STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 02/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification/Complaint Investigation suvey was conducted on 02/04/19 through 2/09/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# OUD911.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint survey was conducted from 2/4/19 through 2/9/19 for Event ID #OUD911. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J. CFR 483.12 at tag F600 at a scope and severity J. CFR 483.25 at tag F684 at a scope and severity J. Tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/04/19 and was removed on 02/09/19. An extended survey was conducted. There were no deficiencies cited as a result of the complaint investigation survey on 2/9/19 for OUD911. An amended Statement of Deficiencies was provided to the facility on 4/5/19 because the Informal Dispute Resolution (IDR) process deleted tags; F-580, F-600 and F-684 and information in tag F-0000 was changed to reflect the results of the IDR. Event# OUD911. An amended Statement of Deficiencies was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/01/2019

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F 000	Continued From page 1 provided to the facility on 5/30/19 because CMS reviewed the facility's IDR results, that deleted tags F-580, F-600 and F-684 and decided each of these tags should be cited at level J. Tags F-580, F-600 and F-684 were reinstated and tag F-0000 was changed to reflect the decision by CMS to keep these tags at a IJ level. Event #OUD911.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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-	F 580		2/10/19

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F 580	Continued From page 2 (A) A change in room or roommate assignment 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview and record review the facility failed to notify a physician for 1 of 1 residents (Resident #389) who experienced a significant change in condition with the sudden onset of diaphoresis (sweating), disorientation and diarrhea. Immediate Jeopardy began on 02/04/19 when Resident #389 experienced a significant change in condition at 3:55 PM. He was diaphoretic, disoriented, and had been incontinent of diarrhea. The facility failed to notify a physician of this sudden significant change in his condition. Nurse Aide #1 (NA) reported to a nurse at least three times during the shift that something was very wrong with the resident. Immediate Jeopardy was removed on 02/09/19 when the facility provided and implemented an acceptable credible	F 580	F580 The Plan of Correcting the specific deficiency. On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory. On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department. On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID for UTI. Resident #389 received 8 doses of Keflex. On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin	

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F 580	Continued From page 3	F 580		

allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

Resident #389 was admitted to the facility on 01/17/19 with diagnoses that included retention of urine, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, gastrostomy, Parkinson's disease and Alzheimer's disease with early onset.

Review of a Medicare 5 Day Admission Minimum Data Set (MDS) Assessment dated 01/24/19 for Resident #389 revealed he had moderately impaired cognition. He had an indwelling catheter.

Documentation reviewed in the nurse progress notes revealed Resident #389 had his urinary catheter replaced several times on 01/21/19, 01/26/19, 01/27/19 and 02/02/19. On 02/01/19 the facility Nurse Practitioner reordered a UA C & S due to hematuria (blood in the urine). Nurse #7 documented in a progress notes dated 02/01/19 that she collected the urine and sent it to the hospital lab but before the results came back Resident #389 was sent to the emergency room for evaluation related to complaints of abdominal pain and distension. Hospital records dated 02/02/19 documented a diagnosis of urinary tract infection associated with indwelling urethral catheter and he was started on the antibiotic Keflex by the emergency room physician. Between 02/02/19 and 02/04/19 he received all 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send.

On 2/4/2019, resident #389 had a physician appointment and returned to the facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode.

His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64.

Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware.

Per NA she checked him at 10pm and he continued to be diaphoretic and out of it. NA reported to Nurse #8.

His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66.

The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable

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F 580	Continued From page 4 scheduled Keflex doses as documented on the MAR (Medication Administration Record). On 02/04/19 the facility Nurse Practitioner discontinued the antibiotic Keflex (lab results dated 02/04/19 showed that it was not effective) and ordered Ampicillin 250 mg every six hours for 7 days for UTI. Review of a nurse progress note written by Nurse #5 on 02/05/19 revealed the Ampicillin had not been available from the pharmacy. Review of the February MAR showed that no doses of Ampicillin had been given to Resident #389. An observation of Resident #389 was made during the initial tour on 02/04/19 at 12:00 noon. He was sitting quietly in his wheelchair at the nurse's station waiting to be transported to a medical appointment. He was alert and oriented, well groomed, with no odors of urine or feces present. No sweat was observed on the residents skin. An interview was conducted on 02/08/19 at 10:40 AM with Nurse #8. She reported that when Resident #389 returned from his medical appointment he was assisted back into bed. She stated that the NA told her that he had not eaten dinner and she gave him a bolus tube feeding between 6:00-6:30 PM. She did not remember him being sweaty. She said she really couldn't remember much but that if she passed on in report that he was sweaty and had to have his sheets changed twice then it must be true but she could not remember. She was sure that she had not called a physician because if she had she would have remembered that. An interview was conducted on 02/08/19 at 11:19 AM with NA #1. She revealed that Resident #389	F 580	and was diaphoretic and was checking often. On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny diarrhea like stools. Applied 02 at 2L. Resident□s o2 stat increased to 94-95%. Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states I don□t feel right. Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff. Resident #389 is currently at the hospital. Root Cause Analysis The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19. The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited. The resident is not currently in the facility.	

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F 580	Continued From page 5 was sweaty, disoriented, and had been incontinent of diarrhea when he returned from his medical appointment on 02/04/19. She reported that Nurse #8 had put the resident into bed and had called her to the room to help. NA #1 stated that she changed his sweaty shirt and sheets at that time. She stated Nurse #8 had observed that he was sweaty, disoriented and incontinent of bowel. She told the nurse when the resident first returned that "something was wrong with him." She checked on him thirty minutes later and noted that he "didn't look good" so she reported to Nurse #8 again that Resident #389 was sweating and disoriented. She stated he was sweating throughout the shift and it got worse as time went on. She remembered that when Nurse #8 was giving the resident his tube feeding the nurse had commented that the resident was "really sweating." She stated that she had told the nurse again at 10:00 PM that Resident #389 was "really sweaty and disoriented." She said Nurse #8 told her he was just wore out from going to the appointment earlier in the day. She commented she passed on in report to the oncoming 3rd shift NA (#6) that Resident #389 "wasn't acting right" and to keep an eye on him. An interview was conducted on 02/08/19 at 12:22 PM with NA #6. She confirmed that NA#1 had passed on in report that she had changed the sheets on the bed for Resident #389 and that he was very sweaty. She said that she could tell he was sweating. After the shift started he kept calling out "help, help". She stated that as soon as she left his room he would immediately start yelling for help again and she would go back to his room. She reported that herself and Nurse #5 checked the resident several times because they could not figure out what was wrong with him.	F 580	On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified. On 2/8/2019, licensed nurses interviewed all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported. On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following: *Licensed Nursing staff will be educated on physician order policy. *Licensed Nursing staff will be educated on change in resident condition policy. *Licensed Nursing staff will be educated on documentation. *CNAs will be educated on Stop and Watch Interact process which includes changes of condition including the following: seems different , talks less, overall needs more help, pain, ate less, no bowel movement or diarrhea, drank less, weight change, agitation, tired, week, change in skin color and help with walking, transferring, toileting more than usual. *CNAs will be educated on Point of Care Alert documentation. *On 2/9/2019, the DON and/or designees will educate all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia.	

