| DEPART                   | MENT OF HEALTH AN  | ID HUMAN SERVICES   |                     |  |        | M APPROVED                 |
|--------------------------|--|---|---------------------|--|--------|----------------------------|
| CENTER                   | S FOR MEDICARE &   | MEDICAID SERVICES   |                     |  | OMB N  | <u>O. 0938-0391</u>        |
|                          | DF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | . ,                 | E CONSTRUCTION   |        | E SURVEY<br>IPLETED        |
|                          |  | 345294  | B. WING             |  | 02     | C<br>2/09/2019             |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |        |                            |
| AUTUMN                   | CARE OF SHALLOTTE  |   |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |
| E 000                    | Initial Comments   |   | E 000               |  |        |                            |
| F 000                    | Investigation suvey w<br>through 2/09/19. The<br>compliance with the r     | equired CFR 483.73,<br>ness. Event ID# OUD911.  | F 000               |  |        |                            |
|                          | from 2/4/19 through 2  | plaint survey was conducted<br>2/9/19 for Event ID<br>e Jeopardy was identified at:   |                     |  |        |                            |
|                          | J.   | 580 at a scope and severity<br>500 at a scope and severity                            |                     |  |        |                            |
|                          | CFR 483.25 at tag F6<br>J.   | 684 at a scope and severity   |                     |  |        |                            |
|                          | Tags F600 and F684<br>Quality of Care.                                     | constituted Substandard   |                     |  |        |                            |
|                          |  | began on 02/04/19 and was<br>An extended survey was                                   |                     |  |        |                            |
|                          |  | encies cited as a result of the on survey on 2/9/19 for                               |                     |  |        |                            |
|                          | provided to the facility<br>Informal Dispute Res<br>deleted tags; F-580, I | 000 was changed to reflect  |                     |  |        |                            |
|                          | An amended Stateme   | ent of Deficiencies was   |                     |  |        |                            |
| LABORATORY               | DIRECTOR'S OR PROVIDER/  | SUPPLIER REPRESENTATIVE'S SIGNATUR  | E                   | TITLE  |        | (X6) DATE                  |
| Electroni                | cally Signed   |   |                     |  |        | 03/01/2019                 |

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.

PRINTED: 06/17/2019

|                          | MENT OF HEALTH AN<br>S FOR MEDICARE & I   |  |                   |  |                                    |    | FORM                       | D: 06/17/2019<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|---|--|-------------------|--|------------------------------------|----|----------------------------|--|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , í               |  | E CONSTRUCTION                     |    | (X3) DATE<br>COMF          | SURVEY<br>LETED                            |
|                          |   | 345294   | B. WING           |  |                                    |    |                            | C<br>09/2019                               |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                   | S  | TREET ADDRESS, CITY, STATE, ZIP CO | DE | •                          |  |
|                          |   |  |                   | 2  | 37 MULBERRY STREET                 |    |                            |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                   | s  | SHALLOTTE, NC 28459                |    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE C |                                    |    | (X5)<br>COMPLETION<br>DATE |  |
| F 000<br>F 580<br>SS=J   | reviewed the facility's<br>tags F-580, F-600 and<br>these tags should be<br>F-600 and F-684 were<br>was changed to reflect<br>keep these tags at a I<br>Notify of Changes (Inj<br>CFR(s): 483.10(g)(14)<br>§483.10(g)(14) Notific<br>(i) A facility must imm<br>consult with the reside<br>consistent with his or<br>representative(s) whe<br>(A) An accident involv<br>results in injury and he<br>physician intervention<br>(B) A significant change<br>mental, or psychosoc<br>deterioration in health<br>status in either life-thr<br>clinical complications)<br>(C) A need to alter tree<br>a need to discontinue<br>treatment due to advec<br>commence a new forr<br>(D) A decision to trans<br>resident from the facili<br>§483.15(c)(1)(ii).<br>(ii) When making notifi<br>(14)(i) of this section,<br>all pertinent informatic<br>is available and provid<br>physician.<br>(iii) The facility must a | r on 5/30/19 because CMS<br>IDR results, that deleted<br>d F-684 and decided each of<br>cited at level J. Tags F-580,<br>e reinstated and tag F-0000<br>ct the decision by CMS to<br>J level. Event #OUD911.<br>ury/Decline/Room, etc.)<br>)(i)-(iv)(15)<br>ration of Changes.<br>ediately inform the resident;<br>ent's physician; and notify,<br>her authority, the resident<br>n there is-<br>ring the resident which<br>as the potential for requiring<br>;<br>ge in the resident's physical,<br>ial status (that is, a<br>, mental, or psychosocial<br>eatening conditions or<br>;<br>atment significantly (that is,<br>an existing form of<br>erse consequences, or to<br>n of treatment); or<br>sfer or discharge the |                   | 000                                      |                                    |    |                            | 2/10/19                                    |

Facility ID: 922957

If continuation sheet Page 2 of 47

|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                   |     |  | F   | NTED: 06/17/201<br>ORM APPROVE<br>3 NO. 0938-039 |  |  |
|--------------------------|---|--|-------------------|-----|--|---|--|--|--|
| STATEMENT C              | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |  |  |  |
|                          |   | 345294   | B. WING           |     |  |   | C<br>02/09/2019                                  |  |  |
| NAME OF PR               | ROVIDER OR SUPPLIER   | -  |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |  |  |  |
|                          | CARE OF SHALLOTTE   |  |                   | 2   | 237 MULBERRY STREET  |   |  |  |  |
| AUTUWIN                  | SARE OF SHALLOTTE   |  |                   |     | SHALLOTTE, NC 28459  |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)    | ERENCED TO THE APPROPRIATE  |  |  |  |
| F 580                    | as specified in §483. <sup>4</sup><br>(B) A change in reside<br>State law or regulatio<br>(e)(10) of this section<br>(iv) The facility must r<br>update the address (r<br>phone number of the<br>representative(s).<br>§483.10(g)(15)<br>Admission to a competing<br>that is a composite di<br>§483.5) must disclose<br>its physical configural<br>locations that comprise<br>part, and must specific<br>room changes betwee<br>under §483.15(c)(9).<br>This REQUIREMENT<br>by:<br>Based on staff interviand record review the<br>physician for 1 of 1 re<br>who experienced a si<br>with the sudden onse<br>disorientation and dia<br>Immediate Jeopardy<br>Resident #389 experi<br>in condition at 3:55 P<br>disoriented, and had<br>The facility failed to n<br>sudden significant ch<br>Aide #1 (NA) reported | or roommate assignment<br>10(e)(6); or<br>ent rights under Federal or<br>ns as specified in paragraph<br>record and periodically<br>nailing and email) and<br>resident<br>osite distinct part. A facility<br>stinct part (as defined in<br>e in its admission agreement<br>tion, including the various<br>se the composite distinct<br>y the policies that apply to<br>en its different locations<br>t is not met as evidenced<br>iews, physician interview<br>e facility failed to notify a<br>residents (Resident #389)<br>gnificant change in condition<br>t of diaphoresis (sweating), | F                 | 580 |  | blood<br>beived for a<br>ected and<br>o receive<br>oratory.<br>all provider<br>the<br>rned from<br>r Keflex |  |  |  |
|                          | was removed on 02/0   | nt. Immediate Jeopardy<br>9/19 when the facility<br>ented an acceptable credible   |                   |     | received 8 doses of Keflex.<br>On 2/4/2019 received hospital of<br>New orders to d/c Keflex, start a |   |  |  |  |

Facility ID: 922957

If continuation sheet Page 3 of 47

|                          |                       |   |                     |  |                                | NO. 0938-03               |
|--------------------------|-----------------------|---|---------------------|--|--------------------------------|---------------------------|
|                          | OF DEFICIENCIES       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                   | · /                 |  | · · · ·                        | ATE SURVEY                |
|                          |                       |   | A. BUILDING         | 3  |                                | С                         |
|                          |                       | 345294  | B. WING             |  |                                |                           |
|                          | ROVIDER OR SUPPLIER   | 010201  |                     | STREET ADDRESS, CITY, STATE, ZIP CC                            |                                | 02/09/2019                |
|                          | NONDER OR OUT LIER    |   |                     | 237 MULBERRY STREET  |                                |                           |
| AUTUMN                   | CARE OF SHALLOTTE     |   |                     | SHALLOTTE, NC 28459  |                                |                           |
|                          |                       |   |                     | PROVIDER'S PLAN OF C   |                                |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC       | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETIC<br>DATE |
| F 580                    | Continued From page   | e 3   | F 58                | 30   |                                |                           |
|                          | allegation of Immedia | ate Jeopardy removal. The   |                     | 250 mg q 6 hours x 7 days f                                    | or a UTI. The                  |                           |
|                          |                       | f compliance at a lower   |                     | provider pharmacy nor local                                    |                                |                           |
|                          |                       | f "D" (no harm with the   |                     | had ampicillin available in th                                 |                                |                           |
|                          |                       | an minimal harm that is not   |                     | ordered. New orders were r                                     |                                |                           |
|                          | immediate jeopardy)   | •   |                     | hold the ampicillin until med                                  | ication was                    |                           |
|                          | systems put in place  | are effective.  |                     | available to send.   |                                |                           |
|                          |                       |   |                     | On 2/4/2019, resident #389                                     |                                |                           |
|                          | Findings included:    |   |                     | physician appointment and i                                    |                                |                           |
|                          | Booidont #290 was a   | dmitted to the facility on  |                     | facility at approximately 3:55                                 | •                              |                           |
|                          |                       | admitted to the facility on ses that included retention of                              |                     | stated resident #389 had an loose stool. Per her stateme       | -                              |                           |
|                          |                       | d reflux uropathy, benign   |                     | diaphoretic and confused.                                      |                                |                           |
|                          |                       | with lower urinary tract  |                     | ADL care including changing                                    | -                              |                           |
|                          |                       | my, Parkinson's disease and   |                     | sheets. Nurse #8 was awa                                       | -                              |                           |
|                          | Alzheimer's disease   |   |                     | stools and diaphoretic episo                                   |                                |                           |
|                          |                       | ý   |                     | His vital signs were obtained                                  |                                |                           |
|                          | Review of a Medicare  | e 5 Day Admission Minimum   |                     | at 5:59pm and included the                                     |                                |                           |
|                          | Data Set (MDS) Asse   | essment dated 01/24/19 for  |                     | Respirations 18. O2 sat 97                                     |                                |                           |
|                          |                       | led he had moderately   |                     | Pulse 68. Temperature 98.4                                     | F. BP                          |                           |
|                          | impaired cognition. I | He had an indwelling  |                     | 102/64.  |                                |                           |
|                          | catheter.             |   |                     | Nurse administered tube fee                                    | -                              |                           |
|                          |                       |   |                     | 6:30pm. Resident was diap                                      |                                |                           |
|                          |                       | wed in the nurse progress   |                     | time and per NA was progre                                     | -                              |                           |
|                          |                       | lent #389 had his urinary<br>veral times on 01/21/19,                                   |                     | worsening. ADL care was p                                      |                                |                           |
|                          |                       | nd 02/02/19. On 02/01/19  |                     | bed sheets changed. Again was aware.                           | , nuise #o                     |                           |
|                          |                       | ctitioner reordered a UA C &  |                     | Per NA she checked him at                                      | 10nm and he                    |                           |
|                          |                       | blood in the urine). Nurse #7   |                     | continued to be diaphoretic                                    |                                |                           |
|                          | ,                     | gress notes dated 02/01/19  |                     | NA reported to Nurse #8.                                       |                                |                           |
|                          |                       | e urine and sent it to the  |                     | His vital signs were obtained                                  | d on 2/5/19 at                 |                           |
|                          |                       | e the results came back   |                     | 2:05am and included the fol                                    |                                |                           |
|                          | Resident #389 was s   | ent to the emergency room   |                     | Respirations 16. O2 sat 97                                     | % room air.                    |                           |
|                          |                       | to complaints of abdominal  |                     | Pulse 70. Temperature 98.6                                     | 6 F. BP                        |                           |
|                          | -                     | Hospital records dated  |                     | 106/66.  |                                |                           |
|                          |                       | d a diagnosis of urinary tract  |                     | The third shift NA confirmed                                   |                                |                           |
|                          |                       | with indwelling urethral  |                     | diaphoretic and she had to d                                   | -                              |                           |
|                          |                       | started on the antibiotic   |                     | bed twice. He was not feelin                                   | -                              |                           |
|                          | Keflex by the emerge  |   |                     | continued to be diaphoretic.                                   |                                |                           |
|                          | ыеtween 02/02/19 ar   | nd 02/04/19 he received all   |                     | shift nurse knew he was und                                    | contortable                    | 1                         |

Facility ID: 922957

| TATEMENT (               | OF DEFICIENCIES         | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA                                      | (X2) MULTIP         | LE CONSTRUCTION   |                              | NO. 0938-03               |
|--------------------------|-------------------------|---|---------------------|---|------------------------------|---------------------------|
| ND PLAN OF               | CORRECTION              | IDENTIFICATION NUMBER:  | A. BUILDING         | ·   | Ć                            | OMPLETED                  |
|                          |                         |   |                     |   |                              | С                         |
|                          |                         | 345294  | B. WING             |   |                              | 02/09/2019                |
| NAME OF P                | ROVIDER OR SUPPLIER     | ·   |                     | STREET ADDRESS, CITY, STATE, ZIP COI  | DE                           |                           |
|                          | CARE OF SHALLOTTE       |   |                     | 237 MULBERRY STREET   |                              |                           |
| AUTOMIN                  | CARE OF SHALLOTTE       |   |                     | SHALLOTTE, NC 28459   |                              |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC         | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 580                    | Continued From page     | ۵ ۵   | F 58                | 0   |                              |                           |
|                          | -                       | es as documented on the   | 1.50                |   | chocking                     |                           |
|                          |                         | ninistration Record). On  |                     | and was diaphoretic and was often.  | SCIECKING                    |                           |
|                          | 02/04/19 the facility N |   |                     | On 2/5/19 at approximately 3  | :00am.                       |                           |
|                          |                         | piotic Keflex (lab results  |                     | resident #389 had a drop in o   |                              |                           |
|                          |                         | ed that it was not effective)   |                     | 84%. RR 36. BP 90/52. No  |                              |                           |
|                          |                         | n 250 mg every six hours for  |                     | output this shift and X2 episo  | des of runny                 |                           |
|                          | 7 days for UTI. Revie   | ew of a nurse progress note   |                     | diarrhea like stools. Applied   | 02 at 2L.                    |                           |
|                          | written by Nurse #5 o   | n 02/05/19 revealed the   |                     | Resident s o2 stat increase   | d to 94-95%.                 |                           |
|                          | Ampicillin had not bee  |   |                     | Received order to administer  |                              |                           |
|                          |                         | f the February MAR showed   |                     | which was effective. O2 sat   |                              |                           |
|                          |                         | icillin had been given to   |                     | Resident still sweating profus  |                              |                           |
|                          | Resident #389.          |   |                     | uncomfortable and calling ou  |                              |                           |
|                          |                         |   |                     | Still states I don □t feel right.   |                              |                           |
|                          |                         | sident #389 was made  |                     | order to send resident to the   |                              |                           |
|                          | •                       | on 02/04/19 at 12:00 noon.  |                     | Resident left the facility at 04  | :01 with the                 |                           |
|                          |                         | in his wheelchair at the  |                     | EMS staff.  | the beenited                 |                           |
|                          |                         | g to be transported to a<br>. He was alert and oriented,                              |                     | Resident #389 is currently at   | the hospital.                |                           |
|                          |                         | -   |                     |   |                              |                           |
|                          | present. No sweat wa    | o odors of urine or feces   |                     | Poot Causo Analysis   |                              |                           |
|                          | residents skin.         | as observed on the  |                     | Root Cause Analysis   | artunity in                  |                           |
|                          | TESIUEIIIS SKIII.       |   |                     | The facility identified an opport   |                              |                           |
|                          | An interview was con    | ducted on 02/08/19 at 10:40   |                     | completing an assessment w  |                              |                           |
|                          |                         | he reported that when   |                     | change in condition and notif   |                              |                           |
|                          | Resident #389 return    |   |                     | to obtain orders if appropriate   |                              |                           |
|                          |                         | assisted back into bed. She   |                     | return from physician appoint   |                              |                           |
|                          |                         | d her that he had not eaten   |                     | #8 was aware of diarrhea an   |                              |                           |
|                          |                         | him a bolus tube feeding  |                     | episode as well as confusion  |                              |                           |
|                          |                         | M. She did not remember   |                     | same shift, nurse #8 was info   |                              |                           |
|                          |                         | he said she really couldn't   |                     | witnessed continued diaphor   |                              |                           |
|                          | • •                     | that if she passed on in  |                     | #8 failed to notify MD of a ch  |                              |                           |
|                          |                         | eaty and had to have his  |                     | condition, failed to assess the   | e resident                   |                           |
|                          | sheets changed twice    | e then it must be true but she  |                     | which ultimately lead to his  |                              |                           |
|                          |                         | She was sure that she had   |                     | re-hospitalization on 2/5/19.   |                              |                           |
|                          |                         | h because if she had she  |                     | The Procedure for Implemen  |                              |                           |
|                          | would have remembe      | ered that.  |                     | Acceptable Plan of Correctio specific deficiency cited.                                   | n for the                    |                           |
|                          | An interview was con    | ducted on 02/08/19 at 11:19   |                     |   |                              |                           |
|                          |                         | revealed that Resident #389   | 1                   | The resident is not currently   |                              | 1                         |

