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AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

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E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 6/26/2023 through 7/10/2023. 08/25/2020. The facility was found in compliance with 42 CFR 483.73 related to E - 0024 (b) (6), Subpart - B - Requirements for Long Term Care Facilities. Event ID #E6KS11.	E 000		
F 000	INITIAL COMMENTS An unanounced survey team entered the facility on 6/26/23 to conduct a complaint survey and exited on 7/06/23. Additional information was obtained on 7/10/23. Therefore, the exit date was changed to 7/10/23.The following intake was investigated NC00203586. 1 of the 3 allegations resulted in deficiency. Event ID # E6KS11.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director, Physician Assistant (PA) and Orthopedic Physician Assistant interviews the facility failed to follow a PA's order written on 05/03/23 to arrange for orthopedic follow up within 2 weeks for a resident. The resident was not seen until 05/31/23 and the Orthopedic PA noted drainage	F 684	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATED ON THE STATEMENT OF DEFICIENCIES.	7/10/23

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

Electronically Signed | 07/21/2023

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F 684	Continued From page 1 from the surgical wound and the staples were still in place and imbedded in the skin. The resident was sent to the hospital due to concern for a periprosthetic joint infection (infection around the hip prosthesis) and on 06/06/23 an incision and drainage was performed to the left hip in the operating room. This deficient practice occurred for 1 of 2 residents reviewed with a surgical wound (Resident #1). The findings included: Resident #1 was readmitted to the facility on 05/01/23 post Left Hip Revision. The hospital discharge instructions dated 05/01/23 included: Administer Doxycycline Monohydrate (an antibiotic) 100 mg 1 capsule every 12 hours. Call for follow up appointment with primary care provider (PCP) and orthopedic surgeon within 1 week. Record review of the Physician orders entered by Nurse #2 on 05/01/23 included in part: Assess surgical bandage to left hip for drainage, warmth, redness, and s/s (signs and symptoms) of infection and document findings in progress note and notify the physician or physician assistant (MD/PA-C) every shift monitoring. Physical therapy (PT) evaluation and treatment. Vital signs and O2 Sats (Oxygen saturation - measures oxygen content in blood) every night shift for monitoring Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) to	F 684	THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW. PROBLEM: Facility failed to make a follow up post-surgical appointment for a resident as ordered and the resident ended up with a hospital stay related to an infected hip wound. 1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #1 is no longer in the facility, did not return after hospitalization. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTISE: All residents who have follow up surgical appointments ordered have the potential to be affected by this deficient practice, therefore on 6/27/23, the Staff Development Coordinator completed a review of all current residents in house to determine who had surgical follow-up appointments to ensure that the appointments have been made as ordered. This review included any new or re-admissions from 6/1/23 to present. Any discrepancies identified were communicated with the ordering provider and appointments scheduled. 3. MEASURE PUT IN PLACE/SYSTEMIC CHANGES TO PREVENT THIS FROM RECURRING:	

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F 684	Continued From page 2 monitor for infection every Tuesday morning. Administer Doxycycline Monohydrated Oral Capsule 100 mg two times a day for surgical incision prophylaxis (for infection prevention) until 05/31/23. Record review of the Medication Regimen Review and Medication Order Recap for May 2023 revealed there was no entry by Nurse #2 to call for a follow up with the orthopedic surgeon within one week. A telephone interview was conducted on 06/29/23 at 9:22 AM. Nurse #2 stated that she reviewed Resident #1's hospital discharge summary and entered the 05/01/23 orders on in the Medication Administration Record (MAR) and Treatment Administration Record (TAR). A copy of the hospital discharge summary contained an appointment on 05/31/23 that was put it into the transportation department's box. Nurse #2 explained the Transportation Aide picked up the appointment orders from box and scheduled all appointments. She remembered appointment for 05/31/23 on Resident #1's hospital discharge summary but did not recall an order for a 1 week follow up appointment with the primary care provider and the orthopedic surgeon. Record review of the quarterly Minimum Data Set (MDS) dated 05/07/23 revealed Resident #1 was cognitively intact. She required assist with activities of daily living (bathing, personal hygiene, dressing, and grooming) and had occasional incontinent bowel or bladder episodes. She used a walker or a wheelchair for mobility. Her diagnoses included Unspecified Dislocation of Left (L) Hip, subsequent encounter; Presence of	F 684	To prevent this from recurring, on 6/27/23 the Director of Nursing (DON) or designee initiated education on the process of scheduling appointments as ordered by the providers to all licensed nursing staff. This education was completed on 6/27/23. This same education will be provided to all agency or new hires after 6/27/23. Clinical leadership staff will review new admission and new orders in clinical morning meeting to ensure appointments are scheduled as ordered. Upon receipt of any order, referral or follow-up appointment recommendation, the nurse receiving the order, referral or follow-up appointment recommendation, will be placed in the transportation communication book. The transporter/scheduler of appointments will check the communication book daily and schedule appointments appropriately. 4. MONITORING TO ASSURE CONTINUED COMPLIANCE: To monitor and maintain ongoing compliance, beginning 6/27/23 the DON or designee, will conduct an audit and document results of 10 residents per week for 12 weeks, to validate that all surgical appointments have been made as ordered. The DON/designee will review the EHR for orders of the previous day daily x 5 days a week and communicate with transportation and DON/designee will meet 2 x weekly to ensure all orders for referrals, orders or follow-up appointment recommendations have been scheduled. The transporter/scheduler of appointments will report any refusals	

