| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345269 | A. BUILDING _____ B. WING _____ | C 05/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF SALISBURY | 1505 BRINGLE FERRY ROAD SALISBURY, NC 28146 |

| (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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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 5/23/22 to 5/26/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# OFDE11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 5/23/22 through 5/26/22. Event ID# OFDE11. The following intakes were investigated: NC00179292, NC00189040, NC00188398, NC00184854, and NC00181263.<br><br>1 of the 13 complaint allegations was substantiated, resulting in a deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility | F 550 | | 6/23/22 |

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

Electronically Signed | 06/16/2022

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| F 550 | Continued From page 1<br>must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to promote dignity by not providing a privacy cover over a catheter draining bag for 1 of 1 resident reviewed for catheters (Resident #187).<br><br>The findings included:<br><br>Resident #187 was admitted to the facility on 5/17/2022 with a diagnosis of obstructive and reflux uropathy.<br><br>The Minimum Data Set assessment was still in progress.<br><br>Resident #187's care plan included a focus area | F 550 | THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATED ON THE STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW.<br><br>1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>The facility replaced the catheter drainage bag for resident #187 to provide privacy of | |

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| F 550 | Continued From page 2<br>of catheter use with interventions to administer peri care per protocol, document output and maintain drainage bag below the bladder level.<br><br>On 5/25/2022 at 8:10 AM, Resident #187 was observed from the hallway lying in her bed. A catheter drainage bag was observed uncovered containing yellow urine hanging on the right side of the bed. Several staff members and a visitor were observed as they walked past the room.<br><br>On 5/26/2022 at 8:45 AM, Resident #187 was observed from the hallway lying in her bed. They catheter drainage bag contained yellow urine and remained uncovered.<br><br>On 5/26/2022 at 3:05 PM, an interview was conducted with Nursing Assistant (NA) #1 who stated urinary drainage bags should be covered and the facility did have some in stock. She stated Resident #187 came from the hospital with the catheter and it had not been changed.<br><br>On 5/26/2022 at 3:36 PM, an interview with the Director of Nursing was conducted who stated catheter bags are supposed to be kept covered for privacy. She stated the resident probably came from the hospital with it uncovered and no one changed it yet. | F 550 | catheter drainage bag. Completed on 5/26/2022.<br><br>2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:<br>The Director of Nursing (DON) completed an audit of all current residents with catheters and ensured that all catheter drainage bags had privacy cover bags in place. The audit was completed on 5/26/2022.<br><br>3. MEASURES PUT IN PLACE/SYSTEMIC CHANGES TO PREVENT THIS FROM RECURRING:<br>The DON/designee has completed education with all licensed staff to ensure that all residents with catheter drainage bags have a privacy cover in place. That includes when changing catheter drainage bags and/or the complete system of the type of catheter. All new admissions that are admitted with any type of catheter as well as any new orders from the Medical Provider regarding catheters will be viewed by the DON/designee on the day of admission or day of the order, to ensure that a privacy cover is in place. Education was completed on 5/27/2022.<br><br>4. MONITORING TO ASSURE CONTINUED COMPLIANCE:<br>The DON/designee will complete audits of all residents in the facility with catheters to ensure privacy cover bags are in place 5 days per week for 4 weeks; then 2 times per week for 4 weeks, then weekly for 4 | |

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| F 550 | Continued From page 3 | F 550 | weeks. An adhoc QAPI meeting was held on May 27, 2022 to review the POC for tag F550. Results from the audit will be monitored in the monthly QAPI meetings for 3 months. The DON will report results of the monitoring to the Executive QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, pharmacy technician and staff interviews, the facility failed to acquire a resident's medications from the pharmacy resulting in staff borrowing medications from another resident for 1 of 1 resident reviewed for pain management (Resident #180).<br><br>The findings included:<br><br>A review of Resident #180's discharge summary revealed an order for Hydrocodone 10-325 milligrams to be administered one by mouth every 6 hours as needed for pain.<br><br>Resident #180 was re-admitted to the facility after a hospitalization on 5/22/2022. Diagnoses included chronic pain, fibromyalgia, right humerus fracture and right femur fracture. | F 658 | 1. CORRECTIVE ACTION FOR AFFECTED RESIDENT:<br>The Director of Nursing (DON) called the pharmacy to ensure that resident's pain medication was being delivered to the facility. The pain medication that was ordered for resident #180 was available in the facility's Omnicel and was given to the resident as ordered.<br><br>2. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected.<br><br>3. MEASURES PUT IN PLACE/SYSTEMIC CHANGES TO | 6/23/22 |

