23 at 11:48 AM, she reported the facility's corporate MDS Nurse completed the assessment and must have mis-clicked the box indicating whether or not Resident #12 had received antipsychotic medications on a routine basis. She verified the Minimum Data Set Assessment was inaccurate and that antipsychotic use should be coded correctly. | F 641 | On 1/5/23 resident #12 Minimum Data Set was modified to reflect use of antipsychotics. There was no negative outcome. On 1/5/23 resident #9 Minimum Data Set was modified to reflect an accurate PASRR. There was no negative outcome. On 1/5/23 resident #90 Minimum Data Set was modified to reflect the proper discharge location. There was no negative outcome.<br><br>All residents have the potential to be affected therefore on 1/19/2023, a review of all residents with antipsychotic medications were complete to ensure these were coded properly on the MDS. Negative findings were corrected on 1/19/23. On 1/24/23 a review of all submitted Minimum Data Set Assessments from the past 30 days was complete to ensure PASRRs were accurate on the Minimum Data Set. On 1/5/23 a review of all discharges within the past 30 days was complete to ensure proper discharge location was coded on the Minimum Data Set. Negative findings were corrected on 1/19/23.<br><br>To prevent this from, reoccurring again 1/19/23 the Regional Clinical Reimbursement Specialists completed education to the Minimum Data Set Coordinators on accuracy of assessments, specifically related to antipsychotic and discharge location. On 1/24/23 the Administrator completed education to the Social Worker and Social Work Assistant on accuracy of assessments, specifically related to | |

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| F 641 | Continued From page 11<br><br>During an interview with the Corporate Nurse on 01/05/23 at 5:06 PM, she reported Minimum Data Set assessments should accurately reflect the use of antipsychotic medications and the error should have been caught before submission and corrected.<br><br>During an interview with the Administrator on 01/06/23 at 7:32 PM he reported the facility had a system in place that audited MDS assessments for accuracy. He stated however, the audit system was not a 100% audit so there were opportunities for inaccuracies to "slip through." He reported MDS assessments should be accurate and reflect the use of antipsychotic medications for Resident #12<br><br>2. Review of document titled Preadmission Screening Resident Review (Pasrr) dated 06/07/22 indicated that Resident #9 was determined to be Level 2 Pasrr.<br><br>Resident #9 was admitted to the facility on 06/16/22 with diagnoses that included paranoid personality disorder and traumatic brain injury.<br><br>Review of the admission comprehensive Minimum Data Set (MDS) dated 06/22/22 indicated that Resident #9 did not have a Level 2 Pasrr and was completed by the MDS Coordinator.<br><br>The MDS Coordinator was interviewed on 01/06/23 at 12:31 PM. The MDS Coordinator confirmed she had completed the admission comprehensive MDS dated 06/22/22 for Resident #9 and confirmed he had a Level 2 Pasrr in place. | F 641 | PASRR coding. New Social Workers and MDS Coordinators will be educated upon hire.<br><br>The MDS Coordinator or designee will audit all submitted MDSs weekly for 4 weeks, then randomly audit 10 for 8 weeks to ensure proper coding of antipsychotic medications, PASRR coding and proper discharge locations.<br><br>The Minimum Data Set Coordinator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 2/2//202 | |

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| F 641 | Continued From page 12 | F 641 | | |

She stated it was "probably an accident, I meant to click yes and accidentally clicked no." The MDS Coordinator stated she would correct the mistake immediately.

The Director of Nursing (DON) was interviewed on 01/06/23 at 4:34 PM. The DON stated that she expected the MDS assessments to be completed accurately including the Pasrr information.

The Administrator was interviewed on 01/06/23 at 5:19 PM. The Administrator stated that the MDS should be coded accurately including the Pasrr information.

3. Resident #90 was admitted to the facility on 10/27/2022 and discharged to home on 11/11/2022.

Review of the facility discharge summary dated 11/8/2022 revealed Resident #90 was to be discharged home with her family.