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F 580	Continued From page 6 She stated that Resident #389 had three bouts of diarrhea on her shift before he was transferred to the emergency room. She commented that Resident #389 went to the hospital toward the end of her shift between 3:30 and 4:00 AM. Review of a nurse progress note written by Nurse #5 on 02/05/19 at 7:44 AM indicated that she had received in report from the previous shift that the resident's bed had to be changed twice on second shift because he was sweating. She documented that she observed the resident laying in bed "sweating profusely." During her shift his oxygen level began to drop along with his blood pressure and his respirations increased. He had no urinary output on her shift. She noted the resident told her he didn't feel good and was having trouble breathing. Nurse #5 contacted the on call physician and transferred the resident to the emergency room via 911. Emergency Medical Service records revealed Resident #389 was transported to the hospital at 4:01 AM on 02/05/19. Review of the hospital records show that Resident #389 arrived at the emergency room at 4:40 AM on 02/05/19. Review of the hospital progress notes on 02/05/19 documented a preliminary diagnosis of sepsis secondary to UTI (Urinary Tract Infection). Further documentation dated 02/06/19 concluded that Resident #389 had blood cultures positive for Escherichia coli or Gram-negative bacteremia, a life-threatening condition. An interview was conducted on 02/08/19 at 1:05 PM with the Attending Physician for Resident	F 580	Education will continue via telephone for staff not available 2/8/19 and 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via telephone, a certified letter with the education provided will be mailed on 2/9/19 with instructions to call the DON to set a time for education. New licensed nurse and NA hires will receive the above education upon hire. The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements. The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks. The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week x 30 days and weekly x 8 weeks. Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for 8 weeks. The Director of Nursing and/or designee will question 3 nursing staff concerning	

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F 580	Continued From page 7 #389. She is also the Medical Director at the facility. She said that she was familiar with Resident #389 because she had completed his assessment when he was admitted to the facility. She was not aware that he had a change in his condition on 02/04/19 until the Nurse Practitioner informed her that he had been transferred to the hospital the next day. She reported that laying down, sweating, and being disoriented was not consistent with what she saw daily with Resident #389. She stated that he was normally up and sitting in his wheelchair. She commented that although he had some confusion he could chat with her when she visited. She stated that she would have considered it an acute significant change when he began sweating and became disoriented on 02/04/19 at the beginning of second shift and had she been in the building she would have assessed him immediately. She expected that the resident would have been assessed when the change in his condition occurred at the beginning of second shift because he had had a UTI that had been untreated and his symptoms were indicative of sepsis. She stated that the type of sepsis Resident #389 had could cause a resident's condition to change very quickly and turn on a dime. She further commented that waiting 12 hours to treat Gram-Negative sepsis could result in death because it enters the blood and acts in a couple of hours. She stated that it certainly could have affected the outcome for Resident #389 had a physician been notified on second shift on 02/04/19 and his acute condition treated sooner. An interview was conducted with the Director of Nursing on 2/9/19 at 2:45 PM. He stated if a resident had a change in condition he would expect the staff to do an assessment, notify the	F 580	the education provided, including asking what response is appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks. The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 2/10/19	

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F 580	Continued From page 8	F 580		

provider if indicated, document the incident in either the progress notes or on an S Bar report when the incident occurred and then transcribe any new orders. He would also expect a nurse aide to fill out a stop and watch form or put a new alert message in Point Click Care (the electronic medical record) if he or she noticed a change of condition in a resident.

The facility Administrator and the Director of Nursing were notified of immediate jeopardy on 02/08/19 at 3:00 PM.

On 02/09/19 at 1:51 PM the facility provided the following credible allegation of immediate jeopardy removal:

F580

The Plan of Correcting the specific deficiency.

On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory.

On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department.

On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID for UTI. Resident #389 received 8 doses of Keflex.

On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy

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F 580	Continued From page 9	F 580		

nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send.

On 2/4/2019, resident #389 had a physician appointment and returned to the facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode.

His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64.

Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware.

Per NA she checked him at 10pm and he continued to be diaphoretic and "out of it". NA reported to Nurse #8.

His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66.

The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable and was diaphoretic and was checking often.

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F 580	Continued From page 10	F 580		

On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny diarrhea like stools. Applied 02 at 2L. Resident's o2 stat increased to 94-95%. Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states "I don't feel right". Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff.

Resident #389 is currently at the hospital.

Root Cause Analysis

The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19.

The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited.

The resident is not currently in the facility.

On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to

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AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

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identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified.

On 2/8/2019, licensed nurses interviewed all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported.

On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following:
*Licensed Nursing staff will be educated on physician order policy.

*Licensed Nursing staff will be educated on change in resident condition policy.

*Licensed Nursing staff will be educated on documentation.

*CNAs will be educated on Stop and Watch Interact process which includes changes of condition including the following: seems different , talks less, overall needs more help, pain, ate less, no bowel movement or diarrhea, drank less, weight change, agitation, tired, week, change in skin color and help with walking, transferring, toileting more than usual.

*CNAs will be educated on Point of Care Alert documentation.

*On 2/9/2019, the DON and/or designees will educate all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia.

Education will continue via telephone for staff not

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available 2/8/19 and 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via telephone, a certified letter with the education provided will be mailed on 2/9/19 with instructions to call the DON to set a time for education.

New licensed nurse and NA hires will receive the above education upon hire.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks.

The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week x 30 days and weekly x 8 weeks.

Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for 8 weeks.

The Director of Nursing and/or designee will question 3 nursing staff concerning the education provided, including asking what response is

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F 580	Continued From page 13 appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks. The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 2/9/19 The credible allegation of Immediate Jeopardy removal was validated on 02/09/19 at 3:07 PM. A sample of staff that included nurses and nurse aides were interviewed regarding in-servicing related to the deficient practice. All interviewed staff members stated they had been in-serviced regarding the physician order policy, change in resident condition policy, documentation, Stop and Watch Interact process, and Point of Care Alert documentation. A review of all documents developed to correct the deficient practice was completed. A review of audit forms that were developed to ensure that in-services presented to staff were understood and allowed an opportunity for staff to interact with dialogue was completed.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		2/10/19

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F 600	Continued From page 14 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview and record review the facility neglected to provide care for 1 of 1 residents (Resident #389) who experienced a significant change in condition with the sudden onset of diaphoresis (sweating), disorientation and diarrhea. Resident #389 was evaluated at a hospital and diagnosed with a urinary tract infection associated with the indwelling urethral catheter, acute kidney injury and Gram-negative bacteremia (bacteria in the blood stream). Immediate Jeopardy began on 02/04/19 when Resident #389 experienced a significant change in condition at 3:55 PM. When he was diaphoretic, disoriented, and had been incontinent of diarrhea. The facility neglected to provide care for Resident #389 after Nurse Aide #1 (NA) reported at least three times during the shift that something was very wrong with the resident. Immediate Jeopardy was removed on 02/09/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of	F 600	F600 Neglect The Plan of Correcting the specific deficiency. On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory. On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department. On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID for UTI. Resident #389 received 8 doses of Keflex. On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send.	

