STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING ______ B. WING ______	12/19/2019

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

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E 000	Initial Comments An unannounced Recertification survey was conducted on 12/16/2019 through 12/19/2019. The facility was found in compliance with the requirement CFR 483.73,Emergency Preparedness. Event ID # GGIV11.	E 000		
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: The facility failed to accurately code a significant change Minimum Data Set (MDS) for 1 of 6 residents reviewed for MDS coding accuracy (Resident # 35). Findings included: Resident # 35 was readmitted to the facility on 08/28/2019 with diagnoses that included immunodeficiency, cutaneous abscess, malignant neoplasm of the brain and skin, depression and malnutrition. A review of a significant change MDS dated 10/24/2019 for Resident # 35 revealed that Resident # 35 was usually understood and usually understands. Resident # 35 had moderate cognitive impairment with periods of inattention and disorganized thinking. Resident # 35 experienced 12 to 14 days of being tired and depressed and required total assist of at least 2 staff for transfers and at lease extensive assist for bed mobility and toileting. Resident # 35 was always incontinent of bowel and bladder, received	F 641	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSIONS STATED ON THE STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW. 1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED: Resident #35 had a Minimum Data Set (MDS) modification submitted to correct the coding to hospice question. The date of correction was December 19, 2019. 2. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	1/13/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/15/2020

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

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F 641	Continued From page 1	F 641		

scheduled pain medication for occasional pain which was rated at a level 4 out of 10. Resident # 35 had a poor prognosis and had received 7 days of insulin injection, 7 days of an anticoagulant and an opioid.

A review of a social worker notes dated 10/14/2019 at 1:44 PM revealed that Resident # 35 was admitted to hospice services on 10/12/2019.

A review of the census or billing section of the medical record of Resident # 35 revealed that hospice services were initiated on 10/12/2019.

On 12/ 19/2019 an interview with the facility business office manager (BOM) was conducted and the BOM confirmed that Resident # 35 was initiated on Hospice services 10/12/2019 and remained on hospice services at present. The BOM confirmed that all department managers were aware of the initiation of hospice services on 10/12/2019 via a form titled "status change."

The MDS RN was interviewed on 12/19/2019 at 12:44 PM. The MDS RN (registered nurse) revealed that she had completed a significant change MDS for Resident # 35 dated 10/24/2019 and that the MDS was initiated because hospice services started for Resident # 35. The MDS RN revealed that she coded all other changes for Resident # 35 and that hospice was not coded as an oversight by the MDS RN. The MDS RN revealed that it was her expectation that all MDSs be coded accurately and as per the Resident Assessment Instrument (RAI).

An interview conducted with the facility administrator on 12/19/2019 at 12:52 PM

RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

Residents who are on hospice have had their most recent MDS checked to validate that they are accurately coded. There were no other issues. This audit date was December 19, 2019 and was performed by the Director of Nursing.

3. MEASURES PUT INTO PLACE OR SYSTEMIATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:

Both MDS coordinators have been reeducated by the Director of Nursing (DON)concerning the expectation that hospice is coded when a resident is placed on hospice care. The date of the education was January 13, 2020.
Newly hired nurses completing MDS's will be educated on the expectation that hospice is coded when a resident is placed on hospice care.

The DON or designee will review the assessments completed each week and cross check with the list of residents on hospice at the time prior to submission. The submissions will be reviewed for accuracy and a report will be given to the Administrator during the weekly review meeting. This will be documented for 12 weeks. The corporate Regional Reimbursement Specialist will be randomly reviewing assessments on an ongoing basis during visits to the facility.