Review of the care plan conference documentation dated 11/10/2022 revealed Resident #90 was scheduled for discharge to home on 11/11/2022.

Review of the discharge Minimum Data Set (MDS) dated 11/11/2022 noted Resident #90 had been discharged to an acute hospital with return not anticipated.

An interview was conducted with the MDS Coordinator on 1/5/2022 at 11:48 AM. The MDS Coordinator stated Resident #90's discharge MDS dated 11/11/2022 should have noted she discharged to the community instead of to an

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| F 641 | Continued From page 13<br>acute hospital. The MDS Coordinator explained this must have been noted by accident.<br><br>An interview was conducted with the Corporate Nurse and the Administrator on 1/5/2022 at 5:06 PM: The Corporate Nurse stated that the discharge MDS dated 11/11/2022 for Resident #90 should reflect that she was discharged to home not to the hospital. The Administrator stated that he expected all MDS data to be coded accurate and to reflect the resident's assessment and disposition. | F 641 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with staff the facility failed to clarify a physician's order for pain medication to include the frequency of administration between doses for 1 of 5 residents reviewed for pain (Resident #96).<br><br>The findings included:<br><br>Resident #96 was admitted to the facility on 12/21/22 with diagnoses including a displaced fracture of left femur.<br><br>Review of the care plan focus for pain initiated on 12/21/22 revealed Resident #96's pain was related to a left hip fracture. Interventions included administer medications as ordered. | F 658 | The medication order was clarified for resident # 96 on 1/5/23.<br><br>All residents have the potential to be affected therefore, on 1/9/2023, a review of all medications were complete to ensure the order was complete.<br><br>On 1/24/23, the Director of Nursing educated all nurses on ensuring orders are entered completely, that the MAR matches to medication label and MD notification if discrepancy is found. New nurses will be educated upon hire.<br><br>The Director of Nursing or designee will | 2/2/23 |

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| F 658 | Continued From page 14<br><br>Review of the admission Minimum Data Set (MDS) dated 12/27/22 assessed Resident #96 as being cognitively intact. The MDS revealed scheduled and as needed pain medication was received or offered during the assessment period.<br><br>Review of the physician's order written on 12/31/22 instructed to give tramadol (an analgesic opioid pain medication) 50 mg as needed for pain. The order did not include frequency of administration between each dose. The physician's order was transcribed by Nurse #6.<br><br>Review of the Medication Administration Record (MAR) revealed a 50 mg dose of tramadol was administered on 01/01/23 at 8:24 AM and a second 50 mg dose at 2:45 PM and a third 50 mg dose at 7:58 PM for pain and documented as effective. The first and second doses of tramadol given on 01/01/23 at 8:24 AM and 2:45 PM were administered by Nurse #3. On 01/02/23 the MAR revealed a 50 mg dose of tramadol was administered at 3:59 PM and a second 50 mg dose was administered at 7:53 PM by Medication Aid #1 for pain and documented as effective.<br><br>An interview was conducted on 01/06/23 at 8:17 AM with Nurse #6. Nurse #6 confirmed she transcribed the physician's order for tramadol on 12/31/22 for Resident #96. After review of the order Nurse #6 stated she transcribed it incorrectly and indicated it was an oversight on her part. Nurse #6 revealed she didn't include the frequency between doses that was a requirement for a complete physician's order of a medication being used as needed. | F 658 | review all medication orders in morning clinical meeting weekly for 12 weeks to ensure orders are entered completely.<br><br>The Director of Nursing or designee will randomly audit 2 medication carts weekly for 12 weeks to ensure medication labels match MARs and MD orders.<br><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.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023. | |

