STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 survey was conducted on 02/11/24 through 02/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G3M711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/11/24 through 02/14/24. Event ID# G3M711. The following intakes were investigated: NC00193436, NC00200277, NC00205595, NC00206320, NC00207206, NC00208550, NC00212189, NC00212810. 3 of 23 complaint allegations resulted in a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with residents, staff and the Nurse Practitioner, the facility failed to assess the ability of a resident to self-administer for 1 of 4 residents observed (Resident#88). The findings included: Resident #88 was admitted to the facility on 1/30/24 with diagnoses of allergies. The admission Minimum Data Set (MDS) assessment dated 2/5/24 indicated Resident #88 was cognitively intact and needed supervision	F 554	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability. Step 1- A medication error and self administration assessment could not be completed on this resident due to him discharging on 02.14.24. Step 2- Current residents have the potential to be affected so the Director of Nursing/Designee will interview all	3/12/24

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

Electronically Signed | 03/04/2024

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F 554	Continued From page 1 with most activities of daily living. A review of Resident #88's medical record indicated no documentation that Resident #88 was assessed for self-administration of medications. Resident #88 did not have a physician's order for self-administration of medications. A review of Resident #88's order summary for February 2024 indicated an active physician's order for Fluticasone Propionate Nasal Suspension 50 micrograms - two sprays both nostrils in morning for allergies and instructions to shake well. During an initial observation of a medication pass for Resident #88 on 02/13/24 at 08:00 AM with Medication Aid (MA) #3 for administration of nasal spray to the resident. The MA #3 sat the nasal spray in front of the resident without shaking the vial. The resident administered the nasal spray of two sprays in each nostril independently without shaking the bottle. An interview with Resident #88 on 02/13/24 at 08:00 AM revealed that he had some confusion about the nasal spray and how many sprays he should use per nostril. Resident #88 stated he was not aware that the nasal spray needed to be shaken before use. An interview with MA #3 on 02/13/24 at 8:45 AM revealed she always allowed resident #88 to administer his own nasal spray. MA #3 stated she was aware that residents needed to have a physician order and a self-administration assessment before they could be allowed to administer their medications. MA #3 stated she	F 554	residents with a BIMS of 12 or above regarding self-administration of medications. Any resident who wishes to self-administer will have a self administration assessment completed, order will be obtained and care plan is in place. This audit was completed on 02.16.2024. Step 3- To prevent this from happening the Director of Nursing/Designee will educate all Licensed Nurses and Medication Aides on not allowing resident to self administer unless resident has an assessment completed, an order obtained and a care plan is in place. This education was completed on 02.14.2024 Step 4- To monitor and maintain compliance, the Director of Nursing/Designee will audit all new admissions with a BIMS of 12 or above if they do wish to self administrate medications an assessment will be completed, order obtained and care plan is in place, weekly for 12 weeks. Audit of findings will be reviewed with the IDT monthly for 3 months. Further interventions will be reviewed and initiated as needed. Date of Compliance: 03.12.2024	

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F 554	Continued From page 2 was not aware that Resident #88 did not have a evaluation for self-medication of the medication, and stated she should have checked before the resident was allowed to self- administer any medication. An interview with the Director of Nursing (DON) on 02/14/24 at 12:35 PM revealed she was not aware that Resident #88 had been self-administrating his nasal spray. The DON stated that before self-administration could occur residents had to be assessed for safety reasons and the doctor had to give a order for self-administration. Her expectation was that staff be aware if a resident could self-administer before they allowed the resident to do so.	F 554		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		3/12/24

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F 644	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for a resident with mental health diagnoses upon admission for 1 of 3 residents reviewed for PASRR (Resident #47). The findings include: Review of Resident #47's medical record revealed a PASRR level I screening had been completed on 08/08/2018. No further PASRR documentation was discovered in Resident #47's medical record. Resident #47 was admitted to the facility on 01/06/23 with diagnoses including bipolar disorder, and dementia with mood disorder. During an interview on 02/14/24 at 1:20 PM with the Social Worker (SW), she revealed she had been employed as the facility SW for the past 36 years and was responsible for completing PASRR referrals upon resident admission. She revealed she would review a resident's diagnoses once they were admitted to see if they would require a level II PASRR referral to be completed. The SW stated Resident #47 had been admitted from the hospital and she believed she had simply overlooked the date of the previous PASRR determination and the admission diagnoses. She explained that based on Resident #47's admission diagnoses of bipolar disorder and dementia with mood disorder, and the date of the preadmission PASRR level I, she should have completed the paperwork for a PASRR level II referral.	F 644	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Step 1- Social worker applied for PASARR level II for resident #47 on 02.15.2024. Step 2- To identify other residents that have the potential to be affected, the Social Worker completed an audit of all residents with mental health diagnosis on 02.15.2024 and any negative findings will be submitted for review 03.11.2024. Step 3- To prevent this from happening again the Social Worker will apply for a new PASARR for all new admissions with a diagnosis and or medication deeming it appropriate for a significant change in status. Social Worker was educated on 02.16.2024 by the Regional Director of Clinical Services on the process for applying for PASSAAR's Step 4- To monitor and maintain ongoing compliance, the Social Worker will audit all new admissions weekly for the need to apply for Level II PASSAR for 12 weeks. The Nursing Home Administrator will audit three new admissions per week for 12 weeks to determine if a Level II PASRR was applied for if needed.The results of the audits will be taken to QAPI for review and recommendations for the next 3 months.	