Facility ID: 922957

|                          | OF DEFICIENCIES         | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA                                      | (X2) MUL           | IPLE CONSTRU |   | OMB NO. 0938-03<br>(X3) DATE SURVEY |
|--------------------------|-------------------------|---|--------------------|--------------|---|-------------------------------------|
| ND PLAN OF               | CORRECTION              | IDENTIFICATION NUMBER:  | A. BUILDI          | NG           |   | COMPLETED                           |
|                          |                         |   |                    |              |   | С                                   |
|                          |                         | 345294  | B. WING            |              |   | 02/09/2019                          |
| NAME OF P                | ROVIDER OR SUPPLIER     |   |                    | STREET ADD   | RESS, CITY, STATE, ZIP CODE   |                                     |
|                          | CARE OF SHALLOTTE       |   |                    | 237 MULBER   | RRY STREET  |                                     |
|                          | CARE OF SHALLOTTE       |   |                    | SHALLOTT     | E, NC 28459   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC         | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>ROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | DATE                                |
| F 580                    | Continued From page     | e 5   | F                  | 580          |   |                                     |
|                          | was sweaty, disorient   |   |                    |              |   |                                     |
|                          | •                       | a when he returned from his   |                    | On 2/8       | /2019, a head to toe assessmen  | t                                   |
|                          |                         | on 02/04/19. She reported   |                    |              | completed on all residents by   | -                                   |
|                          |                         | t the resident into bed and   |                    |              | d staff to identify any sign of   |                                     |
|                          | -                       | room to help. NA #1 stated  |                    |              | e of condition. Any issues identif  | ied                                 |
|                          | that she changed his    | sweaty shirt and sheets at  |                    | the atte     | ending physician and resident   |                                     |
|                          |                         | Nurse #8 had observed that  |                    |              | entative will be notified.  |                                     |
|                          |                         | iented and incontinent of   |                    |              | /2019, licensed nurses interview  |                                     |
|                          |                         | nurse when the resident first   |                    |              | viewable residents if there were  |                                     |
|                          |                         | ning was wrong with him."   |                    | -            | ncerns with the care and treatme  |                                     |
|                          |                         | thirty minutes later and  |                    |              | e provided by staff. No concerr   | IS                                  |
|                          | to Nurse #8 again that  | ook good" so she reported   |                    |              | eported.<br>/2019, the Administrator, Region  |                                     |
|                          |                         | nted. She stated he was   |                    |              | or of Clinical Services and DON   | a                                   |
|                          | -                       | the shift and it got worse as   |                    |              | in-house education on the   |                                     |
|                          |                         | membered that when Nurse  |                    | followin     |   |                                     |
|                          |                         | ident his tube feeding the  |                    |              | sed Nursing staff will be educated  | d                                   |
|                          |                         | d that the resident was   |                    |              | sician order policy.  |                                     |
|                          | "really sweating." Sh   | e stated that she had told  |                    | *Licens      | sed Nursing staff will be educated  | d                                   |
|                          | the nurse again at 10   | :00 PM that Resident #389   |                    | on cha       | nge in resident condition policy.   |                                     |
|                          |                         | nd disoriented." She said   |                    | *Licens      | sed Nursing staff will be educate   | d                                   |
|                          |                         | was just wore out from going  |                    |              | umentation.   |                                     |
|                          | to the appointment ea   |   |                    |              | will be educated on Stop and  |                                     |
|                          | commented she pass      | •   |                    |              | Interact process which includes   |                                     |
|                          | -                       | A (#6) that Resident #389   |                    | -            | es of condition including the   |                                     |
|                          | "wasn't acting right" a | and to keep an eye on him.  |                    |              | ng: seems different , talks less, needs more help, pain, ate less,  |                                     |
|                          | An interview was een    | ducted on 02/08/19 at 12:22   |                    |              | /el movement or diarrhea, drank   |                                     |
|                          |                         | confirmed that NA#1 had   |                    |              | eight change, agitation, tired, we  |                                     |
|                          |                         | hat she had changed the   |                    |              | e in skin color and help with   |                                     |
|                          |                         | Resident #389 and that he   |                    | -            | g, transferring, toileting more that  | n                                   |
|                          |                         | e said that she could tell he   |                    | usual.       | ,, <u> </u>   |                                     |
|                          |                         | the shift started he kept   |                    |              | will be educated on Point of Car  | re                                  |
|                          | •                       | ". She stated that as soon  |                    |              | ocumentation.   |                                     |
|                          |                         | e would immediately start   |                    |              |   |                                     |
|                          |                         | and she would go back to  |                    | *On 2/9      | 9/2019, the DON and/or designe  | es                                  |
|                          | -                       | ed that herself and Nurse #5  |                    |              | ucate all licensed nurses on  |                                     |
|                          |                         | several times because they  |                    |              | s, symptoms, complications,   |                                     |
|                          | could not figure out w  | hat was wrong with him.   | 1                  | diagno       | sis and treatment of septicemia.  | 1                                   |

Facility ID: 922957

If continuation sheet Page 6 of 47

| CENTER                   | S FOR MEDICARE &       | MEDICAID SERVICES   |                     |  | FORM APPRO<br>OMB NO. 0938-   |  |
|--------------------------|------------------------|---|---------------------|--|-------------------------------|--|
|                          | DF DEFICIENCIES        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | <b>、</b> ,          | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|                          |                        | 345294  | B. WING             |  | C<br>02/09/2019               |  |
| NAME OF PI               | ROVIDER OR SUPPLIER    | •   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | •                             |  |
|                          | CARE OF SHALLOTTE      |   | 2                   | 237 MULBERRY STREET  |                               |  |
| AUTOMIN                  | CARE OF SHALLOTTE      |   | 5                   | SHALLOTTE, NC 28459  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC        | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLE                  |  |
| F 580                    | Continued From page    | e 6   | F 580               |  |                               |  |
|                          |                        | dent #389 had three bouts of  | 1 000               |  |                               |  |
|                          |                        | before he was transferred to  |                     | Education will continue via telepho  | ne for                        |  |
|                          |                        | She commented that  |                     | staff not available 2/8/19 and 2/9/1   |                               |  |
|                          | Resident #389 went f   | to the hospital toward the  |                     | person. These staff members will   |                               |  |
|                          | end of her shift betwe | en 3:30 and 4:00 AM.  |                     | permitted to work until education is   | i                             |  |
|                          |                        | <i>.</i>  |                     | received. If unable to reach via   |                               |  |
|                          | · ·                    | ogress note written by Nurse  |                     | telephone, a certified letter with the   |                               |  |
|                          |                        | A AM indicated that she had m the previous shift that the                             |                     | education provided will be mailed of 2/9/19 with instructions to call the I                                |                               |  |
|                          |                        | be changed twice on   |                     | set a time for education.  |                               |  |
|                          |                        | he was sweating. She  |                     |  |                               |  |
|                          |                        | observed the resident   |                     | New licensed nurse and NA hires w  | vill                          |  |
|                          | laying in bed "sweatir | ng profusely." During her   |                     | receive the above education upon   | hire.                         |  |
|                          |                        | began to drop along with his  |                     | The monitoring procedure to assur  |                               |  |
|                          |                        | is respirations increased.  |                     | Plan of Correction is corrected and  |                               |  |
|                          |                        | tput on her shift. She noted  |                     | specific deficiency cited remains co   | prrected                      |  |
|                          |                        | ne didn't feel good and was<br>ing. Nurse #5 contacted the                            |                     | and in compliance with regulatory  |                               |  |
|                          |                        | transferred the resident to   |                     | requirements.<br>The DON and/or designee will revi   | ew all                        |  |
|                          | the emergency room     |   |                     | nursing progress notes to determin   |                               |  |
|                          |                        |   |                     | any possible changes of condition  |                               |  |
|                          | Emergency Medical      | Service records revealed  |                     | interventions were timely, appropri-   | ate and                       |  |
|                          | Resident #389 was tr   | ansported to the hospital at  |                     | includes MD notification. This aud   | it will be                    |  |
|                          | 4:01 AM on 02/05/19    |   |                     | completed 5 x per week for 30 day  | s and                         |  |
|                          |                        |   |                     | weekly x 8 weeks.  |                               |  |
|                          | Review of the hospita  |   |                     | The DON and/or licensed nurse de   |                               |  |
|                          | 4:40 AM on 02/05/19    | d at the emergency room at  |                     | will review census and nursing pro-  | -                             |  |
|                          | 4.40 AIVI 011 02/03/19 |   |                     | notes to identify residents returning hospital to determine that the chan                                  |                               |  |
|                          | Review of the hospita  | al progress notes on  |                     | condition interventions were timely  | -                             |  |
|                          |                        | d a preliminary diagnosis of  |                     | appropriate and includes MD notifie  |                               |  |
|                          |                        | UTI (Urinary Tract Infection).  |                     | This audit will be completed 5 x we  |                               |  |
|                          |                        | on dated 02/06/19 concluded   |                     | days and weekly x 8 weeks.   |                               |  |
|                          |                        | ad blood cultures positive for  |                     | Three residents will be interviewed  | -                             |  |
|                          |                        | ram-negative bacteremia, a  |                     | regarding the care and services pro  |                               |  |
|                          | life-threatening condi | tion.   |                     | by the Director of Nursing or licens   | ed                            |  |
|                          |                        | ducted on 02/08/19 at 1:05  |                     | nurse designee for 8 weeks.  | ianee                         |  |
|                          |                        | 100019 011 02/00/19 8L 1.00   |                     | The Director of Nursing and/or des   | ignee                         |  |

Facility ID: 922957

PRINTED: 06/17/2019 FORM APPROVED

| ATEMENT (                | OF DEFICIENCIES  | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIF         | PLE CONSTRUCTION  | (X3) DATE  | 0. 0938-039<br>SURVEY     |
|--------------------------|--|--|---------------------|---|--|---------------------------|
| ND PLAN OF               | CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING         | G   | COMF   | LETED                     |
|                          |  | 345294   | B. WING             |   |  | C                         |
|                          | ROVIDER OR SUPPLIER  | 545254   | B. WING             | STREET ADDRESS, CITY, STATE, ZI   |  | 09/2019                   |
|                          | COMPER OR GOI T EIER   |  |                     | 237 MULBERRY STREET   |  |                           |
| AUTUMN                   | CARE OF SHALLOTTE  |  |                     | SHALLOTTE, NC 28459   |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE  | ACTION SHOULD BE<br>TO THE APPROPRIATE   | (X5)<br>COMPLETIO<br>DATE |
| F 580                    | Continued From page  | ۵ <i>7</i>   | E 55                | 80  |  |                           |
| F 380                    | #389. She is also the<br>facility. She said that<br>Resident #389 becau<br>assessment when he<br>She was not aware th<br>condition on 02/04/19<br>informed her that he h<br>hospital the next day.<br>down, sweating, and<br>consistent with what s<br>#389. She stated that<br>sitting in his wheelchat<br>although he had some<br>with her when she vist<br>would have considered<br>change when he begat<br>disoriented on 02/04/<br>second shift and had<br>would have assessed<br>expected that the resit<br>assessed when the co<br>occurred at the begin<br>because he had had<br>untreated and his syn<br>sepsis. She stated the<br>Resident #389 had co<br>condition to change v<br>dime. She further con<br>hours to treat Gram-N<br>in death because it er<br>couple of hours. She<br>have affected the oute<br>a physician been notii<br>02/04/19 and his acut | e Medical Director at the<br>she was familiar with<br>se she had completed his<br>was admitted to the facility.<br>hat he had a change in his<br>until the Nurse Practitioner<br>had been transferred to the<br>She reported that laying<br>being disoriented was not<br>she saw daily with Resident<br>it he was normally up and<br>air. She commented that<br>e confusion he could chat<br>sited. She stated that she<br>ed it an acute significant<br>an sweating and became<br>19 at the beginning of<br>she been in the building she<br>him immediately. She<br>ident would have been<br>hange in his condition<br>ning of second shift<br>a UTI that had been<br>nptoms were indicative of<br>hat the type of sepsis<br>build cause a resident's<br>ery quickly and turn on a<br>mmented that waiting 12<br>Negative sepsis could result<br>hters the blood and acts in a<br>stated that it certainly could<br>come for Resident #389 had<br>fied on second shift on<br>te condition treated sooner. | F 58                | the education provided,<br>what response is appropresident has a change in<br>will be documented 3 x w<br>and weekly x 8 weeks.<br>The facility will conduct a<br>Assurance Performance<br>meeting on 2/8/19 with th<br>interdisciplinary team, th<br>President of Operations,<br>Director of Clinical Servi<br>Director to review the co-<br>measures.<br>The title of the person re-<br>implementing the accept<br>correction is the Adminis<br>Date of Alleged Complia | priate when a<br>condition. This<br>week for 30 days<br>an Ad Hoc Quality<br>Improvement<br>he facility<br>he Regional Vice<br>, Regional<br>ces the Medical<br>prrective<br>esponsible for<br>table plan of<br>strator. |                           |
|                          | -  | 2:45 PM. He stated if a<br>e in condition he would   |                     |   |  |                           |
|                          |  | an assessment, notify the  |                     |   |  |                           |

If continuation sheet Page 8 of 47

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |         |     |  | FORM              | APPROVED<br>0. 0938-0391   |
|--------------------------|---|--|---------|-----|--|-------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |         |     | E CONSTRUCTION   | (X3) DATE<br>COMF |                            |
|                          |   | 345294   | B. WING |     |  |                   | 09/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |         | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |  |         |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |         | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 580                    | provider if indicated, of<br>either the progress no<br>when the incident occ<br>any new orders. He wa<br>aide to fill out a stop a<br>alert message in Poir<br>medical record) if he<br>condition in a residen<br>The facility Administra<br>Nursing were notified<br>02/08/19 at 3:00 PM.<br>On 02/09/19 at 1:51 F<br>following credible alle<br>jeopardy removal:<br>F580<br>The Plan of Correctin<br>On 2/1/2019 resident<br>urine. Orders were re<br>sample was collected<br>laboratory.<br>On 2/2/2019 facility a<br>culture from the hosp<br>was pending. On call<br>#389 to go to the Eme<br>On 2/2/2019 resident<br>hospital with a new or<br>for UTI. Resident #38<br>Keflex.<br>On 2/4/2019 received<br>orders to d/c Keflex, s | document the incident in<br>bees or on an S Bar report<br>curred and then transcribe<br>would also expect a nurse<br>and watch form or put a new<br>at Click Care (the electronic<br>or she noticed a change of<br>t.<br>ator and the Director of<br>of immediate jeopardy on<br>PM the facility provided the<br>egation of immediate<br>g the specific deficiency.<br>#389 had blood noted in<br>eceived for a UA C&S. The<br>and sent to the hospital<br>ttempted to receive UA<br>ital laboratory. The culture<br>I provider ordered resident | F       | 580 |  |                   |                            |

Facility ID: 922957

If continuation sheet Page 9 of 47

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                    |     |  | FORM              | MAPPROVED<br>0. 0938-0391  |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|                          |   | 345294  | B. WING            |     |  |                   | C<br>109/2019              |
| NAME OF PF               | ROVIDER OR SUPPLIER   |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 580                    | the dosage ordered.<br>to hold the ampicillin available to send.<br>On 2/4/2019, resident<br>appointment and retu<br>approximately 3:55pm<br>had an episode of loc<br>he was diaphoretic ar<br>ADL care including ch<br>Nurse #8 was aware<br>diaphoretic episode.<br>His vital signs were o<br>5:59pm and included<br>18. O2 sat 97% room<br>Temperature 98.4 F.<br>Nurse administered th<br>Resident was diaphor<br>was progressively wo<br>provided and bed she<br>#8 was aware.<br>Per NA she checked<br>continued to be diaph<br>reported to Nurse #8.<br>His vital signs were o<br>and included the follo<br>sat 97% room air. Pu<br>F. BP 106/66.<br>The third shift NA con<br>and she had to chang<br>not feeling well and co | had ampicillin available in<br>New orders were received<br>until medication was<br>t #389 had a physician<br>rned to the facility at<br>n. NA stated resident #389<br>use stool. Per her statement<br>nd confused. She provided<br>hanging his bed sheets.<br>of loose stools and<br>btained on 2/4/2019 at<br>the following: Respirations<br>n air. Pulse 68.<br>BP 102/64.<br>ube feedings at 6:30pm.<br>retic at this time and per NA<br>resening. ADL care was<br>bets changed. Again, nurse<br>him at 10pm and he<br>poretic and "out of it". NA | F                  | 580 |  |                   |                            |
|                          | The third shift nurse k   |   |                    |     |  |                   |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                    |     |  | FOR              | M APPROVED<br>D. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|------------------|----------------------------|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE<br>COM | E SURVEY<br>PLETED         |
|                          |   | 345294  | B. WING            |     |  |                  | C<br>/ <b>09/2019</b>      |
| NAME OF PF               | ROVIDER OR SUPPLIER   |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  | •                |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE |
| F 580                    | Continued From page<br>On 2/5/19 at approxim<br>#389 had a drop in o2<br>90/52. No urinary out<br>episodes of runny dia<br>at 2L. Resident's o2 at<br>Received order to add<br>was effective. O2 sat<br>sweating profusely, ui<br>for staff. Still states "<br>order to send residen<br>left the facility at 04:0<br>Resident #389 is curr<br>Root Cause Analysis<br>The facility identified a<br>communicating a cha<br>an assessment when<br>notify MD timely to ob<br>Upon return from phy<br>#8 was aware of diarr<br>episode as well as co | e 10<br>nately 3:00am, resident<br>2 sat to 84%. RR 36. BP<br>tput this shift and X2<br>rrhea like stools. Applied 02<br>stat increased to 94-95%.<br>minister Duo Nebs which<br>t now 97%. Resident still<br>ncomfortable and calling out<br>I don't feel right". Received<br>t to the hospital. Resident<br>1 with the EMS staff.<br>ently at the hospital. |                    | 580 | DEFICIENCY)  |                  |                            |
|                          | continued diaphoresis   | s. Nurse #8 failed to notify<br>ndition, failed to assess the<br>tely lead to his   |                    |     |  |                  |                            |
|                          |   | plementing the Acceptable the specific deficiency   |                    |     |  |                  |                            |
|                          | The resident is not cu  | rrently in the facility.  |                    |     |  |                  |                            |
|                          |   | to toe assessment will be<br>dents by licensed staff to   |                    |     |  |                  |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |   | FORM   | MAPPROVED<br>0. 0938-0391 |  |
|--------------------------|---|--|--------------------|-----|---|--|---------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE<br>COMF                            |                           |  |
|                          |   | 345294   | B. WING            |     |   |  | 09/2019                   |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | L  |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | • •  |                           |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |  |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | CTION SHOULD BE COMP<br>D THE APPROPRIATE D4 |                           |  |
| F 580                    | identify any sign of ch<br>issues identified the a<br>resident representativ<br>On 2/8/2019, licensed<br>interviewable residem<br>concerns with the car<br>provided by staff. No<br>On 2/8/2019, the Adm<br>of Clinical Services an<br>education on the follo<br>*Licensed Nursing sta<br>physician order policy<br>*Licensed Nursing sta<br>change in resident co<br>*Licensed Nursing sta<br>documentation.<br>*CNAs will be educate<br>Interact process whic<br>condition including the<br>, talks less, overall ne<br>less, no bowel mover<br>weight change, agitat<br>skin color and help wi<br>toileting more than us<br>*CNAs will be educate<br>skin color and help wi<br>toileting more than us<br>*CNAs will be educate<br>documentation. | hange of condition. Any<br>attending physician and<br>we will be notified.<br>I nurses interviewed all<br>ts if there were any<br>te and treatment they are<br>to concerns were reported.<br>Ininistrator, Regional Director<br>and DON started in-house<br>wing:<br>aff will be educated on<br>widition policy.<br>aff will be educated on<br>widition policy.<br>aff will be educated on<br>widition policy.<br>aff will be educated on<br>the on Stop and Watch<br>h includes changes of<br>e following: seems different<br>beds more help, pain, ate<br>nent or diarrhea, drank less,<br>ion, tired, week, change in<br>ith walking, transferring,<br>sual.<br>ed on Point of Care Alert<br>DN and/or designees will<br>hurses on causes,<br>ions, diagnosis and | F                  | 580 |   |  |                           |  |