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| F 658 | Continued From page 15<br>An interview was conducted on 01/06/23 at 5:41 PM with Nurse #3. Nurse #3 revealed the medication label included the frequency between doses to give every 6 hours and she recalled telling the oncoming nurse to give it every 6 hours because it wasn't on the physician's order or MAR. Nurse #3 stated she should've called the Medical Doctor to clarify the order to include the frequency between doses.<br><br>During an interview on 01/06/23 at 5:18 PM Medication Aid #1 confirmed she administered Resident #96's tramadol on 01/02/23. Medication Aid #1 revealed she did not ask for clarification of the frequency between doses and when Resident #96 asked for the medication she administered it.<br><br>An interview was conducted with the Director of Nursing (DON) on 01/06/23 at 2:46 PM. The DON stated she would expect the administering nurse to get clarification from the Medical Doctor (MD) to include time parameters between doses to administer tramadol as needed. The DON revealed the clinical team reviewed new medication orders and two checks were done to ensure physician orders were complete.<br><br>During an interview on 01/06/23 at 4:46 PM the Administrator stated he would expect the nurse to get clarification for an incomplete order to include when to administer an as needed pain medication with no time parameter between doses. | F 658 | | |
| F 661 SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, | F 661 | | 2/2/23 |

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| F 661 | Continued From page 16<br>but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, and family interviews the facility failed to fully complete and ensure the accuracy of a recapitulation of stay for 1 of 3 residents reviewed for discharge (Resident #143).<br><br>The findings included:<br><br>Resident #143 was admitted to the facility on 07/27/22 with diagnoses that included sequelae of cerebral infarction (stroke) and dysphagia (trouble swallowing). Resident #143 discharged to | F 661 | Resident #143 is no longer at the facility.<br><br>All residents have the potential to be affected therefore, on 1/19/2023, a review of all discharged residents within the last 30 days was complete to ensure accuracy of discharge instructions and discharge summaries. All other findings were corrected.<br><br>On 1/26/23, the Administrator educated the Social Worker, Dietary Manager, | |

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| F 661 | Continued From page 17<br>the community on 08/15/22.<br><br>Review of the comprehensive admission Minimum Data Set (MDS) dated 08/02/22 indicated that Resident #143 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living to include bed mobility, toileting, dressing, and personal hygiene.<br><br>Review of a physician order dated 08/03/22 read cardiac puree diet with nectar thick liquids.<br><br>Review of a physician order dated 08/15/22 read; stable for discharge home on 08/15/22 with home health.<br><br>Review of a facility document titled Discharge Instructions dated 08/15/22 revealed a section titled "Nursing" and included dietary instructions that indicated Resident #143 was discharged on a regular diet with thin liquids and no special diet instructions were noted. The section was signed by Nurse #1. The document further revealed a section titled "Rehab" that was blank and contained no information about the resident's functional mobility or how much assistance was needed for activity of daily living care. The section was not signed by any staff member. The entire document was signed and dated by Resident #143's family member.<br><br>The Social Worker (SW) was interviewed on 01/05/22 at 9:47 AM. The SW stated that each morning in the clinical meeting she would announce the residents that were going to discharge that week. She stated that she would then open the recapitulation of stay or discharge instructions in the electronic medical record and | F 661 | Director of Nursing, Director of Rehabilitation, and Director of Activities to ensure accuracy and completion of discharge summaries and discharge instructions. Licenses nurses were educated on 2/1/23 on accuracy and completion of discharge instructions and summaries. New Social Workers, Dietary Managers, Director of Nurses, Director of Rehabilitation, and Director of Activities will be educated upon hire.<br><br>The Social Services Director or designee will audit all discharges weekly for 12 weeks to ensure accuracy and completion of discharge summaries, discharge instructions and reviewed with Resident or representative.<br><br>The Social Services Director will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023 | |

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each department manager would go in and fill out their appropriate sections. Upon discharge the nurse would print off the document, go over it with the resident and/or family, and then have the family sign the document and provide them a copy while the original copy would be placed in the resident's medical record. The SW stated that the department managers were aware that they were responsible for completing the document prior to the resident's discharge.

