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 02/13/2020

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 000	Initial Comments A recertification survey was conducted 02/10//20 through 02/13//20. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID #: 2PGD11.	E 000		
F 000	INITIAL COMMENTS A complaint investigation was conducted from 02/10/20 through 02/13/20 in conjunction with the annual Recertification survey. There was 1 intake with 4 allegations investigated and all were unsubstantiated. Event ID #2PGD11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

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

Electronically Signed

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 02/13/2020

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 550	Continued From page 1	F 550		

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, family and staff interview the facility failed to treat a resident in a dignified manner by failing to remove a clothing protector after two meals and after it became soiled. This affected 1 of 1 resident investigated for dignity (Resident #84).

The findings included:

Resident #84 was admitted to the facility on 11/27/18 with diagnoses that included vascular dementia and others.

A review of the quarterly Minimum Data Set (MDS) dated 01/23/2020 revealed that Resident #84 was severely impaired for daily decision making and required extensive assistance eating and personal hygiene.

An observation of Resident #84 was made on 02/10/2020 at 10:58 PM. Resident #84 was sitting

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 02/13/2020

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 550	Continued From page 2	F 550		

up in her wheelchair in the dining area. She was dressed appropriately for the weather and had a white clothing protector tucked into the collar of her shirt from the breakfast meal.

An observation of Resident #84 was made on 02/10/2020 at 12:39 PM. Resident #84 was up in her wheelchair being pushed down the main hall of the facility by a staff member. Resident #84 was observed to still have the white clothing protector tucked into the collar of her shirt.

An observation of Resident #84 was made on 02/10/2020 at 3:24 PM. Resident #84 was up in her wheelchair in the common area on the unit. She was dressed appropriately for the weather and the white clothing protector remained tucked into the collar of her shirt. The clothing protector was observed to be soiled with a dark brown liquid that had dried. There was a maroon cloth napkin laying across her lap that also contained a tan/brown dried substance on it. The dried substance was approximately the size of a large orange.

An observation of Resident #84 was made on 02/10/2020 at 4:30 PM. Resident #84 remained up in her wheelchair in the common area on the unit. She remained dressed appropriately for the weather and the white clothing protector remained tucked into the collar of her shift. The white clothing protector was observed to be soiled with a dark brown liquid that had dried. There was a maroon cloth napkin laying across her lap that also contained a tan/brown dried substance on it. The dried substance was approximately the size of a large orange.

An interview was conducted with Nurse Aide (NA)

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 02/13/2020

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 550	Continued From page 3 #2 on 02/12/2020 at 3:51 PM. NA #2 confirmed that she was working on the unit with Resident #84 on 02/10/2020. She stated that Resident #84 was able to feed herself at times and at times she assisted her. NA #2 stated that she was not sure who placed the clothing protector on Resident #84 on 02/10/2020 but stated that everyone should have been diligent and removed the dirty clothing protector and napkin after each meal. She stated that she should not have been left in the soiled clothing protector for as long as she was. An interview was conducted with Resident #84's family member. The family member stated that Resident #84 was very educated and had two master's degrees and years ago in her younger days the soiled clothing protector would have bothered Resident #84. The family member stated that it was "gross" to have soiled dried food on her clothing protector. An interview was conducted with the Director of Nursing (DON) on 02/13/2020 at 1:45 PM The DON stated that the dirty clothing protector should have been removed the minute she was finished eating and her hands cleaned. She added that Resident #84 should have never been taken down the main hall of the facility in the soiled clothing protector and napkin. An interview was conducted with the Administrator on 02/13/2020 at 2:08 PM. The Administrator stated that the soiled clothing protector should have been removed when the meal was done and put in the laundry to be washed and not left on the resident.	F 550		
F 585	Grievances	F 585		

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 02/13/2020

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 585 SS=D	Continued From page 4 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585		

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 02/13/2020

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 585	Continued From page 5	F 585		

number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not

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 02/13/2020

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 585	Continued From page 6	F 585		

confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, family and staff interview the facility failed to provide prompt resolution to a family's grievance about activities of daily living for 1 of 4 residents investigated for activities of daily living (Resident #34).

