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 01/05/2024

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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/4/2024 through 1/5/2024. The following intake was investigated NC00210902. 2 of 2 of the complaint allegations did not result in deficiency. Past non-compliance was identified at: CFR 483.25 at F689 at Scope and Severity (J). The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to ensure a resident was safely transferred into the facility's transportation van, when the Transport Driver failed to utilize the safety strap while the lift platform was being raised on the facility van. This resulted in the resident (Resident #3) falling from the lift and sustaining injuries to the left side of his head, left wrist, and left elbow. This occurred when the facility Transport Driver was picking up	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/25/2024

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.

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 01/05/2024

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
F 689	Continued From page 1	F 689		

Resident #3 from a doctor's office appointment on 11/29/2023. The office personnel called emergency medical services (EMS) and Resident #3 was transported to the emergency room (ER) at Hospital #1, where he was diagnosed with a traumatic subdural hematoma (pool of blood between the brain and the outermost layer that can put pressure on the brain) without loss of consciousness. Resident #3 requested to be transferred to the trauma service at Hospital #2, where he received treatment until he was discharged on 12/7/2023. This was for 1 of 1 resident (Resident #3) reviewed for accidents.

Findings included:

The manufacturer's instructions for the proper use of the van's lift during transportation specified, "that to load a passenger, start with the platform at ground level and the outer barrier [at base] fully extended. Move the passenger onto the lift platform into position within the yellow boundaries. Again, lock the wheelchair brakes or turn off wheelchair power on powered chairs, buckle the handrail belt safety strap if equipped, and have the passenger hold the lift handrails, if possible, for additional support. While being sure to stand clear of the lift, press and hold lift switch on the handheld control." It further read, "that when the platform was at ground level the outer barrier forms a bridge between the platform and the ground and upward movement would be prevented by the interlock system until the outer barrier was fully upright."

Resident #3 was admitted to the facility on 11/15/2023, with diagnosis to include cerebral vascular infarction (stroke) and hemiplegia (paralysis of one side of the body) and

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 01/05/2024

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
F 689	Continued From page 2	F 689		

hemiparesis (weakness on one side of the body) affecting left side. He was admitted to Hospital #2 on 11/29/2023 with a traumatic subdural hemorrhage without loss of consciousness and he was readmitted to the facility on 12/7/2023.

The physician's orders for Resident #3 revealed an order dated 11/16 2023 for Clopidogrel Bisulfate (a medication that prevents clots from forming and increases risk of bleeding) 75 milligrams (mg). Give 1 tablet by mouth one time a day for history of CVA.
Resident #3's Admission Minimum Data Set (MDS) assessment dated 11/21/2023 revealed the resident was moderately cognitively impaired and required assistance of 1 staff member with activities of daily living (ADL). He was coded for using a wheelchair for locomotion on and off the unit.

A review of the written statement written by the Transport Driver on 11/29/2023 revealed in part, "I was attempting to load [Resident #3] onto the van lift after his urologist appointment. His wheelchair had a leg rest that extended outward and because it touched the front yellow bar and wheels touched the back bar (when raised) the electric lift would not work. I was attempting to hand crank him up enough so I could raise the back bar up (it did not come up automatically like it was supposed to). The lift was about 6 inches up, when he shifted, and the chair flipped sideways off the lift. I do not know if the brakes came loose or if he moved in the chair. He sits more to the left in the chair, so his arm rests comfortably in the armrest. I had tried to adjust the leg rest so that it would not touch the front but could not get it to move. After he fell, I ran inside to get help, while a person passing by called 911.