|                          |   | D HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |  | FORM              | APPROVED<br>0. 0938-0391   |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|                          |   | 345294  | B. WING            |     |  |                   | C<br>09/2019               |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | •                  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | •                 |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE                | (X5)<br>COMPLETION<br>DATE |
| F 580                    | available 2/8/19 and 2<br>staff members will not<br>education is received<br>telephone, a certified<br>provided will be maile<br>to call the DON to set<br>New licensed nurse a<br>above education upor<br>The monitoring proce<br>Correction is correcte<br>cited remains correcte<br>regulatory requirement<br>The DON and/or desi<br>progress notes to detuch<br>anges of condition<br>appropriate and inclue<br>audit will be complete<br>and weekly x 8 weeks<br>The DON and/or licer<br>review census and nu-<br>identify residents returd<br>determine that the cha-<br>interventions were tim-<br>includes MD notificati<br>completed 5 x week x<br>weeks.<br>Three residents will b<br>regarding the care an<br>Director of Nursing or<br>8 weeks.<br>The Director of Nursing sta- | <ul> <li>2/9/19 in person. These</li> <li>the permitted to work until</li> <li>If unable to reach via</li> <li>letter with the education</li> <li>d on 2/9/19 with instructions</li> <li>a time for education.</li> <li>and NA hires will receive the</li> <li>a hire.</li> <li>dure to assure the Plan of</li> <li>d and the specific deficiency</li> <li>ed and in compliance with</li> <li>anterventions were timely,</li> <li>des MD notification. This</li> <li>d 5 x per week for 30 days</li> <li>s.</li> </ul> assed nurse designee will arsing progress notes to aning to the hospital to anges of condition hely, appropriate and on. This audit will be a 30 days and weekly x 8 | F                  | 580 |  |                   |                            |

|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |     |   | FORM              | D: 06/17/2019<br>APPROVED<br>D: 0938-0391 |
|--------------------------|---|---|---------------------|-----|---|-------------------|---|
| STATEMENT C              | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,                 |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |   | 345294  | B. WING             |     |   |                   | C<br>09/2019                              |
| NAME OF PF               | ROVIDER OR SUPPLIER   |   |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | •                 |   |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                     |     | 37 MULBERRY STREET<br>HALLOTTE, NC 28459  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIJ<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| F 580<br>F 600<br>SS=J   | condition. This will be<br>30 days and weekly x<br>The facility will conduct<br>Assurance Performant<br>on 2/8/19 with the fact<br>the Regional Director of C<br>Director to review the<br>The title of the person<br>implementing the acc<br>the Administrator.<br>Date of Alleged Comp<br>The credible allegation<br>removal was validated<br>A sample of staff that<br>aides were interviewer<br>related to the deficient<br>staff members stated<br>regarding the physicial<br>resident condition pol<br>and Watch Interact pr<br>Alert documentation.<br>developed to ensure the<br>staff were understood<br>for staff to interact witt<br>Free from Abuse and<br>CFR(s): 483.12(a)(1)<br>§483.12 Freedom from | esident has a change in<br>e documented 3 x week for<br>8 weeks.<br>ct an Ad Hoc Quality<br>ince Improvement meeting<br>ility interdisciplinary team,<br>esident of Operations,<br>Clinical Services the Medical<br>corrective measures.<br>In responsible for<br>eptable plan of correction is<br>of Immediate Jeopardy<br>d on 02/09/19 at 3:07 PM.<br>included nurses and nurse<br>ed regarding in-servicing<br>t practice. All interviewed<br>they had been in-serviced<br>an order policy, change in<br>icy, documentation, Stop<br>occess, and Point of Care<br>A review of all documents<br>the deficient practice was<br>of audit forms that were<br>that in-services presented to<br>I and allowed an opportunity<br>h dialogue was completed. |                     | 580 |   |                   | 2/10/19                                   |
|                          | Exploitation  | n Abuse, Negleu, allu   |                     |     |   |                   |   |

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|                          | MENT OF HEALTH AN<br>S FOR MEDICARE & I   | D HUMAN SERVICES   |         |   |  | FORM                       | : 06/17/2019<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|--|---------|---|--|----------------------------|---|
| STATEMENT                | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,     | CONSTRUCTION  |  | (X3) DATE<br>COMP          | SURVEY<br>LETED                         |
|                          |   | 345294   | B. WING |   |  | (<br>02/                   | C<br>09/2019                            |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | S       | TREET ADDRESS, CITY, STATE, 2   |  |                            |   |
|                          |   |  | 2:      | 37 MULBERRY STREET  |  |                            |   |
| AUTUMN                   | CARE OF SHALLOTTE   |  | s       | HALLOTTE, NC 28459  |  |                            |   |
| (X4) ID<br>PREFIX<br>TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |  |         |   |  | (X5)<br>COMPLETION<br>DATE |   |
| F 600                    | The resident has the ineglect, misappropria<br>and exploitation as definctudes but is not time<br>corporal punishment,<br>any physical or chemit<br>treat the resident's me<br>§483.12(a) The facility<br>§483.12(a)(1) Not use<br>physical abuse, corport<br>involuntary seclusion;<br>This REQUIREMENT<br>by:<br>Based on staff intervit<br>and record review the<br>care for 1 of 1 resident<br>experienced a signific<br>the sudden onset of d<br>disorientation and dia<br>evaluated at a hospita<br>urinary tract infection<br>indwelling urethral cal<br>and Gram-negative ba<br>blood stream).<br>Immediate Jeopardy I<br>Resident #389 experi<br>in condition at 3:55 PI<br>diaphoretic, disoriente<br>of diarrhea. The facility<br>for Resident #389 after<br>reported at least three<br>something was very v<br>Immediate Jeopardy w | right to be free from abuse,<br>tion of resident property,<br>efined in this subpart. This<br>ited to freedom from<br>involuntary seclusion and<br>ical restraint not required to<br>edical symptoms.<br>y must-<br>e verbal, mental, sexual, or<br>oral punishment, or<br>is not met as evidenced<br>fews, physician interview<br>facility neglected to provide<br>the (Resident #389) who<br>cant change in condition with<br>liaphoresis (sweating),<br>rrhea. Resident #389 was<br>al and diagnosed with a<br>associated with the<br>theter, acute kidney injury<br>acteremia (bacteria in the<br>began on 02/04/19 when<br>enced a significant change | F 600   | F600 Neglect<br>The Plan of Correcting<br>deficiency.<br>On 2/1/2019 resident #3<br>noted in urine. Orders<br>UA C&S. The sample v<br>sent to the hospital labo<br>On 2/2/2019 facility atte<br>UA culture from the hos<br>The culture was pendin<br>ordered resident #389 t<br>Emergency Department<br>On 2/2/2019 resident #3<br>the hospital with a new<br>500 mg QID for UTI. R<br>received 8 doses of Kef<br>On 2/4/2019 received h<br>New orders to d/c Kefle<br>250 mg q 6 hours x 7 da<br>provider pharmacy nor<br>had ampicillin available<br>ordered. New orders w<br>hold the ampicillin until<br>available to send. | 389 had blood<br>were received for<br>was collected and<br>pratory.<br>empted to receive<br>spital laboratory.<br>g. On call provid<br>to go to the<br>t.<br>389 returned from<br>order for Keflex<br>esident #389<br>flex.<br>tospital cultures.<br>ex, start ampicillin<br>ays for a UTI. The<br>local pharmacies<br>in the dosage<br>vere received to | d<br>der<br>m<br>n<br>he   |   |

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|                          | OF DEFICIENCIES       | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA                                      | (X2) MULTIF         | PLE CONSTRUCTION   | OMB NO. 093<br>(X3) DATE SURVE         |                        |
|--------------------------|-----------------------|---|---------------------|--|--|------------------------|
| ND PLAN OF               | CORRECTION            | IDENTIFICATION NUMBER:  | . ,                 | G  | COMPLETED                              |                        |
|                          |                       |   |                     |  | С                                      |                        |
|                          |                       | 345294  | B. WING             |  | 02/09/20                               | 19                     |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP C   | ODE                                    |                        |
| AUTUMN                   | CARE OF SHALLOTTE     |   |                     | 237 MULBERRY STREET  |  |                        |
|                          |                       |   |                     | SHALLOTTE, NC 28459  |  |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC       | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE COMP<br>HE APPROPRIATE D | (X5)<br>PLETIO<br>DATE |
| F 600                    | Continued From page   | e 15  | F 60                | 00   |  |                        |
|                          |                       | r scope and severity of "D"   |                     | On 2/4/2019, resident #389   | had a                                  |                        |
|                          |                       | tential for more than minimal   |                     | physician appointment and  |  |                        |
|                          |                       | ediate jeopardy) to ensure  |                     | facility at approximately 3:5  |  |                        |
|                          |                       | but in place are effective.   |                     | stated resident #389 had a   |  |                        |
|                          |                       |   |                     | loose stool. Per her statem  | -                                      |                        |
|                          | Findings included:    |   |                     | diaphoretic and confused.  |  |                        |
|                          |                       |   |                     | ADL care including changin   | -                                      |                        |
|                          |                       | dmitted to the facility on  |                     | sheets. Nurse #8 was awa   |  |                        |
|                          |                       | ses that included retention of  |                     | stools and diaphoretic episo   |  |                        |
|                          |                       | d reflux uropathy, benign<br>with lower urinary tract                                 |                     | His vital signs were obtaine<br>at 5:59pm and included the                       |  |                        |
|                          |                       | my, severe protein calorie  |                     | Respirations 18. O2 sat 97   |  |                        |
|                          |                       | on's disease and Alzheimer's  |                     | Pulse 68. Temperature 98.  |  |                        |
|                          | disease with early on |   |                     | 102/64.  |  |                        |
|                          |                       |   |                     | Nurse administered tube fe   | edings at                              |                        |
|                          |                       | e 5 Day Admission Minimum   |                     | 6:30pm. Resident was diap  | phoretic at this                       |                        |
|                          | , ,                   | essment dated 01/24/19 for  |                     | time and per NA was progre   | -                                      |                        |
|                          |                       | led he had moderately   |                     | worsening. ADL care was  |  |                        |
|                          |                       | le required extensive   |                     | bed sheets changed. Again  | n, nurse #8                            |                        |
|                          |                       | all activities of daily living, neelchair for ambulation and                          |                     | was aware.   | 10 mm and ha                           |                        |
|                          |                       | ndwelling urinary catheter  |                     | Per NA she checked him at<br>continued to be diaphoretic                         |  |                        |
|                          |                       | tube. He received 4 days  |                     | NA reported to Nurse #8.   |  |                        |
|                          |                       | 6 days of Occupational  |                     | His vital signs were obtaine   | ed on 2/5/19 at                        |                        |
|                          |                       | of Physical Therapy during  |                     | 2:05am and included the fo   |  |                        |
|                          | the assessment look   | back period. He expected  |                     | Respirations 16. O2 sat 97   | '% room air.                           |                        |
|                          |                       | ne community when his   |                     | Pulse 70. Temperature 98.  | 6 F. BP                                |                        |
|                          | therapies were comp   | leted.  |                     | 106/66.  |  |                        |
|                          |                       |   |                     | The third shift NA confirmed   |  |                        |
|                          |                       | care dated 02/01/19 for<br>ed focus areas for altered                                 |                     | diaphoretic and she had to   | -                                      |                        |
|                          | neurological status a |   |                     | bed twice. He was not feel continued to be diaphoretic                           | -                                      |                        |
|                          |                       | zheimer's dementia and  |                     | shift nurse knew he was un   |  |                        |
|                          |                       | Interventions included to   |                     | and was diaphoretic and wa   |  |                        |
|                          |                       | ation, assess, document and   |                     | often.   | č                                      |                        |
|                          |                       | n any changes in cognitive  |                     | On 2/5/19 at approximately   |  |                        |
|                          | function.             |   |                     | resident #389 had a drop ir  |  |                        |
|                          |                       |   |                     | 84%. RR 36. BP 90/52. N  |  |                        |
|                          | During Resident #389  | 9's stay at the facility his  |                     | output this shift and X2 epis  | sodes of runny                         |                        |

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|                          |                               | MEDICAID SERVICES   |   |   |                            | NO. 0938-03               |
|--------------------------|-------------------------------|---|---|---|----------------------------|---------------------------|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | . ,   | LE CONSTRUCTION   |                            | OATE SURVEY               |
|                          | CONNECTION                    | IDENTIFICATION NOWDER.  | A. BUILDING   |   |                            |                           |
|                          |                               | 345294  | B. WING   |   |                            | С                         |
|                          |                               | 345294  | B. WING   |   |                            | 02/09/2019                |
| NAME OF P                | ROVIDER OR SUPPLIER           |   |   | STREET ADDRESS, CITY, STA   | IE, ZIP CODE               |                           |
| AUTUMN                   | CARE OF SHALLOTTE             |   |   | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |                            |                           |
|                          |                               |   | ID  |   | PLAN OF CORRECTION         | 0(5)                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION SHOU<br>TAG CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |   |                            | (X5)<br>COMPLETIC<br>DATE |
| F 600                    | Continued From page           | e 16  | F 60  | 0   |                            |                           |
|                          |                               | replaced several times due  |   | diarrhea like stools.   | Applied 02 at 2L.          |                           |
|                          |                               | occlusions documented in  |   |   | increased to 94-95%.       |                           |
|                          | the nursing progress          |   |   | Received order to a   |                            |                           |
|                          | 01/26/19, 01/27/19 a          | nd 02/02/19. On 01/26/19 a  |   | which was effective.  | . O2 sat now 97%.          |                           |
|                          |                               | sitivity (UA C & S) lab test  |   | Resident still sweati   |                            |                           |
|                          | -                             | rse Practitioner to determine   |   | uncomfortable and o   |                            |                           |
|                          |                               | ed up into his urinary tract  |   | Still states I don □t f   |                            |                           |
|                          |                               | amount of time due to an<br>d started to culture bacteria.                            |   | order to send reside  | •                          |                           |
|                          |                               | 3 contacted an on-call  |   | EMS staff.  | ility at 04:01 with the    |                           |
|                          |                               | sted a discontinuation order  |   |   | rrently at the hospital.   |                           |
|                          |                               | because she had reinserted a  |   |   | frontily at the hoopital.  |                           |
|                          |                               | Igement and the returned  |   | Root Cause Analysi  | s                          |                           |
|                          | urine was yellow doc          | -   |   | ,,, , | -                          |                           |
|                          | -                             | 7/19. On 02/01/19 the   |   | The facility identified   | d an opportunity in        |                           |
|                          | facility Nurse Practitio      | oner reordered a UA C & S   |   | communicating a ch  |                            |                           |
|                          | -                             | od in the urine). Nurse #7  |   | completing an asses   |                            |                           |
|                          |                               | gress notes dated 02/01/19  |   |   | and notify MD timely       |                           |
|                          |                               | urine and sent it to the  |   | to obtain orders if an  |                            |                           |
|                          |                               | e the results came back   |   |   | n appointment, nurse       |                           |
|                          |                               | ent to the emergency room   |   |   | Irrhea and diaphoretic     |                           |
|                          |                               | to complaints of abdominal<br>Hospital records dated                                  |   | same shift, nurse #8  | confusion. During the      |                           |
|                          | -                             | d a diagnosis of urinary tract  |   |   | d diaphoresis. Nurse       |                           |
|                          |                               | with indwelling urethral  |   | #8 failed to notify MI  | •                          |                           |
|                          |                               | started on the antibiotic   |   | condition, failed to a  | •                          |                           |
|                          | Keflex by the emerge          |   |   | which ultimately lead   |                            |                           |
|                          | Between 02/02/19 an           | d 02/04/19 he received all  |   | re-hospitalization on   | n 2/5/19.                  |                           |
|                          |                               | ses as documented on the  |   |   |                            |                           |
|                          |                               | ministration Record). On  |   | The Procedure for In  |                            |                           |
|                          | 02/04/19 the facility N       |   |   | Acceptable Plan of (  |                            |                           |
|                          |                               | biotic Keflex (lab results  |   | specific deficiency c   | alea.                      |                           |
|                          |                               | ed that it was not effective)<br>n 250 mg every six hours for                         |   | The resident is not a   | currently in the facility. |                           |
|                          |                               | ew of a nurse progress note   |   |   |                            |                           |
|                          |                               | on 02/05/19 revealed the  |   | The Administrator su  | ubmitted a 24-hour         |                           |
|                          | Ampicillin had not be         |   |   |   | ging neglect by Nurse      |                           |
|                          | -                             | f the February MAR showed   |   | #8 for not following  |                            |                           |
|                          | that no doses of Amp          |   | 1   |   | , not assessing a          | 1                         |

