STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 08/24/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID: OQEK11.	E 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		9/18/20

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

Electronically Signed | 09/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to implement the Centers for Disease Control and Prevention	F 880	All residents have the potential to be affected. Resident signs were chanced to CDC Enhanced Droplet Precaution on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 (CDC) recommended practices for COVID-19 by not placing signage that instructed staff that eye protection must be worn at all times while they worked on the unit at the entrance of the facility's COVID 19 care unit and on the doors of the rooms of 7 of 7 residents who resided on the facility's designated COVID-19 care unit (Residents #1, #2, #3, #4, #5, #6 and #7). The facility also did not require staff to wear eye protection at all times while on the COVID unit as recommended by CDC, when entering the rooms of 2 of 7 residents (Resident #1 and Resident #2) who were newly admitted and resided on the facility's designated COVID-19 unit. This failure occurred during a COVID-19 global pandemic. The findings included: The CDC guideline titled "Responding to Coronavirus (COVID-19) in Nursing Homes" and dated 04/30/20 read in part: Place signage at the entrance to the COVID-19 care unit that instructs Health Care Personnel (HCP) they must wear eye protection and N95 (respirator mask) or high respirator (or facemask if a respirator is not available) at all times while on the unit. Gown and gloves should be added when entering resident rooms. The CDC guideline further stated "all recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of N95 or high level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Review of the resident census for the facility's 500 unit, on 08/24/20 revealed the following:	F 880	COVID Observation and Isolation Unit. Requiring N95 and Face Shields at all times on the unit. The PPE was provided and Staff immediately donned. To prevent having a discrepancy in the CDC recommendation and the sign the facility uses, the facility will use the recommended CDC Enhanced Droplet Precautions sign on our COVID Isolation and Observation unit. The ADON or designee will educate the facility current nursing staff on the appropriate signage, donning and doffing PPE according to the sign, and expectations of eyewear on our COVID Isolation and Observation Unit by 9/18/2020. Education will be provided to new hires at orientation regarding appropriate signage, donning and doffing PPE according to the sign, and expectations of eyewear on our COVID Isolation and Observation Unit. To monitor and maintain ongoing compliance, the DON or designee will audit 500 hall to ensure all appropriate signage is on the hall, staff is donning and doffing appropriately, and eyewear is being worn at all times 5x/week for 2 weeks and weekly for 3 months. The results of the audits will be forwarded to the facility QAPI Committee for further review and recommendations. Any further monitoring will be determined by the committee. DOC: 9/18/2020 Responsible Party: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3	F 880		

· Resident #1 was admitted to Room #504 on droplet precautions on 08/18/20.
· Resident #2 was admitted to Room #506 on droplet precautions on 08/20/20.
· Resident #3 was admitted to Room #507 on droplet precautions on 08/10/20.
· Resident #4 was admitted to Room #508 on droplet/contact precautions on 08/24/20.
· Resident #5 was admitted to Room #514 on droplet precautions on 08/20/20.
· Resident #6 was admitted to Room #516 on droplet precautions on 08/17/20.
· Resident #7 was admitted to Room #518 on droplet precautions on 08/19/20.

An interview was conducted with the Administrator on 08/24/20 at 12:00 PM. The Administrator stated the facility's 500 unit was the designated COVID-19 unit where residents who were COVID-19 positive and/or new admissions or readmissions resided. She further stated that the new admissions stayed on the designated COVID-19 unit for 14 days or until a negative test was obtained.

A tour of the COVID-19 designated unit on 08/24/20 at 12:00 PM revealed no signage that instructed health care personnel to wear eye protection at all times while on the unit. There were seven occupied private resident rooms on the unit. Observations of Room #506, Room #507, Room #514, Room #516, and Room #518 revealed all had signage posted on their door that read Droplet-Contact Precautions: perform hand hygiene, wear mask before entering room, gown before entering room, gloves before entering room, eye protection (face shield or goggles) in addition to contact precautions must be used when performing aerosol generating procedures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

(open suctioning, trach care, respiratory treatments, etc.) when it is likely that there will be splash or spray of any respiratory secretion.

