**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>345511</td>
<td>A. BUILDING ____________________</td>
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<td>B. WING ___________________________</td>
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(345511) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>05/13/2021</td>
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**NAME OF PROVIDER OR SUPPLIER**

ARCTIC CARE OF STATESVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2001 VANHAVEN DRIVE

STATESVILLE, NC 28625

**SUMMARY STATEMENT OF DEFICIENCIES**

- **E 000** Initial Comments
  
  An unannounced Recertification and Complaint Investigation Survey was conducted 05/10/21 through 05/13/21. 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# K1IB11.

- **F 000** INITIAL COMMENTS
  
  An unannounced Recertification and Complaint Investigation Survey was conducted 05/10/21 through 05/13/21. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One of the five allegations was substantiated. Event ID# K1IB11.

- **F 578** Request/Refuse/Discntue Trmnt; Formlte Adv Dir
  
  CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)
  
  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

  (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed

06/07/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 578</td>
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Medical or surgical treatment and, at the resident's option, formulate an advance directive.

- (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
- (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
- (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
- (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.

Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

This REQUIREMENT is not met as evidenced by:

- Based on record review and staff interviews the facility failed to maintain accurate Advanced Directives throughout the Resident's (Resident #38) medical record for 1 of 19 residents reviewed for Advanced Directives.

The finding included:

- Resident #38 was admitted to the facility on 04/02/20 with diagnoses that included atrial fibrillation and heart failure.

- On 05/10/21 at 4:11 PM a review of Resident #38's electronic medical record (EMR) revealed an Advanced Directive order dated 05/03/21 for medical or surgical treatment and, at the resident's option, formulate an advance directive.

**THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATED ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENT UNDER STATE AND FEDERAL LAW.**

**CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:**

- The preparation and submisson of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusion stated on this statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law.
On 5/14/2021 Resident #38 Advanced Directive Medical Record was reviewed to ensure accuracy with Code Status, Care Plan, Order, and Advance Directive Book at nurses station. This was completed on 5/14/2021.

**OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTIONS TAKEN:**

Beginning on 5/14/21 a review of current residents Advance Directive/Medical Records/Code Status was reviewed by Social Worker to include orders, consents, care plans and advance directives in note book at nurses station.

No additional residents were found to have inaccurate advance directive through-out residents medical records. This was completed on 5/14/2021

**Systematic Change Implemented:**

Beginning 5/14/2021 Facility social worker was educated by Regional Director of Clinical Services on policy for Advance Directives and maintaining accurate code status throughout medical record.

Beginning 5/14/2021 current nursing staff, physician, nurse practitioner's was educated on code status maintain throughout residents medical records. All new hires will be educated on residents code status policy. This is added to agency orientation Completed on 5/16/2021.

**Monitoring:**

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| F 578 | Continued From page 2 | F 578 | On 5/14/2021 Resident #38 Advanced Directive Medical Record was reviewed to ensure accuracy with Code Status, Care Plan, Order, and Advance Directive Book at nurses station. This was completed on 5/14/2021.

An interview with Nurse #1 on 05/12/21 at 3:18 PM revealed Nurse #1 explained that the residents' Advanced Directive status was in the EMR as well as in the Code Status notebook that was kept at the nursing desk. An observation was made with Nurse #1 of the Code Status notebook which revealed Resident #1's Advanced Directive was not in the Code Status notebook.

An interview was conducted with the Social Worker (SW) on 05/12/21 at 3:31 PM. The SW explained that she was responsible for the residents' Advanced Directives in that she had to ensure the residents' Advanced Directive in their EMR, and the Code Status notebook matched. The SW stated she conducted an audit of the Advanced Directive every six months and completed the most recent audit last week and all the residents' Advanced Directives matched perfectly. An observation was made of Resident #38's EMR and the Code Status notebooks at both nurses' stations with the SW. The SW noted Resident #38's Advanced Directive was not in the Code Status notebooks and stated she had no explanation as to why, but she would follow up with the correction.