The findings included:

Resident #34 was admitted to the facility on 07/23/18 with diagnoses that included dementia, osteoporosis, osteoarthritis, hypertension, and others.

A review of the quarterly Minimum Data Set (MDS) dated 12/14/19 revealed that Resident #34 was severely cognitively impaired and had no behaviors or rejection of care. The MDS further revealed that Resident #34 required extensive assistance with dressing, personal hygiene, and bathing.
Resident #34 had less than 6 months to live and

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 02/13/2020

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 585	Continued From page 7	F 585		

received hospice services per the MDS.

A review of a grievance filed on 01/23/2020 by Resident #34's family read in part, during care plan meeting Resident #34's family stated that she was consistently left in her brief and the staff did not put pants on Resident #34. The family stated that they have repeatedly asked staff to do this and it never got done. The family stated that the last time they brought the concern up, education was provided. The family remains concerned as nothing has changed. The family explained that Resident #34 scratched herself and the brief ripped easily when she did and not wear anything over the brief. The family had requested Resident #34 to have on soft pants (no leggings) because they won't irritate her skin. The family was also concerned that Resident #34 did not get bathed regularly and was filthy when they see her on the weekends.

The resolution provided to Resident #34's family regarding the grievance filed on 01/23/2020 read in part, resolution will be ongoing. Staff have been educated regarding issues stated. Two staff members have received disciplinary action for lack of care being provided to Resident #34. Care cards now being utilized and have been updated to address the concerns of the family specifically ensuring that Resident #34 has pants on and to ensure she is bathed regularly. The resolution was signed by the Assistant Director of Nursing (ADON).

Review of the care card in Resident #34's closet with no date noted read, please put pants on every day and bed bath daily.

An observation of Resident #34 was made on

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 02/13/2020

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 585	Continued From page 8	F 585		

02/10/2020 at 1:17 PM. Resident #34 was resting in bed with her eyes open. She appeared disheveled. Her hair was very shiny and was going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. Resident #34's family was at bedside assisting her with the lunch meal. The family indicated that they had been "fighting" with the facility to keep pants on Resident #34. The family member stated that she would often times tear her brief apart and she has told the staff if you keep pants on her she cannot get to her brief to tear it apart but they continued to leave her in bed with no pants on.

An observation of Resident #34 was made on 02/11/2020 at 9:17 AM. Resident #34 was again resting in bed with her eyes open. She again appeared disheveled and her hair remained shiny and was going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. She had a piece of egg stuck to the side of her mouth.

An observation of Resident #34 was made on 02/12/2020 at 9:08 AM. Resident #34 was resting in bed with her breakfast tray in front of her. Resident #34 appeared disheveled. Her hair was very shiny and was going in different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet.

An observation of Resident #34 was made on 02/12/2020 at 11:45 AM. Resident #34 was resting in bed with her eyes open. She appeared disheveled. Her hair was very shiny and going in

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 02/13/2020

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 585	Continued From page 9	F 585		

all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on. Resident #34 had pulled the blanket and sheet that were covering her up and balled them up and threw them to the side. Resident #34's brief was exposed and the line on the front indicating the brief was wet or dry indicated the brief was dry.

An observation of Nurse Aide (NA) #1 was made on 02/12/2020 at 12:49 PM. NA #1 was observed to take Resident #34's lunch tray into her room. Resident #34 was resting in bed with her eyes open and appeared disheveled. Her hair was shiny and going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on.

