STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

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E 000	Initial Comments An unannounced Recertification survey was conducted on 2/14/22 through 2/17/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RPG111.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 2/07/22 through 2/10/22. Event ID RGP111.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		2/21/22

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

Electronically Signed | 03/02/2022

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F 758	Continued From page 1 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, pharmacist, and Physician Assistant interviews the facility failed to ensure Physician's order for as needed (PRN) psychotropic medications were time limited in duration for 1 of 5 Residents (Resident #202) reviewed for unnecessary medications. The findings included: Resident #202 was admitted to the facility on 1/31/22 with diagnoses that included a stroke of the spinal cord, major depressive disorder, and muscle weakness. A Physician's order dated for 1/31/22 indicated	F 758	#1 Resident # 202 suffered no harm as a result of no 14 day stop date on the PRN clonazepam medication. A 14 day stop date was obtained on 2/17/2022 by the Director of Nursing and will be reviewed by the provider if the medication continues. #2 To identify other residents that have the potential to be affected a 100% audit of all PRN antipsychotic medications was performed by the Director of Nursing/designee on 2/18/2022 to validate that a 14 day stop date was in place. There were no negative findings.	

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F 758	Continued From page 2 Clonazepam 0.5mg 1 tab twice daily PRN was ordered without a stop date. The admission Minimum Data Assessment completed on 2/7/22 indicated the Resident was cognitively intact. Resident #202 was not coded as having received a PRN psychotropic medication during the assessment period. A care plan was initiated on 2/1/22 for the use of antianxiety medication. Interventions included administer medication as prescribed by the Physician, monitor/report any negative side effects, and implement nonpharmacological interventions when able. An interview was completed with the Director of Nursing on 2/16/22 at 1:25pm. She indicated when Residents were newly admitted to the facility, the discharge medication regimen was reviewed for any PRN psychotropics without stop dates. The medication regimen was then reviewed with the facility physician and stop dates were implemented where indicated. The Physician reassessed Residents for continued use and extended the duration of the medication as needed. The DON indicated she was unsure why Resident #202's PRN Clonazepam did not include a stop date. A telephone interview was completed with the Pharmacy Consultant on 2/16/22 at 1/30pm. She indicated when she completed medication regimen reviews, if a PRN psychotropic medication was found to be ordered without a stop date, she would complete a pharmacy recommendation to the Physician to include a stop date or discontinue the medication. She further stated a monthly medication review	F 758	#3 To prevent this from recurring the Director of Nursing/ designee reeducated all licensed nurses on the CMS regulation on PRN antipsychotic medications must have a 14 days stop date. If the provider continues the medication the resident must be reevaluated by the provider and the medication renewed with a 14 day stop date in place. This education was completed on 2/21/2022 by the Director of Nursing/designee. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. #4 To monitor and maintain ongoing compliance the Director of Nursing/ designee will monitor all new psychotropic medication orders in the morning clinical meeting to ensure there is a 14 day stop date with the order. Monitoring will occur 5x weekly for 12 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 758	Continued From page 3 regimen had not yet been completed on Resident #202 because of his recent admission. A telephone interview was completed with the facility's Physician Assistant on 2/17/22 at 8:27am. She indicated that she was aware that all PRN psychotropic medications need stop dates when prescribing. She stated she evaluated Resident #202 on 2/2/22 for his continued use of PRN Clonazepam for 14 days but was not aware the facility did not include a stop date for the medication. An interview was completed with the DON on 2/17/22 at 2:48pm. It was her expectation all PRN psychotropic medication include stop dates.	F 758	Will be reviewed monthly for 100% compliance for 4 months.	
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		2/18/22

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F 812	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to maintain the kitchen clean and in a sanitary condition to prevent food borne illness by failing to clean one of one steam table shelves and failed to degrease baking sheets. The findings included: During the initial tour on 2/14/22 at 9:35 AM three baking sheets, were observed on top of the convection oven. The sheet pans had a buildup of dried food particles/grease under the 1-inch rim. On 2/17/22 at 9:09 AM 2 sets of baking sheets nested rolls to proof, were observed warming on top of the convection oven. The sheet pans had a buildup of dried food particles/grease under the 1-inch rim. One rolling cart with 6 sheet pans stored upside to dry was observed. The sheet pans had a buildup of dried food particles/grease under the 1-inch rim. In an interview on 2/17/22 at 10:08 AM the dietary manager stated she would have staff clean the steam table shelf and use the degreaser to clean the sheet pans. During an observation of the kitchen on 2/15/22 at 11:44 AM the steamtable area was observed. The 6-foot underside of the was observed to have splashes of dark dried food particles. An observation of the steamtable area was conducted with the dietary manager on 2/17/22 at 10:08 AM revealed the steamtable to be in the same condition. In an interview on 2/17/22 at 10:08 AM the dietary	F 812	#1 No specific resident identified with this issue. The pans under the steam table were cleaned by the Dietary Manager on 2/17/2022. #2 All residents have the potential to be affected by the deficient practice. #3 To prevent this from recurring, the Administrator reeducated the Dietary Manager on 2/18/2022 on the expectation that the pans under the steam table will be checked and clean daily. #4 To monitor and maintain ongoing compliance, the Administrator will check the pans under the steam table to validate they are clean. Monitoring will occur 5 x weekly for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	