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 01/05/2024

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
F 689	Continued From page 3	F 689		

I came back and placed a small pillow under his head and put my jacket over him. When EMS arrived, they put him back in his wheelchair. I spoke to them and asked them to transport him to the ER. I honestly do not understand how it happened; what caused the chair to move. "

The Hospital #1 ER Physician report dated 11/29/2023 at 2:28 PM read in part that Resident #3 was transported via EMS for a fall that occurred when his wheelchair tipped over when he was on the lift platform being raised into the van. Resident #3 sustained a left head, left wrist, and left elbow injury, and he complained of a moderate left sided headache. It further read that there was no change in symptoms during the ER observation, neuro exam unchanged, lungs clear, alert, vital signs stable. The ER Physician reviewed labs, and Cat scan (computed tomography) which were consistent with a UTI (urinary tract infection) and a traumatic subdural hematoma (a pool of blood between the brain and its outermost covering, this can cause pooled blood to push on the brain). The physical exam further revealed that Resident #3 had a 1-centimeter (cm) abrasion over the left eye, and mild tenderness noted over the left elbow and wrist, with a 1 cm superficial laceration noted over the left elbow. Resident #3 was treated with Tranexamic acid (a drug used to control bleeding), Keppra (an antiseizure medication), and Rocephin (an antibiotic) administered intravenously. Resident #3 requested to be transferred to the trauma service at Hospital #2 where he had received care following his stroke. He was accepted by the Trauma Surgeon for transfer, and he was transferred to Hospital #2 on 11/29/2023.

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 01/05/2024

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
F 689	Continued From page 4	F 689		

A progress note written by the Trauma Surgeon at Hospital #2 on 11/30/2023 at 8:37 AM revealed Resident #3 was admitted to the intensive care unit on 11/29/2023 at 4:50 PM with a subdural hematoma, traumatic brain injury, and acute pain secondary to fall from his wheelchair. It further read that Resident #3 was treated with Desmopressin (a medication used to treat increased thirst and urination caused by head surgery or head trauma), and he was administered platelets (tiny cells in the blood that stick together to form clots) intravenously. The note further read that Neurosurgery was consulted and a repeat cat scan of the head had been ordered.

A progress note written by the Nurse Practitioner (NP) for Trauma Surgery dated 12/1/2023 at 8:39 AM revealed Resident #3 was transferred out of ICU to the surgical floor on 11/30/2023, after the repeat CT scan of the head was stable and Neurosurgery was consulted.

The hospital discharge instructions from Hospital #2 revealed that Resident #3 was discharged on 12/7/2023 following treatment for a subdural hematoma, traumatic brain injury and a UTI. It further read that Resident #3 was to follow up with Neurosurgery in 2 weeks with a new head CT prior to the appointment. Resident #3 was not to resume taking his clopidogrel bisulfate or aspirin until cleared at the follow-up appointment.

An interview was conducted with Resident #3 on 1/4/2024 at 11:36 AM. Resident #3 stated that when he was leaving his physician's office on 11/29/2023, he had fallen off the van lift. He further stated that while being loaded into the facility van by the facility Driver, he and the

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 01/05/2024

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
F 689	Continued From page 5	F 689		

wheelchair fell off the left side of the lift and he hit his head on the concrete. Resident #3 indicated that he had a stroke on 10/8/2023 and he was paralyzed on the left side of his body, and therefore he had been unable to break his fall. He stated that it felt like it was a long fall and he that had hurt his head and left elbow. He further stated that he had been diagnosed with subdural hematoma and was in the hospital for over a week. Resident #3 stated that he did not know what had caused him to fall, but he did not blame the Transport Driver.

An interview was conducted with Transport Driver on 1/4/2024 at 3:10 PM. The Transport Driver stated that on 11/29/2023, she was loading Resident #3 onto the lift platform to get him inside the van and was having difficulty positioning the wheelchair. She further stated that the wheelchair must be placed inside the yellow boundaries, or the back lift plate on the outer barrier would not close. The Transport Driver stated that because Resident #3's wheelchair footrest was touching the inner front safety bar, the lift would not operate with the handheld control. She indicated that she had not had any problems with the lift before, so she tried again to reposition the wheelchair onto the lift. The Transport Driver stated that it was cold that day, so she decided to see if she could manually raise the lift off the ground a few inches to see if the back plate would close. The Transport Driver stated she could not remember if she forgot to place the safety strap around Resident #3, or if she did not buckle it securely. She further stated that the hydraulic pump that operated the lift was in the back of the van. The Transport driver indicated that she had climbed up into the van and left the resident on the ground in the lift. The Transport