An observation of Resident #34 was made on 02/12/2020 at 4:29 PM along with NA #1 and the Director of Nursing (DON). Resident #34 was resting in bed with eyes open and appeared disheveled. Her hair was shiny and going in all different directions and she was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. NA #1 stated that the last time she had changed Resident #34 was before lunch and proceeded to pull back the sheet. When the sheet was pulled back a terrible ammonia smell was noted. Resident #34 was rolled to one side and her brief unfastened. The brief was soiled through all the cotton to the edge of the brief. The draw blanket that was under her was wet with a liquid and the blue mattress had a dark ring directly under where Resident #34 was resting. When NA #1 pulled the intact brief off of Resident #34 and threw it in the trash can, it made a loud thump from the weight of the soiled brief. Resident #34's

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 02/13/2020

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 585	Continued From page 10	F 585		

skin was observed and was intact but could see the indentation of the brief on her bottom and back of her legs. NA #1 cleaned the feces off of Resident #34 and placed a new brief under her. When NA #1 was asked by the DON why Resident #34 looked this way and had the same clothes on for several days, NA #1 replied "it was my fault I did not get back in here and kept getting pulled to do different things." When NA #1 and the DON removed the black and red buffalo plaid shirt from Resident #34 balled up cotton fell out from both of her under arms. NA #1 replied "she likes to tear apart her brief." NA #1 then applied a new shirt and a pair of pants and covered Resident #34 with a sheet.

An interview was conducted with NA #1 on 02/13/2020 at 11:15 AM. NA #1 confirmed that she had cared for Resident #34 on 02/10/2020, 02/12/2020, and 02/13/2020. NA #1 stated that she was aware Resident #34 was to have pants on daily and when asked why she did not she replied, "I cannot recall why." NA #1 was again asked why Resident #34 had not been bathed and her clothes changed, and NA #1 again replied "she could not recall."

An interview was conducted with the ADON on 02/13/2020 at 10:47 AM. The ADON recalled the grievance filed on 01/23/2020 by Resident #34's family. She stated that when she got the grievance, she had called the DON to discuss and they together had come up with a plan to resolve the issues. The ADON stated that they educated the staff involved on things like placing pants on Resident #34 and making sure she was bathed and cleaned appropriately. The ADON stated that there was some disciplinary action with the staff involved and the DON choose to

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 02/13/2020

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 585	Continued From page 11	F 585		

reassign the staff members to different area of the facility. She added that they had begun using a care card that was placed on the inside closet of each resident's room and it contained all the information needed to care for the resident. The ADON stated that Resident #34's care card had been updated to add the request of pants and the bed bath daily. Once the education had been provided to the staff and the care cards updated and staff reassigned, she completed the grievance and turned it in for approval.

An interview was conducted with the DON on 02/13/2020 at 1:47 PM. The DON stated that she was off when the grievance come in on 01/23/2020 but stated that the ADON had called her to discuss. After talking with the ADON we came up with a plan that included reeducation to the staff involved, disciplinary action for the staff involved, the implementation of the care cards and the reassignment of the staff involved. The DON stated that she felt like the reassignment of the staff would completely resolve the issues that the family had voiced. The staff that had been reassigned to the other side of the facility did very well but were requesting to move back to the unit where Resident #34 was at. The DON stated that after doing so well on the other side of the building she gave them the benefit of the doubt and let them return to the unit they were one before. The DON stated that the follow up once the staff returned to the unit where Resident #34 was located was not there and she expected the family to have the resolution that they deserved. The DON confirmed that once the staff returned to the unit where Resident #34 resided the follow up required to make sure they were doing what was expected was not there and "fell through the cracks."

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 02/13/2020

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 585	Continued From page 12 An interview was conducted with the Administrator on 02/13/2020 at 2:00 PM. The Administrator stated that anyone can file a grievance and once filled out was screened. During the stand up and stand down meeting the grievances were distributed to the appropriate department for completion. The Administrator stated that he reminded the staff daily during both meetings of any outstanding grievances. Once the grievance was completed, he would review them and sign off on them and then the receptionist was responsible for the written response and placed them in the mail to the person that filed the grievance. The Administrator stated that he believed they needed to look at grievance monitoring and see how they could improve the monitoring process to achieve resolution.	F 585		
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	F 656		

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 02/13/2020

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 13	F 656		

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 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 record review and staff interview the facility failed to implement a care plan and provide incontinent care as needed for 1 of 4 residents sampled for activities of daily living (Resident #34).