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| CENTER                   | S FOR MEDICARE &   | MEDICAID SERVICES   |                     |  | OM  | 3 NO. 0938-039            |
|--------------------------|--|---|---------------------|--|---|---------------------------|
|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   |   | DATE SURVEY<br>COMPLETED  |
|                          |  | 345294  | B. WING             |  |   | C<br>02/09/2019           |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | •                   | STREET ADDRESS, CITY, STATE  | , ZIP CODE  |                           |
| AUTUMN                   | CARE OF SHALLOTTE  |   |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIV<br>CROSS-REFERENCE   | AN OF CORRECTION<br>/E ACTION SHOULD BE<br>D TO THE APPROPRIATE<br>ICIENCY)   | (X5)<br>COMPLETIO<br>DATE |
| F 600                    | Continued From page  | e 17  | F 60                | 00   |   |                           |
|                          | Resident #389.   |   |                     | resident for a change<br>notifiying a MD of a ch   |   |                           |
|                          | during the initial tour of He was sitting quietly                      | sident #389 was made<br>on 02/04/19 at 12:00 noon.<br>in his wheelchair at the<br>g to be transported to a                                      |                     | Nurse #8 was suspen<br>pending an investigati  |   |                           |
|                          |  | He was alert and oriented,<br>o odors of urine or feces<br>as observed on the   |                     | On 2/8/2019, a head t<br>will be completed on a<br>licensed staff to identif<br>change of condition.   | all residents by<br>fy any sign of<br>Any issues identified                   |                           |
|                          | AM with Nurse #8. S<br>Resident #389 return<br>appointment on 02/04    | ducted on 02/08/19 at 10:40<br>he reported that when<br>ed from his medical<br>I/19 he was assisted back<br>that the NA told her that he        |                     | the attending physicia<br>representative will be<br>On 2/8/2019, licensed<br>all interviewable reside<br>any concerns with the<br>they are provided by s | notified.<br>I nurses interviewed<br>ents if there were<br>care and treatment |                           |
|                          | tube feeding between<br>remember him being<br>couldn't remember m      | and she gave him a bolus<br>6:00-6:30 PM. She did not<br>sweaty. She said she really<br>uch but that if she passed<br>as sweaty and had to have |                     | were reported.<br>On 2/8/2019, the Adm<br>Director of Clinical Sel<br>started in-house educa<br>following:   | rvices and DON  |                           |
|                          | his sheets changed to<br>she could not remem                           | wice then it must be true but<br>ber. She was sure that she<br>ician because if she had she   |                     | Licensed Nursing staft<br>the Abuse/Neglect pol<br>Licensed Nursing staft<br>physician order policy<br>Licensed Nursing staft                            | licy.<br>f will be educated on  |                           |
|                          | AM with NA #1. She was sweaty, disorient                               | ducted on 02/08/19 at 11:19<br>revealed that Resident #389<br>ed, and had been<br>a when he returned from his                                   |                     | change in resident cor<br>Licensed Nursing staff<br>documentation.<br>CNAs will be educated  | ndition policy.<br>f will be educated on                                      |                           |
|                          | that Nurse #8 had put<br>had called her to the<br>that she changed his | on 02/04/19. She reported<br>t the resident into bed and<br>room to help. NA #1 stated<br>sweaty shirt and sheets at                            |                     | Watch Interact proces<br>CNAs will be educated<br>Alert documentation.   | d on Point of Care  |                           |
|                          | he was sweaty, disori bowel. She told the r                            | Nurse #8 had observed that<br>iented and incontinent of<br>nurse when the resident first<br>ning was wrong with him."                           |                     | On 2/9/19 the DON ar<br>educate all licensed n<br>symptoms, complication<br>treatment of septicemi   | urses on causes,<br>ons, diagnosis and  |                           |

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|                          |                               |   |                     |   |  | IO. 0938-03               |
|--------------------------|-------------------------------|---|---------------------|---|--|---------------------------|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | · /                 |   |  | E SURVEY                  |
|                          |                               |   | A. BUILDING         | <u> </u>  |  | С                         |
|                          |                               | 345294  | B. WING             |   |  |                           |
|                          | ROVIDER OR SUPPLIER           |   |                     | STREET ADDRESS, CITY, STATE, Z                                    |  | 2/09/2019                 |
|                          |                               |   |                     | 237 MULBERRY STREET   |  |                           |
| AUTUMN                   | CARE OF SHALLOTTE             |   |                     | SHALLOTTE, NC 28459   |  |                           |
|                          |                               |   |                     |   |  | ()(5)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE<br>CROSS-REFERENCED<br>DEFICI | ACTION SHOULD BE<br>TO THE APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 600                    | Continued From page           | e 18  | F 60                | 0   |  |                           |
|                          |                               | look good" so she reported  |                     | Education will continue   | via telephone for                      |                           |
|                          |                               | at Resident #389 was  |                     | staff not available 2/8/1   |  |                           |
|                          | -                             | nted. She stated he was   |                     | person. These staff me  | mbers will not be                      |                           |
|                          |                               | the shift and it got worse as   |                     | permitted to work until e   |  |                           |
|                          |                               | emembered that when Nurse   |                     | received. If unable to re   | • •                                    |                           |
|                          |                               | sident his tube feeding the   |                     | a certified letter with the                                       |  |                           |
|                          |                               | ed that the resident was  |                     | provided will be mailed   |  |                           |
|                          |                               | e stated that she had told  |                     | instructions to call the D  | ION to set a time                      |                           |
|                          |                               | 0:00 PM that Resident #389<br>nd disoriented." She said                               |                     | for education.  |  |                           |
|                          |                               | was just wore out from going  |                     | New licensed nurses ar  | nd NA hires will be                    |                           |
|                          | to the appointment ea         |   |                     | educated to abuse polic   |  |                           |
|                          |                               | sed on in report to the   |                     | The monitoring procedu  |  |                           |
|                          |                               | A (#6) that Resident #389   |                     | Plan of Correction is co  |  |                           |
|                          |                               | and to keep an eye on him.  |                     | specific deficiency cited   | remains corrected                      |                           |
|                          |                               |   |                     | and in compliance with  | regulatory                             |                           |
|                          |                               | iducted on 02/08/19 at 12:22  |                     | requirements.   |  |                           |
|                          |                               | e confirmed that NA#1 had   |                     | The DON and/or design   |  |                           |
|                          |                               | hat she had changed the   |                     | nursing progress notes  |  |                           |
|                          |                               | Resident #389 and that he   |                     | any possible changes o  |  |                           |
|                          |                               | e said that she could tell he   |                     | interventions were time   |  |                           |
|                          |                               | the shift started he kept<br>o". She stated that as soon                              |                     | includes MD notification<br>completed 5 x per week                |  |                           |
|                          |                               | ne would immediately start  |                     | weekly x 8 weeks.   | tion bo days and                       |                           |
|                          |                               | and she would go back to  |                     | The DON and/or license  | ed nurse desianee                      |                           |
|                          |                               | ted that herself and Nurse #5   |                     | will review census and r  |  |                           |
|                          |                               | several times because they  |                     | notes to identify residen   | ••••                                   |                           |
|                          |                               | what was wrong with him.  |                     | hospital to determine th  | at the changes of                      |                           |
|                          |                               | dent #389 had three bouts of  |                     | condition interventions v   |  |                           |
|                          |                               | before he was transferred to  |                     | appropriate and include   |  |                           |
|                          |                               | . She commented that  |                     | This audit will be comple   |  |                           |
|                          |                               | to the hospital toward the  |                     | 30 days and weekly x 8  |  |                           |
|                          | end of her shift betwe        | een 3:30 and 4:00 AM.   |                     | Three residents will be i regarding the care and                  |  |                           |
|                          | Review of a nurse pro         | ogress note written by Nurse  |                     | by the Director of Nursir   | -                                      |                           |
|                          |                               | 4 AM indicated that she had   |                     | nurse designee for 8 we   |  |                           |
|                          |                               | m the previous shift that the   |                     | The Director of Nursing   |  |                           |
|                          |                               | be changed twice on   |                     | nursing staff concerning  |  |                           |
|                          |                               | he was sweating. She  |                     | provided, including aski  |  |                           |

Facility ID: 922957

If continuation sheet Page 19 of 47

|                          | OF DEFICIENCIES                              | MEDICAID SERVICES  | (X2) MULTIF         | PLE CONSTRUCTION                                      |                                      | NO. 0938-03<br>ATE SURVEY |
|--------------------------|--|--|---------------------|---|--------------------------------------|---------------------------|
|                          | CORRECTION                                   | IDENTIFICATION NUMBER:                                       | , <i>'</i>          | G   | · · ·                                | MPLETED                   |
|                          |  |  |                     |   |                                      | С                         |
|                          |  | 345294   | B. WING             |   |                                      | 02/09/2019                |
| NAME OF PI               | ROVIDER OR SUPPLIER                          |  |                     | STREET ADDRESS, CITY, STATE, ZIF                      | PCODE                                |                           |
| AUTUMN                   | CARE OF SHALLOTTE                            |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459            |                                      |                           |
| 0(0)15                   |  | ATEMENT OF DEFICIENCIES                                      |                     | PROVIDER'S PLAN (                                     |                                      | (275)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                              | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | ID<br>PREFIX<br>TAG |   | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 600                    | Continued From page                          | e 19   | F 60                | 00  |                                      |                           |
|                          |  | observed the resident  |                     | is appropriate when a res                             | sident has a                         |                           |
|                          |  | ng profusely." During her                                    |                     | change in condition. This                             | s will be                            |                           |
| s<br>t<br>I              |  | began to drop along with his                                 |                     | documented 3 x week for                               | r 30 days and                        |                           |
|                          | -  | is respirations increased.                                   |                     | weekly x 8 weeks.                                     |                                      |                           |
|                          |  | tput on her shift. She noted                                 |                     | The facility will conduct a                           | •                                    |                           |
|                          |  | ne didn't feel good and was<br>ing. Nurse #5 contacted the   |                     | Assurance Performance meeting on 2/8/19 with the      |                                      |                           |
|                          | -  | transferred the resident to                                  |                     | interdisciplinary team, the                           | ,                                    |                           |
|                          | the emergency room                           |  |                     | President of Operations,                              |                                      |                           |
|                          |  |  |                     | Director of Clinical Service                          | •                                    |                           |
|                          | An interview was con                         | ducted on 02/08/19 2:02 PM                                   |                     | Director to review the cor                            | rrective                             |                           |
|                          | with Nurse #5. She read                      |  |                     | measures.   |                                      |                           |
|                          |  | 89 was resting when she                                      |                     | The title of the person re                            |                                      |                           |
|                          | -  | tated she was called to his who was sweating and could       |                     | implementing the accept<br>correction is the Administ |                                      |                           |
|                          |  | She recalled that his oxygen                                 |                     | Date of Alleged Compliar                              |                                      |                           |
|                          |  | ong with his blood pressure.                                 |                     | Date of Alleged Compila                               |                                      |                           |
|                          |  | ne on-call provider and                                      |                     |   |                                      |                           |
|                          | received an order to g                       | give the resident a breathing                                |                     |   |                                      |                           |
|                          |  | gen level came up but he                                     |                     |   |                                      |                           |
|                          | continued to sweat.                          |  |                     |   |                                      |                           |
|                          |  | ceived an order to send the                                  |                     |   |                                      |                           |
|                          | was either having a h                        | al because she thought he                                    |                     |   |                                      |                           |
|                          |  | I not remember what time                                     |                     |   |                                      |                           |
|                          | she sent him to the er                       |  |                     |   |                                      |                           |
|                          | Emergency Medical S                          | Service records revealed                                     |                     |   |                                      |                           |
|                          | Resident #389 was tr<br>4:01 AM on 02/05/19. | ansported to the hospital at                                 |                     |   |                                      |                           |
|                          | Review of the hospita                        |  |                     |   |                                      |                           |
|                          | Resident #389 arrived<br>4:40 AM on 02/05/19 | d at the emergency room at                                   |                     |   |                                      |                           |
|                          | Review of the hospita                        | Il progress notes on<br>d a preliminary diagnosis of         |                     |   |                                      |                           |
|                          | sepsis secondary to l                        | JTI (Urinary Tract Infection).<br>n dated 02/06/19 concluded |                     |   |                                      |                           |

|                          | S FOR MEDICARE &              |   |                     |   |                              | O. 0938-039                |
|--------------------------|-------------------------------|---|---------------------|---|------------------------------|----------------------------|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | (X2) MULTIP         | LE CONSTRUCTION   | · · ·                        | E SURVEY                   |
| ND FLAN OF               | CORRECTION                    | IDENTIFICATION NUMBER.  | A. BUILDING         | <u> </u>  | COM                          |                            |
|                          |                               |   |                     |   |                              | С                          |
|                          |                               | 345294  | B. WING             |   | 02                           | 2/09/2019                  |
| NAME OF P                | ROVIDER OR SUPPLIER           |   |                     | STREET ADDRESS, CITY, STATE, ZIP COL  | DE                           |                            |
|                          |                               |   |                     | 237 MULBERRY STREET   |                              |                            |
| AUTUMN                   | CARE OF SHALLOTTE             |   |                     | SHALLOTTE, NC 28459   |                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIOI<br>DATE |
| F 600                    | Continued From page           | e 20  | F 60                | 0   |                              |                            |
|                          |                               |   | 1 00                |   |                              |                            |
|                          |                               | ad blood cultures positive for  |                     |   |                              |                            |
|                          | life-threatening condi        | ram-negative bacteremia, a  |                     |   |                              |                            |
|                          |                               | uon.  |                     |   |                              |                            |
|                          | An interview was con          | ducted on 02/08/19 at 1:05  |                     |   |                              |                            |
|                          |                               | g Physician for Resident  |                     |   |                              |                            |
|                          |                               | e Medical Director at the   |                     |   |                              |                            |
|                          |                               | t she was familiar with   |                     |   |                              |                            |
|                          |                               | use she had completed his   |                     |   |                              |                            |
|                          |                               | e was admitted to the facility.   |                     |   |                              |                            |
|                          |                               | hat he had a change in his  |                     |   |                              |                            |
|                          |                               | 9 until the Nurse Practitioner  |                     |   |                              |                            |
|                          |                               | had been transferred to the   |                     |   |                              |                            |
|                          |                               | . She reported that laying  |                     |   |                              |                            |
|                          |                               | being disoriented was not   |                     |   |                              |                            |
|                          | -                             | she saw daily with Resident   |                     |   |                              |                            |
|                          |                               | at he was normally up and   |                     |   |                              |                            |
|                          |                               | air. She commented that   |                     |   |                              |                            |
|                          |                               | e confusion he could chat   |                     |   |                              |                            |
|                          |                               | sited. She stated that she  |                     |   |                              |                            |
|                          | would have considered         | ed it an acute significant  |                     |   |                              |                            |
|                          |                               | an sweating and became  |                     |   |                              |                            |
|                          |                               | 19 at the beginning of  |                     |   |                              |                            |
|                          |                               | she been in the building she  |                     |   |                              |                            |
|                          |                               | d him immediately. She  |                     |   |                              |                            |
|                          |                               | ident would have been   |                     |   |                              |                            |
|                          |                               | hange in his condition  |                     |   |                              |                            |
|                          | occurred at the begin         | 0   |                     |   |                              |                            |
|                          | because he had had            | -   |                     |   |                              |                            |
|                          |                               | nptoms were indicative of   |                     |   |                              |                            |
|                          | sepsis. She stated th         | •   |                     |   |                              |                            |
|                          |                               | ould cause a resident's   |                     |   |                              |                            |
|                          | condition to change v         | very quickly and turn on a  |                     |   |                              |                            |
|                          |                               | mmented that waiting 12   |                     |   |                              |                            |
|                          |                               | Negative sepsis could result  |                     |   |                              |                            |
|                          |                               | nters the blood and acts in a   |                     |   |                              |                            |
|                          | couple of hours. She          | e stated that it certainly could  |                     |   |                              |                            |
|                          |                               | -   |                     |   |                              |                            |
|                          | nave anected the out          | come for Resident #389 had  |                     |   |                              |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |         |  |  | FOR              | M APPROVED<br>D. 0938-0391 |  |
|--------------------------|---|--|---------|--|--|------------------|----------------------------|--|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |         |  | LE CONSTRUCTION                            | (X3) DATE<br>COM | E SURVEY<br>PLETED         |  |
|                          |   | 345294   | B. WING |  |  |                  | C<br>/ <b>09/2019</b>      |  |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |         |  | STREET ADDRESS, CITY, STATE, ZIP CODE      | •                |                            |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |         |  | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459 |                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  |         | ID PROVIDER'S PLAN OF CORRECTION<br>PREFIX (EACH CORRECTIVE ACTION SHOULD BE<br>TAG CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  |                  |                            |  |
| F 600                    | An interview was con<br>Nursing on 2/9/19 at 2<br>resident had a chang<br>expect the staff to do<br>provider if indicated, of<br>either the progress no<br>when the incident occ<br>any new orders. He wait<br>alert message in PCC<br>electronic medical rec<br>change of condition in<br>The facility Administra<br>Nursing were notified<br>02/08/19 at 3:00 PM.<br>On 02/09/19 at 1:51 F<br>following credible alle<br>jeopardy removal:<br>F600 Neglect<br>The Plan of Correction<br>On 2/1/2019 resident<br>urine. Orders were re<br>sample was collected<br>laboratory.<br>On 2/2/2019 facility a<br>culture from the hosp<br>was pending. On cal<br>#389 to go to the Eme | te condition treated sooner.<br>ducted with the Director of<br>2:45 PM. He stated if a<br>e in condition he would<br>an assessment, notify the<br>document the incident in<br>bets or on an S Bar report<br>curred and then transcribe<br>would also expect a nurse<br>and watch form or put a new<br>C (Point Click Care, the<br>cord) if he or she noticed a<br>n a resident.<br>ator and the Director of<br>of immediate jeopardy on<br>PM the facility provided the<br>egation of immediate<br>g the specific deficiency.<br>#389 had blood noted in<br>eceived for a UA C&S. The<br>I and sent to the hospital<br>ttempted to receive UA<br>ital laboratory. The culture<br>I provider ordered resident | F       | 600  |  |                  |                            |  |
|                          |   | #389 returned from the<br>rder for Keflex 500 mg QID   |         |  |  |                  |                            |  |

|                          | -   | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  |   | FORM              | ): 06/17/2019<br>1 APPROVED<br>0. 0938-0391 |  |
|--------------------------|---|--|---------------------|--|---|-------------------|---|--|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 | E CONSTRUCTION                             |   | (X3) DATE<br>COMP | SURVEY<br>LETED                             |  |
|                          |   | 345294   | B. WING             |  | _   | C<br>02/09/2019   |   |  |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, ST                   | ATE, ZIP CODE   |                   |   |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459 | I   |                   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN              | EPLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                  |  |
| F 600                    | Keflex.<br>On 2/4/2019 received<br>orders to d/c Keflex, s<br>hours x 7 days for a L<br>nor local pharmacies<br>the dosage ordered.<br>to hold the ampicillin u<br>available to send.<br>On 2/4/2019, resident<br>appointment and retur<br>approximately 3:55pm<br>had an episode of loo<br>he was diaphoretic an<br>ADL care including ch<br>Nurse #8 was aware of<br>diaphoretic episode.<br>His vital signs were of<br>5:59pm and included<br>18. O2 sat 97% room<br>Temperature 98.4 F.<br>Nurse administered tu<br>Resident was diaphor<br>was progressively wo<br>provided and bed she<br>#8 was aware.<br>Per NA she checked f<br>continued to be diaph<br>reported to Nurse #8.<br>His vital signs were of<br>and included the follow | All Preceived 8 doses of<br>hospital cultures. New<br>start ampicillin 250 mg q 6<br>JTI. The provider pharmacy<br>had ampicillin available in<br>New orders were received<br>until medication was<br>#389 had a physician<br>rmed to the facility at<br>NA stated resident #389<br>se stool. Per her statement<br>id confused. She provided<br>langing his bed sheets.<br>of loose stools and<br>otained on 2/4/2019 at<br>the following: Respirations<br>n air. Pulse 68.<br>BP 102/64.<br>Ibe feedings at 6:30pm.<br>etic at this time and per NA<br>rsening. ADL care was<br>ets changed. Again, nurse<br>him at 10pm and he<br>oretic and "out of it". NA | F 600               |  |   |                   |   |  |
|                          | reported to Nurse #8.<br>His vital signs were of<br>and included the follow   | otained on 2/5/19 at 2:05am  |                     |  |   |                   |   |  |

