STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(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 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness Plan which described the facility's comprehensive approach to meeting health, safety, and security needs for their staff and resident population during an emergency or disaster situation. The findings included: Review of the Emergency Preparedness Plan	E 001	The statements in the plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and State regulations the facility has taken the actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been corrected by 3/27/19.	3/26/19

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

Electronically Signed | 03/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 001	Continued From page 1 (EPP) manual provided by the facility with policies and procedures was conducted. The manual contained written policies and procedures but did not contain a written comprehensive EPP that met the federal requirements. An interview was conducted with the Administrator on 02/28/19 at 5:16 PM. The Administrator stated that when he arrived to work at the facility 3 months ago the facility had no current EPP. He stated the plan that he discovered was an old version dated 2016 or 2017. The Administrator stated that he started updating the EPP by moving and organizing some things around but had not had time to revamp or redo the entire EPP. The Administrator stated he just had not had enough time to put an effective EPP plan in place.	E 001	The emergency preparedness plan (EPP) had numerous sections that were not compliant with current CMS guidelines. No residents suffered any negative outcomes from not having an updated EPP. All residents have the potential to be affected however none were effected directly by this. To prevent this from recurring on 3/29/19 the Regional Vice President of Operations provided and reviewed education to the Administrator regarding the requirement for an effective EPP. The emergency preparedness plan (EPP) will be updated to reflect all CMS guidelines. On 3/8, 3/12, and 3/14/19, education on the updated EPP was provided to all staff. This education will be provided on orientation to all newly hired staff and also on an annual basis. The updated EPP will be reviewed quarterly by QA Committee to ensure accuracy and all items are updated. The EPP will be monitored in QAPI meeting monthly and updated as appropriate. The Administrator is responsible for this compliance.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		3/26/19

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F 561	Continued From page 2 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to honor a resident's wish to leave her room while being on isolation precautions for 1 of 2 residents sampled on isolation precautions (Resident #236). The findings included: Resident #236 was admitted to the facility on 02/15/19 with diagnoses that included clostridium difficile colitis (C diff), hypertension, fracture of	F 561	Facility failed to allow a resident to leave room while on contact precautions for C-diff. R# 236 was reassessed for symptoms of C-diff and provided education to manage c-diff spread. Documentation of assessment was completed in the clinical chart to include psychosocial wellbeing. No negative outcomes identified. To identify other residents that have the potential to be affected, the DON/ADON	

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F 561	Continued From page 3 pubis, and others. Review of the comprehensive Minimum Data Set (MDS) dated 02/22/19 revealed that Resident #236 was cognitively intact and required extensive assistance of 1 staff member with toileting. The MDS further revealed that Resident #236 was occasionally (1 episode) incontinent of bowel. Review of a physician's order dated 02/15/19 read, contact precautions for C diff. Review of a care plan dated 02/18/19 read in part, Resident #236 had an infection. The goal of the care plan read, Resident #236 would remain free of complications related to the infection. The interventions included: administer antibiotics as prescribed and isolation as indicated. An observation and interview of Resident #236 were conducted on 02/25/19 at 4:09 PM. The door to Resident #236 room contained a sign that read, Contact Isolation and instructed the staff to apply personal protective equipment (PPE) before entering the room. Resident #236 was sitting in her recliner in her room and was well groomed. She stated that she admitted to the facility on 02/15/19 after she had a fall at her family's home. She stated that she had C diff and that since she had arrived at the facility she had not been allowed to leave her room. Resident #236 stated that the therapist was coming to her room and doing the therapy that they could do and that her family visited often but she would like to get out of her room. She added that one day her family pushed her out into the hallway and was going to push her around the facility when Nurse #4 gave her a look and when she asked if	F 561	completed assessments on those residents on contact precautions for C-diff. No negative outcomes identified. To prevent this from occurring, on 3/8, 3/12, and 3/14/19, education on Contact Isolation with Enteric Precautions will be provided to all staff. This education will be provided on orientation to all newly hired staff and also on an annual basis. To monitor and maintain ongoing compliance, the DON or designee will review all new admits with a diagnosis of C-Diff or any other residents with a new diagnosis of C-Diff to ensure that correct contact precautions are being followed for 12 weeks. Any negative findings will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations until 100% compliance. The DON is responsible for compliance.	

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F 561	Continued From page 4	F 561		

it was alright if she was out on the unit Nurse #4 shook his head no and stated she needed to return to her room.

An observation and interview were conducted with Resident #236 on 02/26/19 at 4:26 PM. The door to Resident #236's room contained a sign that read, Contact Isolation and instructed the staff to apply PPE before entering the room. Resident #236 was sitting in her recliner and was well groomed visiting with her family. Resident #236 again confirmed that she still had not been permitted to leave her room since admission and stated therapy had been in her room to complete her therapy earlier in the shift. She also added that she had completed her antibiotic treatment for C diff yesterday but had been informed by the staff that they would wait an additional 3 days before removing the isolation and allowing her to leave the room.

An interview was conducted with Nursing Assistant (NA) #1 on 02/27/19 at 10:42 AM. NA #1 stated that she had given Resident #236 a shower earlier in the day in her room. She confirmed that Resident #236 was continent and could not transfer herself to the commode, so she would alert the staff when she needed to use the bathroom. NA #1 stated that Resident #236 was on isolation and could not leave her room at all and therapy had to treat her in her room. NA #1 confirmed that until Resident #236's isolation was lifted she could not leave her room, but she could get up to her recliner in her room.

An interview was conducted with the Occupational Therapist (OT) on 02/27/18 at 2:00 PM. The OT stated that she had been working with Resident #236 since her admission to the

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F 561	Continued From page 5	F 561		

facility. She confirmed that she had been treating Resident #236 in her room and she had not been out of her room to the therapy gym since she admitted on 02/15/19.

An interview was conducted with Nurse #4 on 02/27/19 at 2:14 PM. Nurse #4 stated that Resident #236 was continent of her bowel and bladder and was able to tell the staff when she needed to defecate. He stated that to his knowledge residents that had C diff were not permitted to come out of their room and he had been enforcing that with Resident #236. He confirmed that he had asked Resident #236 to return to her room when her family pushed her out onto the unit. Nurse #4 stated he was doing what he had been instructed to do from the facility management team.

An interview was conducted with the Director of Nursing (DON) on 02/27/19 at 11:18 AM. The DON stated that she had been employed at the facility for about 5 weeks and was very involved with the infection control program at the facility. The DON stated that if a resident tested positive for C diff and was having loose watery stools then they would be placed on isolation precautions. The DON stated that if the resident was continent of bowel then the isolation would not necessarily be required since the resident could use the restroom and the stool was contained. The DON confirmed that Resident #236 was continent of bowel and bladder and should not have been confined to her room, she added that they would ask her to use her private bathroom in her room but that there was no reason why Resident #236 could not leave her room since was continent of bowel and could alert the staff to her toileting needs.