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F 600	Continued From page 15 compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #389 was admitted to the facility on 01/17/19 with diagnoses that included retention of urine, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, gastrostomy, severe protein calorie malnutrition, Parkinson's disease and Alzheimer's disease with early onset. Review of a Medicare 5 Day Admission Minimum Data Set (MDS) Assessment dated 01/24/19 for Resident #389 revealed he had moderately impaired cognition. He required extensive assistance of one for all activities of daily living, used a walker and wheelchair for ambulation and mobility. He had an indwelling urinary catheter and a gastric feeding tube. He received 4 days of Speech Therapy, 6 days of Occupational Therapy and 6 days of Physical Therapy during the assessment look back period. He expected to be discharged to the community when his therapies were completed. Review of the plan of care dated 02/01/19 for Resident #389 included focus areas for altered neurological status and impaired cognitive function related to Alzheimer's dementia and Parkinson's disease. Interventions included to observe for disorientation, assess, document and report to the physician any changes in cognitive function. During Resident #389's stay at the facility his	F 600	On 2/4/2019, resident #389 had a physician appointment and returned to the facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode. His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64. Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware. Per NA she checked him at 10pm and he continued to be diaphoretic and out of it. NA reported to Nurse #8. His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66. The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable and was diaphoretic and was checking often. On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny	

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urinary catheter was replaced several times due to dislodgement and occlusions documented in the nursing progress notes on 01/21/19, 01/26/19, 01/27/19 and 02/02/19. On 01/26/19 a urine culture and sensitivity (UA C & S) lab test was ordered by a Nurse Practitioner to determine if urine that had backed up into his urinary tract for an undetermined amount of time due to an occluded catheter had started to culture bacteria. On 01/27/19 Nurse #3 contacted an on-call physician and requested a discontinuation order for the urine culture because she had reinserted a catheter due to dislodgement and the returned urine was yellow documented in the nurse progress note of 01/27/19. On 02/01/19 the facility Nurse Practitioner reordered a UA C & S due to hematuria (blood in the urine). Nurse #7 documented in a progress notes dated 02/01/19 that she collected the urine and sent it to the hospital lab but before the results came back Resident #389 was sent to the emergency room for evaluation related to complaints of abdominal pain and distension. Hospital records dated 02/02/19 documented a diagnosis of urinary tract infection associated with indwelling urethral catheter and he was started on the antibiotic Keflex by the emergency room physician. Between 02/02/19 and 02/04/19 he received all scheduled Keflex doses as documented on the MAR (Medication Administration Record). On 02/04/19 the facility Nurse Practitioner discontinued the antibiotic Keflex (lab results dated 02/04/19 showed that it was not effective) and ordered Ampicillin 250 mg every six hours for 7 days for UTI. Review of a nurse progress note written by Nurse #5 on 02/05/19 revealed the Ampicillin had not been available from the pharmacy. Review of the February MAR showed that no doses of Ampicillin had been given to

diarrhea like stools. Applied 02 at 2L. Resident□s o2 stat increased to 94-95%. Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states I don□t feel right. Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff.
Resident #389 is currently at the hospital.

Root Cause Analysis

The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19.

The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited.

The resident is not currently in the facility.

The Administrator submitted a 24-hour report on 2/8/19 alleging neglect by Nurse #8 for not following up on a reported change in condition, not assessing a

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F 600	Continued From page 17 Resident #389. An observation of Resident #389 was made during the initial tour on 02/04/19 at 12:00 noon. He was sitting quietly in his wheelchair at the nurse's station waiting to be transported to a medical appointment. He was alert and oriented, well groomed, with no odors of urine or feces present. No sweat was observed on the resident's skin. An interview was conducted on 02/08/19 at 10:40 AM with Nurse #8. She reported that when Resident #389 returned from his medical appointment on 02/04/19 he was assisted back into bed. She stated that the NA told her that he had not eaten dinner and she gave him a bolus tube feeding between 6:00-6:30 PM. She did not remember him being sweaty. She said she really couldn't remember much but that if she passed on in report that he was sweaty and had to have his sheets changed twice then it must be true but she could not remember. She was sure that she had not called a physician because if she had she would have remembered that. An interview was conducted on 02/08/19 at 11:19 AM with NA #1. She revealed that Resident #389 was sweaty, disoriented, and had been incontinent of diarrhea when he returned from his medical appointment on 02/04/19. She reported that Nurse #8 had put the resident into bed and had called her to the room to help. NA #1 stated that she changed his sweaty shirt and sheets at that time. She stated Nurse #8 had observed that he was sweaty, disoriented and incontinent of bowel. She told the nurse when the resident first returned that "something was wrong with him." She checked on him thirty minutes later and	F 600	resident for a change in condition and not notifiying a MD of a change in condition. Nurse #8 was suspended on 2/8/19 pending an investigation of the above. On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified. On 2/8/2019, licensed nurses interviewed all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported. On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following: Licensed Nursing staff will be educated on the Abuse/Neglect policy. Licensed Nursing staff will be educated on physician order policy. Licensed Nursing staff will be educated on change in resident condition policy. Licensed Nursing staff will be educated on documentation. CNAs will be educated on Stop and Watch Interact process. CNAs will be educated on Point of Care Alert documentation. On 2/9/19 the DON and/or designees will educate all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia.	

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F 600	Continued From page 18 noted that he "didn't look good" so she reported to Nurse #8 again that Resident #389 was sweating and disoriented. She stated he was sweating throughout the shift and it got worse as time went on. She remembered that when Nurse #8 was giving the resident his tube feeding the nurse had commented that the resident was "really sweating." She stated that she had told the nurse again at 10:00 PM that Resident #389 was "really sweaty and disoriented." She said Nurse #8 told her he was just wore out from going to the appointment earlier in the day. She commented she passed on in report to the oncoming 3rd shift NA (#6) that Resident #389 "wasn't acting right" and to keep an eye on him. An interview was conducted on 02/08/19 at 12:22 PM with NA #6. She confirmed that NA#1 had passed on in report that she had changed the sheets on the bed for Resident #389 and that he was very sweaty. She said that she could tell he was sweating. After the shift started he kept calling out "help, help". She stated that as soon as she left his room he would immediately start yelling for help again and she would go back to his room. She reported that herself and Nurse #5 checked the resident several times because they could not figure out what was wrong with him. She stated that Resident #389 had three bouts of diarrhea on her shift before he was transferred to the emergency room. She commented that Resident #389 went to the hospital toward the end of her shift between 3:30 and 4:00 AM. Review of a nurse progress note written by Nurse #5 on 02/05/19 at 7:44 AM indicated that she had received in report from the previous shift that the resident's bed had to be changed twice on second shift because he was sweating. She	F 600	Education will continue via telephone for staff not available 2/8/19 or 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via telephone, a certified letter with the education provided will be mailed on 2/9/19 with instructions to call the DON to set a time for education. New licensed nurses and NA hires will be educated to abuse policy upon hire. The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements. The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks. The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week for 30 days and weekly x 8 weeks. Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for 8 weeks. The Director of Nursing will question 3 nursing staff concerning the education provided, including asking what response	

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documented that she observed the resident laying in bed "sweating profusely." During her shift his oxygen level began to drop along with his blood pressure and his respirations increased. He had no urinary output on her shift. She noted the resident told her he didn't feel good and was having trouble breathing. Nurse #5 contacted the on call physician and transferred the resident to the emergency room via 911.