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| F 658 | Continued From page 4<br><br>A physician's order for Hydrocodone 10-325 milligrams one by mouth every 6 hours was dated 5/25/2022.<br><br>On 5/25/2022 at 3:30 PM, an observation of the medication cart that held Resident #180's medications revealed no Hydrocodone 10-325 milligrams was on hand for Resident #180's pain.<br><br>On 5/26/2022 at 10:35 AM, an interview was conducted with Nurse #4. She stated she worked yesterday, 5/25/2022, and there wasn't Hydrocodone 10-325 milligrams in the cart for Resident #180. She stated she informed Nurse #2 who was the charge nurse and she witnessed her as she borrowed a Hydrocodone 10-325 milligrams from another resident. She stated she was unaware she was not supposed to borrow medications.<br><br>On 5/26/2022 at 10:52 AM, an interview was conducted with Nurse #3. She stated there wasn't any Hydrocodone 10-325 milligrams when she worked last, and she had to borrow the medication from another resident. She stated she knew she wasn't supposed to borrow medications, but the resident was in a lot of pain.<br><br>On 5/26/2022 at 11:00 AM, an interview was conducted with Nurse #2. She stated she was informed on 5/25/2022 by Nurse #4 that Resident #180 did not have any Hydrocodone 10-325 milligrams to administer. Nurse #2 stated she witnessed Nurse #4 borrow the medication from another resident. Nurse #2 stated she had a lot of problems with the pharmacy and getting medications and knew borrowing medications from other residents wasn't permitted but | F 658 | PREVENT DEFICIENT PRACTICE FROM OCCURRING AGAIN:<br>The DON/designee educated all licensed nurses and med aides on the proper procedure for medications that are not available in the facility. If an ordered medication for a resident is not available, the nurse will search the Omnicel to see if the medication is available in there. If the medication is not available in the Omnicell, the nurse will call the pharmacy to see if the medication is being sent or if it has already been sent. If the medication is not in route or will not be available by the scheduled dosing time/need, the nurse will call the medical provider to inquire about what medication can be given as a substitute for the ordered medication. Education was completed on 5/27/2022.<br><br>4. MONITORING AND MAINTAINING ONGOING COMPLIANCE:<br>The DON/designee will randomly perform audits of licensed nurses and medication aides to inquire if any resident is out of ordered medications and the procedure they followed to get the medication or a substitute medication for the resident. Audits will be performed 5 times per week for 4 weeks; then 2 times per week for 4 weeks, then weekly for 4 weeks. An adhoc QAPI meeting was held on 5/26/2022 to discuss the plans of correction.<br><br>The DON or her designee will report the results of audits and monitoring to the QAPI committee for review and | |

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| F 658 | Continued From page 5<br>Resident #180 was in a lot of pain and she had to help her. She stated she didn't know why Resident #180 did not have the Hydrocodone 10-325 milligrams on board and she did not call the pharmacy to find out.<br><br>On 5/26/2022 at 11:15 AM, an interview was conducted with the Director of Nursing. She stated when a resident returns from the hospital, the pharmacy sends their medication. She stated the pharmacy may have been waiting for a hard copy of the prescription for the Hydrocodone 10-325. She stated Hydrocodone 10-325 milligrams was available in the Omnicell and nurses should not be borrowing medications from other residents. | F 658 | recommendations for the time frame of the monitoring period or as it is amended by the committee. Results will be reported to the monthly QAPI meeting for 3 months. | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a | F 732 | | 6/23/22 |

