STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

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F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		4/20/17

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

Electronically Signed | 04/07/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interviews, family interview and record review the facility failed to notify a resident's legal representative or interested family member of changes in treatment for one of one sampled residents reviewed for notification (Resident #6). Findings included: In an interview conducted on 03/20/17 at 10:38 A.M. with a family member of Resident #6 she revealed that she was not notified when there was a change in the resident's medications. Record review showed that Resident #6 had the following diagnosis: Dementia, Alzheimer's Disease and Encephalopathy. Review of the most current Annual Minimum Data Set dated 12/01/16 showed that Resident #6 had very severely impaired cognition. Record review revealed that on 02/6/17 the medication Norco had been discontinued by the physician related to a recommendation by the consultant pharmacist. The order was transcribed by Nurse #1. Review of the Physician Order Sheet indicated that the family had not	F 157	F157 Steps taken in regards to those residents found to be affected: Resident # 6□s wife was notified verbally on 3/20/2017 of medication changes by nurse. On 4/07/2017 interim DON reviewed all medications with Resident #6□s wife. Steps taken in regard to those residents having the potential to be affected: Nursing staff will be re-educated by SDC and/or designee to be completed by 4/20/2017 on MD and RP notification of all significant changes including medications. Measures put in place to ensure the deficient practice does to recur: Medication order changes will be audited 5 x week for 4 weeks by the DON and/or designee to ensure RP and MD notification for all medication changes. Monitoring effectiveness of corrective action plan: The RP/MD notification audit will be brought by the DON and/or designee to the Quality Assurance Committee for 3	

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F 157	Continued From page 2 been notified. Record review revealed that on 02/21/17 the medication Nexium had been discontinued by the physician related to a recommendation by the consultant pharmacist. The order was transcribed by Nurse #1. Review of the Physician Order Sheet indicated that the family had not been notified. In an interview with Nurse #1 on 03/21/17 at 10:00 A.M. she stated that if she had notified the family she would have checked the box on the Physician Order Sheets indicating that she had. She did not remember letting the family of Resident #6 know about the medication changes on 02/06/17 or 02/21/17. She said she must not have let the family know but that she gets busy and sometimes forgets. Record review indicated that on 01/04/17 a physician's order was written to decrease the Aspirin dose from 325mg daily to 81mg daily for Resident #6. The order was transcribed by Nurse #2. In a phone interview with Nurse #2 on 03/21/17 at 2:15 P.M. she stated that she did not remember notifying the family of resident #6 of the medication change when she took the order. She said she would normally make a progress note whenever she notifies a family and if there was no note then she did not do it. Record review showed that no note indicating that she had notified the family was written. In an interview with the Director of Nursing on 03/22/17 at 10:20 A.M. she revealed that she expects the staff to notify the family of any	F 157	months. Any areas of concern will be discussed and a further action plan will be developed if needed.	

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F 157	Continued From page 3 changes in a resident's medications or treatments. She said it was the facility policy to notify the family when any charges occur.	F 157		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 356		4/20/17

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F 356	Continued From page 4 (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to post the correct Nurse Staffing Information sheet located in the entrance hallway of the facility. Findings included: An observation on entry to the facility on 03/19/17 at 4:15 P.M. revealed the posted Nurse Staffing Information sheet was dated 03/17/17 with a resident census of 114. At 7:08 P.M. on 03/19/17 the posted Nurse Staffing Information sheet was dated 03/17/17 with a resident census of 114. The actual date was 03/19/17 and record review showed that the facility census was 120. In an interview with the Administrator on 03/20/17 at 10:00 A.M. she stated that she had looked at the posted staffing sheet on 03/19/17 when she arrived at the facility and thought it was right. She	F 356	F356 Steps taken in regards to those residents found to be affected: The posted nurse staffing sheets were corrected on 3/20/17 by the business office. Steps Taken in regard to those Residents having the potential to be affected: Business office personnel were educated by the nursing staff to ensure nurse staffing sheets are posted. Measures put in place to ensure the deficient practice does not recur: The posted nurse staffing sheets will be audited by the business office personnel daily x 4 weeks. Monitoring effectiveness of corrective action plan: Posted nurse staffing audits will be brought by the Administrator to the Quality	