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 01/05/2024

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
F 689	Continued From page 6	F 689		

Driver stated she had inserted the handle into the pump and proceeded to crank the lift up, like a car jack. She further stated that when she had raised the lift approximately 6 inches off the ground, Resident #3 and his wheelchair had suddenly fallen off the lift platform. The Transport Driver stated that he had landed on his left side on the concrete and his head was bleeding. The Transport Driver indicated that a person in the parking lot had called 911, while she was checking on Resident #3. She stated that she had placed a small pillow under his head and her coat over him while they were waiting for EMS to arrive. The Transport Driver further stated that Resident #3's wife had been standing by talking to them when the accident occurred. The Transport Driver indicated that she had been trained to call 911 if there was an accident and to have the resident transported to the hospital.

An interview and observation of the Transport Driver describing the process for securing a wheelchair in the transport van occurred with the Maintenance Director on 1/4/2023 at 3:25 PM. The Transport Driver lowered the lift to the ground and proceeded to explain the process for how the lift operated and how to position the wheelchair properly between the yellow boundaries. She further stated that the lift would not operate electronically if something was touching the front or back lift plate bars on the lift. The Transport Driver stated that when she had been unable to operate the lift using the electric hand control, she had climbed into the back of the van to raise it up off the ground manually. She further stated that she was supposed to be at the same level as the resident when operating the lift and she should not have left him. The Transport Driver explained that she was just going to manually crank the lift

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 01/05/2024

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
F 689	Continued From page 7	F 689		

up a few inches to see if the back plate would close automatically. She stated she would usually ask the resident to hold on to the bars as the lift was being raised up into the van, but Resident #3 was paralyzed on his left side and was unable to hold on. The Transport Driver demonstrated how to secure the safety strap around the wheelchair and that it was working properly. She further stated that she could not remember if she had forgotten to use the safety strap or if she had not secured the buckle securely. The Transport Driver indicated that as she was cranking up the lift to about 6 inches high, Resident #3 and his wheelchair suddenly fell off the lift. The Transport Driver stated that she immediately had gone to check on Resident #3 and a passerby had called 911. The Transport Driver demonstrated how to manually crank the lift up, and how to use the handheld control to automatically raise the lift. She indicated that she had been trained that in case of an emergency, she was supposed call 911 and have the resident transported to the hospital. The Transport Driver stated that she felt her training and education had been adequate prior to transporting residents.

An interview was completed with the Maintenance Director on 1/4/2024 at 2:49 PM. The Maintenance Director stated that when he heard that Resident #3 had fallen off the lift while being loaded into the van, he had inspected the van as soon as the Transport Driver returned to the facility. He further stated that he had found all the equipment to be in working order. The Maintenance Director indicated that the van had been inspected by the Van Lift company on 12/6/2023 and by the Van company on 12/29/2023, and that the van's lift system had passed both inspections. He stated that the

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 01/05/2024

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
F 689	Continued From page 8	F 689		

cause of the accident was determined to be a human error, by not securing the resident with the safety strap on the lift. The Maintenance Director further stated that he did not think it would be possible to fall off the lift if the safety strap was in place. He further stated that he was the person who was responsible for making sure the van was serviced and in good working order. The Maintenance Director indicated that he was the person who was also responsible for the Transport Driver's training and competencies. He stated that he had the Transport Driver watch the lift video and then she was given a written test and she passed. He then stated that the competencies were demonstrated and repeat demonstrations were performed by the Transport Driver. The Maintenance Director indicated that she had performed all the steps correctly. He further stated that he had ridden in the van with the Transport Driver on ride alongs prior to her being allowed to transport residents. The Maintenance Director indicated that the Transport Driver completed these steps prior to being allowed to drive the facility van.

The invoice from the Van Lift company dated 12/6/2023 revealed that the van lift was checked for proper operation and that it was found to be in good, safe, working order.