An interview was conducted on 02/08/19 2:02 PM with Nurse #5. She remembered that on 02/05/19 Resident #389 was resting when she came on duty. She stated she was called to his room by the resident who was sweating and could not get comfortable. She recalled that his oxygen level had dropped along with his blood pressure. She said she called the on-call provider and received an order to give the resident a breathing treatment and his oxygen level came up but he continued to sweat. She called the on-call provider back and received an order to send the resident to the hospital because she thought he was either having a heart attack or had an embolism. She could not remember what time she sent him to the emergency room.

Emergency Medical Service records revealed Resident #389 was transported to the hospital at 4:01 AM on 02/05/19.

Review of the hospital records show that Resident #389 arrived at the emergency room at 4:40 AM on 02/05/19.

Review of the hospital progress notes on 02/05/19 documented a preliminary diagnosis of sepsis secondary to UTI (Urinary Tract Infection). Further documentation dated 02/06/19 concluded

is appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks.
The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures.
The title of the person responsible for implementing the acceptable plan of correction is the Administrator.
Date of Alleged Compliance is: 2/10/19

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that Resident #389 had blood cultures positive for Escherichia coli or Gram-negative bacteremia, a life-threatening condition.

An interview was conducted on 02/08/19 at 1:05 PM with the Attending Physician for Resident #389. She is also the Medical Director at the facility. She said that she was familiar with Resident #389 because she had completed his assessment when he was admitted to the facility. She was not aware that he had a change in his condition on 02/04/19 until the Nurse Practitioner informed her that he had been transferred to the hospital the next day. She reported that laying down, sweating, and being disoriented was not consistent with what she saw daily with Resident #389. She stated that he was normally up and sitting in his wheelchair. She commented that although he had some confusion he could chat with her when she visited. She stated that she would have considered it an acute significant change when he began sweating and became disoriented on 02/04/19 at the beginning of second shift and had she been in the building she would have assessed him immediately. She expected that the resident would have been assessed when the change in his condition occurred at the beginning of second shift because he had had a UTI that had been untreated and his symptoms were indicative of sepsis. She stated that the type of sepsis Resident #389 had could cause a resident's condition to change very quickly and turn on a dime. She further commented that waiting 12 hours to treat Gram-Negative sepsis could result in death because it enters the blood and acts in a couple of hours. She stated that it certainly could have affected the outcome for Resident #389 had a physician been notified on second shift on

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02/04/19 and his acute condition treated sooner.

An interview was conducted with the Director of Nursing on 2/9/19 at 2:45 PM. He stated if a resident had a change in condition he would expect the staff to do an assessment, notify the provider if indicated, document the incident in either the progress notes or on an S Bar report when the incident occurred and then transcribe any new orders. He would also expect a nurse aide to fill out a stop and watch form or put a new alert message in PCC (Point Click Care, the electronic medical record) if he or she noticed a change of condition in a resident.

The facility Administrator and the Director of Nursing were notified of immediate jeopardy on 02/08/19 at 3:00 PM.

On 02/09/19 at 1:51 PM the facility provided the following credible allegation of immediate jeopardy removal:

F600 Neglect

The Plan of Correcting the specific deficiency.

On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory.

On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department.

On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID

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AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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for UTI. Resident #389 received 8 doses of Keflex.

On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send.

On 2/4/2019, resident #389 had a physician appointment and returned to the facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode.

His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64.

Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware.

Per NA she checked him at 10pm and he continued to be diaphoretic and "out of it". NA reported to Nurse #8.

His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66.

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The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable and was diaphoretic and was checking often.

On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny diarrhea like stools. Applied 02 at 2L. Resident's o2 stat increased to 94-95%. Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states "I don't feel right". Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff. Resident #389 is currently at the hospital.

Root Cause Analysis

The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19.

The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited.

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The resident is not currently in the facility.

The Administrator submitted a 24-hour report on 2/8/19 alleging neglect by Nurse #8 for not following up on a reported change in condition, not assessing a resident for a change in condition and not notifying a MD of a change in condition.

Nurse #8 was suspended on 2/8/19 pending an investigation of the above.

On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified.

On 2/8/2019, licensed nurses interviewed all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported.

On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following:
Licensed Nursing staff will be educated on the Abuse/Neglect policy.
Licensed Nursing staff will be educated on physician order policy.
Licensed Nursing staff will be educated on change in resident condition policy.
Licensed Nursing staff will be educated on documentation.
CNAs will be educated on Stop and Watch Interact process.
CNAs will be educated on Point of Care Alert documentation.

On 2/9/19 the DON and/or designees will educate

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all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia.

Education will continue via telephone for staff not available 2/8/19 or 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via telephone, a certified letter with the education provided will be mailed on 2/9/19 with instructions to call the DON to set a time for education.

New licensed nurses and NA hires will be educated to abuse policy upon hire.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks.

The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week for 30 days and weekly x 8 weeks.

Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for

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8 weeks.

The Director of Nursing will question 3 nursing staff concerning the education provided, including asking what response is appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks.

The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures.

The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

Date of Alleged Compliance is: 2/9/19

The credible allegation of Immediate Jeopardy removal was validated on 02/09/19 at 3:07 PM.

A sample of staff that included nurses and nurse aides were interviewed regarding in-servicing related to the deficient practice. All interviewed staff members stated they had been in-serviced regarding the physician order policy, abuse and neglect, change in resident condition policy, documentation, Stop and Watch Interact process, and Point of Care Alert documentation. A review of all documents developed to correct the deficient practice was completed. A review of audit forms that were developed to ensure that in-services presented to staff were understood and allowed an opportunity for staff to interact with dialogue was completed.