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set Assessment was completed and transmitted within 14 days of a resident being admitted into Hospice Care for 1 of 1 residents reviewed for Hospice (Resident #14). Resident #14 was admitted to the facility on 07/23/18 with diagnoses that included anxiety disorder, major depressive disorder, dementia with behaviors, peripheral vascular disease and osteoporosis (weakening of the bones). A review of Resident #14's most recent quarterly Minimum Data Set Assessment dated 12/13/18 revealed Resident #1 was significantly impaired cognitively for daily decision making and was coded as receiving Hospice care while a resident at the facility. A review of Resident #14's physician orders revealed an order written on 09/01/18 for	F 637	MDS failed to capture a change of status for resident that involved hospice service. Change of status assessment for Resident # 14 had been completed prior to the survey. No resident was negatively affected by this untimely assessment. To identify other resident who have the potential to be affected, on 2/28/19 the MDS coordinator reviewed all residents who are receiving hospice services, to ensure assessments had been completed timely. No other findings were noted. To prevent this from recurring on 2/28/19 the Regional Reimbursement Nurse provided and reviewed education to the clinical staff responsible for completing the MDS assessment on the requirement of completing a significant change assessment timely when a resident begins to receive hospice services. All new hired clinical staff that will be responsible for MDS assessment	3/26/19

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F 637	Continued From page 7 "Hospice - End of Life Care". A review of a Minimum Data Set Assessment dated 09/12/18 and coded as a Significant Change assessment revealed it was not completed and transmitted until 10/11/18. During an interview with MDS Nurse #1 on 02/28/19 at 3:42 PM, she reported she had completed the assessment late and it was submitted on 10/12/18. She reported at the time, she was the only assessment coordinator and had voluntarily taken on additional responsibilities which made it difficult to keep assessments completed timely. She reported Resident #14's significant change assessment should have been completed no later than 09/14/18. During an interview with the Director on Nursing on 02/28/19 she reported it was her expectation that Minimum Data Set assessments were completed timely and submitted within the regulated time frames.	F 637	completion will receive training on this requirement. To monitor and maintain ongoing compliance the MDS Coordinators will audit the MDS for each newly admitted residents to hospice services for the next 12 weeks starting 3/18/19 to ensure timely completion of significant change MDS. No clinician will audit their own work. Immediate corrections will be made with any negative findings. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The MDS Coordinator is responsible for compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately code Hospice services on the Minimum Data Set for 1 of 2 sampled residents who received Hospice services (Resident #40). Findings included:	F 641	Inaccurate coding in MDS identified. Resident # 40 had modification of MDS to reflect accurate hospice services. No residents suffered any negative outcome as a result of this miscoding. To identify other residents that have potential to be affected the MDS	3/26/19

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F 641	Continued From page 8 Resident #40 was re-admitted to the facility on 07/13/17 with diagnoses which included chronic kidney disease, difficulty swallowing, depression, anxiety, dementia and Alzheimer's disease. A review of a physician's order dated 10/01/18 revealed Hospice for end of life care. A review of a significant change Minimum Data Set (MDS) dated 10/13/18 revealed Resident #40 was severely impaired in cognition for daily decision making. The MDS further revealed section O was coded for Hospice. A review of a quarterly MDS dated 01/13/19 revealed Section O was not coded for Hospice. A review of a nurse's progress note dated 02/26/19 at 3:02 PM revealed a Hospice Nurse saw Resident #40 for a routine visit. During an interview on 02/28/19 at 3:42 PM, MDS Nurse #2 stated Resident #40 received Hospice services and verified the MDS dated 01/13/19 indicated he had a terminal prognosis. She stated she had neglected to check yes in Section O to indicate Hospice services. She further stated it was a straight up clicking mistake and she would do a modification to correct it. During an interview on 02/28/19 at 4:58 PM, the Administrator stated it was his expectation for MDS staff to code the resident's MDS as accurately as possible to depict an accurate picture.	F 641	Coordinators completed an audit on 2/28/19 to ensure all residents receiving hospice services were coded accurately. No other discrepancies were found. To prevent this from recurring on 2/28/19 the Regional Reimbursement Nurse provided and reviewed education to the MDS Coordinators responsible for completing the MDS assessment on the requirement of accurate coding. All new hired MDS Coordinators that will be responsible for MDS coding will receive training on this requirement. To monitor and maintain ongoing compliance the MDS Coordinators will audit 3 MDSs weekly for accuracy for the next 12 weeks starting 3/18/19 to ensure accurate coding. No clinician will audit their own work. Immediate corrections will be made with any negative findings. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations until 100% compliant. The MDS Coordinator is responsible for compliance. The completion date is 3/26/19.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		3/26/19

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F 655	Continued From page 9	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.

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F 655	Continued From page 10 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to initiate baseline care plans within 48 hours of admission to the facility for 3 of 3 sampled residents (Resident #236, Resident #78, and Resident #69). The findings included: 1. Resident #236 admitted to the facility on 02/15/19 with diagnoses that included clostridium difficile colitis (C diff), hypertension, fracture of pubis, and others. Review of Resident #236's medical record revealed that Nurse #5 completed the admission assessments on 02/15/19. Further review of Resident #236's medical record revealed her baseline care plan was not initiated until 02/18/19, which was greater than 48 hours after admission. The baseline care plans were initiated by Minimum Data Set (MDS) Nurse #1. Review of the comprehensive MDS dated 02/22/19 revealed that Resident #236 was cognitively intact and required extensive assistance with activities of daily living. An interview was conducted with MDS Nurse #1 on 02/27/19 at 4:08 PM. MDS Nurse #1 stated that the admission nurse was expected to complete the required assessments and the	F 655	Facility failed to ensure baseline care plans were created within 48 hours of admission. Identified resident #236, #78, #69 did have a baseline care plan in place at the time of the survey. The current care plan was reviewed by the MDS nurse and no changes were made. There was no negative outcome from this delay. To identify other resident who have the potential to be affected, on 02/28/19, the MDS coordinator and MDS assistant reviewed the last 30 days of admission to ensure all had a baseline care plan. To prevent this from recurring, on 3/8, 3/12, and 3/14/19 the DON educated the licensed nursing staff on the requirement to complete a baseline care plan for each newly admitted resident within 48hours of admission. This education will be provided upon orientation for all newly hired. To monitor and maintain ongoing compliance, the MDS coordinator or designee will review each new admission for completion of the baseline care plan for the next 12 weeks, starting 3/18. Any Negative findings will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The MDS Coordinator is responsible for	

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F 655	Continued From page 11	F 655		

baseline care plans that were generated off those assessments. She added that once the baseline care plans had been initiated the admission nurse was also expected to provide a copy of the care plan to the resident and/or family. MDS Nurse #1 stated that after the baseline care plans were done she would within the next 2 -3 days add any additional care plan that were needed. MDS Nurse #1 could not explain why Resident #236's baseline care plans were not initiated within 48 hours of her admission to the facility.

An interview was conducted with Nurse #5 on 02/27/19 at 5:22 PM. Nurse #5 stated that she had been employed for approximately one month at the facility. Nurse #5 confirmed that she had taken part of the admission process of Resident #236. She stated that she entered Resident #236 in the electronic system, downloaded her medication list, and completed the required assessments. Nurse #5 stated that she did nothing with care plans and stated that the facility had a care plan team that took care of that. Nurse #5 again confirmed that she had not initiated any baseline care plan for Resident #236.