Nurse #1 was interviewed on 01/05/23 at 2:45 PM. Nurse #1 confirmed that she had discharged Resident #143 from the facility on 08/15/22. She further confirmed that she was responsible for completing the section titled "Nursing" on the recapitulation of stay and would have looked up the information to put on the form. Nurse #1 stated that the Rehab program manager would be responsible for completing the "Rehab" section. Each morning in their morning meeting the SW would go over the upcoming discharges and open the recapitulation of stay document in the electronic record then each department manager would go in and complete their section. Nurse #1 added upon discharge she would complete the "nursing" section print off and go over the document with the family and give them a copy and have them sign a copy of the document. Nurse #1 could not explain why the discharge instructions indicated that Resident #143 was a regular diet with thin liquids when she had a physician order to be on puree diet with nectar thick liquids. When asked if she educated the family on preparing thick liquids for Resident #143, she stated "no."

The Rehab Program Manager was interviewed via phone on 01/05/23 at 4:29 PM. The Rehab

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| F 661 | Continued From page 19<br>Program Manager confirmed that it was her responsibility to complete the "Rehab" section of the recapitulation of stay. She explained that the SW would open the document in the electronic medical record and then in the morning meeting let everyone know that the resident was being discarded and when. Then the department managers would go in a fill out their appropriate section of the recapitulation of stay. The Rehab Program Manger stated that it was very possible that she may have missed completing the document for Resident #143 but added the social worker "was really good about letting me know if I had not done my part."<br><br>An interview with Resident #143's family member was conducted via phone on 01/06/23 at 1:31 PM. The family stated that she picked up Resident #143 from the facility on 08/15/22 and cared for her at home with no issues until she found another facility that her mother could go to.<br><br>The Director of Nursing (DON) was interviewed on 01/06/23 at 4:30 PM. The DON stated that each resident that was discharged from the facility was to have a complete an accurate recapitulation of stay with a copy being provided to the resident and/or family.<br><br>The Administrator was interviewed on 01/06/23 at 5:10 PM. The Administrator stated the recapitulation of stay should be completed fully and be accurate and provided to the resident and/or family on discharge from the facility. | F 661 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including | F 695 | | 2/2/23 |

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| F 695 | Continued From page 20<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with staff the facility failed to obtain a physician's order for use of a continuous positive airway pressure (CPAP) machine for a resident admitted with a diagnosis of moderate obstructive sleep apnea (sleep-related breathing disorder) for 1 of 2 residents reviewed for oxygen (Resident #251).<br><br>The findings included:<br><br>Review of the hospital discharge summary revealed Resident #251 was admitted on 05/03/22 with an active list of problems and diagnoses that included moderate obstructive sleep apnea. The hospital discharge also included a summarization of Resident #251's medical history that listed obstructive sleep apnea with the use of a CPAP. Resident #251 was discharge from the hospital on 05/10/22 with no physician orders in place for the use of a CPAP.<br><br>Resident #251 was admitted to the facility on 05/10/22 with diagnoses including heart failure and chronic obstructive pulmonary disease (a chronic inflammatory lung disease obstructing airflow). Resident #251 was discharged to the community on 06/02/22.<br><br>Review of the admission Minimum Data Set | F 695 | Resident #251 is no longer a resident at Autumn Care of Cornelius.<br><br>All residents have the potential to be affected therefore, on 1/24/23 all resident that admitted within the last 30 days were reviewed to ensure that proper respiratory services are being provided, specifically those with sleep apnea needing CPAP machine.<br><br>On 1/26/23, the Director of Nursing educated all licensed nurses on ensuring residents with respiratory diagnoses have the proper physicians order and equipment available to treat all respiratory diagnosis. All new licensed nurses will be educated upon hire.<br><br>The Director of Nursing or designee will review all new admission discharge summaries weekly for 12 weeks to ensure orders and proper equipment are obtained as indicated for residents with respiratory diagnosis.<br><br>The Director of Nursing will report the results of the monitoring to the QAPI committee for review and | |