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F 641	Continued From page 2 revealed the administrator expected that all MDS assessments be coded correctly as per the RAI manual and that a significant change MDS be completed for any resident initiated on hospice services and that the MDS reflect that the resident received hospice service.	F 641	4. PERFORMANCE MONITORING: The Administrator will report the monitoring to the QAPI committee meeting for the duration of the monitoring period for the committee to review and make recommendations.	
F 695 SS=B	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to obtain an order for oxygen for 1 of 1 resident reviewed for respiratory care (Resident #63). Findings included: Resident #63 was admitted to the facility on 8/29/2017 with diagnoses to include hypertension, diabetes and contracture of joint. A nursing note dated 10/15/2019 at 11:00 PM noted that Resident #63 had a low oxygen saturation level of 85 % (normal 88-99%) and the nurse applied oxygen at 2 liters per minute by a nasal cannula.	F 695	CORRECTED ACTION FOR AFFECTED RESIDENT: Resident #63's order for oxygen at 2 liters/minute continuous was clarified with the provider (Medical Director) and then transcribed into the orders for the medical record December 18, 2019. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE: Residents receiving orders during change of condition have been identified for the	1/16/20

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F 695	Continued From page 3 A review of the physician orders for Resident #63 from October 2019 to December 2019 revealed no order was in place for the administration of oxygen. The most recent quarterly Minimum Data Set assessment dated 11/19/2019 assessed Resident #63 to be severely cognitively impaired and she did not to use oxygen. Resident #63's treatment administration record and medication administration record for December 2019 was reviewed and no documentation was present regarding the administration of oxygen. Resident #63 was observed on 12/16/2019 at 12:08 PM in bed. She had a nasal cannula on attached to an oxygen concentrator that was set at 2 liters. An observation was conducted on 12/17/2019 at 9:17 AM of Resident #63 and she was in bed with oxygen administered at 2 liters per minute by nasal cannula. Resident #63's alert and oriented roommate was interviewed on 12/17/2019 at 9:17 AM and she reported Resident #63 had been using oxygen "for a long time." Nursing assistant (NA) #3 was interviewed on 12/17/219 at 9:17 AM and she reported that Resident #63 wore the oxygen "all the time." NA #2 was interviewed on 12/18/2019 at 9:54 AM and she reported Resident #63 wore the oxygen all the time. NA #2 was unable to find orders or directions for the oxygen use in the nursing	F 695	last 30 days. This audit occurred on January 8, 2020 and was done by the Director of Nursing (DON). The documentation has been reviewed to validate that any new intervention had an order transcribed. There were 41 residents with a change in condition during the last 30 days (December 9, 2019 - January 8, 2020.) Of these 41 residents, there were no discrepancies found regarding physician orders not being transcribed into the medical record. MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES TO ENSURE DEFICIENT PRACTICE DOES NOT RECUR: Licensed nurses were reeducated by the DON and Assistant Director of Nursing (ADON)on January 8, 2020 concerning the expectation that an order given during a resident's change in condition be transcribed appropriately into the medical record. PERFORMANCE MONITORING: The DON or designee will review the documentation for any resident with a change in condition to ensure that all interventions have been entered as orders into the medical record. This will be completed during the morning clinical meeting following the change of condition. This will be documented for each clinical meeting for 4 weeks and then one change of condition a week for 8 weeks.	

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F 695	Continued From page 4 assistant Kardex (a program that lists treatments and interventions for nursing assistants to provide care to the residents.) The nurse who wrote the note on 10/15/2019 was not available for interview. Nurse #1 was interviewed on 12/18/2019 at 10:16 AM and she reported that Resident #63 should have an order for the oxygen, but she was unable to locate the order for the oxygen. An interview was conducted with Nurse #2 and the Staff Development Coordinator (SDC) on 12/18/2019 at 10:20 AM and neither were able to find orders for Resident #63 to use oxygen. The SDC reported that oxygen orders should be entered into the electronic order system to populate on the medication administration record. Nurse #2 was interviewed again at 10/18/2019 at 1:50 PM and she reported she was not certain why the order for oxygen had not been entered into the electronic order system. The Director of Nurses (DON) was interviewed on 12/18/2019 at 2:19 PM and she reported that on 10/15/2019 when the resident had a low oxygen level, the nurse applied the oxygen and contacted the physician assistant. The DON reported the order had not been transcribed into the electronic documentation system. The DON reported she felt the transcription of the order had been overlooked and that she expected all orders to be entered into the system. The facility physician was interviewed on 12/19/2019 at 11:53 AM and he reported Resident #63 was not harmed by receiving	F 695	The DON, who is responsible for this plan of correction, will report the results of monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 695	Continued From page 5 oxygen since October. The Administrator was interviewed on 12/19/2019 at 12:36 PM and he reported the facility had initiated a daily clinical meeting to review all residents and check for new orders and to make certain all orders were entered into the system correctly. The Administrator reported the order to apply oxygen to Resident #63 occurred before this morning meeting was started and that was why the order was missed. The Administrator reported that he expected all orders to be entered into the electronic documentation system when the orders were received.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		1/16/20