An interview was conducted with the Director of Nursing (DON) on 02/28/19 at 1:01 PM. The DON stated she had been employed at the facility for approximately 5 weeks and had lots of new staff. The DON further stated that the admission nurse was expected to open the baseline care plans on admission and print them off and give a copy to the resident and/or family. The DON stated she felt like this was an education opportunity to educate the new staff on the process that they may not have been aware of. The DON stated she expected the baseline care plans to be initiated within 48 hours of admission and a copy

compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 12	F 655		

provided to the resident and/or family.

2. Resident #78 was admitted to the facility on 02/08/19 with diagnoses that included congested heart failure, dysphagia, nonrheumatic mitral valve insufficiency, hypertension, and others.

Review of Resident #78's medical record revealed that Nurse #2 admitted Resident #78 to the facility on 02/08/19.

Further review of Resident #78's medical record revealed that her baseline care plans were not initiated until 02/11/19 which was greater than 48 hours after her admission to the facility. The baseline care plan was initiated by MDS Nurse #1.

Review of the comprehensive Minimum Data Set (MDS) dated 02/15/19 revealed that Resident #78 was cognitively intact and required extensive assistance with activities of daily living.

An interview was conducted with MDS Nurse #1 on 02/27/19 at 4:08 PM. MDS Nurse #1 stated that the admission nurse was expected to complete the required assessments and the baseline care plans that were generated off those assessments. She added that once the baseline care plans had been initiated the admission nurse was also expected to provide a copy of the care plan to the resident and/or family. MDS Nurse #1 stated that after the baseline care plans were done she would within the next 2 -3 days add any additional care plan that were needed. MDS Nurse #1 could not explain why Resident #78's baseline care plans were not initiated within 48 hours of her admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 655	Continued From page 13	F 655		

An interview was conducted with Nurse #2 on 02/27/19 at 4:41 PM. Nurse #2 stated that she was a new employee at the facility and was still learning the expectations. Nurse #2 confirmed that she admitted Resident #78 to the facility on 02/08/19. She added that she entered Resident #78 in the electronic system and completed the required assessments. Nurse #2 confirmed that she had not initiated any care plan for Resident #78 and generally she did not have a part in the care planning process.

An interview was conducted with the Director of Nursing (DON) on 02/28/19 at 1:01 PM. The DON stated she had been employed at the facility for approximately 5 weeks and had lots of new staff. The DON further stated that the admission nurse was expected to open the baseline care plans on admission and print them off and give a copy to the resident and/or family. The DON stated she felt like this was an education opportunity to educate the new staff on the process that they may not have been aware of. The DON stated she expected the baseline care plans to be initiated within 48 hours of admission and a copy provided to the resident and/or family.

3. Resident #69 was admitted to the facility on 02/04/19 with diagnoses which included a history of urinary tract infections, chronic kidney disease, obstructive uropathy (obstruction of urine), and anxiety.

A review of the admission Minimum Data Set (MDS) dated 02/11/19 revealed Resident #69 was cognitively intact for daily decision making. The MDS also revealed Resident #69 required extensive assistance with bed mobility, transfers, toileting and hygiene but only required limited assistance with dressing and was independent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 655	Continued From page 14	F 655		

with eating.

A review of a care plan created on 02/20/19 revealed in part a problem statement for Resident #69 for alteration in elimination related to foley (indwelling urinary catheter) secondary to obstructive uropathy.

Further review of care plans revealed there were no baseline care plans that had been created within 48 hours of admission for Resident #69.

During an interview on 02/27/19 at 2:09 PM, Nurse #2 explained she had been employed at the facility for approximately 3 weeks and was still learning the facility's processes. Nurse #2 stated she did not initiate care plans and thought the facility had a care plan team that took care of them.

During an interview on 02/27/19 at 4:08 PM, MDS Nurse #1 stated the admission Nurse was expected to complete the required assessments and the baseline care plans were generated off those assessments. She added that once the baseline care plans had been initiated the admission Nurse was also expected to provide a copy of the care plan to the resident and/or family. MDS Nurse #1 explained after the baseline care plans were done she would within the next 2 -3 days add any additional care plans that were needed. MDS Nurse #1 could not explain why Resident #69's baseline care plans were not initiated within 48 hours of his admission to the facility.

During an interview on 02/28/19 at 1:01 PM, the Director of Nursing (DON) stated she had been employed at the facility for approximately 5 weeks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 15 and had lots of new staff. The DON explained the admission Nurse was expected to open the baseline care plans on admission and print them off and give a copy to the resident and/or family. The DON stated she felt like this was an education opportunity to educate the new staff on the process that they may not have been aware of. The DON further stated she expected the baseline care plans to be initiated within 48 hours of admission and a copy provided to the resident and/or family.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 16 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to implement a care plan intervention by not removing a straw from a resident's water cup for 1 of 1 of residents sampled on aspiration precautions (Resident #77). The facility also failed to implement a care plan with interventions for psychoactive medication use for 1 of 5 residents sampled for unnecessary medications (Resident #39). The findings included: 1. Resident #77 was admitted to the facility on 06/09/17 with diagnoses that include dysphagia and hemiplegia. Review of a physician order dated 04/20/18 read, No straws. Review of a care plan that was updated 11/15/18 read in part, Resident #77 may have increased	F 656	1.) Facility failed to follow resident care plan as stated on the resident□s comprehensive care plan to not use straws. Resident #77 was assessed for adverse reactions related to the use of a straw per the evaluation completed by SLP on 2/28/19. No negative outcomes identified. To identify other residents who have the potential to be affect, the DON/Rehab Director completed an audit on all residents with orders for no straws to ensure compliance with physician□s orders. No negative outcomes were identified. To prevent this from recurring, on 3/8, 3/12, 3/14/19, all nursing staff was educated on the importance of following physician□s orders reflected on the resident□s comprehensive care plan.	