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F 356	Continued From page 5 said that the nursing supervisor on the weekend was in charge of making sure the correct information was posted for nursing staffing each day. She stated it was the supervisor's first weekend on call and that she may not have been aware of this duty. She also revealed that she only glanced at the posting and didn't realize that it was the incorrect information. She said that the Business Office Manager prints the sheets for the staff to use. She also stated that she expects the posting to be current each day. In an interview with Nurse #3 on 03/20/17 at 3:50 P.M. she stated that it was her first weekend on call and that she was not aware that she was supposed to change the posting. She also stated that she was not familiar with the posting or what it was used for. In an interview with the Business Office Manager on 03/20/17 at 3:55 P.M. she revealed that on 03/17/17 she printed all the weekend sheets in advance and put them behind the posting for 03/17/17 for the weekend staff to use. Nurse #3 stated that she was not aware of the extra sheets available for weekend use.	F 356	Assurance Committee for 3 months. Any areas of concern will be discussed and a further action plan will be developed as needed.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371		4/20/17

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F 371	Continued From page 6 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the temperature of Cole slaw made with salad dressing at or below 41 degrees Fahrenheit during operation of the trayline and failed to air dry kitchenware before stacking it on top of one another in storage. Findings included: 1. At 5:55 PM on 03/20/17 a calibrated thermometer, which was used to check the temperature of Cole slaw, registered 49.3 degrees Fahrenheit. All the slaw to be served at the supper meal was in small bowls stacked on three trays near the trayline. At this time the PM cook stated she finished preparing the Cole slaw at about 3:00 PM on 03/20/17, and stored it in the walk-in refrigerator until the trayline began operation. She reported 1 1/2 carts of meal trays had been prepared for residents, and after the present cart was filled, there were 4 more carts of meal trays that would be leaving the kitchen. She commented the Cole slaw was home made, and	F 371	F71 Steps Taken in regards to those residents found to be affected: The Cole Slaw was placed in the freezer on 3/20/2017 so that the temperature would be brought down to 41 degrees Fahrenheit or lower. The temperature of the Cole Slaw was checked prior to serving by the Certified Dietary Manager and was found to be compliant. On 3/23/17 the tray pans and cups were re-washed and air dried appropriately to be compliant by the dietary staff. Steps Taken in regard to those Residents having the potential to be affected: Dietary staff were re-educated on the proper serving temperature of cold foods by the RD and/or designee completed on 4/7/2017.	

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F 371	Continued From page 7 was supposed to remain at or below 41 degrees Fahrenheit during operation of the trayline. At 11:06 AM on 03/23/17 the dietary manager (DM) stated she held a dietary in-service about seven months ago during which she discussed the preparation of chilled salads. She reported staff were encouraged to prepare salads made with mayonnaise or dressing the day before they were to be served. She commented staff were told to only bring out a tray of salads at a time from the walk-in refrigerator. According to the DM, the facility made its own Cole slaw using cabbage, Cole slaw dressing, and a very small amount of salt. The DM provided a copy of the trayline temperature log which documented on 03/20/17 a calibrated thermometer, which was used to check the Cole slaw as the trayline began operation, registered 40 degrees Fahrenheit. She stated chilled salads made with mayonnaise or dressing should remain at 40 degrees Fahrenheit or below during the entire operation of the trayline. At 11:20 AM on 03/23/17 a dietary aide/cook stated she thought it was okay to prepare chilled salads the same day they were served. She reported she was taught to prepare the salads in bulk, place them in individual bowls/cups, place those bowls/cups in the walk-in refrigerator, and only bring out one tray of salads at a time in order to keep them at 40 degrees Fahrenheit or below during the entire operation of the trayline. She commented the cooks used chilled cabbage to prepare the Cole slaw, and wanted to keep it below 40 degrees Fahrenheit to lessen the chance that bacteria would grow in it.	F 371	Dietary staff were re-educated on air drying washed tray pans and cups by the RD and/or designee completed on 4/7/2017. Measures put in place to ensure the deficient practice does not recur: Food temperatures including cold salads will be audited for 5 x a week for 4 weeks by the RD and/or CDM. Washed items will be audited a minimum of 5x a week for 4 weeks by the CDM and/or designee to ensure items are being air dried appropriately. Monitoring Effectiveness of corrective action: Food temperature audits will be brought by the RD and/or CDM to the Quality Assurance Committee for 3 months. Any areas of concern will be discussed and a further action plan will be developed if needed. The air dry audit will be brought by the RD and/or CDM to the Quality Assurance Committee for 3 months. Any areas of concern will be discussed and a further action plan will be developed if needed.	