An invoice from the Van company dated 12/29/2023 revealed that no concerns were found all functions were working properly.

An interview was conducted with the Administrator on 1/4/2024 at 1:17 PM. The Administrator stated that the incident involving Resident #3 falling from the van lift had occurred on 11/29/2023, following a physician's

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 01/05/2024

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
F 689	Continued From page 9	F 689		

appointment. She further stated that the Transport Driver had called the facility and stated that Resident #3 had fallen off the lift platform when she was raising it into the van, and he was being transported by EMS to Hospital #1. The Administrator stated that the first things she did were to suspend the Transport Driver until investigation was completed and take the van out of service until it had been inspected. She indicated that the inspections were completed and there were no mechanical or technical problems found. The Administrator stated that she and the Maintenance Director had determined the root cause was that the safety strap on the lift was not utilized by the Transport Driver when she started to raise the lift. The Administrator stated that the Transport Driver was suspended from duty on 11/29/2023 until she was reeducated by the Maintenance Director with return demonstration on 11/30/2023. The Administrator stated that on 12/1/2023 corrective action was completed with the Transport Driver. She indicated that the facility staff had interviewed the alert and oriented residents on 11/29/2023 that had been transported in the van by the Transport Driver. The Administrator further indicated that all the residents stated they were secured properly in the van, and they felt safe riding with the Transport Driver. She stated that the facility staff had performed skin checks on the residents that were not alert and oriented on 11/29/2023 with no negative findings. She stated that everyone makes mistakes, and she did not think the Transport Driver would forget to utilize the safety strap again. The Administrator stated that to monitor for on-going compliance she or her designee were completing the van restraint competency tool, which includes applying safety straps and loading a resident, applying facility

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 01/05/2024

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
F 689	Continued From page 10	F 689		

safety belts before moving the van and unloading a resident, and do transport observations 5 times per week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks. She further stated that she was going to present the audits to the Quality Assurance Performance Improvement (QAPI) committee each month for review for the duration of the audits. The Administrator indicated that the QAPI committee may extend the plan of correction or change the plan of correction as needed.

The Administrator was notified of Immediate Jeopardy on 1/4/2024 at 4:15 PM.

" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice

The facility failed to ensure Resident #3 was transferred safely into the facility's transportation van after a doctor's appointment. On 11/29/2023 the facility driver failed to utilize the safety strap while the lift platform was being raised on the facility van. Resident #3 fell from the van with resulting injuries to the left head, left wrist and left elbow injury. The urology office personnel called emergency medical services and Resident #3 was transferred to the hospital. Resident #3 was transferred to another local hospital on 11/29/2023 where care was provided until discharge. Resident #3 readmitted to the facility on 12/7/2023. Root cause analysis was completed on 11/29/2023 by facility Administrator and it was determined that the facility driver failed to implement van safety features by forgetting to utilize the safety strap.

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 01/05/2024

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
F 689	Continued From page 11 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice The Administrator, unit managers and the Director of Nursing interviewed all alert and oriented residents that were transported by the facility, during the 14 days prior to the event, to ensure there were no other residents left unattended on the lift with the safety straps not in place. The interviews were completed on 11/29/2023 and there were no additional issues identified. The unit manager assessed all cognitively impaired residents that were transported in the facility van during the 14 days prior to the incident, to ensure there were no signs of injury that may have been a result of a facility van incident. The assessments were completed on 11/29/2023 and there were no negative findings identified on the assessments. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility van was removed from use on 11/29/2023 until it was inspected at a licensed inspection facility on 12/6/2023. The facility driver was suspended from duty on 11/29/2023 until re-educated by the facility Maintenance Director with return demonstration on 11/30/2023. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained On 11/30/2023 a decision was made to monitor performance and take the plan of action to the	F 689		

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 01/05/2024

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
F 689	Continued From page 12	F 689		

Quality Assurance Performance Improvement committee. The Administrator and Maintenance Director will perform van restraint competency tool, which includes applying safety straps and loading a resident, applying facility safety belts before moving the van and unloading a resident, and do transport observations 5 times per week for 4 weeks then 3 times per week for 4 weeks and then weekly for 4 weeks. The Administrator will present the audits to the Quality Assurance Performance Improvement committee each month for review for the duration of the audits. The Quality Assurance Performance Improvement committee may extend the plan of correction or change the plan of action as needed to ensure ongoing compliance.