Further observations of the COVID-19 designated unit on 08/24/20 at 1:15 PM. revealed Room #504 had a sign posted on the door that read, Droplet-Contact Precautions: perform hand hygiene, wear mask before entering room, gown before entering room, gloves before entering room, eye protection (face shield or goggles) in addition to contact precautions must be used when performing aerosol generating procedures (open suctioning, trach care, respiratory treatments, etc.) when it is likely that there will be splash or spray of any respiratory secretion. On 8/24/20 at 1:15 PM, Nurse Aide (NA) #1 was observed to have a N95 mask in place and donned a gown and gloves before she entered room #504 to assist the resident. She did not don eye protection before entering room #504 to assist the resident.

Another observation of NA #1 on 08/24/20 at 2:40 PM revealed NA #1 was assisting a newly admitted resident to Room #508. There was a sign posted on the door of Room #508 that read, Droplet-Contact Precautions: perform hand hygiene, wear mask before entering room, gown before entering room, gloves before entering room, eye protection (face shield or goggles) in addition to contact precautions must be used when performing aerosol generating procedures (open suctioning, trach care, respiratory treatments, etc.) when it is likely that there will be splash or spray of any respiratory secretion. On 08/24/20 at 2:40 PM, NA #1 was observed wearing a N95 mask and before she entered the resident ' s room, she donned a gown and gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5	F 880		

NA #1 was observed to enter the resident's room without eye protection.

An interview was conducted with NA #1 on 08/24/20 at 2:26 PM. NA #1 stated all of her residents on the 500 unit were on precautions and she always wore gown, gloves, and mask when entering a resident room. NA #1 stated the staff had been instructed to only wear eye protection if the resident was COVID-19 positive. She stated she was following the sign on the door and since none of the residents on the unit were COVID-19 positive she did not apply eye protection.

An interview was conducted with Nurse #1 on 08/24/20 at 2:43 PM. Nurse #1 stated he routinely worked the 500 unit and was observed to wear a N95 mask while on the unit but did not have eye protection on. Nurse #1 stated that everyone on the unit was placed there from the time of their admission for 14 days or until a negative COVID-19 test was obtained. He added all the residents were on precautions and the staff always wore gown, gloves and mask when entering a resident's room on the unit. Nurse #1 added that the only time he and the staff wore eye protection was when they were performing a resident's aerosol or nebulizer treatment. He added that the eye protection was kept on a different cart at the nurse's station. Nurse #1 stated that NA #1 would follow the signage posted on the resident's door regarding what PPE was needed to be worn. Nurse #1 also confirmed that all the residents on the 500 halls (designated COVID019 unit) were on Droplet-Contact precautions which included staff to perform hand hygiene prior to entering the room, and to wear a mask, gown, and gloves before entering room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880		

Eye protection was only worn by staff if they were performing aerosol or nebulizer treatments.

An interview was conducted with the Director of Nursing (DON) on 08/24/20 at 3:23 PM. The DON stated she also served as the facility's Infection Control Preventionist (ICP). The DON/ICP stated that the 500 hall was the designated COVID-19 unit where all new admission/readmissions were quarantined for 14 days or until they facility had obtained a negative COVID-19 test. She added the residents on the 500 hall were quarantined using the Droplet-Contact precautions signs as directed by their corporation. The DON stated that up to a week ago the facility was posting 2 signs on door of each resident's room one said droplet precautions and one said contact precautions and they were combined into one sign. The DON/ICP stated that they had been directed to only wear eye protection when performing aerosol procedures which is what the sign indicated. She stated that staff had been educated on that and knew when to apply eye protection. The DON/ICP further stated that she was aware of the Enhanced Droplet precaution sign being available, which specified the need for staff to wear eye protection and had requested to use those but was directed otherwise.

An interview was conducted with the Administrator on 08/24/20 at 4:20 PM. The Administrator stated that they used the Enhanced Droplet precautions signs at one time but with all the new information coming down they had been instructed by the corporate office to change them and practice the droplet-contact precautions. The Administrator stated that she would resume using the Enhanced droplet precaution signs that were consistent with the CDC guidelines and practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	08/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 The Administrator added that the staff had not worn the eye protection previously but would be educated according to the CDC guidelines to wear eye protection at all times while on the unit.	F 880		