STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345165	A. BUILDING _____ B. WING _____	C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARION	1264 AIRPORT ROAD MARION, NC 28752

(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 An unannounced recertification and complain investigation survey was conducted on 4/11/2022 through 4/13/2022. The facility was found in compliance with the requirement CFR § 483.73 emergency Preparedness. Event ID #BXQM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 4/11/2022 through 4/13/2022. There were 3 intakes associated with the survey NC00185330, NC00183321, and NC00181749. 7 of 7 allegations were unsubstantiated. Event ID #BXQM11.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/17/22

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

Electronically Signed | 05/05/2022

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F 761	Continued From page 1 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure pre-mixed medications on 1 of 6 medication carts (200 hall medication cart) and discard expired medications in 2 of 6 medication carts (Short hall medication cart and Long hall medication cart). The findings included: 1. An observation of the 200 hall medication cart on 4/12/22 at 8:23 AM revealed 4 plastic cups of clear, colorless liquid were on top of the medication cart. The cups were half-full of approximately 4 ounces of liquid with straws in each cup and were unlabeled with any resident name. The medication cart was locked, and Nurse #1 was observed administering medications to Resident #60 while away from the medication cart. Other staff members were observed walking on the hallway where the 200 hall medication cart was parked. An interview with Nurse #1 on 4/12/22 at 8:28 AM with the Assistant Director of Nursing (ADON) present revealed she had pre-mixed Polyethylene glycol with warm water and the 4 cups that were left on top of the 200 hall medication cart contained this solution. Polyethylene glycol is a laxative used to treat occasional constipation. Nurse #1 stated she had to use warm water to dissolve the medication better and said she had a hard time dissolving Polyethylene glycol right before medication administration, so she had to	F 761	Element 1 On 4/12/22, the four plastic cups of clear, colorless liquid were removed and discarded properly from 200 Hall Medication cart. On 4/13/22 the expired medications were removed from long and short hall medication carts and sent back to the Pharmacy per protocol. No residents were affected by this deficient practice. Element 2 To identify other residents who have the potential to be affected, on 4/15/22 a 100% medication cart audit was completed by the Nursing Administrative staff with no further expired medications were noted. On April 15th the DON performed observation rounds during medication pass times with no observation noted for pre-mixed medications stored unsecured on the medication carts. Element 3 To prevent this from recurring, an in-service was completed by the DON to the licensed nurses, medication aides and agency licensed staff on ensuring that all medications are secured properly and that all medications in each cart that are expired and disposed of properly. During routine rounds the DON and or clinical management staff will monitor for Medication storage compliance. Any	

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F 761	Continued From page 2 mix it ahead of time and let it sit until it dissolved. Nurse #1 stated she didn't think it was unacceptable to leave the pre-mixed medication on top of the medication cart. An interview with the ADON on 4/12/22 at 8:30 AM revealed she could understand why Nurse #1 had to pre-mix the Polyethylene glycol ahead of time in order to dissolve it better, but it was probably not acceptable to leave the pre-mixed medication cups on top of the medication cart and unsecured. An interview with the Director of Nursing (DON) on 4/13/22 at 2:31 PM revealed it was not acceptable that Nurse #1 left pre-mixed Polyethylene glycol unsecured on top of the medication cart and she should have pulled and prepared medications right before administration. 2.a. An observation of the Short hall medication cart on 4/13/22 at 10:32 AM with Nurse #2 revealed a sealed bottle of Nitroglycerin tablets available for use on the top drawer labeled with an expiration date of 12/2021 and belonged to Resident #12. Nitroglycerin is a vasodilator (medications that open/dilate blood vessels) used to treat and prevent chest pain. An interview with Nurse #2 on 4/13/22 at 10:35 AM revealed Resident #12 had not received a Nitroglycerin tablet since October 2021 and it had been ordered to be given only if she had chest pain. Nurse #2 stated that was probably why the expired bottle of Nitroglycerin bottle had been missed but all the nurses should be checking the medication carts for expired medications. b. An observation of the Long hall medication	F 761	negative findings will be corrected immediately. All newly hired licensed staff and licensed agency staff will be educated on this expectation as a part of the orientation on or after 5/5/22. Element 4 To monitor and maintain compliance the DON/ Designee will perform an audit of all medication carts 2 times weekly for 8 weeks. Audit to include the following: monitoring for medication expiration dates, proper storage and security of medications in and on the medications carts to ensure residents safety. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The DON is responsible for compliance. Compliance date 5/17/22	

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F 761	Continued From page 3	F 761		

cart on 4/13/22 at 10:40 AM with Nurse #3 revealed two opened bottles of Lactulose belonging to Resident #29 available for use on the right third drawer labeled with an expiration date of 1/2022. Lactulose is a laxative and ammonia reducer used to treat constipation. Two opened bottles of Latanoprost eye drops were also available for use on the top drawer. Latanoprost is a medication used to treat glaucoma. One of the Latanoprost eye drop bottles belonged to Resident #70 and was labeled as having been opened on 2/22/22. The other Latanoprost eye drop bottle belonged to Resident #9 and was labeled as having been opened on 2/5/22. Both Latanoprost eye drop bottles had a sticker that read "discard after 6 weeks after opening."