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| F 695 | Continued From page 21<br>(MDS) dated 05/12/22 assessed Resident #251 as being cognitively intact and indicated the use of oxygen and a CPAP occurred while a resident at the facility.<br><br>Review of the physician orders written on 05/20/22 directed staff to put on the CPAP for Resident #251 at bedtime every night using the home settings for sleep and remove every morning.<br><br>Review of the comprehensive care plan revealed on 05/23/22 the use of a CPAP was initiated and included the intervention for nursing staff to put the CPAP on Resident #251 at bedtime and remove in the morning per Medical Doctor (MD) orders.<br><br>During an interview on 01/05/23 at 2:27 PM Nurse #1 confirmed she completed the admission assessment but didn't recall Resident #251. Nurse #1 stated if Resident #251 was admitted with a CPAP it was the nurses responsibility to assist putting it on and would be left on the home settings. Nurse #1 stated an MD order was needed for the use of a CPAP machine.<br><br>During an interview on 01/06/23 at 11:09 AM the MDS Coordinator revealed she would review the hospital records when a resident was admitted and if Resident #251's discharge summary discussed the use of a CPAP for the diagnosis of obstructive sleep apnea a physician's order was needed. The MDS Coordinator stated we should've clarified the use of the CPAP with the MD and obtained an order for the use prior to 5/20/22.<br><br>An interview was conducted on 01/06/23 at 2:54 | F 695 | recommendations for the time frame of the monitoring period.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023. | |

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| F 695 | Continued From page 22<br>PM with Director of Nursing (DON). The DON stated if there was no MD order, she would expect the nurses to clarify the use of the CPAP with the physician and obtain an order.<br><br>An interview was conducted on 01/06/23 at 4:37 PM with the Administrator. The Administrator stated he would expect an MD order was in place for the use of a CPAP at the time of admission. The Administrator revealed if the hospital discharge summary identified Resident #251 had sleep apnea and used a CPAP with no physician order, he would expect the nurse to obtain clarification from the MD. | F 695 | | |
| F 814 SS=E | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to ensure the area around the dumpster was free of trash and debris for 1 of 2 dumpster reviewed.<br><br>The findings included:<br><br>An observation of the dumpster area and interview with the Dietary Manager (DM) was conducted on 01/03/23 at 11:05 AM. The observation revealed 2 dumpsters one for cardboard that was noted to be empty. The other dumpster was for trash, the door on the left side was open and a clear trash bag that was busted laid next to the open door. The bag was busted with food and trash littered all over the ground and up against the dumpster. There were multiple | F 814 | Dumpster trash was cleaned on 1/3/23.<br><br>The facility has one dumpster area and therefore no other area has potential for the same deficient practice.<br><br>To prevent this from, reoccurring again on 1/24/23 the Director of Nursing completed education for all staff to ensure dumpster areas are clean. New staff will be educated upon hire.<br><br>The Maintenance Supervisor or designee will audit the dumpster area 5 days per week for 12 weeks to ensure continued compliance for dumpster area. | 2/2/23 |

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| F 814 | Continued From page 23<br>clear bags that were busted and debris of food, food pans, cups, utensils, broken and unbroken plates, glass plates, used gloves, glove boxes, and paper was littered approximately ten feet around the dumpster area. The DM stated she was not sure who was responsible for cleaning the dumpster area.<br><br>An interview was conducted with Dietary Aide (DA) #1 on 01/03/23 at 11:08 AM. DA #1 stated that the DM had summoned him to the dumpster area with a broom and dustpan. He stated that the dumpsters were emptied every 2-3 days but usually they only emptied them about every 4 days. DA #1 stated that it was housekeeping and maintenance responsibility to keep the dumpster area clean.<br><br>An interview was conducted with the Floor Tech on 01/03/23 at 11:11 AM who stated he also worked in the maintenance department at the facility. He stated that the dumpsters were emptied every day, and they just did a "cleanup" in the dumpster area not too long ago. The Floor Tech added that it was everyone's responsibility to keep the area clean. He described the area as "nasty" and indicated that all the food and debris should be in the dumpster because it had the potential to attract rats and other rodents.<br><br>The Administrator was interviewed on 01/06/23 at 6:45 PM who confirmed the dumpsters were emptied two times a week and the maintenance staff would go out there once a week to ensure the area was clean and that there was no trash or debris on the ground. The Administrator stated that he had sent out a text to all the departments last week letting everyone know that they were responsible for ensuring their own trash was | F 814 | The Administrator or designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023. | |