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F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview and record review the facility failed to assess 1 of 1 residents who experienced a significant change in condition involving a sudden onset of diaphoresis (sweating), disorientation and diarrhea (Resident #389). Immediate Jeopardy began on 02/04/19 when Resident #389 experienced a significant change in condition upon return to the facility from a medical appointment at 3:55 PM. When he returned he was diaphoretic, disoriented, and had been incontinent of diarrhea. Nurse Aide #1 (NA) reported at least three times during the shift that something was very wrong with the resident. Immediate Jeopardy was removed on 02/09/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included:	F 684	F684 The Plan of Correcting the specific deficiency. On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory. On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department. On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID for UTI. Resident #389 received 8 doses of Keflex. On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send. On 2/4/2019, resident #389 had a physician appointment and returned to the	2/10/19

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Resident #389 was admitted to the facility on 01/17/19 with diagnoses that included retention of urine, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, gastrostomy, severe protein calorie malnutrition, Parkinson's disease and Alzheimer's disease with early onset.

Review of a Medicare 5 Day Admission Minimum Data Set (MDS) Assessment dated 01/24/19 for Resident #389 revealed he had moderately impaired cognition. He required extensive assistance of one for all activities of daily living, used a walker and wheelchair for ambulation and mobility. He had an indwelling urinary catheter and a gastric feeding tube. He received 4 days of Speech Therapy, 6 days of Occupational Therapy and 6 days of Physical Therapy during the assessment look back period. He expected to be discharged to the community when his therapies were completed.

Review of the plan of care dated 02/01/19 for Resident #389 included focus areas for altered neurological status and impaired cognitive function related to Alzheimer's dementia and Parkinson's disease. Interventions included to observe for disorientation, assess, document and report to the physician any changes in cognitive function.

During Resident #389's stay at the facility his urinary catheter was replaced several times due to dislodgement and occlusions documented in the nursing progress notes on 01/21/19, 01/26/19, 01/27/19 and 02/02/19. On 01/26/19 a urine culture and sensitivity (UA C & S) lab test was ordered by a Nurse Practitioner to determine if urine that had backed up into his urinary tract

facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode.
His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64.
Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware.
Per NA she checked him at 10pm and he continued to be diaphoretic and out of it. NA reported to Nurse #8.
His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66.
The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable and was diaphoretic and was checking often.
On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny diarrhea like stools. Applied 02 at 2L. Resident□s o2 stat increased to 94-95%.

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F 684	Continued From page 29 for an undetermined amount of time due to an occluded catheter had started to culture bacteria. On 01/27/19 Nurse #3 contacted an on-call physician and requested a discontinuation order for the urine culture because she had reinserted a catheter due to dislodgement and the returned urine was yellow documented in the nurse progress note of 01/27/19. On 02/01/19 the facility Nurse Practitioner reordered a UA C & S due to hematuria (blood in the urine). Nurse #7 documented in a progress notes dated 02/01/19 that she collected the urine and sent it to the hospital lab but before the results came back Resident #389 was sent to the emergency room for evaluation related to complaints of abdominal pain and distension. Hospital records dated 02/02/19 documented a diagnosis of urinary tract infection associated with indwelling urethral catheter and he was started on the antibiotic Keflex by the emergency room physician. Between 02/02/19 and 02/04/19 he received all scheduled Keflex doses as documented on the MAR (Medication Administration Record). On 02/04/19 the facility Nurse Practitioner discontinued the antibiotic Keflex (lab results dated 02/04/19 showed that it was not effective) and ordered Ampicillin 250 mg every six hours for 7 days for UTI. Review of a nurse progress note written by Nurse #5 on 02/05/19 revealed the Ampicillin had not been available from the pharmacy. Review of the February MAR showed that no doses of Ampicillin had been given to Resident #389. An observation of Resident #389 was made during the initial tour on 02/04/19 at 12:00 noon. He was sitting quietly in his wheelchair at the nurse's station waiting to be transported to a medical appointment. He was alert and oriented,	F 684	Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states I don□t feel right. Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff. Resident #389 is currently at the hospital. Root Cause Analysis The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19. The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited. The resident is not currently in the facility. On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified. On 2/8/2019, licensed nurses interviewed	

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well groomed, with no odors of urine or feces present. No sweat was observed on the residents skin.

An interview was conducted on 02/08/19 at 10:40 AM with Nurse #8. She reported that when Resident #389 returned from his medical appointment he was assisted back into bed. She stated that the NA told her that he had not eaten dinner and she gave him a bolus tube feeding between 6:00-6:30 PM. She did not remember him being sweaty. She said she really couldn't remember much but that if she passed on in report that he was sweaty and had to have his sheets changed twice then it must be true but she could not remember. She was sure that she had not called a physician because if she had she would have remembered that.

An interview was conducted on 02/08/19 at 11:19 AM with NA #1. She revealed that Resident #389 was sweaty, disoriented, and had been incontinent of diarrhea when he returned from his medical appointment on 02/04/19. She reported that Nurse #8 had put the resident into bed and had called her to the room to help. NA #1 stated that she changed his sweaty shirt and sheets at that time. She stated Nurse #8 had observed that he was sweaty, disoriented and incontinent of bowel. She told the nurse when the resident first returned that "something was wrong with him." She checked on him thirty minutes later and noted that he "didn't look good" so she reported to Nurse #8 again that Resident #389 was sweating and disoriented. She stated he was sweating throughout the shift and it got worse as time went on. She remembered that when Nurse #8 was giving the resident his tube feeding the nurse had commented that the resident was

all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported.
On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following:
*Licensed Nursing staff will be educated on physician order policy.
*Licensed Nursing staff will be educated on change in resident condition policy.
*Licensed Nursing staff will be educated on documentation.
*CNAs will be educated on Stop and Watch Interact process which includes changes of condition including the following: seems different , talks less, overall needs more help, pain, ate less, no bowel movement or diarrhea, drank less, weight change, agitation, tired, week, change in skin color and help with walking, transferring, toileting more than usual.
*CNAs will be educated on Point of Care Alert documentation.

*On 2/9/2019, the DON and/or designees will educate all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia.

Education will continue via telephone for staff not available 2/8/19 and 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via telephone, a certified letter with the education provided will be mailed on

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"really sweating." She stated that she had told the nurse again at 10:00 PM that Resident #389 was "really sweaty and disoriented." She said Nurse #8 told her he was just wore out from going to the appointment earlier in the day. She commented she passed on in report to the oncoming 3rd shift NA (#6) that Resident #389 "wasn't acting right" and to keep an eye on him.

An interview was conducted on 02/08/19 at 12:22 PM with NA #6. She confirmed that NA#1 had passed on in report that she had changed the sheets on the bed for Resident #389 and that he was very sweaty. She said that she could tell he was sweating. After the shift started he kept calling out "help, help". She stated that as soon as she left his room he would immediately start yelling for help again and she would go back to his room. She reported that herself and Nurse #5 checked the resident several times because they could not figure out what was wrong with him. She stated that Resident #389 had three bouts of diarrhea on her shift before he was transferred to the emergency room. She commented that Resident #389 went to the hospital toward the end of her shift between 3:30 and 4:00 AM.