On 05/13/21 at 1:48 PM an interview with the Administrator revealed, the Administrator stated she understood the importance of making sure the two places for the residents' Advanced Directive information matched (EMR and Code Status notebook) and that it was her expectation
F 578  Continued From page 3

that the two places matched.

F 644 Coordination of PASARR and Assessments

CFR(s): 483.20(e)(1)(2)

§483.20(e) Coordination.
A facility must coordinate assessments with the
pre-admission screening and resident review
(PASARR) program under Medicaid in subpart C
of this part to the maximum extent practicable to
avoid duplicative testing and effort. Coordination
includes:

§483.20(e)(1) Incorporating the recommendations
from the PASARR level II determination and the
PASARR evaluation report into a resident's
assessment, care planning, and transitions of
care.

§483.20(e)(2) Referring all level II residents and
all residents with newly evident or possible
serious mental disorder, intellectual disability, or a
related condition for level II resident review upon
a significant change in status assessment.

This REQUIREMENT  is not met as evidenced
by:

Based on record reviews and facility staff
interviews, the facility failed to initiate a PASARR
review for a resident who had a new mental
health diagnosis for 1 of 1 resident reviewed for
PASARR (Resident #45).

The Findings Included:

Beginning 5/14/2021 facility social
worker/designee will monitor monitor code
status/advance directives weekly x 12
weeks to ensure code status maintained
accurately in each residents medical
record.
Resident #45 was most recently admitted to the facility on 03/26/21 with diagnoses that included Parkinson's disease, dementia, and schizoaffective disorder.

A review of Resident #45's admission Minimum Data Set Assessment dated 04/01/21 revealed she was severely impaired for daily decision making with no documented psychosis or behaviors. Resident #45 required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. She was totally dependent on others for bathing. Resident was coded as having a diagnosis of Schizoaffective disorder.

A review of Resident #45's electronic documents revealed when she admitted to the facility, it was with a PASARR that was completed in May of 2017. Review of Resident #45's medical records during that time it was revealed that she did not have a diagnosis of schizoaffective disorder while admitted and was diagnosed with schizoaffective disorder before her admission to the facility on 03/26/21.

During an interview with the facility's Social Worker (SW) on 05/13/21 at 11:08 AM, she reported she was responsible for ensuring all residents that admitted to the facility had an appropriate PASARR number. She reported she was unaware that she was required to request a PASARR review for any resident what was diagnosed with a new mental health condition. She reported when Resident #45 admitted to the facility she verified that she had a PASARR initiated in May of 2017 but was unaware she needed to request a review since Resident #45

THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW.

CORRECTION ACTION FOR THE AFFECTED RESIDENT:

Resident #45 PASRR was corrected to include the new Mental Health diagnosis.

OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN:

Beginning on 5/14/2021 all current residents were reviewed to ensure PASRR#'s are with current diagnosis. This was completed on 5/14/2021.

SYSTEMATIC CHANGES IMPLEMENTED:

Beginning on 5/14/2021 facility's social worker was educated on PASARR company policy and, and initiation of PASRR's with new mental health diagnosis. This was completed on 5/14/2021

MONITORING:

Beginning on 5/14/2021 Facility Social Worker/designee will complete an ongoing audit that consist of Residents name; Admit date; PASSR List Number with effective date; PASSR if short term approval list in column is 7 day, 30 day, 60 day with date; Level 2 screening; If short
**NAME OF PROVIDER OR SUPPLIER**  
AUTUMN CARE OF STATESVILLE