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| F 814 | Continued From page 24<br>disposed of properly. | F 814 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to | F 867 | | 2/2/23 |

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| F 867 | Continued From page 25 | F 867 | | |

adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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| F 867 | Continued From page 26<br>resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility's Quality Assurance and | F 867 | The Administrator has been reeducated by the Regional Vice President of | |

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| F 867 | Continued From page 27<br>Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey of 06/04/21 and the focused infection control and complaint survey of 7/23/2020. This was for two deficiencies that were originally cited in June and July 2020 in the area of respiratory care and infection control and prevention and was subsequently recited on the current recertification survey of 01/07/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.<br><br>The Findings Included:<br><br>This tag is cross referred to:<br><br>F695 - Based on record review and interviews with staff the facility failed to obtain a physician's order for use of a continuous positive airway pressure (CPAP) machine for a resident admitted with a diagnosis of moderate obstructive sleep apnea (sleep-related breathing disorder) for 1 of 2 residents reviewed for oxygen (Resident #251).<br><br>During the recertification and complaint investigation survey completed on 06/04/21 the facility failed to ensure an oxygen tank had oxygen in it and was delivering oxygen to the resident.<br><br>F880 - Based on record review, observations, and interviews with staff the facility 1) failed to implement their policy and procedures for Hand Hygiene when Nurse Aide #2 did not perform hand hygiene before donning gloves and after possible contact with body fluids before touching | F 867 | Operations concerning the policy Quality Assurance and Performance Improvement (QAPI) Program.<br><br>The facility will hold monthly meetings, utilizing the company's standard QAPI format to review plans for areas identified in state surveys, mock surveys, facility audits, regional team visits, concern form reviews and any other feedback given to the facility. The committee will evaluate the effectiveness of each plan based on the monitoring feedback and decide if there needs to be a continuation, changed or resolution of the plans.<br><br>The meeting minutes will be reviewed by the Regional Vice President of Operations or Regional Director of Clinical Services each month for 3 months. Random audits of identified issues will be done by the Regional Director of Clinical Services during visits.<br><br>The Administrator is responsible for this plan of correction. Compliance date is 2/2/23. | |

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| F 867 | Continued From page 28 | F 867 | | |

other surfaces in the room for 1 of 1 resident reviewed for incontinence care (Resident #49), 2) failed to store soiled linens off the floor for 1 of 1 laundry room, 3) failed to follow the "Droplet Precautions" signage posted by the door of a resident's room when 1 of 1 staff (Activity Assistant #1) did not don a gown while feeding a resident for 1 of 4 residents on droplet/contact precautions (Resident #98).

During the recertification and complaint investigation survey completed on 06/04/21 the facility failed to implement enhanced droplet precautions for a resident who readmitted to the facility and was unvaccinated against COVID-19 and failed to implement enhanced droplet precautions for a newly admitted resident who was unvaccinated against COVID-19.

During the focused infection control and complaint survey on 7/23/20 the facility failed to ensure staff performed hand hygiene after contact with a resident or objects in the residents room for 3 of 3 residents failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage indicating Advance Droplet Contact Precautions for 3 of 3 residents (Resident #1, #2,and #3), failed to perform proper decontamination and removal of items removed from a room with signage indicating Advanced Droplet Contact Precautions (Resident #3), the facility failed to develop and implement policies on wearing face coverings (Staff 1 of 1), the facility failed to develop and implement policies for wearing PPE and performing hand hygiene when entering and exiting resident care rooms for residents on Advanced Droplet Contact Precautions (Staff 5 of 5), and ensure proper