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| F 732 | Continued From page 6<br>daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and review of the daily nursing staff postings, the facility failed to include the number of certified nurse assistants (CNAs) and actual hours worked during first shift (7:00 AM-3:00 PM) for 1 of 30 days, and failed to include the census on the daily nursing staff posting for 3 of 30 days.<br><br>Findings included:<br><br>1. The daily nursing staff postings were reviewed for April 25-May 24, 2022. The postings did not include the number of CNAs and actual hours worked for first shift on 4/26/22.<br><br>On 5/26/22 at 1:38 PM an interview was completed with Nurse #1. She expressed she filled out the daily staff posting for the 7:00 AM-3:00 PM shift and added the number of licensed staff who worked during the shift and the | F 732 | 1. CORRECTIVE ACTION FOR THE AFFECTED STAFF POSTING SHEETS:<br>The number of Certified Nursing Assistants (CNAs) and actual hours worked on 1st shift was added to the one incomplete daily staffing sheet. The census was completed for the 3 of 30 incomplete daily staffing sheets.<br><br>2. IDENTIFICATION OF OTHER STAFFING SHEETS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:<br>To identify other postings that have the potential to be affected, all staffing sheets have the potential to be affected.<br><br>3. MEASURES PUT INTO PLACE/SYSTEMIC CHANGES TO PREVENT DEFICIENT PRACTICE | |

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| F 732 | Continued From page 7<br>actual number of hours worked. The daily staff posting was reviewed for 4/26/22 with Nurse #1. She confirmed she completed the staff posting for the first shift and said it was an oversight that the number of CNAs and actual hours worked was not included on the posting.<br><br>In interviews with the Director of Nursing (DON) on 5/26/22 at 1:25 PM and 2:41 PM, she reported the charge nurse on each shift was responsible to complete the staffing information on the daily nursing staff posting. She explained the charge nurse was supposed to enter the census number, number of hours worked and number of licensed staff who worked each shift. The DON was unsure why the number of CNAs and actual hours worked was not included on the staff posting for 4/26/22.<br><br>2. The daily nursing staff postings were reviewed for April 25-May 24, 2022. The postings did not include the facility census on the following dates: 5/1/22 (third shift), 5/10/22 (second and third shifts), and 5/14/22 (third shift).<br><br>During an interview with Nurse #2 on 5/26/22 at 3:24 PM, she explained she completed the information on the daily nursing staff posting for the 3:00-11:00 PM shift. The information she entered on the posting included the census for the shift, the number of licensed staff and the number of actual hours worked by the licensed staff. Nurse #2 verified she worked on 5/10/22 and said it was an oversight that the census was not recorded on the daily posting.<br><br>The DON was interviewed on 5/26/22 at 2:41 PM. She stated there was a charge nurse for each shift who entered the census number on the daily | F 732 | FROM HAPPENING AGAIN:<br>All charge nurses from each shift in addition to the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and the Human Resource Director (HRD) (i.e. all individuals who would complete the staffing sheet,) have been inserviced regarding the State regulation and facility policy & procedure for properly completing the staffing sheet.<br>The HRD or Administrator will audit each staffing sheet daily for accuracy-comparing it to the census, number of staff and staffing hours for that specific day. On Mondays, the sheets for the previous Friday, Saturday and Sunday will be audited for accuracy.<br><br>4. MONITORING TO MAINTAIN ONGOING COMPLIANCE:<br>The Administrator or his designee will perform documented audits for 3 days per week for 4 weeks, then 2 days per week for 2 weeks, then 1 time per week for 2 weeks. An adhoc QAPI meeting was held on 5/26/2022 to discuss this plan of correction. The Administrator 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. Results from the audits will be brought to the monthly QAPI meetings for 3 months. | |

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| F 732 | Continued From page 8<br>staff posting for their respective shifts. She said the second and third shift charge nurses had been educated to enter the census on the posting at the beginning of their shift. The DON was unsure why the information had not been entered on the daily staff postings. | F 732 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in | F 755 | | 6/23/22 |