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	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 nutrition/hydration risk related to altered ability to feed self. The goal of the care plan read, Resident #77 will be of free significant weight changes every month. The interventions included: adaptive equipment and No straw. Review of the quarterly minimum data set (MDS) dated 02/14/19 revealed that Resident #77 was cognitively intact and required only set up assistance with eating. The MDS further revealed that Resident #77 required a therapeutic diet. An observation and interview were conducted with Resident #77 on 02/25/19 at 12:50 PM. Resident #77 was sitting up in bed with her lunch in front of her. There was a Styrofoam cup with clear liquids in it and the cup was noted to have a straw in it. Resident #77 was observed to sip from the straw throughout the interview. She stated that she sipped through the straw throughout the day on her favorite flavored sparking water. Resident #77 denied any issues with her cup or straw. An observation of Resident #77 was made on 02/26/19 at 9:20 AM. Resident #77 was resting in bed with her eyes closed. She was noted to have a Styrofoam cup with clear liquids in it and the cup was noted to have a straw in it. An observation of Resident #77 was made on 02/26/19 at 1:22 PM. Resident #77's family was at bedside. Resident #77 had eaten her lunch that her family had brought to her and she was observed to have a Styrofoam cup with clear liquids in it the cup was noted to have a straw in it. Resident #77 was observed to sip through the straw during the observation.	F 656	This education will be provided upon orientation for all newly hired employees and annually. Also, Care Plans will be updated with any new Physician□s orders during clinical morning meeting. To monitor and maintain ongoing compliance, the DON or designee will review all new physician□s orders and review the care plan for updates for the next 12 weeks, starting 3/18/2019. Any negative finding will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance. 2.) The facility failed to implement a care plan for a resident who was receiving antipsychotic medication. A care plan was developed for Resident # 39 by the MDS Coordinator. The resident did not have any negative outcomes. To identify other residents who have the potential to be affected, on 2/28, the MDS Coordinator completed a review of all residents who have antipsychotics to ensure that all residents have an active care plan in place. No other negative findings were observed. To prevent this from recurring, on 2/28/2019 the Regional Director of Reimbursement provided education to the staff who are responsible for care plan development on the requirement for developing care plans to reflect accurate and timely changes for resident care and services. All newly hired clinical staff that will be responsible for MDS coding will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 An observation and interview were conducted with Resident #77 on 02/27/19 at 10:11 AM. Resident #77 was resting in bed. She stated that the staff routinely poured her sparkling water into the Styrofoam cup with the straw and she would drink that throughout the day. Resident #77 stated she had no issues when drinking from the straw. An interview was conducted with Nurse #4 on 02/22/19 at 2:21 PM. Nurse #4 stated that Resident #77 could have carbonated beverages via a regular cup and he was not sure about the use of the straw he would have to clarify with the ST if a straw was appropriate or not. An interview was conducted with the Speech Therapist (ST) on 02/27/19 at 2:04 PM. The ST stated that Resident #77 had a swallowing study done in November 2018 and it recommended thin liquids with a provale (special cup that limits the amount of fluid taken with each swallow) except for carbonated beverages could be consumed in a regular cup but she should not have a straw per the physician order. The ST stated that the use of the straw would increase Resident #77's risk of aspiration due to the larger quantity of liquids with each suck from the straw. An interview was conducted with the Director of Nursing (DON) on 02/28/19 at 1:07 PM. The DON stated that she expected the staff to follow the care plan and they should have removed the straw from Resident #77's drinking cup. She added that if Resident #77 wanted the straw they needed to provide her education and document that in her medical record. An interview was conducted with the Medical	F 656	receive training on this requirement. To monitor and maintain ongoing compliance, the MDS interdisciplinary staff will audit 5 residents per week that receive antipsychotics, to ensure each resident has a current care plan that addressed the use of the antipsychotic medication. The monitoring will start 3/18/2019 and continue for 12 weeks. No clinician will audit their own work. Immediate corrections will be made with any negative finding. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The MDS Coordinator is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19	F 656		

Doctor (MD) on 02/28/19 at 4:10 PM. The MD stated he expected the staff to follow the physician order and swallow study recommendations for the use of no straw.

2. Resident #39 was re-admitted to the facility on 08/25/16 with diagnoses which included type 2 diabetes, difficulty swallowing, high blood pressure, anemia, peripheral vascular disease (poor circulation in legs), atherosclerosis (fatty deposits on the walls of arteries), anxiety disorder and dementia.

A review of a physician's order dated 06/22/18 indicated Zoloft Tablet 100 milligrams (mg) by mouth in the morning for a skin excoriation disorder (scratching disorder).

A review of the annual Minimum Data Set (MDS) dated 07/13/18 revealed Resident #39 was severely impaired in cognition for daily decision making. The MDS also revealed Resident #39 required extensive assistance with bed mobility and transfers but required total assistance with eating, toileting and hygiene. A review of a section labeled Care Area Assessments indicated psychotropic drug use triggered.

A review of monthly physician's orders dated 02/01/19 through 02/28/19 indicated in part Zoloft Tablet 100 milligrams (mg) by mouth in the morning for a skin excoriation (scratching disorder).

A review of care plans revealed there were no care plans or interventions for psychoactive medication use.

During an interview on 02/27/19 at 2:09 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 Nurse #2 stated she had only worked at the facility for the last 3 weeks. She further stated she did not initiate care plans but thought the facility had a care plan team that took care of them. During an interview on 02/28/19 at 1:01 PM, the Director of Nursing stated she had been employed at the facility for approximately 5 weeks and had lots of new staff. She stated she expected for care plans to be initiated and this was an educational opportunity for staff to learn expectations. During an interview on 02/28/19 at 3:52 PM, MDS Nurse #2 explained the whole interdisciplinary team added to care plans. She further explained it was the usual practice to have a care plan for psychoactive medications for those residents who received psychoactive medications so staff would monitor for any symptoms and side effects. She confirmed after review of Resident #39's care plans she did not have a care plan with interventions for psychoactive medications. She stated there was no excuse and a care plan should have been done for Resident #39 for psychoactive medications.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 658	Facility failed to follow physician□s order	3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 21 and staff interview the facility failed to follow a physician order for a resident to have no straw for 1 of 1 of residents sampled on aspiration precautions (Resident #77). The findings included: Resident #77 was admitted to the facility on 06/09/17 with diagnoses that include dysphagia and hemiplegia. Review of a physician order dated 04/20/18 read, No straws. Review of the quarterly minimum data set (MDS) dated 02/14/19 revealed that Resident #77 was cognitively imtact and required only set up assistance with eating. The MDS further revealed that Resident #77 required a therapeutic diet. An observation and interview were conducted with Resident #77 on 02/25/19 at 12:50 PM. Resident #77 was sitting up in bed with her lunch in front of her. There was a Styrofoam cup with clear liquids in it and the cup was noted to have a straw in it. Resident #77 was observed to sip from the straw throughout the interview. She stated that she sipped through the straw throughout the day on her favorite flavored sparking water. Resident #77 denied any issues with her cup or straw. An observation of Resident #77 was made on 02/26/19 at 9:20 AM. Resident #77 was resting in bed with her eyes closed. She was noted to have a Styrofoam cup with clear liquids in it and the cup was noted to have a straw in it. An observation of Resident #77 was made on	F 658	as stated on the resident□s comprehensive care plan to not use straws. Resident #77 was assessed for adverse reactions related to the use of a straw per the evaluation completed by SLP on 2/28/19. No negative outcomes identified. To identify other residents who have the potential to be affect, the DON/Rehab Director completed an audit on all residents with orders for no straws to ensure compliance with physician□s orders. No negative outcomes were identified. To prevent this from recurring, on 3/8, 3/12, 3/14/19, all nursing staff we educated on the importance of following physician□s orders reflected on the resident□s comprehensive care plan. This education will be provided upon orientation for all newly hired employees and annually. Also, Care Plans will be updated with any new Physician□s orders during clinical morning meeting. To monitor and maintain ongoing compliance, the DON or designee will review all new physician□s orders and review the care plan for updates for the next 12 weeks, starting 3/18/2019. Any negative finding will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 22	F 658		

02/26/19 at 1:22 PM. Resident #77's family was at bedside. Resident #77 had eaten her lunch that her family had brought to her and she was observed to have a Styrofoam cup with clear liquids in it and the cup was noted a have a straw in it. Resident #77 was observed to sip through the straw during the observation.