The findings included:

Resident #34 was admitted to the facility on 07/23/18 with diagnoses that included dementia, osteoporosis, osteoarthritis, hypertension, and others.

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 02/13/2020

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 14	F 656		

A review of a care plan updated on 10/18/19 read in part, Alteration in elimination related to frequently incontinent of bowel and bladder. Decline in function expected secondary to end of life progression. The goal read, resident will be clean, dry, and odor free through the next review. The interventions included: provide incontinent care as needed.

A review of the quarterly Minimum Data Set (MDS) dated 12/14/19 revealed that Resident #34 was severely cognitively impaired and had no behaviors or rejection of care. The MDS further revealed that Resident #34 required extensive assistance with toileting and was always incontinent of bowel and bladder. Resident #34 had less than 6 months to live and received hospice services per the MDS.

An observation of Resident #34 was made on 02/12/2020 at 11:45 AM. Resident #34 was resting in bed with her eyes open. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on. Resident #34 had pulled the blanket and sheet that were covering her up and balled them up and threw them to the side. Resident #34's brief was exposed and the line on the front indicating the brief was wet or dry indicated the brief was dry.

An observation of Resident #34 was made on 02/12/2020 at 4:29 PM along with Nurse Aide (NA) #1 and the Director of Nursing (DON). Resident #34 was resting in bed with eyes open. NA #1 stated that the last time she had changed Resident #34 was before lunch and proceed to pull back the sheet. When the sheet was pulled back a terrible ammonia smell was noted. Resident #34 was rolled to one side and her brief

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 02/13/2020

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 15	F 656		

unfastened. The brief was soiled through all the cotton to the edge of the brief. The draw blanket that was under her was wet with a liquid and the blue mattress had a dark ring directly under where Resident #34 was resting. When NA #1 pulled the intact brief off of Resident #34 and threw it in the trash can, it made a loud thump from the weight of the soiled brief. Resident #34's skin was observed and was intact but could see the indentation of the brief on her bottom and back of her legs. NA #1 cleaned the feces off of Resident #34 and placed a new brief under her. When NA #1 was asked by the DON why Resident #34 looked this way, NA #1 replied "it was my fault I did not get back in here and kept getting pulled to do different things.

An interview was conducted with the DON on 02/12/2020 at 4: 40 PM. The DON stated she was very disappointed in her staff, they had 3 NAs on the unit today and they were fully aware of my expectations. The DON stated she worked alongside the NAs and rounded with them and they know that all they have to do is ask for help. The DON further stated she did not care what NA #1 got sidetracked doing they know they have to communicate with me so I can help with issues like this.

An interview was conducted with NA #1 on 02/13/2020 at 11:15 AM. NA #1 confirmed that she had cared for Resident #34 on 02/10/2020, 02/12/2020, and 02/13/2020. NA #1 stated that she was overwhelmed, and it was not fair to the residents. NA #1 was again asked why Resident #34 had not been changed and NA #1 replied "she could not recall."

A follow up interview was conducted with the

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 02/13/2020

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 16 DON on 02/13/2020 at 1:47 PM The DON stated she expected the NAs to follow the plan of care and provide routine incontinent care to Resident #34. The DON further stated it was unacceptable for Resident #34 to look the way she looked and to have been soiled for that period of time. An interview was conducted with the Administrator on 02/13/2020 at 2:00 PM. The Administrator stated that the facility had policy and procedures in place to have incontinent care provided, and the staff should have followed those to ensure the needs of the resident were met.	F 656		
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, family, and staff interview the facility failed to provide a bed bath, dressing and incontinent care to a dependent resident (Resident #34) and failed to set up a breakfast tray for a dependent resident (Resident #246). This affected 2 of 4 residents sampled for activities of daily living. The findings included: 1. Resident #34 was admitted to the facility on 07/23/18 with diagnoses that included dementia, osteoporosis, osteoarthritis, hypertension, and others.	F 677		

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 02/13/2020

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 677	Continued From page 17	F 677		

A review of the quarterly Minimum Data Set (MDS) dated 12/14/19 revealed that Resident #34 was severely cognitively impaired and had no behaviors or rejection of care. The MDS further revealed that Resident #34 required extensive assistance with dressing, toileting, personal hygiene, and bathing.
Resident #34 had less than 6 months to live and received hospice services per the MDS.