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F 684	Continued From page 3 Artificial Hip Joint; Unilateral Primary Osteoarthritis of the L Hip; Stroke and Anxiety Disorder. Resident #1's care plan dated 05/07/2023 indicated to readmit after total revision of left hip arthroplasty-surgical incision with dressing in place to be removed and follow up with orthopedics. Interventions included: Assess and document the status of the area (healing vs declining). Monitor, document, and report to Physician changes in color, temperature, sensation, pain, or presence of drainage and/or odor. Vital signs / labs as ordered. Consult MD (physician) with any abnormal values. Wound documentation per protocol. Record review of the Treatment Administration. Record review of the Treatment Administration Record for May 2023 indicated that the surgical dressing was checked every day on first shift as indicated by nurses' initials. Record view of the Medication Administration Record for May 2023 indicated assess surgical bandage to left hip for drainage, warmth, redness, and signs and symptoms of infection. Document findings in progress note and notify the Physician or Physician Assistant every shift, for monitoring. Review of Resident #1's May 2023 MAR revealed nurses' initials confirming that the surgical bandage was checked every shift. In addition, Resident #1 was administered one Doxycycline 100 mg capsule every 12 hours daily as prescribed. Resident #1's weekly skin assessments completed by the nurses dated 05/01/23, 05/08/23, 05/15/23, 05/22/23, 05/29/23 and	F 684	and/or schedule changes to the DON/designee as or if they occur. Any negative finding will have follow-up done promptly including notification to the ordering provider. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. The QAPI committee reserves the right to modify the plan of correction in the event that there are concerns identified through the auditing process. The facility Director of Nursing is responsible for compliance. Date of compliance 6/27/23.	

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05/30/23 revealed left hip dressing was intact and with no signs and symptoms of infection.

Record review of Resident #1's Complete Blood Count (CBC) revealed a white blood count (WBC- a measurement used to determine infection with normal range of 3.8-10.8 K/uL).

WBC on 05/02/23 - 5.4 K/uL (thousands per cubic milliliter).

Review of the Physician Assistant's (PA) progress note dated 05/02/23 revealed Resident #1 was alert and oriented to self alone. She was up in her wheelchair and her vital signs were stable. Resident #1 had pain with movement of the LLE (left lower extremity) but no longer with pain during palpation of the left calf/thigh. Plan included follow up with Ortho within 2 weeks and strict posterior hip precaution measures. A small WC cushion was placed that day but Resident #1 did not have adequate recall/compliance with the cushion. Staff to continue the best they can to always encourage placement. Left hip surgical dressing to be assessed every day by nursing and wound care RN as well and to notify ortho of any compromise. Resident #1 remains on post-op Abx (antibiotics) per ortho through the end of May.

Review of PA orders dated 05/03/23 included:
Assess L hip surgical dressing once daily.
Notify Orthopedics if any compromise every day for wound care.
Arrange for orthopedic follow up within 2 weeks regarding L hip Arthroplasty.

During a telephone interview on 06/27/23 at 3:30PM, the Physician's Assistant stated that she

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had ordered the nurses on 05/03/23 to obtain a 2 week follow up appointment at the orthopedic office. She was not aware of any compromise of the surgical incision or the dressing.