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F 371	Continued From page 8	F 371		

2. During initial tour of the kitchen, beginning at 4:45 PM on 03/19/17, 7 of 12 tray pans stacked on top of one another on a storage rack had moisture trapped inside of them. At this time a dietary aide reported these tray pans were washed and stacked earlier in the day after the lunch meal.

At 5:52 PM on 03/22/15 7 of 13 tray pans stacked on top of one another on a storage rack had moisture trapped inside of them. At this time a dietary aide reported these tray pans were washed and stacked earlier in the day after the lunch meal.

At 5:56 PM on 03/22/16 5 of 15 eight-ounce cups were stacked on top of one another with moisture trapped inside. At this time a dietary aide reported these cups were washed and stacked earlier in the day after the lunch meal.

At 11:06 AM on 03/23/17 the dietary manager (DM) stated about a month ago she held in-servicing during which the dietary staff was reminded that they should air dry kitchenware before stacking it on top of one another in storage. She reported she thought sometimes her staff got in too much of a hurry, and did not allow the air drying process to be completed before stacking kitchenware on storage shelving. The DM commented water trapped between pieces of kitchenware could create a moist environment in which bacteria could grow over time.

At 11:20 AM on 03/23/17 a dietary aide/cook stated she was taught that kitchenware should be free of dried food particles and completely dry before it was stacked in storage. She reported it

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F 371	Continued From page 9 was important to make sure the final rinse temperature of the dish machine and the drying agent feeding into it met manufacturer's specifications to speed up the drying process. She also commented it was important to find a drying environment where kitchenware could drain properly. Otherwise, the aide/cook stated moisture trapped in stacked kitchenware could grow bacteria and mold which could make residents sick.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		4/20/17

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F 431	Continued From page 10 (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. (h) Storage of Drugs and Biologicals. (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. (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 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 observation, staff interviews and the facility medication storage policy review the facility failed to remove expired medications from 2 of 5 medication carts (200 hall and 400 hall). Findings included: 1. On 03/22/17 at 11:35 A.M. the medication cart on the 400 hall was observed and found to have stored on it at room temperature: (1) Lantus Solostar Insulin Pen that was opened on 01/15/17 and expired on 02/11/7; (1) Levemir	F 431	F431 Steps Taken in regards to those residents found to be affected: The expired insulin pens and the expired bottle of Acid Gas Relief found on the 400 hall Med Cart and 200 hall med cart were discarded by the DON on 3/22/17. Steps Taken in regard to those Residents having the potential to be affected: Nursing staff were re-educated by the SDC and/or designee on expired	

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F 431	Continued From page 11 Flextouch Insulin Pen opened on 01/06/17 and expired on 02/16/17; (2) Humalog U-100 Insulin Kwikpens opened on 01/08/17 and expired on 020/4/17; and (1) bottle of Mi-Acid Gas Relief stock that had expired in February 2017. In an interview with Nurse #1 on 03/22/17 at 12:05 P.M. she agreed that the above medications on the 400 hall medication cart had expired and had not been discarded. 2. On 03/22/17 at 12:30 P.M. the medication cart on the 200 hall was observed and found to have stored on it at room temperature: (1) Novolog Mix Insulin FlexPen 70-30 that was opened on 03/2/17 and expired on 03/15/17 and (1) Novolog Mix Insulin FlexPen 70-30 opened on 02/13/17 and expired on 02/26/17. The Omnicare/facility Insulin Storage Recommendations were reviewed. In an interview with the Director of Nursing on 03/22/17 at 2:30 P.M. she revealed that the facility policy was to remove medications from the medication storage areas when they expire and dispose of them appropriately.	F 431	medication policy completed on 4/20/2017. Measures put in place to ensure the deficient practice does not recur: Medication carts will be audited by the DON and/or designee 5 x a week for 4 weeks to ensure there are no expired medications. Monitoring Effectiveness of corrective action: Medication cart audit forms will be brought to the monthly QAPI meetings monthly for 3 months to monitor for effectiveness. Any areas of concern will be discussed and a further action plan will be developed if needed.	