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F 644	Continued From page 4 During an interview on 02/14/24 at 2:38 PM with the Administrator she revealed a PASRR level II referral should be completed in a timely manner upon admission for a resident with a mental health diagnosis. She stated based on Resident #47's admission diagnoses of bipolar disorder and dementia with mood disorder, a PASRR level II referral should have been completed.	F 644	Date of Compliance: 03.12.24	
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, staff, and Hospice Nurse Aide interviews, the facility failed to provide incontinence care to prevent a resident (Resident #45) from having urinary incontinence through her brief, pants, lift pad and onto her wheelchair pad for 1 of 3 residents reviewed for activities of daily living for dependent residents. The findings included: Resident #45 was admitted to the facility on 12/07/22 with diagnoses which included hemiplegia following a stroke, dysphagia, muscle weakness and dementia. Review of Resident #45's care plan dated 12/07/23 revealed a focus area for the resident having an activities of daily living (ADL) self-care deficit due to stroke with left hemiparesis and resident required extensive to total assistance	F 677	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability. Step 1- Director of Nursing/Designee completed skin assessments of resident #45 on 02.16.24 to ensure she had no adverse outcome due to the incontinent episode. No negative findings were noted. Step 2- To identify other residents that have the potential to be affected. The Director of Nursing or Designee completed skin assessments on residents who are dependent on staff for incontinent care to ensure no adverse outcomes from incontinent episodes and audited residents being wet, dry or saturated.This audit was completed on 02.19.2024.	3/12/24

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F 677	Continued From page 5 with ADL. Resident #45 was also at risk for further unavoidable declines related to diagnosis of dementia. The interventions included assist with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities, transfers with assist of mechanical lift, and refer to therapy as needed. Review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated 12/30/23 revealed she was severely cognitively impaired and dependent on 1-2 staff members for all activities of daily living except eating. The assessment also revealed Resident #45 had less than 6 months life expectancy and was followed by hospice. An observation on 02/13/24 at 10:17 AM of Resident #45 receiving incontinence care from the Hospice NA revealed when Resident #45 was lifted via mechanical lift from her wheelchair to her bed the wheelchair cushion had a spot that was wet and the Hospice NA wiped it with a paper towel and it was wet with yellow colored liquid. The Hospice NA wiped the liquid from the cushion and cleaned the cushion. As the resident was being lifted from the chair to the bed by the Hospice Nurse Aide (NA) and NA #4, her lift pad was noted to be wet in the area she was sitting on it and her pants were wet in the crotch area from front to back. When the Hospice NA removed Resident #45's brief, it was observed to be saturated from front to back with urine and the brief filling had started to bunch up in areas. The Hospice NA proceeded to clean the resident and applied a clean brief. Interview on 02/13/24 at 10:47 AM with the	F 677	Step 3- To prevent this from happening the Director of Nursing/Designee educated all nursing staff on performing incontinent care and rounds in a timely manner. Education will be completed by 03.05.24. Step 4- The Director of Nursing/Designee will observe 5 residents who are dependent on staff for ADL's including incontinent care has been provided. The results of these items will be taken to QAPI for review and recommendation monthly for 3 months. Date of Compliance: 03.12.2024	

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F 677	Continued From page 6	F 677		

Hospice NA revealed she came to see Resident #45 on Monday, Tuesday, and Friday and on Monday provided Resident #45 with a shower and on Tuesday and Friday provided her with a bed bath. The Hospice NA stated she used to come around 1:00 PM and Resident #45 would have been up since early morning and would be wet. She further stated she had found the resident wet before through her clothing but couldn't recall when the last time she found the resident that way.