Review of a nurse progress note written by Nurse #5 on 02/05/19 at 7:44 AM indicated that she had received in report from the previous shift that the resident's bed had to be changed twice on second shift because he was sweating. She documented that she observed the resident laying in bed "sweating profusely." During her shift his oxygen level began to drop along with his blood pressure and his respirations increased. He had no urinary output on her shift. She noted the resident told her he didn't feel good and was having trouble breathing. Nurse #5 contacted the

2/9/19 with instructions to call the DON to set a time for education.

New licensed nurse and NA hires will receive the above education upon hire.
The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.
The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks.
The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week x 30 days and weekly x 8 weeks.
Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for 8 weeks.
The Director of Nursing and/or designee will question 3 nursing staff concerning the education provided, including asking what response is appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks.
The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility

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F 684	Continued From page 32 on call physician and transferred the resident to the emergency room via 911. An interview was conducted on 02/08/19 2:02 PM with Nurse #5. She remembered that on 02/05/19 Resident #389 was resting when she came on duty. She stated she was called to his room by the resident who was sweating and could not get comfortable. She recalled that his oxygen level had dropped along with his blood pressure. She said she called the on-call provider and received an order to give the resident a breathing treatment and his oxygen level came up but he continued to sweat. She called the on-call provider back and received an order to send the resident to the hospital because she thought he was either having a heart attack or had an embolism. She could not remember what time she sent him to the emergency room. Emergency Medical Service records revealed Resident #389 was transported to the hospital at 4:01 AM on 02/05/19. Review of the hospital records show that Resident #389 arrived at the emergency room at 4:40 AM on 02/05/19. Review of the hospital progress notes on 02/05/19 documented a preliminary diagnosis of sepsis secondary to UTI (Urinary Tract Infection). Further documentation dated 02/06/19 concluded that Resident #389 had blood cultures positive for Escherichia coli or Gram-negative bacteremia, a life-threatening condition. An interview was conducted on 02/08/19 at 1:05 PM with the Attending Physician for Resident #389. She is also the Medical Director at the	F 684	interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 2/10/19	

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facility. She said that she was familiar with Resident #389 because she had completed his assessment when he was admitted to the facility. She was not aware that he had a change in his condition on 02/04/19 until the Nurse Practitioner informed her that he had been transferred to the hospital the next day. She reported that laying down, sweating, and being disoriented was not consistent with what she saw daily with Resident #389. She stated that he was normally up and sitting in his wheelchair. She commented that although he had some confusion he could chat with her when she visited. She stated that she would have considered it an acute significant change when he began sweating and became disoriented on 02/04/19 at the beginning of second shift and had she been in the building she would have assessed him immediately. She expected that the resident would have been assessed when the change in his condition occurred at the beginning of second shift because he had had a UTI that had been untreated and his symptoms were indicative of sepsis. She stated that the type of sepsis Resident #389 had could cause a resident's condition to change very quickly and turn on a dime. She further commented that waiting 12 hours to treat Gram-Negative sepsis could result in death because it enters the blood and acts in a couple of hours. She stated that it certainly could have affected the outcome for Resident #389 had a physician been notified on second shift on 02/04/19 and his acute condition treated sooner.

An interview was conducted with the Director of Nursing on 2/9/19 at 2:45 PM. He stated if a resident had a change in condition he would expect the staff to do an assessment, notify the provider if indicated, document the incident in

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either the progress notes or on an S Bar report (an electronic change in condition report) when the incident occurred and then transcribe any new orders. He would also expect a nurse aide to fill out a stop and watch form or put a new alert message in PCC (Point Click Care, electronic medication record) if he or she noticed a change of condition in a resident.

The facility Administrator and the Director of Nursing were notified of immediate jeopardy on 02/08/19 at 3:00 PM.

On 02/09/19 at 1:51 PM the facility provided the following credible allegation of immediate jeopardy removal:

F684

The Plan of Correcting the specific deficiency.

On 2/1/2019 resident #389 had blood noted in urine. Orders were received for a UA C&S. The sample was collected and sent to the hospital laboratory.

On 2/2/2019 facility attempted to receive UA culture from the hospital laboratory. The culture was pending. On call provider ordered resident #389 to go to the Emergency Department.

On 2/2/2019 resident #389 returned from the hospital with a new order for Keflex 500 mg QID for UTI. Resident #389 received 8 doses of Keflex.

On 2/4/2019 received hospital cultures. New orders to d/c Keflex, start ampicillin 250 mg q 6 hours x 7 days for a UTI. The provider pharmacy

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nor local pharmacies had ampicillin available in the dosage ordered. New orders were received to hold the ampicillin until medication was available to send.

On 2/4/2019, resident #389 had a physician appointment and returned to the facility at approximately 3:55pm. NA stated resident #389 had an episode of loose stool. Per her statement he was diaphoretic and confused. She provided ADL care including changing his bed sheets. Nurse #8 was aware of loose stools and diaphoretic episode.

His vital signs were obtained on 2/4/2019 at 5:59pm and included the following: Respirations 18. O2 sat 97% room air. Pulse 68. Temperature 98.4 F. BP 102/64.

Nurse administered tube feedings at 6:30pm. Resident was diaphoretic at this time and per NA was progressively worsening. ADL care was provided and bed sheets changed. Again, nurse #8 was aware.

Per NA she checked him at 10pm and he continued to be diaphoretic and "out of it". NA reported to Nurse #8.

His vital signs were obtained on 2/5/19 at 2:05am and included the following: Respirations 16. O2 sat 97% room air. Pulse 70. Temperature 98.6 F. BP 106/66.

The third shift NA confirmed he was diaphoretic and she had to change the bed twice. He was not feeling well and continued to be diaphoretic. The third shift nurse knew he was uncomfortable and was diaphoretic and was checking often.

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On 2/5/19 at approximately 3:00am, resident #389 had a drop in o2 sat to 84%. RR 36. BP 90/52. No urinary output this shift and X2 episodes of runny diarrhea like stools. Applied 02 at 2L. Resident's o2 stat increased to 94-95%. Received order to administer Duo Nebs which was effective. O2 sat now 97%. Resident still sweating profusely, uncomfortable and calling out for staff. Still states "I don't feel right". Received order to send resident to the hospital. Resident left the facility at 04:01 with the EMS staff. Resident #389 is currently at the hospital.

Root Cause Analysis
The facility identified an opportunity in communicating a change in condition, completing an assessment when a change in condition and notify MD timely to obtain orders if appropriate. Upon return from physician appointment, nurse #8 was aware of diarrhea and diaphoretic episode as well as confusion. During the same shift, nurse #8 was informed and witnessed continued diaphoresis. Nurse #8 failed to notify MD of a change in condition, failed to assess the resident which ultimately lead to his re-hospitalization on 2/5/19.

The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited.

The resident is not currently in the facility.

On 2/8/2019, a head to toe assessment will be completed on all residents by licensed staff to identify any sign of change of condition. Any issues identified the attending physician and resident representative will be notified.