An observation and interview were conducted with Resident #77 on 02/27/19 at 10:11 AM. Resident #77 was resting in bed. She stated that the staff routinely poured her sparkling water into the Styrofoam cup with the straw and she would drink that throughout the day. Resident #77 stated she had no issues when drinking from the straw.

An interview was conducted with the Speech Therapist (ST) on 02/27/19 at 2:04 PM. The ST stated that Resident #77 had a swallowing study done in November 2018 and it recommended thin liquids with a provale (special cup that limits the amount of fluid taken with each swallow) except for carbonated beverages could be consumed in a regular cup but she should not have a straw per the physician order. The ST stated that the use of the straw would increase Resident #77's risk of aspiration due to the larger quantity of liquids with each suck from the straw.

An interview was conducted with Nurse #4 on 02/22/19 at 2:21 PM. Nurse #4 stated that Resident #77 could have carbonated beverages via a regular cup and he was not sure about the use of the straw he would have to clarify with the ST if a straw was appropriate or not.

An interview was conducted with the Director of Nursing (DON) on 02/28/19 at 1:07 PM. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23 stated that she expected the staff to follow the physicians order and should have removed the straw from Resident #77's drinking cup. She added that if Resident #77 wanted the straw they needed to provide her education and document that in her medical record. An interview was conducted with the Medical Doctor (MD) on 02/28/19 at 4:10 PM. The MD stated he expected the staff to follow the physician order and swallow study recommendations for the use of no straw.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to keep a dependent resident clean shaven for 1 of 5 residents sampled for activities of daily living (Resident #66). The findings included: Resident #66 was admitted to the facility on 02/09/16 with diagnoses that include dysphagia, hypertension, adult failure to thrive, chronic obstructive pulmonary disease, and dementia. Review of the annual Minimum data set (MDS) dated 02/09/19 revealed that Resident #66 required extensive assistance of 2 staff members with activities of daily living. Resident #66's	F 677	The facility failed to provide ADLs to dependent resident who was not shaved and had food on face. Resident was shaved and food removed from his face by nurse on hall. The resident did not have any negative outcomes. To identify residents who have the potential to affected, on 2/28, the DON checked all residents to ensure residents had food removed from their mouth and that all were shaved appropriately. No other negative finding were observed. To prevent this from reoccurring, on 3/8, 3/12, and 3/14/19, the DON provided education to staff who are responsible for ensuring residents receive proper ADLs	3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

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F 677	Continued From page 24 cognition was not assessed on the MDS. An observation of Resident #66 was made on 02/25/19 at 10:24 AM. Resident #66 was resting in bed on his side. He was alert but non-verbal. Resident #66 appeared unkept, his hair was disheveled and shiny, he had stubble facial hair, his white t-shirt was wrinkled and contained a brownish stain on the left shoulder area. An observation of Resident #66 was made on 02/25/19 at 3:58 PM. Resident #66 remained in bed but had been turned and repositioned. Resident #66 again appeared unkept, his hair was disheveled and shiny, he had stubble facial hair, his white t-shirt was wrinkled and contained a brownish stain on the left shoulder area. An observation of Resident #66 was made on 02/26/19 at 9:17 AM. Resident #66 was sitting up in the bed and was alert but remained non-verbal. Resident #66 appeared unkept, he remained in the same white t-shirt from 02/25/19 with a brownish stain on the left shoulder area, his hair remained disheveled and shiny, and his face had stubble hair. An observation of Resident #66 was made on 02/26/19 at 4:16 PM. Resident #66 remained in the bed and alert but non-verbal. His t-shirt had been changed and his hair combed but it remained shiny. His facial hair has not been removed and still had stubble noted. An observation of Resident #66 was made on 02/27/19 at 10:03 AM. Resident #66 remained in bed and alert but non-verbal. Resident #66 had a clean white t-shirt on, his hair remained shiny and his facial hair had not been removed and still had	F 677	regarding the importance of ensuring that all residents are properly shaved and food removed from their faces. All newly hired staff will be trained in orientation regarding the importance of ensuring that all residents are properly shaved and food removed from their faces. To monitor and maintain ongoing compliance, the Clinical Leadership team will audit 5 residents per week that need assistance with ADLs to ensure that each resident is properly shaved and food removed from face. This monitoring will start 3/18/19 and continue for 12 weeks. Immediate corrections will be made with any negative findings. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance.	

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F 677	Continued From page 25	F 677		

stubble noted.

An interview was conducted with Nursing Assistant (NA) #1 on 02/27/19 at 10:37 AM. NA #1 stated that she was caring for Resident #66 and she had to perform all of his activities of daily living that included shaving him. NA #1 stated that Resident #66's family came 2 days a week to eat lunch with him and on those days, she would get him up out of bed. NA #1 stated that she had not worked with Resident #66 on 02/25/19 or 02/26/19 but stated he clearly needed to be shaved and she would take care of that today.

An observation of Resident #66 was made on 02/27/19 at 1:59 PM. Resident #66 was resting in with his eyes closed. His hair was no longer shiny, he had been shaved, and his clothes were clean. He appeared to have been groomed.

An interview was conducted with NA #2 on 02/27/19 at 12:19 PM. NA #2 confirmed that she had cared for Resident #66 on 02/24/19 and 02/25/19 and had given him a bed bath but had not shaved him. NA #2 stated that she was not aware that he needed to be shaved that day because the residents were generally shaved when they went to the shower and he had only received a bed bath.

An interview was conducted with Nurse #4 on 02/28/19 at 12:07 PM. Nurse #4 stated that Resident #66 should be shaved on his shower day and anytime that the staff noticed he needed to shaved.

An interview was conducted with the Director of Nursing (DON) on 02/28/19 at 1:15 PM. The DON stated she expected the staff to shave Resident

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F 677	Continued From page 26 #66 on his shower days or anytime that his face had stubble.	F 677		
F 684 SS=D	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 record reviews and staff interviews the facility failed to assess a resident and obtain treatment orders for a resident with redness in her groin who had a history of yeast infections for 1 of 3 residents who were sampled for changes in condition (Resident #285). Findings included: Resident #285 was admitted to the facility on 01/10/18 with diagnoses which included generalized muscle weakness, abnormal gait and mobility, congestive heart failure, chronic peripheral venous insufficiency (poor blood flow in legs) with an ulcer (open area of skin), atrial fibrillation (rapid and irregular heart rate), history of a stroke, chronic kidney disease, iron deficiency anemia, high blood pressure and depression. A review of a care plan initiated on 01/11/18 revealed in part Resident #285 was at risk for	F 684	The facility failed to follow up on skin condition changes noted on bi-weekly skin assessments to obtain a physician order for treatment. Resident # 285 bi-weekly skin assessment noted a skin change and no follow up was completed until 2/15/19 when the physician□s order was obtained to treat identified area with Nystatin powder. To identify other residents who have the potential to be affected, on 2/28/19, the Wound Care Nurse completed audits of all recent bi-weekly akin assessments to ensure all areas have been addressed and order to treat are in place. No negative outcomes were identified. To prevent this from reoccurring, on 3/8, 3/12, and 3/14/19, the wound care nurse provided education to all nurses who complete bi-weekly skin checks on the requirement of reporting all skin condition	3/26/19