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| F 867 | Continued From page 29<br>usage of face coverings by reception staff when screening employees and visitors. (Staff 1 of 1). These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19.<br><br>During an interview with the Administrator on 01/06/23 he reported the facility's Quality Assurance (QA) Team met once a month and reviewed current plans within the QA process. He indicated that respiratory care was not currently in the QA plans but reported it would included moving forward. The Administrator stated however, infection control and prevention was in the QA process and that he felt the breakdown with infection control during the recertification survey revolved around his staff being in a rush and a lack of "thorough thinking". He reported the staff member at the center of the infection control breakdown had received training upon hire and then multiple other times during their employment at the facility. The Administrator stated all repeat citations would be placed back into the QA process along with additional new citations and all non-cited complaint allegation areas. | F 867 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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. | F 880 | | 2/2/23 |

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§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:
(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

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| | 345567 | A. BUILDING _____ B. WING _____ | C 01/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF CORNELIUS | 19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031 |

| (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 |
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| F 880 | Continued From page 31<br>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and interviews with staff the facility 1) failed to implement their policy and procedures for Hand Hygiene when Nurse Aide #2 did not perform hand hygiene before donning gloves and after possible contact with body fluids before touching other surfaces in the room for 1 of 1 resident reviewed for incontinence care (Resident #49), 2) failed to store soiled linens off the floor for 1 of 1 laundry room, 3) failed to follow the "Droplet Precautions" signage posted by the door of a resident's room when 1 of 1 staff (Activity Assistant #1) did not don a gown while feeding a resident for 1 of 4 residents on droplet/contact precautions (Resident #98).<br><br>The findings included:<br><br>Review of the facilities Hand Hygiene/Hand | F 880 | Resident #49 did not have negative outcomes due to not performing hand hygiene before donning gloves and after possible contact with body fluids before touching other surfaces in the room. Linen was removed off the floor on 1/24/23. Resident #98 did not have negative findings due to staff not wearing proper PPE in isolation room.<br><br>All residents have the potential to be affected, therefore on 1/26/23 a round was made by the Administrator and Director of Nursing to ensure gloves were not being worn in the hallway, linen was not on the laundry room floor, and staff were wearing appropriate PPE in isolation rooms. | |

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| F 880 | Continued From page 32<br>Washing policy revised on 07/14/21 read in part, "hand washing was the most important component for preventing the spread of infection and the use of gloves does not replace the need for hand cleaning." The policy provided guidance when to perform hand hygiene including before and after having direct contact with residents and after contact with body fluids or excretions.<br><br>1. During an observation and interview on 01/05/23 at 1:07 PM Nurse Aide (NA) #2 donned a pair of gloves without performing hand hygiene and began to provide care for an episode of urinary incontinence for Resident #49. NA #2 used premoistened wipes to clean the front peri-area then asked Resident #49 to roll to the side then wiped the buttocks. Without removing her gloves and performing hand hygiene NA #2 applied a clean brief then removed a tube of barrier cream from the nightstand drawer. NA #2 applied the cream to Resident #49's buttocks and replaced the tube back in the drawer and closed it. Without removing her gloves and performing hand hygiene NA #2 used the opposite hand to grab the bed remote and reposition the head of the bed. NA #2 then removed her gloves. NA #2 revealed she knew infection control procedures and should've washed her hand hands before donning gloves and removed her gloves and performed hand hygiene after possible contact with body fluids before she touched other items in the room.<br><br>An interview was conducted on 01/06/23 at 8:45 AM with Unit Manager #1. Unit Manager #1 revealed she provided infection control and hand hygiene education to NA staff during their orientation upon hire and ongoing throughout their employment. Unit Manager #1 explained she | F 880 | To prevent this from, reoccurring again 1/26/23 the Director of Nursing completed education for all staff on infection control practices and procures including hand hygiene, donning gloves, gowns, and goggles per policy, gloves being worn in the hallway, linen on the laundry room floor, and ensuring the proper PPE is worn while in isolation rooms. New staff will be educated on these items during orientation.<br><br>The Director of Nursing or designee will randomly audit 5 staff weekly to ensure proper hand hygiene is being completed during routine resident care for 12 weeks.<br><br>The Administrator or designee will randomly audit the laundry room 5 times a week for 12 weeks to ensure proper linen storage and linen not being stored on the floor.<br><br>The Director of Nursing or designee will randomly audit 5 staff weekly to ensure that staff are wearing proper PPE in isolation rooms and that staff are not wearing gloves in the hallways for 12 weeks.<br><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.<br><br>The Administrator is responsible for compliance. Compliance date is 2/2/2023 | |