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F 812	Continued From page 5 manager stated she would have staff clean the steam table shelf and use the degreaser to clean the sheet pans.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview the facility failed to maintain the area surrounding the dumpster free of debris for 2 of 2 dumpsters observed. The findings included: During an observation of the dumpster area on 2/16/22 at 1:34 PM, 2 disposable gloves, and assorted papers were observed beside dumpster # 1. A Styrofoam cup, assorted papers, straw papers, 2 empty plastic drink bottles, and jelly cup were observed behind dumpster #1 and dumpster # 2. During an observation of the dumpster area on 2/17/22 at 8:15 AM, 3 disposable gloves, and assorted papers were observed beside dumpster # 1. One Styrofoam cup, assorted papers, straw papers, 2 empty plastic drink bottles, and jelly cup were behind dumpster #1 and dumpster # 2. An observation of the dumpster area was conducted with the dietary manager on 2/17/22 at 10:08 AM revealed the dumpster area to be in the same condition. During an interview on 2/17/22 at 10:08 AM the dietary manager stated housekeeping took the	F 814	#1 No specific resident was affected as a result of this practice. The debris around both dumpsters was removed by the Maintenance Director on 2/17/2022. #2 All residents have the potential to be affected by this practice. #3 To prevent this from recurring, the Administrator reeducated the Maintenance Director and housekeeping supervisor that the dumpsters must be checked daily for any debris and removed as soon as possible. This education was completed on 2/18/2022. #4 To monitor and maintain ongoing compliance, the Administrator will monitor the dumpsters for any debris and validate that it has been removed timely. Monitoring will occur 5 x weekly for 3 weeks, then 3 times weekly 3 weeks, then 2 times weekly for 3 weeks then	2/18/22

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F 814	Continued From page 6 trash to the dumpster the dietary department did not. In an interview on 2/17/22 at 10:09 AM the floor technician stated he took the trash out for the kitchen. He indicated some of the trash fell off when the garbage truck emptied the dumpster, and he felt the driver should clean up the dumpster area. During an interview on 02/17/22 11:17 AM the Administrator indicated he would have staff check and clean the dumpster area.	F 814	weekly for 3 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		2/28/22

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F 880	Continued From page 7 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 8 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and Administrator interview, the facility failed to implement a Legionella prevention program with a water management program or testing protocols. This deficient practice had the potential to affect all 54 residents. Findings included: Review of the Legionella Assessment and Prevention Program policy revised on 9/9/19 revealed the facility would ensure a Legionella assessment was conducted in accordance with state and federal requirements. The assessment included multiple control measures of temperature management, physical controls, disinfection level control, visual inspection/environmental testing for pathogens, and temperature management. The Administrator would assign the responsible person to complete the assessment and maintain proper documentation. During an interview with the Administrator on 2/17/22 at 10:35 AM, he revealed the facility had policies and procedures to monitor for Legionella last revised on 9/9/19. He stated the water was last tested in September 2019, and Legionella was not detected. The Administrator further stated the town of Nashville did not perform Legionella testing regularly for the facility, but they did test for nitrate and contaminants/disinfectant biproducts/other contaminants. The Administrator indicated at 12:03 PM that he did	F 880	#1 No residents suffered any harm as a result of the deficient practice. #2 All residents are at risk for this deficient practice. A facility legionella assessment was performed by administrator on 2/17/22. The assessment revealed that the facility is at a low level of risk for legionella contamination. Legionella testing was performed by the Administrator on 2/28/2022 and sent to the lab. #3 To prevent this from reoccurring the Regional Director of Clinical Services reeducated the Administrator on 2/17/2022 on the Legionella policy and the expectations of annual testing. #4 Annual Testing will be completed by the Administrator or designee	

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F 880	Continued From page 9 not have any documentation of water temperature or testing for Legionella available since 2019. He stated this was due to the previous maintenance supervisor not performing the necessary water testing, who left the facility without notice 3 months ago.	F 880		