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F 684	Continued From page 27 skin breakdown related to decreased mobility, weakness, peripheral vascular disease and venous ulcers. The goals indicated areas would show signs and symptoms of improvement over the review period. The interventions indicated in part to assess for increased or decreased edema (swelling) when giving care, administer medications and treatments as ordered, monitor for skin breakdown and notify physician as needed with any changes. A review of a Bi-Weekly Skin Check dated 12/17/18 at 11:50 AM documented by Nurse #6 indicated Resident #285 had current skin issues in groin area but there was no assessment and no treatment was indicated. A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's groin area on 12/17/18. A review of a Bi-Weekly Skin Check dated 12/23/18 at 11:50 AM documented by Nurse #6 indicated Resident #285 had current skin issues in groin area but there was no assessment and no treatment was indicated. A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's groin area on 12/23/18. A review of a Bi-Weekly Skin Check dated 12/29/18 at 11:50 AM documented by Nurse #7 indicated Resident #285 had current skin issues but there was no assessment. A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's groin area on 12/29/18.	F 684	changes to the physician as needed. This education will be provided upon orientation for all newly hired staff. To monitor and maintain ongoing compliance, the wound care nurse or designee will review 5 resident's bi-weekly skin assessments weekly for any skin change conditions and follow-up with the physician for orders to treat for 12 weeks starting on 3/18/19. Any negative finding will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations until 100% compliant. The Wound Care Nurse or designee is responsible for compliance. Completion date is 3/26/2019.	

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F 684	Continued From page 28	F 684		

A review of the most recent comprehensive (annual) Minimum Data Set dated 01/06/19 revealed Resident #285 was cognitively intact for daily decision making. The MDS also indicated Resident #285 required extensive assistance with activities of daily living except she only required supervision with eating.

A review of a Bi-Weekly Skin Check dated 01/08/19 at 8:00 PM documented by Nurse #6 indicated Resident #285 had current skin issues in groin area but there was no assessment and no treatment was indicated.

A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's groin area on 01/08/19.

A review of a Bi-Weekly Skin Check dated 01/24/19 at 8:00 PM documented by Nurse #8 indicated Resident #285 had current skin issues with redness to buttocks and groin but there was no assessment of the areas and there was no treatment indicated.

A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's buttocks or groin on 01/24/19.

A review of a Bi-Weekly Skin Check dated 01/27/19 at 8:00 PM documented by Nurse #8 indicated Resident #285 had current skin issues with redness to buttocks and groin but there was no assessment of the area and there was no treatment indicated.

A review of Nurses Progress Notes revealed there was no skin asssessment of Resident

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F 684	Continued From page 29	F 684		

#285's buttocks or groin area on 01/27/19.

A review of a Bi-Weekly Skin Check dated 02/05/19 at 8:00 PM documented my Nurse #6 indicated Resident #285 had current skin issues but there was no assessment.

A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285 on 02/05/19.

A review of a Bi-Weekly Skin Check dated 02/08/19 at 8:00 PM documented by Nurse #8 indicated Resident #285 had current skin issues in part with redness to coccyx and buttocks but there was no assessment of the areas and there was no treatment indicated.

A review of Nurses Progress Notes revealed there was no skin asssessment of Resident #285's coccyx and buttocks documented on 02/08/19.

A review of a physician's order dated 02/10/19 indicated Nystatin Powder 100,000 units per gram and apply to groin and abdominal folds every day and evening shifts for yeast infection.

During a telephone interview on 02/28/19 at 12:16 PM, Nurse #6 stated she recalled Resident #285 had some yeast infections. She explained if a Nurse Aide (NA) told her a resident had redness in their groin area or other areas on their skin she was expected to assess it and call the physician if needed. She further stated she could not recall assessments of Resident #285's skin.

An attempt on 02/28/19 at 12:18 PM to contact Nurse #7 was unsuccessful.

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F 684	Continued From page 30	F 684		

An attempt on 02/28/19 at 12:24 PM to contact Nurse #8 was unsuccessful.

During a telephone interview on 02/28/19 at 12:29 PM, Nurse #9 stated she recalled Resident #285 but did not recall her having yeast infections or redness in her groin area. She further stated if a resident had redness in their groin or peri area the Nurse was expected to assess it and contact the physician for treatment orders.

During a telephone interview on 02/28/19 at 12:43 PM Nurse #10 stated she had only worked at the facility for less than 3 months. She further stated she recalled Resident #285 but did not recall she had redness in her groin or peri area. She explained she had looked at the Bi-Weekly skin checks but she felt they were vague and did not provide details of assessments or a description of the skin issues.

During an interview on 02/28/19 at 2:26 PM, the Wound Nurse (WN) with the Assistant Director of Nursing (ADON) present explained the Bi-Weekly skin checks were supposed to be used for assessment and documentation of any type of skin issue. She stated the skin checks should be specific and should describe what the skin issue looked like. She explained it was her expectation when a NA reported skin issues to a Nurse the Nurse should assess and follow up with the physician. She stated Nurses should have assessed and followed up with the Physician regarding the redness in Resident #285's groin area and on her coccyx and bottom. She confirmed no staff had reached out to her to evaluate Resident #285's skin. The ADON added they had used staff as needed (PRN) in the past

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F 684	Continued From page 31 but they had hired permanent staff and were looking for consistency of care. She further stated some of the Nurses who had documented on the Bi-Weekly Skin Checks no longer worked at the facility. During an interview on 02/28/19 at 3:06 PM, the Director of Nursing stated it was her expectation for Nurses to do a head to toe assessment and identify any new or present conditions. She stated she expected for them to document exactly where the problem was and follow up with the physician for orders. During an interview on 02/28/19 at 4:10 PM, the Physician who was also the facility Medical Director stated it was his expectation for Nurses to assess a resident if the resident had skin redness and to contact the provider for treatment orders.	F 684		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		3/26/19

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F 700	Continued From page 32 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess the need for side rails for one of two residents reviewed for accidents (Resident #74). Findings Included: Resident #74 was admitted to the facility on 04/06/15 with diagnoses that included congestive heart failure, lack of coordination, obstructive sleep apnea, insomnia, and history of falls. A review of Resident #74's annual comprehensive Minimum Data Set (MDS) Assessment dated 02/11/19 revealed Resident #74 was cognitively intact and required extensive assistance with bed mobility and transfer. An observation of Resident #74 on 02/26/19 revealed she had quarter length side rails to both sides of her bed. These side rails were continued to be observed on Resident #74's bed the remainder of the survey. A review of Resident #74's medical record revealed There were no assessments completed for the use of side rails or bed rails. During an interview with Nurse #3 on 02/28/19 at 8:33 AM, she revealed that hall nurses were responsible for completing side rail assessments	F 700	Facility failed to ensure assessments were completed on residents who had side rails in place. Resident #74 was assessed for use of the side rails by the ADON on 2/28/19. Documentation was completed in the clinical chart. The resident did not have any negative outcome. To identify other residents who have the potential to be affected, the ADON and Director of Rehab completed side rail assessments on all residents who are currently using side rails on 3/18/19. To prevent this from recurring, on 3/8, 3/12, and 3/14/19, the nurses and CNAs were educated on the side rail policy by the DON. This education will be provided upon orientation for all newly hired staff. Side rail assessments will be reviewed quarterly and with any significant change. To monitor and maintain ongoing compliance, the DON or designee will review completion of the side rail assessment for each new admission, any current residents with significant change in side rail use, or quarterly MDS assessments for 12 weeks, starting 3/18/19. Any negative findings will be corrected. The results of the audits will be forwarded	