Review of the care card in Resident #34's closet with no date noted read, please put pants on every day. Bed bath daily and assist with meals.

An observation of Resident #34 was made on 02/10/2020 at 1:17 PM. Resident #34 was resting in bed with her eyes open. She appeared disheveled. Her hair was very shiny and was going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. Resident #34's family was at bedside assisting her with the lunch meal. The family indicated that they had been "fighting" with the facility to keep pants on Resident #34. The family member stated that she would often times tear her brief apart and she has told the staff if you keep pants on her she cannot get to her brief to tear it apart but they continued to leave her in bed with no pants on.

An observation of Resident #34 was made on 02/11/2020 at 9:17 AM. Resident #34 was again resting in bed with her eyes open. She again appeared disheveled and her hair remained shiny and was going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. She had a piece of egg stuck to the

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 02/13/2020

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 677	Continued From page 18	F 677		

side of her mouth.

An observation of Resident #34 was made on 02/12/2020 at 9:08 AM. Resident #34 was resting in bed with her breakfast tray in front of her. Resident #34 was leaning against the right side rail. Some of the food on the breakfast tray had been eaten. Resident #34 appeared disheveled. Her hair was very shiny and was going in different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. Nurse #1 entered the room and began feeding Resident #34 the remainder of the food on her breakfast tray.

An observation of Resident #34 was made on 02/12/2020 at 11:45 AM. Resident #34 was resting in bed with her eyes open and was leaning against the right side rail. She appeared disheveled. Her hair was very shiny and going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on. Resident #34 had pulled the blanket and sheet that were covering her up and balled them up and threw them to the side. Resident #34's brief was exposed and the line on the front indicating the brief was wet or dry indicated the brief was dry. Her breakfast tray remained on the over bed table directly in front of Resident #34 in the same position it was in on 02/12/2020 at 9:08 AM.

An observation of Nurse Aide (NA) #1 was made on 02/12/2020 at 12:49 PM. NA #1 was observed to take Resident #34's lunch tray into her room. Resident #34 was resting in bed with her eyes open leaning against the right side rail and appeared disheveled. Her hair was shiny and

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 02/13/2020

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 677	Continued From page 19	F 677		

going in all different directions. Resident #34 was dressed in a black and red buffalo plaid flannel shirt and had no pants on. Resident #34's breakfast tray remained directly in front of her on the her over the bed table. NA #1 had to remove the breakfast tray before sitting down the lunch tray. NA #1 then proceed to sit down and assist Resident #34 with her lunch tray.

An observation of Resident #34 was made on 02/12/2020 at 4:29 PM along with NA #1 and the Director of Nursing (DON). Resident #34 was resting in bed with eyes open. She was leaning against the right side rail and appeared disheveled. Her hair was shiny and going in all different directions and she was dressed in a black and red buffalo plaid flannel shirt and had no pants on but was covered with a sheet. NA #1 stated that the last time she had changed Resident #34 was before lunch and proceed to pull back the sheet. When the sheet was pulled back a terrible ammonia smell was noted. Resident #34 was rolled to one side and her brief unfastened. The brief was soiled through all the cotton to the edge of the brief. The draw blanket that was under her was wet with a liquid and the blue mattress had a dark ring directly under where Resident #34 was resting. When NA #1 pulled the intact brief off of Resident #34 and threw it in the trash can, it made a loud thump from the weight of the soiled brief. Resident #34's skin was observed and was intact but could see the indentation of the brief on her bottom and back of her legs. NA #1 cleaned the feces off of Resident #34 and placed a new brief under her. When NA #1 was asked by the DON why Resident #34 looked this way and had the same clothes on for several days, NA #1 replied "it was my fault I did not get back in here and kept