Record review of Nurse #1's progress note dated 05/03/23 revealed PA came in for readmission visit and wrote orders to assess the left hip incision daily and to make a follow up appointment with the orthopedic office.

On a telephone interview on 06/29/23 at 10:48 AM with Nurse #1, she recalled the 05/03/23 PA order and stated she made a copy of the follow up appointment order and put it into the transportation department's box.

Vital signs on 05/03/23 at 3:49 AM: BP (Blood pressure) 113/74; T (Temperature) 97.4; P (Pulse) 67; R (Respiration) 18; O2 Sat (Oxygen Saturation - blood oxygen level) 98% on room air (RA).

Review of the May 2023 transportation calendar revealed no appointment was scheduled for Resident #1's follow-up appointment between May 1st through the 14th.

An interview on 06/27/23 at 9:25 AM with the Scheduler/Transportation Aide indicated the nurses put the copy of the appointment order in the transportation box and she checked the box daily. Orders were written on her calendar, and she also made the up follow up appointments as ordered. She stated that the only appointment she received for Resident #1 with the orthopedic surgeon was for 05/31/23.

A follow up telephone interview with the

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Scheduler/Transportation Aide was completed on 06/29/23 at 9:32 AM. She clarified that she did not receive the order dated 05/03/23 to make a 2-week orthopedic follow up.

Review of PA notes on 05/16/23 indicated in part Resident #1 was alert, oriented to self alone and had short recall. She was up in her wheelchair working with therapy and tolerating well. Pain was stable and minimal when changing from sitting to standing position. Resident was eating/drinking and tolerating diet. Orthopedic follow up in place per staff. Plan included a follow up with Ortho within 2 weeks and strict posterior hip precaution measures. Resident continued to have small WC cushion, but resident did not have adequate recall/compliance with using it. Staff was to continue to do the best they can to always encourage placement. Dressing was to be assessed every day by nursing and wound care RN as well and to notify orthopedic providers of any compromise. Pain management was in place. Weight bearing as tolerated (WBAT). Resident #1 remained on post-op antibiotics through 05/31/23.

WBC on 05/04/23 was 5.4 K/uL.

Vital signs on 05/04/23 at 5:35 AM: BP 114/72; T 97.7; P 80; R 16; O2 Sat 98% on RA.

WBC on 05/09/23 was 9.4 K/uL.

Vital signs on 05/09 at 4:49 AM: BP 134/85; T 96.8; P 78; R 18; O2 Sat 99% on RA.

WBC on 05/11/23 was 6.3 K/uL.

Vital signs on 05/10/23 at 6:09 AM: BP 136/76; T

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97.5; P 78; R 18; O2 Sat 98% on RA.

WBC on 05/18/23 was 6.9 K/uL.

Vital signs on 05/18/23 at 5:09 AM: BP 124/74; T 97.8; P 76; R 18; O2 Sat 97% on RA.

WBC on 05/25/23 was elevated to 15.1 K/uL.

Vital signs on 05/25/23 at 2:29 AM: BP 130/74; T 97.2; P 72; R 18; O2 Sat 97% on RA.

During an interview with Nurse #4 on 07/05/23 at 9:50 AM, she stated she notified the facility medical director of the increased WBC on Resident #1 on 05/25/23. She printed out the lab result and Medical Director signed the hard copy when he was rounding that day. She added that there were no orders written by Medical Director that day. She denied notifying the surgeon since their facility protocol was to notify Medical Director or PA of abnormal laboratory results.

An interview was completed on 06/27/23 at 4:15 PM with Nurse #2. She revealed that when she completed Resident's #1 skin evaluation on 05/29/23, the surgical dressing was not the original dressing It was dry and had no odor. Nurse #2 assisted Resident #1 to stand to assess the dressing on the hip.

During a follow-up telephone interview on 06/29/23 at 9:22 AM Nurse #2, revealed she completed skilled note dated 05/29/23 and marked a checkbox indicating the incision on the left hip was intact and well approximated. She stated she did not look at the actual wound.

Vital signs on 05/30/23 at 12:02 AM: BP 128/70;

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T 97.9; P 74; R 16; O2 Sat 95% on RA.