An interview with Nurse #3 on 4/13/22 at 10:44 AM revealed Resident #29 had been refusing to take the Lactulose and this was probably why they had missed the expiration date on the bottles. Nurse #3 stated the Latanoprost eye drops were scheduled to be given at 8 PM and both Resident #70 and Resident #9 last received it on 4/12/22. Nurse #3 stated all nurses were supposed to be checking the medication carts for expired medications and the evening shift nurse should have looked at the opened dates on the bottles and discarded the expired eye drop bottles.

An interview with the Director of Nursing (DON) on 4/13/22 at 2:31 PM revealed the expired medications should have been discarded and not left on the medication cart available for use. The DON stated all nurses were responsible for checking the medication carts for expired medications and they needed to re-educate all

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F 761	Continued From page 4 the nurses about this responsibility.	F 761		
F 880 SS=D	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; §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	F 880		5/17/22

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F 880	Continued From page 5 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. §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 reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 1 of 6 staff members (Housekeeper #1) failed to wear full Personal Protective Equipment (PPE) when entering a resident's room on enhanced droplet	F 880	Element 1. The facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 1 of 6 staff members (Housekeeper #1) failed to wear full Personal Protective Equipment (PPE) when entering a	

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F 880	Continued From page 6	F 880		

precautions (Resident #11). In addition, Nurse Aide #1 failed to disinfect a non-dedicated resident medical equipment in between resident use for 1 of 3 residents (Resident #11) reviewed for infection control. These failures occurred during a COVID-19 pandemic.

The findings included:

1. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following statement under Section 2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: *HCP (Healthcare personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

The facility's policy entitled, "Infection Control - Transmission Based Precautions," revised in April 2016 indicated the following statements under Droplet Precautions: A mask is worn for close contact with infectious resident. Gloves, gown, eye protection are worn adhering to Standard Precaution guidelines.

The facility's policy entitled, "COVID-19 Testing Guidance," updated on 2/7/22 indicated the following statement: Residents with signs or symptoms must be tested and be placed in full

resident's room on enhanced droplet precautions (Resident #11). In addition, Nurse Aide #1 failed to disinfect a non-dedicated resident medical equipment in between resident use for 1 of 3 residents (Resident #11) reviewed for infection control. These failures occurred during a COVID-19 pandemic.
On 4/11/2022 appropriate disinfection wipes were placed on the non-dedicated resident equipment that was identified in the observation. The aide was provided verbal re-education at that time on proper cleaning of equipment by the Director of Nursing and the Infection Preventionist.

On 4/11/2022, housekeeper #1, had appropriate sized N95 masks made immediately accessible for use.

The results of Resident #11 Covid 19 polymerase chain reaction test was negative and isolation was discontinued on 4/12/2022.
Element 2.
Because all residents and staff that are Covid negative are at risk for contracting/transmitting Covid 19 virus, the facility Infection Preventionist (IP), began focused training to all staff, beginning the week of April 18th, on the transmission of Covid 19, including the requirement to disinfect non-dedicated equipment in between resident use and adherence to wearing proper Personal Protective Equipment (PPE). All staff training will be completed by 5/6/2022 by the Infection Preventionist. Any staff not educated by this time will be educated prior to their next scheduled shift.
Element 3.