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 02/13/2020

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 677	Continued From page 20	F 677		

getting pulled to do different things." When NA #1 and the DON removed the black and red buffalo plaid shirt from Resident #34 balled up cotton fell out from both of her under arms. NA #1 replied "she likes to tear apart her brief." NA #1 then applied a new shirt and a pair of pants and covered Resident #34 with a sheet.

An interview was conducted with the DON on 02/12/2020 at 4:40 PM. The DON stated she was very disappointed in her staff, they had 3 NAs on the unit today and they were fully aware of my expectations. The DON stated she worked along side the NAs and rounded with them and they know that all they have to do is ask for help. The DON further stated she did not care what NA #1 got sidetracked doing they know they have to communicate with me so I can help with issues like this.

An interview was conducted with NA #1 on 02/13/2020 at 11:15 AM. NA #1 confirmed that she had cared for Resident #34 on 02/10/2020, 02/12/2020, and 02/13/2020. She stated that the Hospice team usually showered Resident #34 two times a week and then she would do a bed bath on the other days. When NA #1 to describe the care she provided on the days that Hospice was not present it the facility she stated, "I do incontinent care and wash them up down there" and indicated that was her bed bath. NA #1 stated that she was overwhelmed, and it was not fair to the residents. NA #1 stated that she was aware Resident #34 was to have pants on daily and when asked why she did not she replied, "I cannot recall why." NA #1 was again asked why Resident #34 had not been bathed and her clothes changed, and NA #1 again replied "she could not recall."

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 02/13/2020

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 677	Continued From page 21	F 677		

A follow up interview was conducted with the DON on 02/13/2020 at 1:47 PM The DON stated she expected the NAs to provide a sponge bath daily to Resident #34 in addition to changing her brief, clothes and placing pants on the resident. She added if Resident #34 was combative then the NAs should have reported it to the nurse and reproached her a later time. The DON stated, "they cannot leave someone like that" and the staff know my expectations.

An interview was conducted with the Administrator on 02/13/2020 at 2:00 PM. The Administrator stated that the facility had policy and procedures in place to have residents bathed, dressed, and incontinent care provided, and the staff should have followed those to ensure the needs of the resident were met.

2. Resident #246 was readmitted to the facility on 10/31/19 with diagnoses that included metabolic encephalopathy, adult failure to thrive, dementia and others.

A review of the comprehensive Minimum Data Set (MDS) dated 11/06/19 revealed that Resident #246 was severely impaired for daily decision making and required set up assistance with eating.

An observation of Resident #246 was made on 02/10/2020 at 11:45 AM. Resident #246 is resting in bed with her eyes closed and did not arouse to verbal stimuli. Her breakfast tray was sitting next to her bed with the lid still over the plate. The plate contained a whole sausage patty and piece of French toast. Neither the sausage patty or French toast had been cut up and the silverware

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 02/13/2020

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 677	Continued From page 22	F 677		

remained wrapped in the cloth napkin. The orange juice on the tray had a lid on it that had not been removed.

An interview was conducted with Nurse Aide (NA) #2 on 02/10/2020 at 11:49 AM. NA #2 confirmed that she was working on the unit but had not delivered Resident #246's breakfast tray. She stated that Resident #246 could feed herself and indicated she would get to it later.

An interview was conducted with Nurse #1 on 02/10/2020 at 11:51 AM. Nurse #1 confirmed that she was responsible for Resident #246. She stated she had not delivered her breakfast tray and did not know who had delivered the tray. Nurse #1 indicated that Resident #246 could feed herself but would need the tray set up for her.