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|  |  |   |  |   |   | APPROVED<br>0.0938-0391   |
|--|--|---|--|---|---|---|
| ICAID SERVICES<br>PROVIDER/SUPPLIER/CLIA<br>DENTIFICATION NUMBER:  | 1 · ·  |   |  |   | (X3) DATE<br>COMP   | SURVEY<br>LETED   |
| 345294   | B. WING  |   |  |   |   | C<br>09/2019  |
|  |  | ST  | REET ADDRESS, CITY, STAT   | E, ZIP CODE   |   |   |
|  |  | 237   | 7 MULBERRY STREET  |   |   |   |
|  |  | S⊦  | ALLOTTE, NC 28459  |   |   |   |
| ENT OF DEFICIENCIES<br>IT BE PRECEDED BY FULL<br>ENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | (   | (EACH CORRECTI<br>CROSS-REFERENC   | VE ACTION SHOULD BE<br>ED TO THE APPROPRIA                                  |   | (X5)<br>COMPLETION<br>DATE  |
|  | F 6  | 00  |  |   |   |   |
| ed he was diaphoretic<br>e bed twice. He was<br>ued to be diaphoretic.<br>he was uncomfortable<br>vas checking often.<br>y 3:00am, resident<br>to 84%. RR 36. BP<br>his shift and X2<br>a like stools. Applied 02<br>ncreased to 94-95%.<br>ther Duo Nebs which<br>y 97%. Resident still<br>nfortable and calling out<br>'t feel right". Received<br>he hospital. Resident<br>h the EMS staff.<br>the hospital. Resident<br>h the EMS staff.<br>the hospital.<br>poportunity in<br>in condition, completing<br>ange in condition and<br>orders if appropriate.<br>In appointment, nurse<br>and diaphoretic<br>ion. During the same<br>ed and witnessed<br>urse #8 failed to notify<br>on, failed to assess the<br>ead to his<br>9.   |  |   |  |   |   |   |
| The second of th | A state of the second s | PROVIDER/SUPPLIER/CLIA       (X2) MULTI         DENTIFICATION NUMBER:       A. BUILDIN         345294       B. WING_         INT OF DEFICIENCIES       ID         T BE PRECEDED BY FULL       PREFIX         ENTIFYING INFORMATION)       TAG         F 6       de de was diaphoretic         e bed twice. He was       ued to be diaphoretic.         he was uncomfortable       ras checking often.         y 3:00am, resident       to 84%. RR 36. BP         his shift and X2       hike stools. Applied 02         ncreased to 94-95%.       ter Duo Nebs which         97%. Resident still       offortable and calling out         tf feel right". Received       ne hospital. Resident         n the EMS staff.       at the hospital.         at the hospital.       numere         and diaphoretic       nodition and         orders if appropriate.       nappointment, nurse         and diaphoretic       no. During the same         ed and witnessed       urse #8 failed to notify         on, failed to assess the       ad to his         o.       ead to his | PROVIDER/SUPPLIER/CLIA       (x2) MULTIPLE 4         DENTIFICATION NUMBER:       A. BUILDING         345294       B. WING         23       St         23       St         23       St         23       St         24       B. WING         23       St         24       B. WING         25       St         26       St         27       St         28       St         29       St         29       St         29       St         29       St         29       St         29       St         20       St         20       St         21       St         22       St         23       St         24       St         25       St         26       St         27       St         28       St         29       St         20       St         21       St         22       St         23       St         24 | PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         A. BUILDING | PROVIDER/SUPPLIE/CLIA       (X2) MULTIPLE CONSTRUCTION         A BUILDING | PROVIDERSUPPLIERCLIA<br>A BUILDING       (X2) MULTIPLE CONSTRUCTION<br>A BUILDING       (X3) DATE<br>COMP         345294       B. WING       (02)         345294       STREET ADDRESS, CITY, STATE, ZIP CODE       237 MULBERRY STREET         STREET ADDRESS, CITY, STATE, ZIP CODE       237 MULBERRY STREET       SHALLOTTE, NC 28459         NT OF DEFICIENCIES<br>TE E PRECEDED BY FULL<br>ENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDERS PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         VB db twice. He was<br>ued to be diaphoretic<br>be bed twice. He was<br>ued to be diaphoretic.<br>he was uncomfortable<br>ras checking often.       F 600         V 3:00am, resident<br>to 84%. RR 36. BP<br>his shift and X2<br>tifke stols. Applied 02<br>coreased to 94-95%.<br>ter Duo Nebs which<br>97%. Resident still<br>fortable and calling out<br>the EMS staff.<br>at the hospital.       F 600         oportunity in<br>n condition, completing<br>ange in condition and<br>orders if appropriate.<br>n appointment, nurse<br>and diaphoretic<br>on. During the same<br>ad and witnessed<br>tree #6 failed to notify<br>on, failed to assist he<br>gad to his<br>3.       Image Acceptable |

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|                          |   | D HUMAN SERVICES<br>MEDICAID SERVICES  |                    |     |  |  | FORM              | D: 06/17/2019<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|--|-------------------|--|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ,                |     | CONSTRUCTION                             |  | (X3) DATE<br>COMP | SURVEY<br>PLETED                           |
|                          |   | 345294   | B. WING            |     |  |  |                   | C<br>09/2019                               |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE               | E, ZIP CODE  |                   |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 37 MULBERRY STREET<br>HALLOTTE, NC 28459 |  |                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | (EACH CORRECT)<br>CROSS-REFERENCE        | LAN OF CORRECTION<br>VE ACTION SHOULD BE<br>ED TO THE APPROPRIA<br>FICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                 |
| F 600                    | 2/8/19 alleging neglect<br>following up on a repor-<br>not assessing a reside<br>and not notifying a MI<br>Nurse #8 was suspen-<br>investigation of the ab<br>On 2/8/2019, a head for<br>completed on all reside<br>identify any sign of ch<br>issues identified the a<br>resident representative<br>On 2/8/2019, licensed<br>interviewable resident<br>concerns with the car-<br>provided by staff. Not<br>On 2/8/2019, the Adm<br>of Clinical Services ar<br>education on the follo<br>Licensed Nursing staff<br>Abuse/Neglect policy.<br>Licensed Nursing staff<br>change in resident co<br>Licensed Nursing staff<br>change in resident co<br>Licensed Nursing staff<br>documentation.<br>CNAs will be educate<br>Interact process. | rrently in the facility.<br>printed a 24-hour report on<br>at by Nurse #8 for not<br>pred change in condition,<br>ent for a change in condition.<br>D of a change in condition.<br>aded on 2/8/19 pending an<br>pove.<br>to toe assessment will be<br>lents by licensed staff to<br>ange of condition. Any<br>ttending physician and<br>re will be notified.<br>A nurses interviewed all<br>ts if there were any<br>e and treatment they are<br>to concerns were reported.<br>A nurses interviewed all<br>ts if there were any<br>e and treatment they are<br>to concerns were reported.<br>A nurse director<br>and DON started in-house<br>wing:<br>f will be educated on<br>f.<br>f will be educated on<br>ndition policy.<br>f will be educated on<br>and on Stop and Watch | F                  | 600 | DEF                                      | -ICIENCY)  |                   |  |
|                          | documentation.  | d on Point of Care Alert   |                    |     |  |  |                   |  |
|                          | On 2/9/19 the DON a   | nd/or designees will educate   |                    |     |  |  |                   |  |

Facility ID: 922957

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                    |     |  | FORM                       | M APPROVED<br>0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|----------------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |  | (X3) DATE<br>COMF          | SURVEY<br>PLETED           |
|                          |   | 345294  | B. WING            |     |  |                            | C<br>/ <b>09/2019</b>      |
| NAME OF PI               | ROVIDER OR SUPPLIER   | L   | <b>I</b>           |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                            |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                            |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                            |
| F 600                    | available 2/8/19 or 2/8<br>members will not be p<br>education is received<br>telephone, a certified<br>provided will be maile<br>to call the DON to set<br>New licensed nurses<br>educated to abuse por<br>The monitoring proce<br>Correction is correcte<br>cited remains correcte<br>regulatory requiremen<br>The DON and/or desi<br>progress notes to det<br>changes of condition<br>appropriate and inclu-<br>audit will be complete<br>and weekly x 8 weeks<br>The DON and/or licer<br>review census and nu-<br>identify residents retu<br>determine that the ch<br>interventions were tim<br>includes MD notificati<br>completed 5 x week f<br>weeks. | <ul> <li>a causes, symptoms, osis and treatment of</li> <li>be via telephone for staff not 9/19 in person. These staff permitted to work until</li> <li>I funable to reach via letter with the education ed on 2/9/19 with instructions is a time for education.</li> <li>and NA hires will be olicy upon hire.</li> <li>dure to assure the Plan of ed and the specific deficiency ed and in compliance with hts.</li> <li>gnee will review all nursing ermine that any possible interventions were timely, des MD notification. This ed 5 x per week for 30 days s.</li> <li>and nurse designee will ursing progress notes to anges of condition hely, appropriate and on. This audit will be or 30 days and weekly x 8</li> <li>e interviewed weekly</li> </ul> | F                  | 600 |  |                            |                            |
|                          | regarding the care an   | e interviewed weekly<br>d services provided by the<br>licensed nurse designee for   |                    |     |  |                            |                            |

If continuation sheet Page 26 of 47

|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |                              |   | FORM              | D: 06/17/2019<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|---|--|---------------------|------------------------------|---|-------------------|--|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | E CONSTRUCTION               |   | (X3) DATE<br>COMP | SURVEY<br>LETED                            |
|                          |   | 345294   | B. WING             |                              | _   |                   | C<br>09/2019                               |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  | 5                   | STREET ADDRESS, CITY, ST     | TATE, ZIP CODE  |                   |  |
|                          |   |  | 2                   | 37 MULBERRY STREET           |   |                   |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  | 5                   | SHALLOTTE, NC 28459          | )   |                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFERE | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD B<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                 |
| F 600                    | Continued From page<br>8 weeks.   | 26   | F 600               |                              |   |                   |  |
|                          | staff concerning the e<br>asking what response<br>resident has a change   | ng will question 3 nursing<br>education provided, including<br>e is appropriate when a<br>e in condition. This will be<br>k for 30 days and weekly x 8 |                     |                              |   |                   |  |
|                          | on 2/8/19 with the fac<br>the Regional Vice Pre   | nce Improvement meeting<br>ility interdisciplinary team,<br>esident of Operations,<br>Clinical Services the Medical                                    |                     |                              |   |                   |  |
|                          | The title of the persor<br>implementing the acc<br>the Administrator.   | n responsible for<br>eptable plan of correction is   |                     |                              |   |                   |  |
|                          | Date of Alleged Comp  | bliance is: 2/9/19   |                     |                              |   |                   |  |
|                          |   | n of Immediate Jeopardy<br>d on 02/09/19 at 3:07 PM.   |                     |                              |   |                   |  |
|                          | aides were interviewe<br>related to the deficien<br>staff members stated<br>regarding the physicia<br>neglect, change in res<br>documentation, Stop<br>and Point of Care Ale<br>of all documents deve<br>deficient practice was<br>audit forms that were<br>in-services presented | completed. A review of<br>developed to ensure that<br>to staff were understood<br>tunity for staff to interact   |                     |                              |   |                   |  |

If continuation sheet Page 27 of 47

|                          | -  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |   | FORM   | APPROVED<br>0. 0938-0391   |  |
|--------------------------|--|--|---------------------|---|--|----------------------------|--|
| STATEMENT (              | DF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 · /               | E CONSTRUCTION  | (X3) DATE<br>COMP                              | SURVEY<br>LETED            |  |
|                          |  | 345294   | B. WING             |   |  | C<br>09/2019               |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | -  |                            |  |
| AUTUMN                   | CARE OF SHALLOTTE  |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |  |
| F 684<br>SS=J            | CFR(s): 483.25<br>§ 483.25 Quality of ca<br>Quality of care is a fur<br>applies to all treatment<br>facility residents. Base<br>assessment of a resident<br>that residents receive<br>accordance with profe<br>practice, the comprehend<br>care plan, and the resident<br>this REQUIREMENT<br>by:<br>Based on staff intervition<br>and record review the<br>1 residents who expension<br>in condition involving<br>diaphoresis (sweating<br>diarrhea (Resident #33)<br>Immediate Jeopardy I<br>Resident #389 experision<br>in condition upon retur<br>medical appointment<br>returned he was diaphonesis<br>something was very work<br>Immediate Jeopardy work<br>when the facility provident<br>acceptable credible and<br>Jeopardy removal. The<br>compliance at a lower<br>(no harm with the pote<br>harm that is not immediants) | ndamental principle that<br>and care provided to<br>ed on the comprehensive<br>lent, the facility must ensure<br>treatment and care in<br>essional standards of<br>ensive person-centered<br>sidents' choices.<br>is not met as evidenced<br>ews, physician interview<br>facility failed to assess 1 of<br>rienced a significant change<br>a sudden onset of<br>(), disorientation and | F 684               | F684<br>The Plan of Correcting the specific<br>deficiency.<br>On 2/1/2019 resident #389 had blood<br>noted in urine. Orders were received f<br>UA C&S. The sample was collected an<br>sent to the hospital laboratory.<br>On 2/2/2019 facility attempted to receive<br>UA culture from the hospital laboratory<br>The culture was pending. On call prov<br>ordered resident #389 to go to the<br>Emergency Department.<br>On 2/2/2019 resident #389 returned from<br>the hospital with a new order for Keflex<br>500 mg QID for UTI. Resident #389<br>received 8 doses of Keflex.<br>On 2/4/2019 received hospital cultures<br>New orders to d/c Keflex, start ampicill<br>250 mg q 6 hours x 7 days for a UTI.<br>provider pharmacy nor local pharmacie<br>had ampicillin available in the dosage<br>ordered. New orders were received to<br>hold the ampicillin until medication was<br>available to send.<br>On 2/4/2019, resident #389 had a<br>physician appointment and returned to | nd<br>ve<br>ider<br>om<br>c<br>in<br>Fhe<br>es | 2/10/19                    |  |

Facility ID: 922957

If continuation sheet Page 28 of 47

|                          |                               |   | 0.00                |  |   |
|--------------------------|-------------------------------|---|---------------------|--|---|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | ` '                 | PLE CONSTRUCTION G   | (X3) DATE SURVEY<br>COMPLETED                     |
|                          |                               |   |                     | ~  | с   |
|                          |                               | 345294  | B. WING             |  | 02/09/2019  |
| NAME OF PF               | ROVIDER OR SUPPLIER           |   |                     | STREET ADDRESS, CITY, STATE, ZI  | •   |
| A                        |                               |   |                     | 237 MULBERRY STREET  |   |
|                          | CARE OF SHALLOTTE             |   |                     | SHALLOTTE, NC 28459  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE | CTION SHOULD BE COMPLET<br>O THE APPROPRIATE DATE |
| F 684                    | Continued From page           | 28  | F 68                | 34   |   |
|                          |                               | dmitted to the facility on  | 1.00                | facility at approximately 3  | 3:55pm NA   |
|                          |                               | ses that included retention of  |                     | stated resident #389 had   |   |
|                          | -                             | l reflux uropathy, benign   |                     | loose stool. Per her stat  | -   |
|                          |                               | with lower urinary tract  |                     | diaphoretic and confused   | d. She provided                                   |
|                          |                               | my, severe protein calorie  |                     | ADL care including chan  |   |
|                          | •                             | on's disease and Alzheimer's  |                     | sheets. Nurse #8 was a   |   |
|                          | disease with early on         | set.  |                     | stools and diaphoretic er  |   |
|                          | Deview of a Madicara          |   |                     | His vital signs were obta  |   |
|                          |                               | e 5 Day Admission Minimum<br>essment dated 01/24/19 for                               |                     | at 5:59pm and included t<br>Respirations 18. O2 sat                    |   |
|                          |                               | led he had moderately   |                     | Pulse 68. Temperature 9  |   |
|                          | impaired cognition. H         | -   |                     | 102/64.  |   |
|                          | · •                           | all activities of daily living,   |                     | Nurse administered tube  | feedings at                                       |
|                          | used a walker and wh          | neelchair for ambulation and  |                     | 6:30pm. Resident was c   | liaphoretic at this                               |
|                          | -                             | ndwelling urinary catheter  |                     | time and per NA was pro  |   |
|                          |                               | tube. He received 4 days  |                     | worsening. ADL care wa   |   |
|                          |                               | 6 days of Occupational  |                     | bed sheets changed. Ag   | gain, nurse #8                                    |
|                          |                               | of Physical Therapy during  |                     | was aware.   | et 10pm and ba                                    |
|                          |                               | back period. He expected<br>ne community when his                                     |                     | Per NA she checked him<br>continued to be diaphore                     |   |
|                          | therapies were compl          | -   |                     | NA reported to Nurse #8  |   |
|                          |                               |   |                     | His vital signs were obta  |   |
|                          | Review of the plan of         | care dated 02/01/19 for   |                     | 2:05am and included the  |   |
|                          | Resident #389 includ          | ed focus areas for altered  |                     | Respirations 16. O2 sat  | 97% room air.                                     |
|                          | neurological status ar        |   |                     | Pulse 70. Temperature  | 98.6 F. BP  |
|                          |                               | zheimer's dementia and  |                     | 106/66.  |   |
|                          |                               | Interventions included to   |                     | The third shift NA confirm   |   |
|                          |                               | ation, assess, document and<br>n any changes in cognitive                             |                     | diaphoretic and she had<br>bed twice. He was not fe                    |   |
|                          | function.                     |   |                     | continued to be diaphore   |   |
|                          |                               |   |                     | shift nurse knew he was  |   |
|                          | During Resident #389          | 9's stay at the facility his  |                     | and was diaphoretic and  |   |
|                          | urinary catheter was          | replaced several times due  |                     | often.   | -   |
|                          |                               | occlusions documented in  |                     | On 2/5/19 at approximate   | -   |
|                          | the nursing progress          |   |                     | resident #389 had a drop   |   |
|                          |                               | nd 02/02/19. On 01/26/19 a  |                     | 84%. RR 36. BP 90/52.  |   |
|                          |                               | sitivity (UA C & S) lab test  |                     | output this shift and X2 e   | -   |
|                          | if urine that had back        | rse Practitioner to determine   |                     | diarrhea like stools. App  | meu UZ at ZL.                                     |