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F 812	Continued From page 6 Based on observations, staff interviews and record reviews, the facility failed to follow their policies and procedures for storing refrigerated food off the floor and storing dry food in sealed containers, that were not labeled and dated once the items were opened in 1 of 1 walk-in refrigerator, 1 of 1 walk-in cooler and 1 of 1 dry storage room in the kitchen, and 2 of 2 nourishment refrigerators. The nourishment refrigerators were located at the main nursing station and on the 600 hall. Furthermore, food brought in from outside the facility did not have the resident's name or date, nor were the items discarded within seven days. Findings included: Record review of the facility's policies related to Food Storage revealed the following: Policy dated 2/19/19 titled Storage of Refrigerated Food, read in part that refrigerated items must be stored at least 6 inches off the floor and labeled with the date opened. The policy for Storage of Dry Food, dated 2/20/19 read in part: all food must be sealed in tight-fitting containers, labeled and dated. The policy titled, Food Brought in from Outside the Facility, dated 2/25/19, read in part: all opened food will be stored with the name of the food item, resident name, dated and discarded within seven days to ensure food safety. 1. During the initial tour of the kitchen on 12/16/19 from 9:54-10:30am with the Dietary Manager, an inspection was completed of the walk-in refrigerator, walk-in freezer and the dry storage room. The following was observed: The following items had previously been opened and were not labeled with an open date or an	F 812	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Any and all food that was found to be open and/or unlabeled was disposed of immediately. OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The rest of the food in the dry storage pantry, nourishment rooms and the refrigerated and frozen storage areas in the kitchen were examined by the Certified Dietary Manager(CDM)to determine if any items were open and unlabeled or expired. Any items identified without proper label, date or were expired were discarded. MEASURES PUT INTO PLACE AND/OR SYSTEMATIC CHANGES TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: All Dietary employees were reeducated by the Certified Dietary Manager on December 18 and 19, 2019 regarding the following policies: * Storage of Dry Food * Storage of Refrigerated Foods The CDM was re-educated by the Regional Registered Dietician (RD) on January 7, 2020. First shift Housekeeping will inspect nourishment room refrigerators and freezers daily to ensure	