An interview was conducted with NA #1 on 02/10/2020 at 11:57 AM. NA #1 confirmed that she was working on the unit and stated that NA #2 had delivered Resident #246's breakfast tray to her. She added that she could feed herself but would need help setting the meal tray up. NA #1 was informed that Resident #246's breakfast tray had not been touched and the silverware were still wrapped in the cloth napkin. NA #1 entered Residents #246's room and was observed to tear the meal ticket up and stated, "she refused" and lunch will be coming soon and exited the room.

An interview was conducted with the Director of Nursing (DON) on 02/13/2020 at 1:47 PM. The DON stated that the staff had shared with her that on 02/10/2020 Resident #246 had not eaten her breakfast but failed to share with her that her tray had not been set up or opened and offered to the resident. The DON stated that the staff have been

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 02/13/2020

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 677	Continued From page 23 educated on how to set up a tray and instructed to open everything on the tray and put a bit to the resident's mouth in an attempt to get them awake to eat. The DON stated she expected the staff to open the tray and set it up and offer the resident the meal and if she woke up and wanted to eat, she could have done so. An interview was conducted with the Administrator on 02/13/2020 at 2:00 PM. The Administrator stated that someone dropped off Resident #246's breakfast tray and from his understanding was expected to stimulate the resident and offer to help set up the tray and make sure the resident preferences were met prior to leaving the room.	F 677		
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.	F 812		

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 02/13/2020

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 812	Continued From page 24	F 812		

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to label and date open and used food items available for resident use stored in 1 of 1 walk-in refrigerators, 1 of 1 walk-in freezers, and 1 of 1 dry storage areas in the facility's kitchen.

Findings Included:

An observation of the facility's walk-in refrigerator on 02/10/20 at 10:01 AM revealed an undated block of unsliced ham wrapped in clear plastic wrap.

An observation of the facility's walk-in freezer on 02/10/20 at 10:06 AM revealed an open and undated ½ bag of frozen broccoli, an undated ¾ bag of frozen potato wedges, 2 open and undated ¼ bags of frozen chicken breast strips, an open and undated ½ bag of frozen cinnamon rolls, and an open and undated ½ bag of frozen waffles.

An observation of the facility's dry storage room on 02/10/20 at 10:11 AM revealed an undated ¼ bag of brioche style dinner rolls, a rolled up and undated bag of 5 minute quick grits, an open and undated bag of sandwich buns, and an open and undated ½ bag of brown sugar.

During an interview and walk-through of the kitchen with the Dietary Manager on 02/10/20 at 10:14 AM, he confirmed that the food items found that were open and undated should have been stored properly within sealed zip closure bags and dated. He reported he felt most of the undated food items were items used over the weekend, but they should have been stored

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 02/13/2020

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 812	Continued From page 25	F 812		

properly. The Dietary Manager also confirmed that the food items found in the walk-in refrigerator, walk-in freezer, and dry storage room were available for resident use.

During a recheck of the facility's walk-in refrigerator, walk-in freezer, and dry storage rooms on 02/12/20 at 11:35 AM 1 open and undated ¾ bag of brioche style butter rolls was found in the dry storage area. In the walk-in freezer; 1 open and undated bag of tater tots was observed along with 1 open and undated ¼ bag of frozen fish fillets, and 1 open and undated ½ bag of frozen greens.

During a follow up interview with the Dietary Manager on 02/12/20 at 11:47 AM, he reported he had no excuse for why there continued to be open, unsealed, and undated food items found in the walk-in freezer and dry storage rooms. He reported he had hired some new employees but reported they should be aware of the proper procedure for storing open food items. He stated he felt there had been a lack of supervision and reported there was "definitely room for improvement".

During an interview with the Administrator on 02/13/20 at 2:28 PM he reported there were a lot of new staff in the kitchen, though they should be aware of proper procedure for storing opened food items. He reported it appeared that additional training was needed on that procedure and stated it was unacceptable to find improperly stored food items in multiple storage locations, on multiple days.