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F 880	Continued From page 7 Transmission Based Precautions (TBP) pending results. Follow facility protocol once results are received. A progress note dated 4/11/22 at 10:41 AM indicated Resident #11 was coughing this morning and she was placed on enhanced droplet precautions. COVID-19 antigen and PCR (polymerase chain reaction) tests were obtained. An observation on the 100 hall on 4/11/22 at 9:43 AM revealed an enhanced droplet precautions sign posted on the wall beside Resident #11's door. The sign indicated instructions that all healthcare personnel must: clean hands before entering and when leaving room, wear a gown when entering room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, protective eyewear (face shield or goggles) and wear gloves when entering room and remove before leaving. A plastic drawer cart which contained N95 masks, face shields, gowns and gloves was located under the sign and beside Resident #11's door. An observation on 4/11/22 at 12:19 PM revealed Housekeeper #1 cleaning inside Resident #11's room while wearing a surgical mask, a face shield, a gown, and gloves. Resident #11 was present in the room and was observed coughing at intervals. A phone interview with Housekeeper #1 on 4/13/22 at 2:20 PM revealed she did not pay attention to the sign beside Resident #11's door and did not realize she was supposed to change into an N95 mask prior to entering Resident #11's room. Housekeeper #1 stated she had received	F 880	On 4/13/2022 a full sweep of the community was completed by the Administrator and Director of nursing to ensure that there was easy accessible and readily available PPE supplies, including appropriate masks and disinfecting cleaner for staff use on non-dedicated resident equipment. To prevent this from re-occurring, the facility Infection Preventionist, will provide education to all current staff by 5/6/2022, on following infection control practices, including proper PPE use for residents on isolation, and disinfecting of non-dedicated resident equipment after resident use. Education will be provided to new hires after 5/6/2022 and any agency staff. Any staff not educated by this time will be educated prior to their next scheduled shift. Leadership staff will conduct routine rounds and will monitor for compliance with proper PPE use and disinfecting of equipment after resident use. Any observed negative findings will be immediately corrected. Root cause analysis was completed and it was determined that the community did not have PPE supplies and disinfecting supplies convenient and readily accessible for the staff. Element 4. To monitor and maintain ongoing compliance the facility Administrator or designee, will audit for proper PPE use and disinfecting of non-dedicated resident equipment after use, 5 observations 5 times per week for 8 weeks beginning the	

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F 880	Continued From page 8 education on Personal Protective Equipment (PPE) use for rooms on enhanced droplet precautions, but she thought she was only required to wear a gown, a face shield, and gloves in addition to her surgical mask. She also stated that the N95 masks that were available on the cart were too big for her face and they were supposed to order her a size small. An interview with the Infection Preventionist (IP) on 4/13/22 at 1:58 PM revealed Housekeeper #1 should have switched her surgical mask into an N95 mask prior to entering Resident #11's room. The IP confirmed that Housekeeper #1 had received training on PPE use for residents who were placed on enhanced droplet precautions. 2. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following statement under Environmental Infection Control: Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient. The facility's policy entitled, "Infection Control - Transmission Based Precautions," revised in April 2016 indicated the following statement: Care equipment - use disposable non-critical equipment (thermometers, blood pressure cuffs, stethoscope, etc.) or implement	F 880	week of 5/9/2022. The results of this monitoring will be discussed at the community QAPI committee meetings for review and further recommendations for the duration of the auditing. Date of Compliance is 05/17/2022 Administrator is responsible for compliance.	

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F 880	Continued From page 9	F 880		

resident-dedicated equipment. If common use of equipment is unavoidable, clean and disinfect equipment before use on another resident.

A continuous observation on 4/11/22 from 3:39 PM to 3:44 PM revealed Nurse Aide (NA) #1 entering Resident #11's room while pushing a vital sign monitor equipment. NA #1 plugged Resident #11's phone into the charger per Resident #11's request and proceeded to take Resident #11's temperature by placing a disposable probe over the thermometer and putting it inside Resident #11's mouth. When she obtained Resident #11's temperature, she discarded the probe in the trash can and placed the thermometer back into the holder on the vital sign equipment. She obtained Resident #11's blood pressure using the blood pressure cuff on the vital sign equipment and then folded it and placed it back into the holder. NA #1 used hand sanitizer and then washed her hands in Resident #11's room sink prior to leaving Resident #11's room. She did not disinfectant the vital sign equipment that was just used on Resident #11. NA #1 pushed the vital sign equipment and proceeded to go inside Resident #13's room.

An interview with NA #1 on 4/11/22 at 3:45 PM revealed she knew she was supposed to sanitize the vital sign equipment before and after using it on each resident. NA #1 stated she used alcohol prep to wipe the thermometer and the inside part of the blood pressure cuff she used on Resident #11.

An interview with the Infection Preventionist (IP) on 4/11/22 at 3:56 PM revealed NA #1 should have sanitized the vital sign equipment she used on Resident #11 before using it on another

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F 880	Continued From page 10	F 880		

resident.

A follow-up interview with the IP on 4/12/22 at 8:25 AM revealed she had talked to NA #1 on 4/11/22 and NA #1 had admitted to her that she did not sanitize the vital sign equipment after she used it on Resident #11.

An interview with the Director of Nursing (DON) on 4/13/22 at 2:31 PM revealed all the staff members which included Housekeeper #1 had been told that they should wear an N-95 mask and full PPE when going into an enhanced droplet precaution room. The DON stated he had some N95 masks in his office and Housekeeper #1 should have obtained some from him. He stated Housekeeper #1 had been sized down to a small N95 mask when she was fit-tested, and they had discussed with her that they were ordering her size and they had been available for her to use. The DON also stated NA #1 had told them that she was used to the sign being on the actual door of the resident and not on the wall beside it but she should have received report from the outgoing shift before she took over the hall so she would know Resident #11 had been placed on enhanced droplet precautions. He also stated NA #1 should have sanitized the vital sign equipment prior to using it on each resident.