Facility ID: 922957

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| TATEMENT C               | F DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPI        | LE CONSTRUCTION                                    | (X3) DAT   | E SURVEY                  |
|--------------------------|-------------------------|---|---------------------|--|--|---------------------------|
|                          | CORRECTION              | IDENTIFICATION NUMBER:  | . ,                 |  |  | MPLETED                   |
|                          |                         |   |                     |  |  | С                         |
|                          |                         | 345294  | B. WING             |  | 0  | 2/09/2019                 |
| NAME OF PF               | ROVIDER OR SUPPLIER     | ·   |                     | STREET ADDRESS, CITY, STATE,                       | ZIP CODE   |                           |
|                          | CARE OF SHALLOTTE       |   |                     | 237 MULBERRY STREET                                |  |                           |
|                          | CARE OF SHALLOTTE       |   |                     | SHALLOTTE, NC 28459                                |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC         | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE<br>CROSS-REFERENCED               | N OF CORRECTION<br>E ACTION SHOULD BE<br>TO THE APPROPRIATE<br>CIENCY) | (X5)<br>COMPLETIO<br>DATE |
| F 684                    | Continued From page     | e 29  | F 684               | 4  |  |                           |
|                          |                         | amount of time due to an  |                     | Received order to adm                              | inister Duo Nebs   |                           |
|                          |                         | d started to culture bacteria.  |                     | which was effective. O                             |  |                           |
|                          |                         | 3 contacted an on-call  |                     | Resident still sweating                            |  |                           |
|                          |                         | ted a discontinuation order   |                     | uncomfortable and call                             | ing out for staff.   |                           |
|                          |                         | ecause she had reinserted a   |                     | Still states I don □t feel                         | •  |                           |
|                          |                         | lgement and the returned  |                     | order to send resident                             | •  |                           |
|                          | urine was yellow doc    |   |                     | Resident left the facility                         | at 04:01 with the  |                           |
|                          |                         | 7/19. On 02/01/19 the   |                     | EMS staff.   |  |                           |
|                          | -                       | oner reordered a UA C & S   |                     | Resident #389 is curren                            | ntiy at the hospital.  |                           |
|                          |                         | ood in the urine). Nurse #7<br>gress notes dated 02/01/19                             |                     |  |  |                           |
|                          |                         | e urine and sent it to the  |                     | Root Cause Analysis                                |  |                           |
|                          |                         | e the results came back   |                     | The facility identified ar                         | n opportunity in   |                           |
|                          | -                       | ent to the emergency room   |                     | communicating a change                             |  |                           |
|                          |                         | to complaints of abdominal  |                     | completing an assessm                              | -  |                           |
|                          |                         | Hospital records dated  |                     | change in condition and                            |  |                           |
|                          | 02/02/19 documented     | d a diagnosis of urinary tract  |                     | to obtain orders if appre                          | opriate. Upon  |                           |
|                          |                         | with indwelling urethral  |                     | return from physician a                            |  |                           |
|                          |                         | started on the antibiotic   |                     | #8 was aware of diarrh                             | -  |                           |
|                          | Keflex by the emerge    |   |                     | episode as well as con                             | -  |                           |
|                          |                         | d 02/04/19 he received all  |                     | same shift, nurse #8 wa                            |  |                           |
|                          |                         | ses as documented on the  |                     | witnessed continued di                             |  |                           |
|                          | 02/04/19 the facility N | ministration Record). On  |                     | #8 failed to notify MD o condition, failed to asse | •  |                           |
|                          | -                       | biotic Keflex (lab results  |                     | which ultimately lead to                           |  |                           |
|                          |                         | ed that it was not effective)   |                     | re-hospitalization on 2/                           |  |                           |
|                          |                         | n 250 mg every six hours for  |                     | The Procedure for Impl                             |  |                           |
|                          | -                       | ew of a nurse progress note   |                     | Acceptable Plan of Cor                             | -  |                           |
|                          |                         | n 02/05/19 revealed the   |                     | specific deficiency cited                          |  |                           |
|                          | that no doses of Amp    | f the February MAR showed<br>icillin had been given to                                |                     | The resident is not curr                           |  |                           |
|                          | Resident #389.          |   |                     | On 2/8/2019, a head to                             |  |                           |
|                          | A 1                     |   |                     | will be completed on al                            |  |                           |
|                          |                         | sident #389 was made  |                     | licensed staff to identify                         |  |                           |
|                          | -                       | on 02/04/19 at 12:00 noon.  |                     | change of condition. A                             |  |                           |
|                          |                         | in his wheelchair at the g to be transported to a                                     |                     | the attending physician representative will be n   |  |                           |
|                          | nurse's station waiting |   | 1                   | I representative will be n                         | IONNEO   | 1                         |

Event ID: OUD911

Facility ID: 922957

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|                          |                               | MEDICAID SERVICES   |                     |  | OMB NO. 0938-                 |
|--------------------------|-------------------------------|---|---------------------|--|-------------------------------|
|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | . ,                 |  | (X3) DATE SURVEY<br>COMPLETED |
|                          | CONNECTION                    | IDENTIFICATION NOMBER.  | A. BUILDING         | G  |                               |
|                          |                               |   |                     |  | C                             |
|                          |                               | 345294  | B. WING             |  | 02/09/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER           |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |
| AUTUMN                   | CARE OF SHALLOTTE             |   |                     | 237 MULBERRY STREET  |                               |
|                          |                               |   |                     | SHALLOTTE, NC 28459  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE COMPLE               |
| F 684                    | Continued From page           | e 30  | F 68                | 34   |                               |
|                          |                               | o odors of urine or feces   |                     | all interviewable residents if the   | are were                      |
|                          | present. No sweat w           |   |                     | any concerns with the care and   |                               |
|                          | residents skin.               |   |                     | they are provided by staff. No   |                               |
|                          |                               |   |                     | were reported.   |                               |
|                          | An interview was con          | ducted on 02/08/19 at 10:40   |                     | On 2/8/2019, the Administrator   | , Regional                    |
|                          | AM with Nurse #8. S           | She reported that when  |                     | Director of Clinical Services and  | d DON                         |
|                          | Resident #389 return          | ed from his medical   |                     | started in-house education on t  | he                            |
|                          | appointment he was            | assisted back into bed. She   |                     | following:   |                               |
|                          |                               | d her that he had not eaten   |                     | *Licensed Nursing staff will be  | educated                      |
|                          | -                             | him a bolus tube feeding  |                     | on physician order policy.   |                               |
|                          |                               | M. She did not remember   |                     | *Licensed Nursing staff will be  |                               |
|                          |                               | he said she really couldn't   |                     | on change in resident condition  |                               |
|                          |                               | that if she passed on in  |                     | *Licensed Nursing staff will be  | educated                      |
|                          |                               | veaty and had to have his   |                     | on documentation.<br>*CNAs will be educated on Sto   | n and                         |
|                          | -                             | e then it must be true but she<br>She was sure that she had                           |                     | Watch Interact process which in  |                               |
|                          |                               | because if she had she  |                     | changes of condition including   |                               |
|                          | would have remember           |   |                     | following: seems different , tall  |                               |
|                          |                               |   |                     | overall needs more help, pain,   |                               |
|                          | An interview was con          | ducted on 02/08/19 at 11:19   |                     | no bowel movement or diarrhea  |                               |
|                          |                               | revealed that Resident #389   |                     | less, weight change, agitation,  |                               |
|                          | was sweaty, disorien          |   |                     | change in skin color and help w  |                               |
|                          |                               | a when he returned from his   |                     | walking, transferring, toileting n   |                               |
|                          |                               | on 02/04/19. She reported   |                     | usual.   |                               |
|                          |                               | t the resident into bed and   |                     | *CNAs will be educated on Poir   | nt of Care                    |
|                          | had called her to the         | room to help. NA #1 stated  |                     | Alert documentation.   |                               |
|                          | that she changed his          | sweaty shirt and sheets at  |                     |  |                               |
|                          |                               | Nurse #8 had observed that  |                     | *On 2/9/2019, the DON and/or   | designees                     |
|                          | -                             | iented and incontinent of   |                     | will educate all licensed nurses   |                               |
|                          |                               | nurse when the resident first   |                     | causes, symptoms, complication   |                               |
|                          |                               | ning was wrong with him."   |                     | diagnosis and treatment of sep   | ticemia.                      |
|                          |                               | thirty minutes later and  |                     |  |                               |
|                          |                               | look good" so she reported  |                     | Education will continue via tele   |                               |
|                          | to Nurse #8 again tha         |   |                     | staff not available 2/8/19 and 2   |                               |
|                          |                               | nted. She stated he was   |                     | person. These staff members  |                               |
|                          |                               | the shift and it got worse as   |                     | permitted to work until education  |                               |
|                          |                               | emembered that when Nurse   |                     | received. If unable to reach via   |                               |
|                          |                               | -   |                     |  |                               |
|                          | #8 was giving the res         | ident his tube feeding the<br>ed that the resident was                                |                     | telephone, a certified letter with<br>education provided will be mail                            | the                           |

Facility ID: 922957

If continuation sheet Page 31 of 47

|               | OF DEFICIENCIES         | MEDICAID SERVICES  |               |       | STRUCTION   |        | NO. 0938-03<br>TE SURVEY |
|---------------|-------------------------|--|---------------|-------|---|--------|--------------------------|
|               | CORRECTION              | IDENTIFICATION NUMBER:                                       | ` <i>'</i>    |       |   | 1 Y /  | MPLETED                  |
|               |                         |  | A. BUILDIN    | G     |   |        | С                        |
|               |                         | 345294   | B. WING       |       |   |        | )2/09/2019               |
| NAME OF P     | ROVIDER OR SUPPLIER     |  |               | STREE | TADDRESS, CITY, STATE, ZIP CODE   |        | 12/09/2019               |
|               |                         |  |               |       | JLBERRY STREET  |        |                          |
| AUTUMN        | CARE OF SHALLOTTE       |  |               |       | LOTTE, NC 28459   |        |                          |
| (X4) ID       | SUMMARY ST              | ATEMENT OF DEFICIENCIES                                      | ID            |       | PROVIDER'S PLAN OF CORRECTIO  | DN .   | (X5)                     |
| PRÉFIX<br>TAG |                         | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG |       | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) |        | COMPLETIO<br>DATE        |
| F 684         | Continued From page     | e 31   | F 68          | 84    |   |        |                          |
|               | "really sweating." Sh   | e stated that she had told                                   |               | 2/    | 9/19 with instructions to call the D0   | DN to  |                          |
|               | the nurse again at 10   | 0:00 PM that Resident #389<br>nd disoriented." She said      |               | se    | t a time for education.   |        |                          |
|               |                         | was just wore out from going                                 |               | Ne    | ew licensed nurse and NA hires wi   | I      |                          |
|               | to the appointment ea   |  |               |       | ceive the above education upon hi   |        |                          |
|               |                         | sed on in report to the                                      |               |       | ne monitoring procedure to assure   |        |                          |
|               |                         | A (#6) that Resident #389                                    |               |       | an of Correction is corrected and t   |        |                          |
|               | "wasn't acting right" a | and to keep an eye on him.                                   |               | sp    | ecific deficiency cited remains con   | rected |                          |
|               |                         |  |               | ar    | id in compliance with regulatory  |        |                          |
|               | An interview was con    | ducted on 02/08/19 at 12:22                                  |               |       | quirements.   |        |                          |
|               |                         | e confirmed that NA#1 had                                    |               |       | ne DON and/or designee will review  |        |                          |
|               |                         | hat she had changed the                                      |               |       | irsing progress notes to determine  | that   |                          |
|               |                         | Resident #389 and that he                                    |               |       | y possible changes of condition   |        |                          |
|               |                         | e said that she could tell he                                |               |       | erventions were timely, appropriat  |        |                          |
|               | -                       | the shift started he kept                                    |               |       | cludes MD notification. This audit mpleted 5 x per week for 30 days             |        |                          |
|               |                         | o". She stated that as soon<br>ne would immediately start    |               |       | eekly x 8 weeks.  | anu    |                          |
|               |                         | and she would go back to                                     |               |       | ne DON and/or licensed nurse desi   | ianee  |                          |
|               |                         | ed that herself and Nurse #5                                 |               |       | Il review census and nursing progr  | •      |                          |
|               |                         | several times because they                                   |               |       | otes to identify residents returning t  |        |                          |
|               |                         | vhat was wrong with him.                                     |               |       | spital to determine that the change   |        |                          |
|               |                         | dent #389 had three bouts of                                 |               |       | ndition interventions were timely,  |        |                          |
|               | diarrhea on her shift   | before he was transferred to                                 |               | ap    | propriate and includes MD notifica  | tion.  |                          |
|               | the emergency room      | . She commented that   |               | Th    | nis audit will be completed 5 x wee   | k x 30 |                          |
|               |                         | to the hospital toward the                                   |               |       | iys and weekly x 8 weeks.   |        |                          |
|               | end of her shift betwe  | een 3:30 and 4:00 AM.  |               |       | nree residents will be interviewed w  |        |                          |
|               |                         |  |               |       | garding the care and services prov  |        |                          |
|               |                         | ogress note written by Nurse                                 |               | 1 2   | the Director of Nursing or licensed   | a      |                          |
|               |                         | AM indicated that she had method the previous shift that the |               |       | Irse designee for 8 weeks.  | nec    |                          |
|               |                         | be changed twice on  |               |       | ne Director of Nursing and/or desig<br>Il question 3 nursing staff concerni     |        |                          |
|               |                         | he was sweating. She   |               |       | e education provided, including as  |        |                          |
|               |                         | observed the resident  |               |       | nat response is appropriate when a  | -      |                          |
|               |                         | ng profusely." During her                                    |               |       | sident has a change in condition.   |        |                          |
|               |                         | began to drop along with his                                 |               |       | Il be documented 3 x week for 30 o  |        |                          |
|               |                         | is respirations increased.                                   |               |       | id weekly x 8 weeks.  | -      |                          |
|               |                         | tput on her shift. She noted                                 |               |       | ne facility will conduct an Ad Hoc Q  | uality |                          |
|               |                         | he didn't feel good and was                                  |               |       | ssurance Performance Improveme  | nt     |                          |
|               | having trouble breath   | ing. Nurse #5 contacted the                                  |               | m     | eeting on 2/8/19 with the facility  |        |                          |

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345294         NAME OF PROVIDER OR SUPPLIER         AUTUMN CARE OF SHALLOTTE         (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         PREFIX         TAG |  |  | A. BUILDING<br>B. WING<br>S<br>2 | E CONSTRUCTION<br>TREET ADDRESS, CITY, STATE, ZIP CODE<br>37 MULBERRY STREET<br>SHALLOTTE, NC 28459<br>PROVIDER'S PLAN OF COR   | FORI<br>OMB NC<br>(X3) DATE<br>COMF<br>02      | D: 06/17/2019<br>M APPROVED<br>D. 0938-0391<br>SURVEY<br>PLETED<br>C<br>/09/2019 |
|--|--|--|----------------------------------|---|--|--|
| PREFIX   | ,  |  | PREFIX<br>TAG                    | (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE                                      | COMPLETION<br>DATE   |
| F 684  | the emergency room of<br>An interview was con-<br>with Nurse #5. She ro<br>02/05/19 Resident #3<br>came on duty. She si<br>room by the resident of<br>not get comfortable. Is<br>level had dropped alo<br>She said she called the<br>received an order to get<br>treatment and his oxy<br>continued to sweat. So<br>provider back and recor-<br>resident to the hospita<br>was either having a h-<br>embolism. She could<br>she sent him to the er<br>Emergency Medical So<br>Resident #389 was tra<br>4:01 AM on 02/05/19.<br>Review of the hospita<br>Resident #389 arrived<br>4:40 AM on 02/05/19.<br>Review of the hospita<br>02/05/19 documented<br>sepsis secondary to U<br>Further documentation<br>that Resident #389 has<br>Escherichia coli or Gr<br>life-threatening condit<br>An interview was come<br>PM with the Attending | transferred the resident to<br>via 911.<br>ducted on 02/08/19 2:02 PM<br>emembered that on<br>89 was resting when she<br>tated she was called to his<br>who was sweating and could<br>She recalled that his oxygen<br>ng with his blood pressure.<br>The on-call provider and<br>give the resident a breathing<br>gen level came up but he<br>She called the on-call<br>eived an order to send the<br>al because she thought he<br>eart attack or had an<br>not remember what time<br>mergency room.<br>Gervice records revealed<br>ansported to the hospital at<br>I records show that<br>a at the emergency room at<br>I progress notes on<br>a preliminary diagnosis of<br>JTI (Urinary Tract Infection).<br>In dated 02/06/19 concluded<br>ad blood cultures positive for<br>am-negative bacteremia, a | F 684                            | interdisciplinary team, the Regi<br>President of Operations, Regio<br>Director of Clinical Services the<br>Director to review the corrective<br>measures.<br>The title of the person respons<br>implementing the acceptable p<br>correction is the Administrator.<br>Date of Alleged Compliance is: | onal<br>e Medical<br>re<br>ible for<br>olan of |  |

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|                          | MENT OF HEALTH AN<br>S FOR MEDICARE & I  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |                              |  | FORM              | ): 06/17/2019<br>1 APPROVED<br>0. 0938-0391 |
|--------------------------|--|--|---------------------|------------------------------|--|-------------------|---|
| STATEMENT C              | DF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | LE CONSTRUCTION              |  | (X3) DATE<br>COMP | SURVEY<br>LETED                             |
|                          |  | 345294   | B. WING             |                              | _  | (<br>02/0         | 。<br>09/2019                                |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, ST     | TATE, ZIP CODE   |                   |   |
| AUTUMN                   | CARE OF SHALLOTTE  |  |                     | 237 MULBERRY STREET          |  |                   |   |
|                          |  |  |                     | SHALLOTTE, NC 28459          | 9  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRE)<br>CROSS-REFERE | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                  |
| F 684                    | Continued From page<br>facility. She said that<br>Resident #389 becau<br>assessment when he<br>She was not aware th<br>condition on 02/04/19<br>informed her that he f<br>hospital the next day.<br>down, sweating, and<br>consistent with what s<br>#389. She stated tha<br>sitting in his wheelcha<br>although he had some<br>with her when she vis<br>would have considered<br>change when he bega<br>disoriented on 02/04/7<br>second shift and had<br>would have assessed<br>expected that the resi<br>assessed when the col<br>occurred at the begin<br>because he had had a<br>untreated and his sym<br>sepsis. She stated th<br>Resident #389 had co<br>condition to change v<br>dime. She further cor<br>hours to treat Gram-N<br>in death because it er<br>couple of hours. She<br>have affected the out<br>a physician been notif | e 33<br>she was familiar with<br>se she had completed his<br>was admitted to the facility.<br>at he had a change in his<br>until the Nurse Practitioner<br>had been transferred to the<br>She reported that laying<br>being disoriented was not<br>she saw daily with Resident<br>the was normally up and<br>hir. She commented that<br>e confusion he could chat<br>ited. She stated that she<br>id it an acute significant<br>an sweating and became<br>19 at the beginning of<br>she been in the building she<br>him immediately. She<br>dent would have been<br>hange in his condition<br>hing of second shift<br>a UTI that had been<br>hotoms were indicative of | F 68                |                              |  |                   |   |
|                          | Nursing on 2/9/19 at 2<br>resident had a change<br>expect the staff to do  | ducted with the Director of<br>2:45 PM. He stated if a<br>e in condition he would<br>an assessment, notify the<br>locument the incident in   |                     |                              |  |                   |   |