Vital signs on 05/31/23 at 3:03 AM: BP 130/70; T 97.9; P 74; R 18; O2 Sat 96% on RA.

Record review of skilled nursing notes completed Nurse #1 on 05/30/23 and 05/31/23 revealed Resident #1 was alert and oriented. She had clear speech and needed assistance with activities of daily living (ADL) and transfers, but she was able to propel herself in a wheelchair. She had incontinent episodes at times. Dressing to L hip was clean dry and intact. Left hip incision was intact and edges were well approximated. Skin was warm and dry to touch.

A telephone interview on 07/05/23 at 2:37 PM Nurse #1 indicated no recall of Resident #1's incision on 5/30/23 or 5/31/23. She stated she assumed the checkbox on the skilled notes forms were to verify that the dressing was dry and intact. She did not recall a malodor. She stated the orthopedic physician was called when a resident had drainage or odor in a wound. In addition, the wound care nurse was notified if the dressing was saturated.

Record review of Physical Therapy Discharge Summary dated 05/31/23 at 10:09 AM revealed Resident #1 has met her maximum potential and did not require further skilled PT at that time.

During an interview on 06/27/23 at 9:50 AM the Physical Therapist (PT) revealed Resident # 1 as having some cognitive or memory issues, impulsive at times, but followed commands. She had high anxiety, was unstable and was still high risk for falls but displayed improvement. She walked 225 steps with the use of a walker with

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contact guard by 05/31/23. PT stated they do not assess surgical wounds, but they notified nurses when there were issues with dressings. The PT stated he notified the nurse of Resident #1's dressing coming loose on 05/31/23.

An interview was completed on 06/27/23 at 8:50 AM with the Wound Care Nurse (WCN). She indicated she had changed Resident #1's dressing one morning when the PT notified her of the dressing "coming loose". She did not recall when this was. She observed the staples were intact, and she noted a small amount of clear drainage. She did not observe any odor and did not document in Resident #1's progress notes. She stated Resident #1 did have the original dressing and that she monitored her dressing daily. She was aware of a follow up appointment with Resident #1's surgeon for 05/31/23 and added that was what the surgeon's office had set up.

A follow up telephone interview with the WCN on 6/28/23 at 9:05 AM revealed that monitoring of the surgical site was completed every shift. This was documented by nurses on the TAR that was checked daily. If there were changes, she documented on the progress note, and notified the physician.

An additional follow up telephone interview was completed with WCN on 07/3/23 at 10:00AM which revealed the surgical site was clean, dry, and intact, no scabs, no swelling, no odor on 05/31/23. This was when she became aware there were staples. She revealed that the order was to keep the area clean dry and protected. She put an absorbent pad over the surgical wound to keep it clean.

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A telephone interview was conducted on 07/06/23 at 8:49 AM with Nurse Aide #2. She stated she assisted Resident #1 the morning of 5/31/23. Resident #1 was assisted in ambulating to the bathroom and in getting dressed for her doctor's appointment. She added that Resident #1 was behaving as usual and did not complain of any pain or discomfort. She did not recall the dressing being soiled or any bad odor from the wound on 05/31/23. Nurse Aide #2 explained if she observed odor from a wound or if there were any changes in a resident's condition, she notified the nurse. Resident #1 had no complaints on 5/31/23.

Record review of the Orthopedic Physician Assistant note dated 05/31/23 revealed Resident #1 did not follow up with her routine 2-week postoperative appointment. The surgical dressing to the left hip was soiled, malodorous and saturated with serosanguinous fluid (clear fluid mixed with some blood). The surgical staples were still in place and embedded on the skin. The upper wound was fully healed but the lower incision showed a persistently draining sinus tract/fistula. Resident #1 was doing well on examination and denied any numbness, tingling, fevers/chills, nausea or vomiting (N/V), swelling, shortness of breath, or chest pain. The staples were removed during this visit and Resident #1 was subsequently sent to the emergency department for concern of a periprosthetic joint infection.