" Include dates when corrective action will be completed.

The facility implemented all corrective action and was in compliance on 12/01/2023.

As part of the validation process on 1/5/2024, the plan of correction was reviewed and included a sample of staff which included the Transport Driver, Administrator, and Maintenance Director regarding in-services and training related to deficient practice. The Transport driver verified the reeducation and training, and the continuing audits. An observation of the Transport Driver operating the lift correctly was conducted on 1/4/2024 at 3:25 PM. The Transportation Review Checklist and the Driver Ride-Along Evaluation Form monitoring tools were verified. A review of all the documents provided to correct the deficient practice was completed. The completion date of

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 01/05/2024

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
F 689	Continued From page 13 12/1/2023 was confirmed.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. 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: §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. §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. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §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		1/25/24

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 01/05/2024

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
F 867	Continued From page 14	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

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 01/05/2024

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
F 867	Continued From page 15 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §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. §483.75(g) Quality assessment and assurance. §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: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility's Quality	F 867	F867 Quality Improvement Activities	

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 01/05/2024

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
F 867	Continued From page 16 Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 7/27/2023. This was for a deficiency cited in the area of Accidents Hazard/ Supervision/Devices (F689) that was subsequently recited during the complaint investigation conducted on 1/5/2024. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. This tag is cross-referenced to: F689 Based on record review, observations, and staff and resident interviews, the facility failed to ensure a resident was safely transferred into the facility's transportation van, when the Transport Driver failed to utilize the safety strap while the lift platform was being raised on the facility van. This resulted in the resident (Resident #3) falling from the lift and sustaining injuries to the left side of his head, left wrist, and left elbow. This occurred when the facility Transport Driver was picking up Resident #3 from a doctor's office appointment on 11/29/2023. The office personnel called emergency medical services (EMS) and Resident #3 was transported to the emergency room (ER) at Hospital #1, where he was diagnosed with a traumatic subdural hematoma (pool of blood between the brain and the outermost layer that can put pressure on the brain) without loss of consciousness. Resident #3 requested to be transferred to the trauma service at Hospital #2, where he received treatment until he was discharged on 12/7/2023. This was for 1 of 1 resident (Resident #3) reviewed for accidents.	F 867	1. Facility failed to maintain an effective Quality Assurance Performance Improvement process to implement systemic changes to effect: Free of accidents and hazards (F689) 2. (F689) The Administrator, unit managers and the Director of Nursing interviewed all alert and oriented residents that were transported by the facility, during the 14 days prior to the event, to ensure there were no other residents left unattended on the lift with the safety straps not in place. The interviews were completed on 11/29/2023 and there were no additional issues identified. The unit manager assessed all cognitively impaired residents that were transported in the facility van during the 14 days prior to the incident, to ensure there were no signs of injury that may have been a result of a facility van incident. The assessments were completed on 11/29/2023 and there were no negative findings identified on the assessments. 3. The facility administrator was educated by the Regional Director of Clinical services on 1/24/2024 on QAPI program using educational materials: QAPI at a glance. 4. To monitor ongoing Quality Assurance Performance Improvement, the Regional Director of Clinical Services or the Regional Director of Operations will review monthly Quality Assurance Performance Improvement meeting to assure pertinent items are included and	

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 01/05/2024

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
F 867	Continued From page 17 During the recertification and complaint investigation survey conducted on 7/27/2023, the facility was cited for failure to use 2-person assistance when transferring a resident using the mechanical lift and according to care planned interventions.	F 867	worked on monthly for 3 months.	