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|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |  | FORM              | MAPPROVED<br>0. 0938-0391  |
|--------------------------|---|--|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ,                |     | LE CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|                          |   | 345294   | B. WING            |     |  |                   | C<br>109/2019              |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | <b>I</b>           | 3   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 684                    | (an electronic change<br>the incident occurred<br>orders. He would also<br>out a stop and watch<br>message in PCC (Poi<br>medication record) if I<br>of condition in a resid<br>The facility Administra<br>Nursing were notified<br>02/08/19 at 3:00 PM.<br>On 02/09/19 at 1:51 F<br>following credible alle<br>jeopardy removal:<br>F684<br>The Plan of Correctin<br>On 2/1/2019 resident<br>urine. Orders were re<br>sample was collected<br>laboratory.<br>On 2/2/2019 facility a<br>culture from the hosp<br>was pending. On call<br>#389 to go to the Eme<br>On 2/2/2019 resident<br>hospital with a new or<br>for UTI. Resident #38<br>Keflex.<br>On 2/4/2019 received<br>orders to d/c Keflex, s | etes or on an S Bar report<br>e in condition report) when<br>and then transcribe any new<br>o expect a nurse aide to fill<br>form or put a new alert<br>int Click Care, electronic<br>he or she noticed a change<br>ent.<br>ator and the Director of<br>of immediate jeopardy on<br>PM the facility provided the<br>gation of immediate<br>g the specific deficiency.<br>#389 had blood noted in<br>eceived for a UA C&S. The<br>and sent to the hospital<br>ttempted to receive UA<br>ital laboratory. The culture<br>provider ordered resident | F                  | 684 | 4  |                   |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |  | FORM   | APPROVED<br>0. 0938-0391 |  |
|--------------------------|---|--|--------------------|-----|--|--|--------------------------|--|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION                            | (X3) DATE<br>COMP  | SURVEY<br>PLETED         |  |
|                          |   | 345294   | B. WING            |     |  |  | C<br>09/2019             |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE      |  |                          |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459 |  |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | (EACH CORRECTIVE ACTION SHOULD E           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE C<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                          |  |
| F 684                    | nor local pharmacies<br>the dosage ordered.<br>to hold the ampicillin<br>available to send.<br>On 2/4/2019, resident<br>appointment and retu<br>approximately 3:55pm<br>had an episode of loc<br>he was diaphoretic ar<br>ADL care including cf<br>Nurse #8 was aware<br>diaphoretic episode.<br>His vital signs were o<br>5:59pm and included<br>18. O2 sat 97% room<br>Temperature 98.4 F.<br>Nurse administered to<br>Resident was diaphor<br>was progressively wo<br>provided and bed she<br>#8 was aware.<br>Per NA she checked<br>continued to be diaph<br>reported to Nurse #8.<br>His vital signs were o<br>and included the follo<br>sat 97% room air. Pu<br>F. BP 106/66.<br>The third shift NA com<br>and she had to chang<br>not feeling well and co<br>The third shift nurse k | had ampicillin available in<br>New orders were received<br>until medication was<br>t #389 had a physician<br>rned to the facility at<br>n. NA stated resident #389<br>use stool. Per her statement<br>and confused. She provided<br>hanging his bed sheets.<br>of loose stools and<br>btained on 2/4/2019 at<br>the following: Respirations<br>in air. Pulse 68.<br>BP 102/64.<br>ube feedings at 6:30pm.<br>retic at this time and per NA<br>rsening. ADL care was<br>bets changed. Again, nurse<br>him at 10pm and he<br>poretic and "out of it". NA | F                  | 684 | 4  |  |                          |  |

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|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                    |     |   | FOR                           | M APPROVED<br>D. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------------------|----------------------------|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|                          |  | 345294  | B. WING            |     |   |                               | C<br>/ <b>09/2019</b>      |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   | •                  |     | STREET ADDRESS, CITY, STATE, ZIP CODE   | •                             |                            |
| AUTUMN                   | CARE OF SHALLOTTE  |   |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 684                    | Continued From page<br>On 2/5/19 at approxim<br>#389 had a drop in o2<br>90/52. No urinary out<br>episodes of runny dia<br>at 2L. Resident's o2 s<br>Received order to adr<br>was effective. O2 sat<br>sweating profusely, ui<br>for staff. Still states "<br>order to send residen<br>left the facility at 04:0<br>Resident #389 is curr<br>Root Cause Analysis<br>The facility identified a<br>communicating a cha<br>an assessment when<br>notify MD timely to ob<br>Upon return from phy<br>#8 was aware of diarr<br>episode as well as co<br>shift, nurse #8 was in<br>continued diaphoresis<br>MD of a change in co<br>resident which ultimat<br>re-hospitalization on 2 | e 36<br>nately 3:00am, resident<br>2 sat to 84%. RR 36. BP<br>tput this shift and X2<br>rrhea like stools. Applied 02<br>stat increased to 94-95%.<br>minister Duo Nebs which<br>thow 97%. Resident still<br>ncomfortable and calling out<br>I don't feel right". Received<br>t to the hospital. Resident<br>1 with the EMS staff.<br>ently at the hospital.<br>an opportunity in<br>nge in condition, completing<br>a change in condition and<br>obtain orders if appropriate.<br>sician appointment, nurse<br>thea and diaphoretic<br>infusion. During the same<br>formed and witnessed<br>s. Nurse #8 failed to notify<br>ndition, failed to assess the<br>tely lead to his<br>2/5/19. |                    | 684 | DEFICIENCY)   |                               |                            |
|                          |  | plementing the Acceptable<br>the specific deficiency  |                    |     |   |                               |                            |
|                          | completed on all resid<br>identify any sign of ch  | to toe assessment will be<br>dents by licensed staff to<br>nange of condition. Any<br>attending physician and   |                    |     |   |                               |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |  | FORM              | APPROVED<br>0. 0938-0391   |
|--------------------------|---|--|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ,                |     | E CONSTRUCTION   | (X3) DATE<br>COMP |                            |
|                          |   | 345294   | B. WING            |     |  |                   | 09/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER   | I  |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u>          |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | х   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 684                    | Continued From page   | e 37   | F                  | 684 |  |                   |                            |
|                          | interviewable residen<br>concerns with the car<br>provided by staff. No<br>On 2/8/2019, the Adn<br>of Clinical Services a<br>education on the follo<br>*Licensed Nursing sta<br>physician order policy<br>*Licensed Nursing sta | e and treatment they are<br>o concerns were reported.<br>ninistrator, Regional Director<br>nd DON started in-house<br>wing:<br>aff will be educated on<br><i>r</i> .   |                    |     |  |                   |                            |
|                          | change in resident co<br>*Licensed Nursing sta<br>documentation.  | ndition policy.<br>aff will be educated on   |                    |     |  |                   |                            |
|                          | Interact process whic<br>condition including th<br>, talks less, overall ne<br>less, no bowel mover<br>weight change, agitat  | ed on Stop and Watch<br>h includes changes of<br>e following: seems different<br>eds more help, pain, ate<br>nent or diarrhea, drank less,<br>ion, tired, week, change in<br>ith walking, transferring,<br>sual. |                    |     |  |                   |                            |
|                          | *CNAs will be educat documentation.   | ed on Point of Care Alert  |                    |     |  |                   |                            |
|                          | *On 2/9/2019, the DC<br>educate all licensed r<br>symptoms, complicat<br>treatment of septicer  | ions, diagnosis and  |                    |     |  |                   |                            |
|                          | available 2/8/19 and 2 staff members will no  | ue via telephone for staff not<br>2/9/19 in person. These<br>t be permitted to work until<br>. If unable to reach via  |                    |     |  |                   |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |   | FOR               | M APPROVED<br>0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|                          |   | 345294   | B. WING            |     |   |                   | C<br>109/2019              |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                   |                            |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                    |     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | 3E                | (X5)<br>COMPLETION<br>DATE |
| F 684                    | telephone, a certified<br>provided will be maile<br>to call the DON to set<br>New licensed nurse a<br>above education upon<br>The monitoring proce<br>Correction is correcte<br>cited remains correcte<br>regulatory requiremen<br>The DON and/or desi<br>progress notes to det<br>changes of condition<br>appropriate and inclu-<br>audit will be complete<br>and weekly x 8 weeks<br>The DON and/or licer<br>review census and nu-<br>identify residents retu<br>determine that the ch<br>interventions were tim<br>includes MD notificati<br>completed 5 x week x<br>weeks.<br>Three residents will b<br>regarding the care an<br>Director of Nursing or<br>8 weeks.<br>The Director of Nursing sta<br>provided, including as<br>appropriate when a re | letter with the education<br>ed on 2/9/19 with instructions<br>a time for education.<br>and NA hires will receive the<br>n hire.<br>dure to assure the Plan of<br>ed and the specific deficiency<br>ed and in compliance with<br>nts.<br>gnee will review all nursing<br>ermine that any possible<br>interventions were timely,<br>des MD notification. This<br>ed 5 x per week for 30 days<br>s.<br>nsed nurse designee will<br>ursing progress notes to<br>irrning to the hospital to<br>anges of condition<br>nely, appropriate and<br>on. This audit will be<br>a 30 days and weekly x 8<br>e interviewed weekly<br>d services provided by the<br>flicensed nurse designee for | F                  | 684 |   |                   |                            |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |  |   | FORM | APPROVED<br>0. 0938-0391   |  |  |  |
|--------------------------|---|--|---------------------|--|---|------|----------------------------|--|--|--|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |  | CONSTRUCTION  |      | LETED                      |  |  |  |
|                          |   | 345294   | B. WING _           |  |   |      | C<br>09/2019               |  |  |  |
| NAME OF PF               | ROVIDER OR SUPPLIER   |  |                     |  | TREET ADDRESS, CITY, STATE, ZIP CODE  |      |                            |  |  |  |
| AUTUMN                   | CARE OF SHALLOTTE   |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459 |   |      |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |  |  |  |
| F 684                    | Continued From page   | 39   | Fe                  | 684  |   |      |                            |  |  |  |
|                          | on 2/8/19 with the fac<br>the Regional Vice Pre   | ility interdisciplinary team,<br>esident of Operations,<br>Clinical Services the Medical   |                     |  |   |      |                            |  |  |  |
|                          | The title of the person<br>implementing the acc<br>the Administrator.   | responsible for<br>eptable plan of correction is   |                     |  |   |      |                            |  |  |  |
|                          | Date of Alleged Comp  | pliance is: 2/9/19   |                     |  |   |      |                            |  |  |  |
|                          | •   | n of Immediate Jeopardy<br>d on 02/09/19 at 3:07 PM.   |                     |  |   |      |                            |  |  |  |
| F 759<br>SS=D            | aides were interviewer<br>related to the deficient<br>staff members stated<br>regarding the physicia<br>resident condition pol<br>and Watch Interact pr<br>Alert documentation.<br>developed to correct<br>completed. A review<br>developed to ensure to<br>staff were understood<br>for staff to interact with | included nurses and nurse<br>ed regarding in-servicing<br>t practice. All interviewed<br>they had been in-serviced<br>an order policy, change in<br>icy, documentation, Stop<br>ocess, and Point of Care<br>A review of all documents<br>the deficient practice was<br>of audit forms that were<br>that in-services presented to<br>and allowed an opportunity<br>h dialogue was completed.<br>ror Rts 5 Prcnt or More | F7                  | 759  |   |      | 3/1/19                     |  |  |  |
|                          | §483.45(f) Medication<br>The facility must ensu<br>§483.45(f)(1) Medicat<br>percent or greater;   |  |                     |  |   |      |                            |  |  |  |

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|                          |                          | MEDICAID SERVICES  | (X2) MUI           |                                       | CONSTRUCTION  |       | NO. 0938-03               |
|--------------------------|--------------------------|--|--------------------|---------------------------------------|---|-------|---------------------------|
|                          | CORRECTION               | IDENTIFICATION NUMBER:   |                    |                                       |   | · · · | OMPLETED                  |
|                          |                          |  |                    |                                       |   |       | С                         |
|                          |                          | 345294   | B. WING            | _                                     |   |       | 02/09/2019                |
| NAME OF P                | ROVIDER OR SUPPLIER      |  |                    | S                                     | TREET ADDRESS, CITY, STATE, ZIP CODE  |       |                           |
| AUTUMN                   | CARE OF SHALLOTTE        |  |                    |                                       | 37 MULBERRY STREET<br>HALLOTTE, NC 28459  |       |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC          | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)      | ID<br>PREFI<br>TAG |                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE    | (X5)<br>COMPLETIO<br>DATE |
| F 759                    | Continued From page      | e 40   | É F                | 759                                   |   |       |                           |
|                          |                          | is not met as evidenced  | -                  |                                       |   |       |                           |
|                          | by:                      |  |                    |                                       |   |       |                           |
|                          |                          | n, record review, and staff  |                    |                                       | F 759   |       |                           |
|                          |                          | failed to ensure it was free   |                    |                                       | 1. Resident #12 received his metop  | rolol |                           |
|                          |                          | of medication error rates greater than 5% as<br>evidenced by 2 medication errors out of 25 |                    |                                       | as soon as the issue was identified.  |       |                           |
|                          |                          | ig in a medication error rate  |                    |                                       | Resident #12 s lactulose was<br>discontinued on 2/27/18 by the physic   | nian  |                           |
|                          | of 8% for 1 of 6 reside  | •  |                    |                                       | due to repeated refusals.   | Jan   |                           |
|                          |                          | lication administration.   |                    |                                       |   |       |                           |
|                          | Findings included:       |  |                    |                                       | 2. To identify other residents that ha  | ave   |                           |
|                          |                          |  |                    |                                       | the potential to be affected, the   |       |                           |
|                          | During a medication a    | administration observation   |                    |                                       | medication administration record will   | be    |                           |
|                          | on 02/06/19 at 9:15 A    |  |                    | compared to the contents of the       |   |       |                           |
|                          | passing medications      |  |                    | medication cart to ensure all ordered |   |       |                           |
|                          |                          | mg (milligrams), buspirone   |                    |                                       | medications are in the cart.  |       |                           |
|                          |                          | 5 mg, and a vitamin from the   |                    |                                       |   |       |                           |
|                          |                          | eparation for administration<br>rse #10 provided the four                                  |                    |                                       | 3. To prevent this from recurring, Th   |       |                           |
|                          |                          | ent #12 without incident.  |                    |                                       | Director of Nursing or licensed design<br>will reeducate licensed nurses concer                                   |       |                           |
|                          |                          |  |                    |                                       | appropriate medication administration   | -     |                           |
|                          | During a medication r    | reconciliation on 02/6/19 at   |                    |                                       | They will also be educated concerning   |       |                           |
|                          | 9:35 AM Resident #1      |  |                    |                                       | processes to obtain medication that is  | -     |                           |
|                          | Medication Administra    |  |                    |                                       | in the cart at the time that medication   |       |                           |
|                          |                          | lactulose 10 grams in 15 ml  |                    |                                       | due.  |       |                           |
|                          | (milliliters) give 30 ml |  |                    |                                       |   |       |                           |
|                          |                          | AM for constipation. The   |                    |                                       | 4. To monitor and maintain ongoing  |       |                           |
|                          |                          | eckmark signifying the   |                    |                                       | compliance, the Director of Nursing o   |       |                           |
|                          |                          | administered. There was  |                    |                                       | licensed designee will observe medic  |       |                           |
|                          |                          | oprolol 12.5 mg scheduled<br>9:30 AM for hypertension.                                     |                    |                                       | administration by nurses for complian with policy. This will be documented  |       |                           |
|                          |                          | a checkmark signifying the   |                    |                                       | nurses per week for 12 weeks.   | 101 5 |                           |
|                          |                          | administered and Resident  |                    |                                       | The Director of Nursing or licensed   |       |                           |
|                          | #12's blood pressure     |  |                    |                                       | designee will review the documentation  | on by |                           |
|                          |                          | -  |                    |                                       | the nurses of any medications to ensu   |       |                           |
|                          |                          | /06/19 at 9:40 AM Nurse #10  |                    |                                       | that appropriate follow up occurred ar  | nd to |                           |
|                          | -                        | rovide lactulose to Resident   |                    |                                       | identify any trends in this issue.  |       |                           |
|                          |                          | hat she signed it off because  |                    |                                       |   |       |                           |
|                          |                          | ed for 9:30 AM, it was   |                    |                                       | MAR to cart audit will be completed for   |       |                           |
|                          | always given at hight    | . She indicated she should   |                    |                                       | each cart weekly for 4 weeks and the  | 11    |                           |