A telephone interview with Orthopedic Physician Assistant (PA) on 07/05/23 at 9:12 AM revealed he had noted the odor coming from Resident #1 surgical wound from across the room when he assessed Resident #1 on 05/31/23. The dressing

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was reinforced with tape, and it was soiled with malodorous drainage. He stated that the purpose of the follow up 2-week appointment was to remove the staples and evaluate the wound. The staples were imbedded into the wound and overgrown. The wound was 4 weeks old and serosanguinous drainage saturated the dressing. The nursing home did not report any elevated labs or drainage to the orthopedic office. He indicated that hospitalization may have been avoided if Resident #1 had been brought in for her two week follow up appointment. He stated he expected a call from the nursing home with a draining wound and staples still intact after 4 weeks. The PA did not say that the staples not being removed were the cause of infection.

Review of hospital records dated 05/31/23 revealed Resident #1 was initially evaluated in the emergency department (ED) for Left Hip Prosthetic Joint Infection. Examination by physician revealed Resident #1 had a normal mood and behavior. She was sitting comfortably in a chair with stable blood pressure, temperature, pulse and breathing. Review of systems were negative for fever. VS obtained at 17:32: BP 120/78, P 66, R 16, T 97.6 °F and O2 Sat 100 % on RA. There was no shortness of breath, and no chest pain. She was alert and stood with assistance. The left hip incision was healed from the top of the incision but had a small opening at the bottom of the incision. There was a purulent (sign of infection) discharge on dressing. The staples were out of the incision and there was no obvious cellulitis or edema. Resident #1's skin was warm, dry not diaphoretic and not cyanotic. The CBC on 05/31/23 revealed a normal white count at 8.3 K/uL. Her C-Reactive Protein (CRP - protein released by liver into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 07/10/2023

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

(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
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bloodstream in the presence of inflammation) was high at 27.75 mg/dl (milligram per deciliter, the normal level was below 0.3 mg/dl; serious level is above 50 mg/dl). Blood culture specimen was also drawn that day on 05/31/23. The final result for the blood culture was negative.

Review of hospitalist's progress note on 06/01/23 indicate Resident #1 had no acute events overnight and Resident #1 denied hip pain or discomfort. There was persistent serosanguinous drainage. Resident #1 denied any sensation of swelling, fevers or chills, nausea or vomiting, malaise, fatigue, or any other symptoms. A wound culture collected on 6/2/23 revealed light growth of pseudomonas aeruginosa (gram-negative, aerobic, non-spore forming rod that could cause a variety of infections) which was indicative of a bacterial infection. Review of a computerized tomography scan (series of x-rays) on 06/03/23 of the left hip identified cellulitis.

Record review of the surgical note dated 06/06/23 revealed an incision and drainage was performed to the left hip in the operating room. A large collection of subcutaneous purulent drainage or pus was noted extending to the posterior capsule into the hip joint where the prosthesis was. The area was irrigated (washed out), and antibiotic beads were implanted in the surrounding tissues. A tissue culture of debris was obtained during the incision and drainage. The tissue culture result was negative for any infection.

During a telephone interview on 06/27/23 at 3:50 PM with the facility's Medical Director, he stated Resident #1 was initially admitted on 01/26/23. She exhibited cognitive decline and had a poor functional level. He explained that this

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back-to-back surgery worsened Resident #1's cognitive ability and there was already a concern for infection setting up when he spoke with Orthopedic Physician on 05/01/23. Additionally Resident # 1 was readmitted on 05/1/23 on chronic antibiotic therapy due to the high risk of infection, especially with the third surgery. He indicated his impression was that the follow up appointment was 05/31/23.

A follow up telephone interview was completed with the facility's Medical Director on 06/29/23 at 10:55 AM. He stated there was a mix up with the follow up appointment on Resident #1's discharge summary. The PA clarified the order on 05/03/23 and wrote for an Orthopedic follow up within 2 weeks. He explained Resident #1 was already on chronic antibiotic therapy when readmitted on 05/01/23. He stated she went to the appointment on the 05/31/23 and directly to the hospital from the office due to a strong suspicion of internal infection. He indicated that the facility monitored the complete blood count (CBC) weekly. He stated that on 05/25/23 her white count went up to 15,000. A follow up CBC was already scheduled for 06/01/23 and that she was already on an antibiotic. He stated he was not aware the staples had not been removed until 5/31/23 but stated this had no negative impact on the wound. The Medical Director stated this did not play a big part in the infection but stated they should have been removed in 2 weeks.

The Director of Nursing (DON) was not available for interview during the investigation.

A telephone interview on 07/10/23 at 12:23 PM Administrator revealed that physician orders need to be followed and to clarify if there were

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