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F 700	Continued From page 33 on residents when they were admitted to the facility. She stated assessments were to be completed before side rails were installed. Nurse #3 reported once the side rail assessments were completed they were to be printed off, signed by the resident or the resident's family and then scanned into the resident's record. During an interview with the Assistant Director of Nursing on 02/28/18 at 9:42 AM, she revealed that hall nurses were responsible for completing side rail assessments when a resident was admitted to the facility. She reported once the assessment was completed it was to be included in the resident's medical record and if the side rail assessment was not in the medical record then it was not completed. During an interview with the Director of Nursing on 02/28/19 at 4:34 PM she stated it was her expectation that side rail assessments be completed when a resident was admitted to the facility and the assessment should be a part of the resident's medical record. She reported all residents with side rails on their bed should have a side rail assessment completed. She also stated that side rail assessments should be completed upon a resident's admission or readmission and then yearly thereafter.	F 700	to the facility QAPI committee for further review and recommendations until 100% compliant. The DON is responsible for compliance. Completion date is 3/26/2019.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

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F 761	Continued From page 34 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from the medication carts, failed to date opened insulins and eye drops, and failed to properly label medications that were available to be used on 4 of 4 medication carts reviewed for medication storage and labeling. The findings included: A Policy titled "Storage and Expiration of Medications ...." dated 10/31/16 indicated in part ... "The facility should ensure that medications that have an expiration date on the label were returned to the pharmacy", "the facility should record the opened date on the medication when the medication has a shortened expiration date once opened", ... And "the facility should	F 761	Facility failed to store and label medications in the medication carts appropriately. Items that were found on the medication cart that were not stored or labeled appropriately were removed immediately by the assigned nurse. No residents had any negative outcomes. To identify other resident who have the potential to be affected, all medication carts were audited by the DON on 2/28/19 to ensure that there were no other negative findings. To prevent this from recurring, in-service will be conducted on 3/8, 3/12, and 3/14/19, by the DON to the licensed nursing staff as well as the Medication Aides on proper storage and labeling of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 35 destroy or reorder medications with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels." On 02/28/19 at 11:25 AM during a review of the 300/400 medication cart the following medications were found: one opened and undated Xalatan eye drops, two opened and undated vials of insulin, and one insulin flex pen with no label or opened date. An interview with Nurse #1 who was the Nurse on the cart and had been employed by the facility for 2 weeks stated she had not had a medication pass review from the facility staff or the pharmacy staff since she had been employed. The Nurse also stated it was the responsibility of each Nurse to maintain the medication carts according to the facilitiy's policies. On 02/28/19 at 12:17 PM a review of the 700/800 medication cart revealed: one insulin pen with an opened date of 01/18/19, and one Budesonide inhaler with no opened date on inhaler or pouch. An interview with Nurse #2 who had been employed for 3 weeks stated she had not had a medication pass review from the facility staff or the pharmacy staff but that it was the responsibility of the Nurse on the medication cart to monitor the expiration dates on the medications and to assure they were appropriately dated and labeled. On 02/28/19 at 2:04 PM during a review of 500/600 medication cart the observation revealed: one Lantus pen with an opened date of 01/20/19. During an interview with Nurse #3 who had been employed for 6 months stated she had not had a medication pass review from the facility staff or the pharmacy staff but that it was the	F 761	medications and location of the quick reference guide as well as the importance of daily auditing of there med carts. This education will be provided upon orientation for all newly hired staff. A recommended storage sheet from pharmacy was placed on each medication cart on 2/28/19 by the DON for staff quick reference. To monitor and maintain ongoing compliance the DON or designee will perform a complete audit of 2 medication carts and 2 med rooms weekly for 12 weeks, starting 3/18/19. Any negative discrepancies will be corrected immediately. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance. Completion date is 3/26/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 761	Continued From page 36	F 761		

responsibility of the Nurse on the medication cart to assure the medications were maintained according to the facility's policies.

On 02/28/19 at 3:07 PM a review of the 100/200 medication cart revealed: one opened bottle of Xalatan dated 01/05/19 and one opened and undated vial of Humalog eye drops. During an interview with Nurse #4 who had been employed for 6 years stated it was the responsibility of the Nurse on each medication cart to maintain the medication cart according to the facility's policies.

During an interview with the Director of Nursing (DON) on 02/28/19 at 3:14 PM she explained the nurses had one Pharmacy inservice that addressed the maintenance of the medications and medication carts but hardly anyone showed up for it and that would it be addressed. The DON stated there were Pharmacy reference notebooks that were kept at each nurses' station that addressed policies and procedures of how to maintain the medication carts and medications and she expected the nurses to follow it.

An interview was conducted with the Pharmacy Consultant (PC) on 02/28/19 at 3:40 PM. The PC stated she had been the consultant for 2 years which included monthly resident medical record reviews and medication cart reviews in which she had already completed the medication cart reviews on all of the mediation carts for the month of February 2019 and addressed her findings with the nurse assigned to the medication cart at the time.

On 02/28/19 at 5:52 PM the Administrator stated his expectation was for the Nurses to maintain the medication carts according to the facility's

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	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 761	Continued From page 37 policies.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 842	Continued From page 38 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document the location or a description of skin issues on Bi-Weekly Skin Checks for a resident who had a history of redness in her groin, coccyx and buttocks and had a history of yeast infections for 1 of 2 residents who were sampled for non-pressure related skin issues (Resident #285).	F 842	Facility failed to document accurate skin conditions on the bi-weekly skin checks. Resident #285 was assessed and a current skin check was completed and documented in the clinical record by the wound nurse. The resident did not have any negative outcome and proper treatments were in place at the time of the	

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	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 842	Continued From page 39 Findings included: Resident #285 was admitted to the facility on 01/10/18 with diagnoses which included generalized muscle weakness, abnormal gait and mobility, congestive heart failure, chronic peripheral venous insufficiency (poor blood flow in legs), atrial fibrillation (rapid and irregular heart rate), history of a stroke, chronic kidney disease, iron deficiency anemia, high blood pressure and depression. A review of a care plan initiated on 01/11/18 revealed in part Resident #285 was at risk for skin breakdown related to decreased mobility, weakness and peripheral vascular disease. The goals indicated areas would show signs and symptoms of improvement over the review period. The interventions indicated in part to assess for increased or decreased edema (swelling) when giving care, administer medications and treatments as ordered, monitor for skin breakdown and notify physician as needed with any changes. A review of a Bi-Weekly Skin Check dated 12/08/18 at 11:50 AM documented by Nurse #6 indicated Resident #285 had current skin issues but there was no site or description of the skin issues. A review of a Bi-Weekly Skin Check dated 12/14/18 at 11:50 AM documented by Nurse #6 indicated Resident #285 had current skin issues but there was no site or description of the skin issues. A review of a Bi-Weekly Skin Check dated	F 842	survey. To identify other residents who have the potential to be affected, on 3/1/19 the wound nurse completed a 100% audit on all residents to ensure accurate bi-weekly skin checks had been completed. To prevent this from recurring, on 3/8, 3/12, and 3/14/19, the licensed staff were educated by the wound care nurse on the requirements of accurate bi-weekly skin check documentation. This education will be provided upon orientation for all newly hired staff. To monitor and maintain ongoing compliance, the wound nurse or designee will review 5 residents bi-weekly skin checks weekly for accuracy for the next 12 weeks, starting 3/18/19. Any negative findings will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations until 100% compliant. The Wound Care Nurse is responsible for compliance. Completion date is 3/26/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 842	Continued From page 40	F 842		