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|                          | -   | D HUMAN SERVICES<br>MEDICAID SERVICES   |                     |    |   | FORM              | D: 06/17/2019<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|---|---|---------------------|----|---|-------------------|--|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    | CONSTRUCTION  | (X3) DATE<br>COMF | E SURVEY<br>PLETED                         |
|                          |   | 345294  | B. WING _           |    |   |                   | C<br>/ <b>09/2019</b>                      |
| NAME OF PF               | ROVIDER OR SUPPLIER   |   |                     | ST | REET ADDRESS, CITY, STATE, ZIP CODE   |                   |  |
| AUTUMN                   | CARE OF SHALLOTTE   |   |                     |    | 7 MULBERRY STREET<br>HALLOTTE, NC 28459   |                   |  |
|                          |   |   |                     | 31 | ,   |                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |                   | (X5)<br>COMPLETION<br>DATE                 |
| F 759<br>F 812<br>SS=F   | order to have the schuhad not. Nurse #10 v<br>metoprolol to Resider<br>medication cart and re<br>metoprolol in the med<br>#12. Nurse #10 state<br>metoprolol to Resider<br>because she was bein<br>that all medications sl<br>In an interview on 02/<br>Director of Nursing (D<br>medication error rate<br>indicated that realistic<br>and do make mistake<br>rate should be less th<br>Food Procurement, St<br>CFR(s): 483.60(i)(1)(2<br>§483.60(i) Food safet<br>The facility must -<br>§483.60(i)(1) - Procur<br>approved or consider<br>state or local authoriti<br>(i) This may include for<br>from local producers,<br>and local laws or regu<br>(ii) This provision doe<br>facilities from using pr<br>gardens, subject to co<br>safe growing and food<br>(iii) This provision doe<br>from consuming foods<br>§483.60(i)(2) - Store, | sician and requested an<br>eduled time changed but<br>erified she had not provided<br>at #12 after checking in the<br>ealizing there was no<br>lication cart for Resident<br>d she thought she gave the<br>at #12 but was nervous<br>ng observed. She stated<br>hould be given as ordered.<br>08/19 at 2:54 PM the<br>ON) stated he expected the<br>in the facility to be zero. He<br>cally, since we are human<br>s, that the medication error<br>an 5%.<br>ore/Prepare/Serve-Sanitary<br>2)<br>y requirements.<br>e food from sources<br>ed satisfactory by federal,<br>es.<br>bod items obtained directly<br>subject to applicable State<br>lations.<br>s not prohibit or prevent<br>roduce grown in facility<br>ompliance with applicable<br>d-handling practices.<br>es not preclude residents<br>s not procured by the facility.<br>prepare, distribute and | F 7                 |    | DEFICIENCY)<br>monthly for 2 months.<br>The Director of Nursing will report the<br>results of the monitoring to the QAPI<br>committee for review and<br>recommendations for the time frame of<br>the monitoring period or as it is amend<br>by the committee.<br>5. Date of alleged compliance 3/1/20 | ed                | 3/1/19                                     |
|                          | (iii) This provision doe from consuming foods   | es not preclude residents<br>s not procured by the facility.<br>prepare, distribute and   |                     |    |   |                   |  |

Facility ID: 922957

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|                          |                             | MEDICAID SERVICES   |                     |  |                                  | NO. 0938-03               |
|--------------------------|-----------------------------|---|---------------------|--|----------------------------------|---------------------------|
|                          | OF DEFICIENCIES             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | . ,                 |  | · · ·                            | TE SURVEY                 |
|                          |                             |   | A. BUILDING         | 3  |                                  | С                         |
|                          |                             | 345294  | B. WING             |  |                                  | )2/09/2019                |
| NAME OF P                | ROVIDER OR SUPPLIER         |   |                     | STREET ADDRESS, CITY, STATE, ZIP C   |                                  | 12/09/2019                |
|                          |                             |   |                     | 237 MULBERRY STREET  |                                  |                           |
| AUTUMN                   | CARE OF SHALLOTTE           |   |                     | SHALLOTTE, NC 28459  |                                  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC             | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 812                    | Continued From page         | . 40  | F 01                | 2  |                                  |                           |
| F 012                    |                             |   | F 81                | 2  |                                  |                           |
|                          |                             | rvice safety.<br>is not met as evidenced  |                     |  |                                  |                           |
|                          | by:<br>Record on obconvotio | n and staff interview the   |                     | F 812  |                                  |                           |
|                          |                             | or dish machine temperature   |                     | FOIZ   |                                  |                           |
|                          | -                           | d in kitchenware not being  |                     | 1. The opened bags of sp   | paghetti and                     |                           |
|                          |                             | inse temperatures did not   |                     | elbow macaroni pasta in th   |                                  |                           |
|                          |                             | pecifications. The facility   |                     | room were discarded on 2/  |                                  |                           |
|                          | also failed to remove       | dust and dirt from 3 of 4   |                     | unlabeled and dated open   | bags of raisin                   |                           |
|                          | -                           | he kitchen, and failed to   |                     | bran and toasted oats cere   |                                  |                           |
|                          |                             | s which resulted in thawing   |                     | storage container of grits w   |                                  |                           |
|                          |                             | oull date" on them and  |                     | The shredded cheese and  |                                  |                           |
|                          |                             | eing stored without labels  |                     | were in the walk-in refrigera  |                                  |                           |
|                          | and dates. Findings         | Included:   |                     | dates or labels were discar<br>hamburger that was thawin                         |                                  |                           |
|                          | 1. A 01/02/19 dish m        | achine service  |                     | refrigerator without a pull d  | -                                |                           |
|                          |                             | eport documented the  |                     | corrected with a date and u  |                                  |                           |
|                          |                             | was functioning correctly   |                     | In the walk-in freezer open  | •                                |                           |
|                          |                             | ent necessary being titration   |                     | onion rings were discarded   | •                                |                           |
|                          |                             | detergent into the dish   |                     | peas/carrot medley that we   |                                  |                           |
|                          | machine.                    |   |                     | labels were used on 2/4/19   | same day as                      |                           |
|                          | Review of the dish m        | achine temperature log on   |                     | being opened.  |                                  |                           |
|                          |                             | revealed the final rinse  |                     |  |                                  |                           |
|                          |                             | enware being washed after   |                     | The kitchen ceiling fans we  | re cleaned on                    |                           |
|                          | -                           | ad not been recorded yet for  |                     | 2/6/2019.  |                                  |                           |
|                          |                             | cumented as being 165   |                     |  |                                  |                           |
|                          | degrees Fahrenheit o        | -   |                     | The dish machine was ider  |                                  |                           |
|                          |                             |   |                     | working properly on 2/7/19   |                                  |                           |
|                          | During observation of       |   |                     | products were used until 2/  | 14/19.                           |                           |
|                          |                             | M until 9:38 AM seven racks   |                     |  |                                  |                           |
|                          | of kitchenware were r       | -   |                     | 2. To ensure that there w  |                                  |                           |
|                          |                             | Il rinse temperatures ranged<br>ees Fahrenheit. Three                                 |                     | food at risk, the kitchen sto<br>including dry storage, walk                     | •                                |                           |
|                          |                             | ere involved in carrying out  |                     | and walk in freezer were at  | -                                |                           |
|                          |                             | cess, but none of those   |                     | 2/5/19 through 2/8/19 by th  |                                  |                           |
|                          |                             | itoring the dish machine  |                     | Registered Dietitian and Di  |                                  |                           |
|                          | temperature gauges.         |   |                     | to ensure there were no ad   |                                  |                           |
|                          |                             |   | 1                   |  |                                  | 1                         |

Facility ID: 922957

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|               |                         | MEDICAID SERVICES   |           |      |  |       | NO. 0938-03          |
|---------------|-------------------------|---|-----------|------|--|-------|----------------------|
|               | OF DEFICIENCIES         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       | · ,       |      | CONSTRUCTION   | · · · | TE SURVEY<br>MPLETED |
|               |                         |   | A. BUILDI | NG _ |  |       |                      |
|               |                         | 345294  | B. WING   |      |  |       | C                    |
|               | ROVIDER OR SUPPLIER     | 545254  |           |      | TREET ADDRESS, CITY, STATE, ZIP CODE   | 0     | 2/09/2019            |
| NAME OF P     | ROVIDER OR SUPPLIER     |   |           |      | 37 MULBERRY STREET   |       |                      |
| AUTUMN        | CARE OF SHALLOTTE       |   |           |      | SHALLOTTE, NC 28459  |       |                      |
| (X4) ID       | SUMMARY S               | TATEMENT OF DEFICIENCIES                                    | ID        |      | PROVIDER'S PLAN OF CORRECTION  | 1     | (X5)                 |
| PREFIX<br>TAG | (EACH DEFICIENC         | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI     |      | (EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE    | COMPLETIO            |
| F 812         | Continued From pag      | e 43  | F         | 812  |  |       |                      |
|               | 1.0                     | AM strips were attached to                                  |           | 012  | noted.   |       |                      |
|               |                         | through the dish machine.                                   |           |      | Ceiling fans throughout the facility we  | re    |                      |
|               |                         | nsing bar on these strips did                               |           |      | audited by the Maintenance Director of   |       |                      |
|               |                         | ange color specified by the                                 |           |      | 2/20/19 for cleanliness. Those that  | -     |                      |
|               |                         | strips which would have                                     |           |      | needed to be cleaned were completed  | d on  |                      |
|               | indicated that the ten  | nperature of the final rinse                                |           |      | 2/20/19 and 2/21/19. The dish machin   |       |                      |
|               | water met the minim     | um requirement for adequate                                 |           |      | was identified as not working properly   | on    |                      |
|               | sanitization of the kit | chenware.   |           |      | 2/7/19. Paper products were used un  | til   |                      |
|               |                         |   |           |      | 2/14/19.   |       |                      |
|               |                         | AM the Dietary Manager                                      |           |      |  |       |                      |
|               |                         | en water pitchers were run                                  |           |      | 2 To provent this from requiring di  | ton   |                      |
|               | -                       | chine earlier around 6:30 AM rinse gauge registered over    |           |      | 3. To prevent this from recurring, die staff were educated on proper storage       | -     |                      |
|               | 180 degrees Fahren      |   |           |      | labeling, and dating opened items by dietary manager.                              |       |                      |
|               | During a follow-up in   | terview with the DM on                                      |           |      |  |       |                      |
|               |                         | she stated that the dietary                                 |           |      | The facility □s Certified Dietary Manag  | er    |                      |
|               | employee retrieving     | sanitized kitchenware from                                  |           |      | provided education on the dish machin  | ne    |                      |
|               |                         | s supposed to be watching                                   |           |      | with the dietary department.   |       |                      |
|               |                         | ges periodically. She                                       |           |      | Maintenance Director was educated o  |       |                      |
|               | -                       | representative from the dish                                |           |      | new cleaning schedule for the kitchen  |       |                      |
|               |                         | ad educated the dietary                                     |           |      | ceiling fans on 2/20/2019 by the   |       |                      |
|               | employees that the n    |   |           |      | Administrator.   |       |                      |
|               | -                       | d to be at least 180 degrees                                |           |      | 4. To maintain ongoing compliance  |       |                      |
|               |                         | mmented that dietary<br>erviced to notify her if the        |           |      | audits on proper storage, labeling, and  |       |                      |
|               |                         | s registering below the 180                                 |           |      | dating opened items will be conducted<br>the dietary manager or designee three     |       |                      |
|               |                         | d involve the Maintenance                                   |           |      | days a week for twelve weeks with res  |       |                      |
|               | •                       | e representative if needed.                                 |           |      | brought to the facility QAPI meetings.   |       |                      |
|               |                         | , final rinse temperatures                                  |           |      |  |       |                      |
|               |                         | ahrenheit were not effective                                |           |      | Audits will be conducted on fan  |       |                      |
|               | •                       | enware, and germs and                                       |           |      | cleanliness three days a week for twe  | lve   |                      |
|               | -                       | read which had the potential                                |           |      | weeks by the maintenance director or   |       |                      |
|               | -                       | sick. The DM stated she                                     |           |      | designee with results brought to the   |       |                      |
|               |                         | h machine temperature log                                   |           |      | facility QAPI meetings.  |       |                      |
|               | -                       | it a review of the logs for                                 |           |      |  |       |                      |
|               |                         | mber 2018 revealed the final                                |           |      | A dish machine audit will be conducte  | d 5   |                      |
|               | -                       | vere documented as being                                    |           |      | days a week for twelve weeks by the  | ulto  |                      |
|               | between 180 - 190 d     | egrees Fahrenheit.  |           |      | dietary manager or designee with resu  | JIIS  |                      |

Facility ID: 922957

|                          |  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |   | F   | NTED: 06/17/2019<br>FORM APPROVED<br>B NO. 0938-0391 |
|--------------------------|--|--|---------------------|---|---|--|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 |   | (X3)  | DATE SURVEY<br>COMPLETED                             |
|                          |  | 345294   | B. WING             |   |   | C<br>02/09/2019                                      |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | •                   | STREET ADDRESS, CITY, STATE, ZIP CO   | )<br>JDE  |  |
| AUTUMN                   | CARE OF SHALLOTTE  |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC   | ON SHOULD BE<br>HE APPROPRIATE  | (X5)<br>COMPLETION<br>DATE                           |
| F 812                    | 02/07/19 at 10:06 AM<br>dish machine gauges<br>and when the final rin<br>180 degrees Fahrenh<br>her DM know.<br>On 02/08/19 at 10:28<br>though service repress<br>wires, valves, and the<br>currently working on t<br>the dish machine was<br>rinse temperatures of<br>During an interview w<br>on 02/09/19 at 9:12 A<br>home had no resident<br>foodborne illness. He<br>expectation that the ra<br>home be protected ag<br>dish machine which w<br>temperatures which th<br>documented as being<br>kitchenware.<br>2. During an initial too<br>02/04/19, beginning a<br>were hanging from the<br>of dust and dirt could<br>of 4 ceiling fans in the<br>the steam table was r<br>a food preparation co<br>no food preparation ta<br>at the time.<br>During a follow-up tou<br>02/06/19, beginning a | ith Dietary Employee #1 on<br>she stated she checked the<br>about every five minutes,<br>se gauge registered below<br>eit she was supposed to let<br>AM the DM stated even<br>entatives had replaced<br>rmostats, and were<br>he dish machine diaphragm,<br>e still not able to sustain final<br>180 degrees Fahrenheit.<br>ith the Director of Nursing<br>M he stated the nursing<br>ts who were diagnosed with<br>e reported it was his<br>esidents in the nursing<br>gainst foodborne illness by a<br>vas able to sustain final rinse<br>he manufacturer<br>effective in sanitizing<br>ur of the kitchen on<br>tt 11:18 AM, strands of dust<br>e blades and accumulations<br>be seen on the blades of 2<br>e kitchen. The fan above<br>not running, but the fan near<br>unter was running although<br>asks were being completed | F 81                | 2<br>brought to the facility QAPI<br>Audits will be reviewed wee<br>facility s Risk Meeting and<br>meeting for a period of 3 m<br>facility s decision to extend<br>be based on the results of t<br>5. Date of alleged complia<br>3/1/2019 | ekly in the<br>in the QAPI<br>onths. The<br>d the audits will<br>he audits. |  |
|                          | During a follow-up tou<br>02/06/19, beginning a  |  |                     |   |   |  |

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|                          | -  | D HUMAN SERVICES   |                     |  |  | FORM              | 0: 06/17/2019<br>APPROVED  |
|--------------------------|--|--|---------------------|--|--|-------------------|----------------------------|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION  | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,                 | E CONSTRUCTION                             |  | (X3) DATE<br>COMP | LETED                      |
|                          |  | 345294   | B. WING             |  | _  | 02/0              | C<br>09/2019               |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, ST                   | ATE, ZIP CODE  |                   |                            |
| AUTUMN                   | CARE OF SHALLOTTE  |  |                     | 237 MULBERRY STREET<br>SHALLOTTE, NC 28459 | )  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRE)<br>CROSS-REFERE               | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 812                    | running. Sandwiches<br>a preparation counter<br>them was running. The<br>clumps of dust on the<br>Upon closer inspection<br>and dirt on a third ceill<br>near a storage rack he<br>During an interview we<br>Manager (MM) on 02/<br>stated maintenance at<br>to make sure vents ar<br>remained clean. He re<br>ceiling fan above the sibecause it was non-on<br>needed to be replaced<br>he was unable to exp<br>ceiling fans had not be<br>During an interview we<br>(DM) on 02/06/19 at 10<br>ceiling fans were on the<br>schedule, and starting<br>now had a dietary em<br>clean the fans as opp<br>maintenance respons<br>task.<br>During a follow-up inter<br>02/07/19 at 9:58 AM se<br>from the ceiling fans i<br>the food being prepar<br>cause cross-contaminer<br>for making residents as<br>During an interview we<br>02/07/19 at 10:06 AM | steam table which was not<br>a were being assembled on<br>, and the ceiling fan near<br>nere were also strands and<br>blades of this ceiling fan.<br>In there were clumps of dust<br>ing fan which was running<br>ousing sanitized pitchers.<br>With the Maintenance<br>06/19 at 10:08 AM he<br>nd dietary worked together<br>nd ceiling fans in the kitchen<br>eported he thought the<br>steam table got overlooked<br>perational at present, and<br>d. However, he commented<br>lain why the other two<br>een cleaned.<br>With the Dietary Manager<br>0:13 AM she stated the<br>ne monthly cleaning<br>g in December 2018 she<br>ployee who was available to<br>osed to holding<br>ible for carrying out the<br>erview with the DM on<br>she stated the dust and dirt<br>in the kitchen could fall into<br>ed for the residents and<br>lation, and had the potential | F 812               |  |  |                   |                            |

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| CENTER<br>STATEMENT (<br>AND PLAN OF<br>NAME OF P | -   | D HUMAN SERVICES<br>MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>345294  | · /               | NG _ | TREET ADDRESS, CITY, ST       | -   | FORM<br>OMB NC<br>(X3) DATE<br>COMP | 0: 06/17/2019<br>1 APPROVED<br>0. 0938-0391<br>SURVEY<br>LETED<br>C<br>09/2019 |
|---|---|---|-------------------|------|-------------------------------|---|-------------------------------------|--|
|   |   |   |                   | S    | HALLOTTE, NC 28459            |   |                                     |  |
| (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | (EACH CORREC<br>CROSS-REFEREN | EPLAN OF CORRECTION<br>CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                                     | (X5)<br>COMPLETION<br>DATE   |
| F 812   | the food being served<br>make them sick.<br>3. During an initial too<br>02/04/19, beginning a<br>labels and dates on o<br>and toasted oat cerea<br>container of grits, and<br>and elbow macaroni p<br>room. In the walk-in ref<br>rolls/tubes of thawing<br>without "pull dates" to<br>process began. The l<br>pink, and there were n<br>However, at this time<br>stated "pull dates" we<br>the meat was still fres<br>walk-in freezer opene<br>green peas/carrot me<br>dates.<br>During an interview w<br>9:58 AM she stated a<br>be labeled and dated<br>were served the fresh<br>During an interview w<br>02/07/19 at 10:06 AM<br>that any dietary emplo<br>was supposed to plac<br>packaging if the items<br>reported she was not | increased the chance that<br>to the residents could<br>ur of the kitchen on<br>t 11:18 AM, there were no<br>pened bags of raisin bran<br>als, a plastic storage<br>opened bags of spaghetti<br>basta in the dry storage<br>refrigerator there were<br>ng shredded cheese and<br>e without labels and dates.<br>rigerator there were three<br>hamburger which were<br>indicate when the thawing<br>hamburger meat was still<br>no signs of spoilage.<br>the Dietary Manager (DM)<br>re necessary to make sure<br>th and safe to use. In the<br>d bags of onion rings and<br>dley were without labels and<br>ith the DM on 02/07/19 at<br>Il opened food items should<br>to ensure that residents | F                 | 812  |                               |   |                                     |  |

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