Interview on 02/13/24 at 1:58 PM with NA #4 and NA #5 who were assigned to the 500 hall residents on 1st shift on 02/13/24 revealed they had changed Resident #45 and gotten her dressed around 7:30 AM before they had gotten her up in the wheelchair. NA #5 stated they had put her back to bed around 9:30 and changed her again but later in the conversation realized it was not Resident #45 they had changed at 9:30 AM but was another resident. NA #4 and NA #5 could not remember getting her back to bed or changing her after 7:30 AM and before she had been changed at 10:17 AM. NA #4 and NA #5 stated they usually did rounds at 7:00 AM, 9:00 AM, 11:30 AM and 1:30 PM for their shift. NA #4 and NA #5 stated she usually drank a lot of fluids during her meals but could not recall having found her wet through her clothing before today. NA #4 stated she heard the Hospice NA say the resident was wet through her clothing but said she didn't see the wetness because she was operating the lift to get the resident back to bed.

Interview on 02/14/24 with Nurse #3 revealed she had been assigned to care for Resident #45 on 02/13/24 and 02/14/24. She stated the staff usually got Resident #45 up around 7:30 so she

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F 677	Continued From page 7 was up for breakfast and said sometimes 3rd shift got her up if she wanted to get up after they got her dressed. Nurse #3 further stated she was not aware Resident #45 had wet through her clothing on 02/13/24 and said she typically did not find her that way. Nurse #3 stated maintenance and housekeeping had washed the wheelchairs the night before but said she didn't think the NAs would have put her in a wet wheelchair. Nurse #3 said she was not sure why Resident #45 had wet through her clothing because she was not on a diuretic and wasn't sure what or how many fluids, she had to drink at breakfast that morning. Interview on 02/14/24 at 12:38 PM with the Director of Nursing (DON) revealed she would not expect a resident to go without incontinence care until they were wet through their clothing and was not sure if that had happened with Resident #45 before or not.	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 medication errors out of 32 opportunities resulting in a medication error rate of 6.25% for 2 of 4 residents (Resident #26 and Resident #76) observed during medication administration observation.	F 759	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Step 1- The Director of Nursing or designee completed medication error on	3/12/24

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F 759	Continued From page 8 The findings included: 1. Resident #26 was admitted to the facility on 05/13/13 with diagnoses that included hypertension (HTN). A Physician order dated 05/13/12 revealed Resident #26 was to receive Metoprolol Tartrate 25 mg (milligrams) one tablet by mouth twice a day for hypertension. Instructions on the physician orders read to hold medication for systolic pressure less than 100 or a heart rate less than 60. During medication pass observation 02/14/24 at 8:15 AM Nurse #2 prepared medications for Resident #26. Nurse #2 was observed taking a Metoprolol Tartrate 25mg tablet out of a blister package and placing it in a medicine cup. The label on the blister package included instructions to hold medication for systolic pressure less than 100 or a heart rate less than 60. Nurse #2 was asked if she had a current set of vitals on the resident and she stated no she did not. Nurse #2 proceeded to Resident #26 room at 8:35 AM and administered the Metoprolol Tartrate 25mg tablet to the resident. An interview with Nurse #2 on 02/14/24 at 10:12 AM revealed Resident #26 was no longer on daily vitals, so they no longer checked Resident #26 vitals before giving the metoprolol. Nurse #2 revealed she did not notice the instructions on top of the blister package or on the medication administration record. 2. Resident #76 was admitted to the facility on 12/08/23 with a diagnosis that includes coronary	F 759	resident #76 on 02.13.2024 The physician was notified on both med errors with no new orders. RDCS educated individual nurse and medication aide on the five rights of medication administration immediately after errors were noted. Step 2- Current residents and newly admitted residents have the potential to be affected. Director of Nursing/Designee audited all residents receiving blood pressure medication to ensure they all have parameters and supplemental documentation if ordered, any areas identified were corrected immediate. Current residents have the potential to be affected by administering incorrect dosage of medication. Medication Aide and Nurse received the education on the five rights of medication administration and were observed performing a med pass prior to working again. This was completed on 02.13.24 for the Medication Aide and on 02.14.24 for the nurse. Step 3- To prevent this from happening the Director of Nursing will educate all Licensed Nurses and Medication Aides on ensuring correct dosage of medication is administered and the Five Rights of Medication Administration and to obtain vital signs before prior to administering medication if ordered and ensure supplementary documentation in PCC if ordered.The pharmacy came in to facility to perform med pass observations on 02.22.24 and the Director of Nursing or Clinical Managers will complete 100% of med pass observations on all nurses and	