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F 684	Continued From page 37 On 2/8/2019, licensed nurses interviewed all interviewable residents if there were any concerns with the care and treatment they are provided by staff. No concerns were reported. On 2/8/2019, the Administrator, Regional Director of Clinical Services and DON started in-house education on the following: *Licensed Nursing staff will be educated on physician order policy. *Licensed Nursing staff will be educated on change in resident condition policy. *Licensed Nursing staff will be educated on documentation. *CNAs will be educated on Stop and Watch Interact process which includes changes of condition including the following: seems different , talks less, overall needs more help, pain, ate less, no bowel movement or diarrhea, drank less, weight change, agitation, tired, week, change in skin color and help with walking, transferring, toileting more than usual. *CNAs will be educated on Point of Care Alert documentation. *On 2/9/2019, the DON and/or designees will educate all licensed nurses on causes, symptoms, complications, diagnosis and treatment of septicemia. Education will continue via telephone for staff not available 2/8/19 and 2/9/19 in person. These staff members will not be permitted to work until education is received. If unable to reach via	F 684		

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telephone, a certified letter with the education provided will be mailed on 2/9/19 with instructions to call the DON to set a time for education.

New licensed nurse and NA hires will receive the above education upon hire.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.

The DON and/or designee will review all nursing progress notes to determine that any possible changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x per week for 30 days and weekly x 8 weeks.

The DON and/or licensed nurse designee will review census and nursing progress notes to identify residents returning to the hospital to determine that the changes of condition interventions were timely, appropriate and includes MD notification. This audit will be completed 5 x week x 30 days and weekly x 8 weeks.

Three residents will be interviewed weekly regarding the care and services provided by the Director of Nursing or licensed nurse designee for 8 weeks.

The Director of Nursing and/or designee will question 3 nursing staff concerning the education provided, including asking what response is appropriate when a resident has a change in condition. This will be documented 3 x week for 30 days and weekly x 8 weeks.

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F 684	Continued From page 39 The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 2/8/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. Date of Alleged Compliance is: 2/9/19 The credible allegation of Immediate Jeopardy removal was validated on 02/09/19 at 3:07 PM. A sample of staff that included nurses and nurse aides were interviewed regarding in-servicing related to the deficient practice. All interviewed staff members stated they had been in-serviced regarding the physician order policy, change in resident condition policy, documentation, Stop and Watch Interact process, and Point of Care Alert documentation. A review of all documents developed to correct the deficient practice was completed. A review of audit forms that were developed to ensure that in-services presented to staff were understood and allowed an opportunity for staff to interact with dialogue was completed.	F 684		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		3/1/19

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F 759	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 6 residents (Resident #12) observed during medication administration. Findings included: During a medication administration observation on 02/06/19 at 9:15 AM Nurse #10 was observed passing medications to Resident #12. Nurse #10 removed baclofen 20 mg (milligrams), buspirone 10 mg, venlafaxine 75 mg, and a vitamin from the medication cart in preparation for administration to Resident #12. Nurse #10 provided the four medications to Resident #12 without incident. During a medication reconciliation on 02/6/19 at 9:35 AM Resident #12's February 2019 Medication Administration Record (MAR) revealed an order for lactulose 10 grams in 15 ml (milliliters) give 30 ml scheduled to be administered at 9:30 AM for constipation. The medication had a checkmark signifying the medication had been administered. There was also an order for metoprolol 12.5 mg scheduled to be administered at 9:30 AM for hypertension. The medication had a checkmark signifying the medication had been administered and Resident #12's blood pressure reading was 146/84. In an interview on 02/06/19 at 9:40 AM Nurse #10 verified she did not provide lactulose to Resident #12. She indicated that she signed it off because although it was ordered for 9:30 AM, it was always given at night. She indicated she should	F 759	F 759 1. Resident #12 received his metoprolol as soon as the issue was identified. Resident #12□s lactulose was discontinued on 2/27/18 by the physician due to repeated refusals. 2. To identify other residents that have the potential to be affected, the medication administration record will be compared to the contents of the medication cart to ensure all ordered medications are in the cart. 3. To prevent this from recurring, The Director of Nursing or licensed designee will reeducate licensed nurses concerning appropriate medication administration. They will also be educated concerning the processes to obtain medication that is not in the cart at the time that medication is due. 4. To monitor and maintain ongoing compliance, the Director of Nursing or licensed designee will observe medication administration by nurses for compliance with policy. This will be documented for 3 nurses per week for 12 weeks. The Director of Nursing or licensed designee will review the documentation by the nurses of any medications to ensure that appropriate follow up occurred and to identify any trends in this issue. MAR to cart audit will be completed for each cart weekly for 4 weeks and then	

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F 759	Continued From page 41 have notified the physician and requested an order to have the scheduled time changed but had not. Nurse #10 verified she had not provided metoprolol to Resident #12 after checking in the medication cart and realizing there was no metoprolol in the medication cart for Resident #12. Nurse #10 stated she thought she gave the metoprolol to Resident #12 but was nervous because she was being observed. She stated that all medications should be given as ordered. In an interview on 02/08/19 at 2:54 PM the Director of Nursing (DON) stated he expected the medication error rate in the facility to be zero. He indicated that realistically, since we are human and do make mistakes, that the medication error rate should be less than 5%.	F 759	monthly for 2 months. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. 5. Date of alleged compliance 3/1/2019	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		3/1/19

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F 812	Continued From page 42 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to monitor dish machine temperature gauges which resulted in kitchenware not being sanitized when final rinse temperatures did not meet manufacturer specifications. The facility also failed to remove dust and dirt from 3 of 4 clean ceiling fans in the kitchen, and failed to monitor storage areas which resulted in thawing meats not having a "pull date" on them and opened food items being stored without labels and dates. Findings included: 1. A 01/02/19 dish machine service representative audit report documented the facility's dish machine was functioning correctly with the only adjustment necessary being titration of the release of the detergent into the dish machine. Review of the dish machine temperature log on 02/06/19 at 9:20 AM revealed the final rinse temperature for kitchenware being washed after the breakfast meal had not been recorded yet for 02/06/19, but was documented as being 165 degrees Fahrenheit on 02/05/19. During observation of the dish machine on 02/06/19 from 9:24 AM until 9:38 AM seven racks of kitchenware were run through the dish machine, and the final rinse temperatures ranged from 152 to 156 degrees Fahrenheit. Three dietary employees were involved in carrying out the dish machine process, but none of those employees were monitoring the dish machine temperature gauges.	F 812	F 812 1. The opened bags of spaghetti and elbow macaroni pasta in the dry storage room were discarded on 2/4/19. The unlabeled and dated open bags of raisin bran and toasted oats cereals, plastic storage container of grits were discarded. The shredded cheese and sliced ham that were in the walk-in refrigerator with no dates or labels were discarded. The hamburger that was thawing in the walk-in refrigerator without a pull date was corrected with a date and used same day. In the walk-in freezer opened bags of onion rings were discarded and green peas/carrot medley that were without labels were used on 2/4/19 same day as being opened. The kitchen ceiling fans were cleaned on 2/6/2019. The dish machine was identified as not working properly on 2/7/19. Paper products were used until 2/14/19. 2. To ensure that there were no other food at risk, the kitchen storage areas including dry storage, walk in refrigerator and walk in freezer were audited on 2/5/19 through 2/8/19 by the Regional Registered Dietitian and Dietary Manager to ensure there were no additional unlabeled items. No concerns were	