12/17/18 at 11:50 AM documented by Nurse #6 indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

A review of a Bi-Weekly Skin Check dated 12/29/18 at 11:50 AM documented by Nurse #7 indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

A review of the most recent comprehensive (annual) Minimum Data Set dated 01/06/19 revealed Resident #285 was cognitively intact for daily decision making. The MDS also indicated Resident #285 required extensive assistance with activities of daily living except she only required supervision with eating.

A review of a Bi-Weekly Skin Check dated 01/18/19 at 8:00 PM documented by Nurse #6 indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

A review of a Bi-Weekly Skin Check dated 01/21/19 at 8:00 PM documented by Nurse #6 indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

A review of a Bi-Weekly Skin Check dated 01/30/19 at 8:00 PM documented by Nurse #11 indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

A review of a Bi-Weekly Skin Check dated 02/05/19 at 8:00 PM documented by Nurse #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 842	Continued From page 41	F 842		

indicated Resident #285 had current skin issues but there was no site or description of the skin issues.

During a telephone interview on 02/28/19 at 12:16 PM, Nurse #6 stated she was not sure about documentation of skin issues. She further stated she was not sure of the requirements for documenting on the Bi-Weekly Skin Checks.

An attempt on 02/28/19 at 12:18 PM to contact Nurse #7 was unsuccessful.

An attempt on 02/28/19 at 12:24 PM to contact Nurse #8 was unsuccessful.

An attempt on 02/28/19 at 12:26 PM to contact Nurse #11 was unsuccessful.

During a telephone interview on 02/28/19 at 12:29 PM, Nurse #9 stated she had been told to document things like surgical incisions, skin tears or any open areas on a resident's skin on the Bi-Weekly Skin Checks. She further stated it would make sense to document redness or pain regarding yeast and what the treatment would be.

During a telephone interview on 02/28/19 at 12:43 PM, Nurse #10 stated she had only worked in the facility for approximately 3 months. She explained she felt the Bi-Weekly Skin Checks were vague. She explained she had looked at them and sometimes they indicated a resident had a skin issue in one location but when she assessed the resident they had a skin issue in a different location.

During an interview on 02/28/19 at 2:26 PM, the Wound Nurse (WN) with the Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 842	Continued From page 42 Nursing present she explained the Bi-Weekly Skin Checks should include any type of skin issue such as bruising, skin tears, blisters redness and anything that was different with the resident skin. She stated after review of documentation on Resident #285's Bi-Weekly Skin Checks some of them did not indicate a site of the skin issue or a description. She stated it was her expectation if a Nurse indicated a resident had current skin issues they should document the location and a description of the skin issue. She further stated she expected for the documentation to be specific. She explained some of the Nurses who had signed off on the Bi-Weekly Skin Checks no longer worked at the facility and she had identified there was a problem with their documentation. During an interview on 02/28/19 at 3:06 PM, the Director of Nursing stated documentation of skin issues should be specific as to location and what the area looked like. She further stated she expected for Nurses to document what they saw and follow up with the physician for treatment orders. During an interview on 02/28/19 at 4:58 PM, the Administrator stated documentation had been identified as a problem. He further stated they had a long way to go but they were aware they needed to improve.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

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F 883	Continued From page 43 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

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F 883	Continued From page 44 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the resident medical record included education regarding the benefits and potential side effects of the influenza immunization for 3 of 5 residents sampled for immunizations (Resident #42, Resident #77, and Resident #66). The findings included: Review of a facility policy titled, Influenza Vaccine dated September 2008 and revised 08/14/17 read in part, nursing staff will document the provision of education in the resident's medical record. a. Resident #42 admitted to the facility on 10/09/18 with diagnoses that included history of falls, atrial fibrillation, chronic kidney disease, and others. Review of Resident #42's quarterly minimum data set (MDS) dated 01/16/19 indicated that she was cognitively impaired. Review of Resident #42's immunization record revealed that Resident #42 had received the influenza vaccine in the facility on 11/08/18.	F 883	Facility failed to ensure immunization consents were present in the clinical record. To monitor and maintain ongoing compliance, the DON or designee will review completion of the immunization consent for each new admission for the next 12 weeks, starting 3/18/19. Immunization consent forms were completed during the survey for Residents #42, 77, and 66. The residents did not have any negative outcome and had their immunization based on verbal consent that had been obtained. To identify other resident who have the potential to be affected, on 3/18/19 the DON complete 100% audit on all residents to ensure consents were completed and uploaded into the resident□s medical record. To prevent this from recurring, on 3/8, 3/12, and 3/14/19, the nurses and medical records staff were educated by the DON on the requirement of and chart maintenance for immunization consents. This education will be provided upon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 45 Review of Resident #42's medical revealed no influenza consent form or education that was provided to the family. b. Resident #77 admitted to the facility on 06/09/17 with diagnoses that included dysphagia, hemiplegia, diabetes, dementia, and others. Review of the quarterly minimum data set (MDS) dated 02/14/19 indicated that Resident #77 was cognitively intact. Review of Resident #77's immunization record revealed that she had received the influenza vaccine in the facility on 11/07/18. Review of Resident #77's medical record revealed no influenza consent form or education that was provided to the family. c. Resident #66 was admitted to the facility on 02/09/16 and readmitted to the facility on 02/02/18 with diagnoses that included dysphagia, adult failure to thrive, dementia and others. Review of the comprehensive minimum data set (MDS) dated 02/09/19 revealed that his cognition was not assessed on the MDS. Review of Resident #66's immunization record revealed he had received the influenza vaccine in the facility on 11/03/18. Review of Resident #66's medical record revealed no influenza vaccine consent or education that was provided to the family. An interview was conducted with the Director of	F 883	orientation for all newly hired staff. Any negative findings will be corrected. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 883	Continued From page 46 Nursing (DON) on 02/27/19 at 2:39 PM. The DON stated that they obtained influenza vaccine on admission and annually. She stated that they mailed the education out to the families before the vaccine was given. The DON stated that they were not able to locate the consents because they had not been scanned into the electronic medical record. She stated that they were searching empty office looking for the consents. A follow up interview was conducted with the DON on 02/28/19 at 1:19 PM. The DON stated she was finally able to locate some of the influenza consents but confirmed that they were not a part of the resident's medical record. The DON stated that she had only been at the facility for a little over a month and she planned to revamp the influenza program and would be following the facilities policy to ensure that the consent and education were a part of the resident's medical record.	F 883		