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| F 755 | Continued From page 9<br>order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, pharmacy technician and staff interviews the facility failed to maintain record of the disposition (the process or returning and/or destroying) of a controlled medication after a resident was discharged to the hospital for 1 of 1 resident reviewed for pain management (Resident #180).<br><br>The findings included:<br><br>Resident #180 was admitted to the facility on 5/3/2022 with diagnoses of chronic pain, fibromyalgia, right humerus fracture and right femur fracture and discharged to the hospital on 5/15/2022.<br><br>A physician's order dated 5/15/2022 revealed send to Emergency Room for chest pain, Covid positive and nausea/vomiting.<br><br>A review of Resident #180's physician's orders for May 2022 included Hydrocodone 10-325 milligrams give one by mouth every six hours as needed for pain dated 5/4/2022 and discontinued on 5/14/2022. On 5/14/2022, Hydrocodone 10-325 milligrams was changed to one tablet every six hours.<br><br>On 5/25/2022 at 3:30 PM, an observation of the medication cart that held Resident #180's medications revealed Resident #180 did not have Hydrocodone 10-325 milligrams on hand for pain.<br><br>On 5/26/2022 at 8:34 AM, an interview was conducted with Pharmacy Technician #1 who | F 755 | 1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>Resident #180's Hydrocodone/APAP 10/325 card of 30 tablets was sent from the pharmacy to the facility on May 26, 2022.<br><br>2. IDENTIFICATION OF OTHER RESIDENTS THAT HAVE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br>All residents with narcotic prescriptions sent to the facility have the potential to be affected.<br><br>3. MEASURES PUT IN PLACE/SYSTEMATIC CHANGES TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:<br>The Director of Nursing (DON)/designee completed an audit of all narcotic medications on all medication carts to ensure that the declining sheet totals equaled the narcotic card counts as well as the remaining quantity that is available. The audit findings were correct.<br>All licensed nurses and medication aides were inserviced on the new procedure put into place in regards to the narcotic declining count sheets, shift change controlled substance inventory count sheets, and that the DON/designee will be conducting daily random audits to ensure that all declining sheets and shift change controlled substance inventory count | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345269 | A. BUILDING _____ B. WING _____ | C 05/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF SALISBURY | 1505 BRINGLE FERRY ROAD SALISBURY, NC 28146 |

| (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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| F 755 | Continued From page 10<br>stated when a resident was sent to the hospital all medications should be sent back to the pharmacy. She stated the facility received a 30-day supply of Hydrocodone 10-325 milligrams on 5/13/2022 and the pharmacy did not receive the medication back when Resident #180 was discharged to the hospital on 5/15/2022. She stated Resident #180 still had 2 refills for Hydrocodone 10-325 milligrams that she could sent out.<br><br>On 5/26/2022 at 11:15 AM, an interview was conduced with Medication Aide #1. She stated when a resident is discharged to the hospital their medications are sent back to the pharmacy. She stated if a controlled substance must be returned, it is placed into a plastic bag with a tracking number and placed in a locked cabinet in the medication room until the pharmacy picks it up. There is also a receipt that goes into the bag after it is faxed to the pharmacy. One copy of the form stays in the facility and goes in the Director of Nursing's (DON) box. She stated the Controlled Substance Declining Inventory sheet also goes to the DON.<br><br>On 5/26/2022 at 11:30 AM, an interview with the DON revealed when a resident is sent to the hospital, all the medications, including controlled substances are to be returned to the pharmacy and she kept track of the return receipts and Controlled Substance Declining Inventory sheets. She could not locate the Controlled Substance Declining Inventory sheet or receipt of the disposition of Resident #180's Hydrocodone. | F 755 | sheets are accounted for. No narcotic cards or declining sheets will be removed from the medication carts without a 2nd nurse or medication aide being present when narcotic medications need to be returned to the pharmacy or destroyed.<br><br>4. MONITORING/MAINTAINING ONGOING COMPLIANCE:<br>Documented audits will be performed by the Assistant Director of Nursing (ADON)/designee daily 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks. An adhoc QAPI meeting was held on 5/26/2022 to discuss plans of correction. The Administrator/DON 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. Results from the documented audits will be brought to the monthly QAPI meetings for 3 months and reviewed. | |