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<td>had a new diagnosis of schizoaffective disorder. She stated she would request a review immediately.</td>
<td>F 644</td>
<td>term PASSR approval; New PASSR completed with date completed; FL2 received if applicable, date applied; Were any significant PASSR's needed? If yes, add date completed; List any time specific PASSR with date and roll over from prior month; Date of weekly meeting, list those in attendance. This information will be audited weekly x 12 weeks to ensure up to date and any new mental diagnosis added.</td>
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<td>F 761</td>
<td>Label/Store Drugs and Biologicals</td>
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<td>5/27/21</td>
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<tr>
<td>SS=D</td>
<td>CFR(s): 483.45(g)(h)(1)(2)</td>
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- §483.45(g) Labeling of Drugs and Biologicals
- Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

- §483.45(h) Storage of Drugs and Biologicals
- §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
- §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit
F 761 Continued From page 6

package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (Cart 200 and Cart 400/500/600) reviewed for expired medications.

The findings included:

a. An observation of Cart 200 was made on 05/12/21 at 4:43 PM along with Nurse #2. The observation revealed the following expired medication that were on the medication cart and available for use:

1 card of Reglan (Antiemetic) 10 milligrams that contained 30 pills that expired 02/28/21.
1 card of Lexapro (antidepressant) 20 milligrams that contained 21 pills that expired on 03/31/21.

An interview was conducted with Nurse #2 on 05/12/21 at 4:44 PM. Nurse #2 stated she worked at the facility through an agency and was not familiar with the policy and procedures on medication carts. She stated she was not sure who was responsible for checking the medication cart. She added that she had gone through the over the counter medication and made sure all the insulin pens were dated but that was it. Nurse #2 stated if she discovered expired medication, she would put them in the medication room and send it back to the pharmacy.

b. An observation of Cart 400/500/600 was made on 05/12/21 at 3:52 PM along with Nurse #3. The observation revealed the following medication

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CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:

On 5/13/21, all expired medication have been removed from all medication carts 200 and 400/500/600.

OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN:

Beginning on 5/14/2021 each medication cart was reviewed for any expired medications, any medication that had an expired date have been removed and sent back to the facility's pharmacy or otherwise destroyed. This was completed on 5/14/2021

SYSTEMATIC CHANGES IMPLEMENTED:
**SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<td>F 761</td>
<td>Continued From page 7</td>
<td>expired and on the medication cart available for use:</td>
<td>Beginning on 5/14/2021 current nurses have been educated on policy for expired medications. New hires will be educated on policy for expired medication. Agency nurse packets for orientation will include education on expired medication policy.</td>
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<td><strong>MONITORING:</strong></td>
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<td>Beginning on 5/16/2021 Unit Manager/Designee will audit medication carts for expired medications 2x a week for 4 weeks then weekly x8 weeks. Director of Nursing will review all audits.</td>
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<td>An interview was conducted with Nurse #3 on 05/12/21 at 3:57 PM. Nurse #3 stated she thought the Unit Manager (UM) checked the medication carts for expired medication. She stated she had not checked the medication cart for expired medication today and added she was an agency nurse that usually worked at the facility 3 days a week. Nurse #3 stated she would give the expired medication to the UM to handle.</td>
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<td>An interview was conducted with the UM on 05/12/21 at 4:02 PM. The UM stated that she just took over the UM position a few days ago and was instructed to go through the medication carts. I assumed they were just referring to the over the counter medications and the insulin pens because night shift staff was responsible for checking the medication carts for expired medications. She added the hall nurses should also be going through the carts before they administer medications. The UM stated that the expired medication should be removed from the medication cart and returned to the pharmacy.</td>
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<td>An interview was conducted with the Director of Nursing (DON) on 05/13/21 at 12:40 PM. The DON stated that the UM should be going through</td>
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the medication carts at least weekly if not twice a week. She stated that sometimes the UM would have the hall nurses go through them first and then they would follow up behind and make sure nothing was missed. The DON stated if the UM was not available the Assistant Director of Nursing (ADON) could help out with the process. She indicated the expired medication should be removed from the medication cart and returned to the pharmacy for destruction.

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**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>Continued From page 8 the medication carts at least weekly if not twice a week.</td>
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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)