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F 812	Continued From page 7 expiration date. a. Walk in refrigerator-1 large bottle of nectar thickened water, 1 large bottle of nectar thickened orange juice, 1 container of whipped cream and 1 bottle of lemon juice. b. Walk-in cooler-Two unsealed boxes of frozen breaded chicken were open without a date. The tape on both boxes was torn on all four sides. c. Dry Storage Area-The following items were expired based on the labeled date-croutons in a clear plastic bag with a sealed zip top, opened 6/15/19. The items that did not have a label for the required opened date included 1 bottle each of grape jelly and Heinz 57 sauce, and 2 bottles of green and red food coloring. An interview was conducted on 12/16/19 at 10:30am with the Dietary Manager (DM) whom stated these items listed above should all have been labeled. The Dietary Manager stated the boxes of chicken had not been used and the tape was torn when placed under shelf. She stated the croutons were good for 1 month from the opened date and the condiments should have been labeled with an open date. 2. On 12/18/19 at 3:38pm a follow-up interview with the Dietary Manager was conducted regarding the non-labeled food items. The DM stated items should have been properly labeled. She stated these items had now been discarded. 3. On 12/18/19 at 3:55pm a follow-up observation with the DM was conducted for the kitchen and dietary storage areas and checked for labeling and expired food.	F 812	open items are dated, labeled and discarded timely. This is documented on quality audit tools daily and will be done daily for 2 weeks then weekly for 8 weeks. Housekeeping staff were re-educated on food storage, cleanliness of nourishment room refrigerators and freezers by facility Administrator on December 31, 2019. Ongoing monitoring of nourishment rooms will be done by the facility RD and the corporate RD quarterly. PERFORMANCE MONITORING: The CDM, or designee on weekends, will monitor/inspect the storage of both dry and refrigerated foods daily to ensure that items open were dated as they were opened and all items are labeled and discarded by expiration date. This will be documented daily for 7 days then 5 days/week for 3 weeks, then weekly for 8 weeks. On going monitoring will be completed by facility RD monthly and corporate Regional RD quarterly. The CDM will report the results of all monitoring and corrective action to the QAPI committee monthly for review for the time frame of the monitoring period or as it is amended by the committee.	

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a. The dry storage room had 1 bottle of grape jelly not labeled. A large bag of grits was open in a zip sealed plastic bag that was not closed at the top and without a label.

b. Observation of the walk-in refrigerator revealed a large net bag of multiple heads of cabbage (greater than 10) on the floor of and an opened bottle of nectar thickened water with no label on the shelf.

4. On 12/18/19 at 4:10pm, an observation of the 2 nourishment rooms near the main nursing station and the 600 hallway was made with the DM present.
a. Nourishment Room 1 near the main nursing desk was inspected. Review of the items in the freezer in Nourishment Room 1 revealed a frozen dinner of chicken fettuccine with a date written in black marker of 11-3-18. The frozen dinner had a used by date of 8/2019. Other items not labeled or dated included: reusable water bottle with a pull up lid with water inside, purple grapes in a gray plastic bag, an opened large bottle of nectar thickened water, an opened carton of Resource 2.0 and 21 assorted pudding, yogurt and fruit cups.

b. The 600 Hall Nourishment Refrigerator/Freezer items that observed to not be labeled or labeled incorrectly were: a gray plastic bag in the freezer with a small fast food cup of chocolate ice cream and a sealed vanilla caramel ice cream bar. This bag was marked with a room number that could not be determined, and there was no name or date. An opened frozen bottle of red fruit drink, an opened disposable water bottle, a chicken pot pie with no

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name, date or room, 4 small cups of Breyers ice cream with no expiration date visible, no name, date or room, 4 vanilla pudding cups with the name but no date or room, 1 large box of frosted flakes with a 10/4/19 expiration date, numerous yogurts without the resident's names or dates, several had an expired manufacture date.

An interview was conducted with the DM during the observation at 4:10PM on 12/18/19. The DM stated the nourishment rooms were not the dietary department's responsibility.

On 12/18/19 at 4:46 PM observations of both nourishment rooms with the Director of Nursing (DON) revealed that the above named items were still in the refrigerator. The DON discarded all the expired and unlabeled food items.

At 12/18/19 5:00 PM an interview with the DON stated both nourishment rooms should be checked nightly by nursing staff and any food in any refrigerator or freezer without the name, date, room should be discarded.

An interview was conducted 12/18/19 at 5:19 PM with the Administrator and he was informed of findings in the kitchen, and the two nourishment refrigerators/freezers. The Administrator stated the process would be that the kitchen staff are to label an item when it is opened with the date, and that the nourishment rooms are checked on third shift. Staff are accountable to go through employee and resident refrigerators/freezers and ensure all items are dated and labeled and discard any items that are not.