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F 812	Continued From page 43 On 02/06/19 at 9:42 AM strips were attached to several racks going through the dish machine. The temperature-sensing bar on these strips did not turn the bright orange color specified by the manufacturer of the strips which would have indicated that the temperature of the final rinse water met the minimum requirement for adequate sanitization of the kitchenware. On 02/06/19 at 9:48 AM the Dietary Manager (DM) stated that when water pitchers were run through the dish machine earlier around 6:30 AM on 02/06/19 the final rinse gauge registered over 180 degrees Fahrenheit. During a follow-up interview with the DM on 02/07/19 at 9:58 AM she stated that the dietary employee retrieving sanitized kitchenware from the dish machine was supposed to be watching the temperature gauges periodically. She reported the service representative from the dish machine company had educated the dietary employees that the machine's final rinse temperatures needed to be at least 180 degrees Fahrenheit. She commented that dietary employees were in-serviced to notify her if the final rinse gauge was registering below the 180 degrees so she could involve the Maintenance Manager and service representative if needed. According to the DM, final rinse temperatures below 180 degrees Fahrenheit were not effective in sanitizing the kitchenware, and germs and bacteria could be spread which had the potential for making residents sick. The DM stated she could not find the dish machine temperature log for January 2019, but a review of the logs for November and December 2018 revealed the final rinse temperatures were documented as being between 180 - 190 degrees Fahrenheit.	F 812	noted. Ceiling fans throughout the facility were audited by the Maintenance Director on 2/20/19 for cleanliness. Those that needed to be cleaned were completed on 2/20/19 and 2/21/19. The dish machine was identified as not working properly on 2/7/19. Paper products were used until 2/14/19. 3. To prevent this from recurring, dietary staff were educated on proper storage, labeling, and dating opened items by the dietary manager. The facility□s Certified Dietary Manager provided education on the dish machine with the dietary department. Maintenance Director was educated on a new cleaning schedule for the kitchen ceiling fans on 2/20/2019 by the Administrator. 4. To maintain ongoing compliance, audits on proper storage, labeling, and dating opened items will be conducted by the dietary manager or designee three days a week for twelve weeks with results brought to the facility QAPI meetings. Audits will be conducted on fan cleanliness three days a week for twelve weeks by the maintenance director or designee with results brought to the facility QAPI meetings. A dish machine audit will be conducted 5 days a week for twelve weeks by the dietary manager or designee with results	

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F 812	Continued From page 44 During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated she checked the dish machine gauges about every five minutes, and when the final rinse gauge registered below 180 degrees Fahrenheit she was supposed to let her DM know. On 02/08/19 at 10:28 AM the DM stated even though service representatives had replaced wires, valves, and thermostats, and were currently working on the dish machine diaphragm, the dish machine was still not able to sustain final rinse temperatures of 180 degrees Fahrenheit. During an interview with the Director of Nursing on 02/09/19 at 9:12 AM he stated the nursing home had no residents who were diagnosed with foodborne illness. He reported it was his expectation that the residents in the nursing home be protected against foodborne illness by a dish machine which was able to sustain final rinse temperatures which the manufacturer documented as being effective in sanitizing kitchenware. 2. During an initial tour of the kitchen on 02/04/19, beginning at 11:18 AM, strands of dust were hanging from the blades and accumulations of dust and dirt could be seen on the blades of 2 of 4 ceiling fans in the kitchen. The fan above the steam table was not running, but the fan near a food preparation counter was running although no food preparation tasks were being completed at the time. During a follow-up tour of the kitchen on 02/06/19, beginning at 9:20 AM, there were still strands and clumps of dust on the blades of the	F 812	brought to the facility QAPI meetings. Audits will be reviewed weekly in the facility□s Risk Meeting and in the QAPI meeting for a period of 3 months. The facility□s decision to extend the audits will be based on the results of the audits. 5. Date of alleged compliance is 3/1/2019	

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ceiling fan above the steam table which was not running. Sandwiches were being assembled on a preparation counter, and the ceiling fan near them was running. There were also strands and clumps of dust on the blades of this ceiling fan. Upon closer inspection there were clumps of dust and dirt on a third ceiling fan which was running near a storage rack housing sanitized pitchers.

During an interview with the Maintenance Manager (MM) on 02/06/19 at 10:08 AM he stated maintenance and dietary worked together to make sure vents and ceiling fans in the kitchen remained clean. He reported he thought the ceiling fan above the steam table got overlooked because it was non-operational at present, and needed to be replaced. However, he commented he was unable to explain why the other two ceiling fans had not been cleaned.

During an interview with the Dietary Manager (DM) on 02/06/19 at 10:13 AM she stated the ceiling fans were on the monthly cleaning schedule, and starting in December 2018 she now had a dietary employee who was available to clean the fans as opposed to holding maintenance responsible for carrying out the task.

During a follow-up interview with the DM on 02/07/19 at 9:58 AM she stated the dust and dirt from the ceiling fans in the kitchen could fall into the food being prepared for the residents and cause cross-contamination, and had the potential for making residents sick.

During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated the ceiling fans in the kitchen should be kept free from dust and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 02/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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dirt, and not doing so, increased the chance that the food being served to the residents could make them sick.

3. During an initial tour of the kitchen on 02/04/19, beginning at 11:18 AM, there were no labels and dates on opened bags of raisin bran and toasted oat cereals, a plastic storage container of grits, and opened bags of spaghetti and elbow macaroni pasta in the dry storage room. In the walk-in refrigerator there were opened bags containing shredded cheese and sliced ham which were without labels and dates. Also in the walk-in refrigerator there were three rolls/tubes of thawing hamburger which were without "pull dates" to indicate when the thawing process began. The hamburger meat was still pink, and there were no signs of spoilage. However, at this time the Dietary Manager (DM) stated "pull dates" were necessary to make sure the meat was still fresh and safe to use. In the walk-in freezer opened bags of onion rings and green peas/carrot medley were without labels and dates.

During an interview with the DM on 02/07/19 at 9:58 AM she stated all opened food items should be labeled and dated to ensure that residents were served the freshest food possible.

During an interview with Dietary Employee #1 on 02/07/19 at 10:06 AM she stated she was trained that any dietary employee who opened food items was supposed to place labels and dates on the packaging if the items were not all used up. She reported she was not sure if any one employee was in charge of monitoring the storage areas on a regular basis.