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| F 880 | Continued From page 33 | F 880 | | |

reviewed procedures for when to wash your hands that included before donning gloves and if there was possible contact with body fluids. Unit Manager #1 stated she expected the NA staff to wash their hands prior to donning gloves and remove gloves and wash their hands after wiping a resident clean for incontinence before touching other surfaces in the room.

2. An observation and interview were conducted on 01/06/23 at 9:58 AM of the laundry room with Housekeeper/Laundry Aide #1. A small pile of bed linens and blankets were observed on the floor by the washing machine. Housekeeper/Laundry Aide #1 revealed the laundry on the floor was dirty and putting it there made it easier to sort. Housekeeper/Laundry Aide #1 revealed she was used to seeing dirty/soiled laundry on the floor in the laundry room. There were 2 large sized empty storage bins available and located close to the dirty laundry. Housekeeper/Laundry Aide #1 donned gloves and removed the soiled linens and blankets off the floor and placed in a storage bin.

An interview was conducted on 01/06/23 at 10:09 AM with the Maintenance/Laundry Supervisor. The Maintenance/Laundry Supervisor stated soiled laundry should not be placed directly on the floor instead placed in the designated laundry bins and pointed to the 2 large empty bins located by where the soiled laundry was on the floor. The Maintenance/Laundry Supervisor revealed the 2 bins were dedicated for soiled laundry and he would label them to make it easier for the staff to identify where to place dirty/soiled laundry.

An interview was conducted on 01/06/23 at 2:58

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| F 880 | Continued From page 34 | F 880 | | |

PM with the DON. The DON stated soiled laundry should not be placed directly on the floor in the laundry room. The DON stated she would expect Housekeeping/Laundry staff to use the designated soiled linen bin in the laundry room.

3. Droplet Precautions include:

a. A mask is worn for close contact with infectious resident.
b. Gloves, gown, eye protection are worn adhering to Standard Precaution guidelines.

An observation of a sign titled "Droplet Precautions" outside Resident #98's room on 01/04/23 at 09:23 AM revealed the sign stated anyone entering the room must perform hand hygiene and wear a surgical mask, gloves, and a gown. A cart containing isolation gowns was positioned outside Resident #98's room.

An observation of Activity Assistant #1 on 01/04/22 at 09:24 AM revealed she was feeding Resident #98 breakfast. Activity Assistant #1 was observed to be wearing a mask and gloves. Activity Assistant #1 was not wearing a gown while feeding Resident #98.

During an interview with Activity Assistant #1 on 01/04/23 at 09:32 AM she confirmed she was not wearing a gown while feeding Resident #98. When Activity Assistant #1 was asked if she saw the sign outside Resident #98's room directing anyone who entered the room to wear a gown, gloves, and mask she stated she did not. Activity Assistant #1 stated if she had seen the "Droplet Precautions" sign outside Resident #98's room she would have put on a gown before entering the room.

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| F 880 | Continued From page 35<br><br>An interview with Unit Manager #1 on 01/05/22 at 02:16 PM revealed Resident #98 was placed on droplet precautions on 01/02/23 due to her roommate testing positive for COVID-19 on 01/02/23.<br><br>An interview with the Director of Nursing (DON) on 01/06/23 at 03:14 AM revealed if a resident was on droplet precautions she expected staff to wear a gown while feeding the resident. | F 880 | | |