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F 759	Continued From page 9 artery disease, and heart failure. A Physician order dated 12/08/23 revealed Resident #76 was to receive Aspirin (ASA) 81 mg (milligrams) one tablet by mouth once a day for coronary artery disease. During medication pass observation 02/13/24 at 8:35 AM Medication Aid (MA) # 3 prepared medications for Resident #76. MA #3 was observed taking an ASA 325mg tablet out of an opened stock medication bottle and placing it in a medicine cup. MA #3 proceeded to Resident #76's room at 8:45 AM and administered the ASA 325 mg tablet to the resident. On 02/13/24 at 9:30 AM an interview and observation were conducted with Medication Aid (MA) #3. MA #3 returned the medication cart and reviewed Resident #76's ASA order and she confirmed the resident had a physician order for ASA 81 mg. She stated that the two bottles of ASA were next to each other in the medication cart, and she just grabbed the wrong bottle. MA # 3 explained she had separated the two bottles of ASA so that this mistake did not happen again. On 02/14/24 at 12:35 PM an interview was conducted with the Director of Nursing (DON). During the interview, DON was notified of the medication error rate of 6.25%. The DON stated she expected nurses and med aids to check the five rights before medications were given and to check vital signs as ordered when administering medications.	F 759	medication aides. Observations were completed by 03.03.2024 Step 4- The Director of Nursing/Designee will perform Med pass observation on 4 Nurses weekly for 12 weeks to ensure they are following the Five Rights of med pass, administer the correct dosage and that vital signs are completed prior to administering medications as ordered. The Director of Nursing or Designee will audit new orders Monday-Friday to ensure supplementary documentation is on PCC if ordered for 4 weeks and then weekly for 8 weeks. The results of these audits will be taken to QAPI for review and recommendations monthly for three months. Date of Compliance: 03.12.2024	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals	F 809		3/12/24

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F 809	Continued From page 10 §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews and staff interviews the facility failed to have systems in place for providing evening snacks to residents for 5 of 5 halls. The deficient practice had the potential to affect all residents requesting an evening snack. The findings included: An interview conducted on 02/13/24 at 6:30 AM with Nurse Aide (NA) #2 revealed she worked second shift and residents during second shift (3:00 PM to 11:00 PM) had not received a bedtime snack on multiple days because staff were unable to get into the nourishment room on either floor. NA #2 further revealed the nourishment rooms had a code that was not provided to them, and the kitchen was locked. The NA indicated she had reported this to a	F 809	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Step 1- Dietary Manager immediately supplied the nourishment room with a variety of snacks. Step 2- All residents have the potential to be affected, the Dietary Manager completed a 100% audit if the nourishment room on 02.14.2024 and placed a food order on 02.16.24 to ensure that adequate of amount of snacks for each shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 809	Continued From page 11 Nurse on duty over the past few months but could not recall which Nurse. An interview conducted with Nurse #1 on 02/13/24 at 7:20 AM revealed nursing staff were often unable to access the kitchen and nourishment rooms at night to retrieve snacks because the doors had a code that had not been provided to her. The Nurse further revealed she had reported these concerns and was told the code would be written at the nurses ' desk but had not occurred. An interview conducted during a Resident Council Meeting on 02/13/24 at 1:50 PM revealed residents had not received or been offered snacks in the evenings by nursing staff. The Resident Council President (Resident #58) and Resident #1 both stated nursing staff did not offer evening snacks frequently and when residents asked nursing staff for snacks, they were told nursing staff were unable to get in the nourishment room or there were no snacks available. An interview conducted with the Dietary Manager (DM) on 02/13/24 at 9:50 AM revealed four weeks ago she was made aware by residents that there were several nights residents had not received a bedtime snack. The DM further revealed dietary staff checked and stocked the nourishment rooms daily and felt that nursing were not offering bedtime snacks as needed for the residents. The DM indicated she had tried to educate staff on providing bedtime snacks to all residents. The DM indicated she was not sure how staff were educated on the codes for the doors on the nourishment rooms.	F 809	Step 3- To prevent this from happening again, the Regional Director of Clinical Services educated the Dietary Manager on ensuring adequate amount of snacks are ordered and available to all shifts in the nourishment room on 02.16.24. The Dietary Manager educated all kitchen staff ensuring adequate snacks in the nourishment room and to replenish as needed prior to leaving at the end of the day 02.16.24. The Director of Nursing/Designee will educate all Nursing staff on the door code for nourishment rooms and will place the code at both nurses stations. This education was completed on 02.16.2024. Step 4- To monitor and maintain compliance the Dietary Manager will audit the nourishment rooms 3 times per week for 12 weeks to ensure adequate snacks are available. The Administrator will audit the nourishment rooms 1 time per week for 12 weeks, prior to leaving for the day to ensure adequate snacks are available. The Director of Nursing/Designee will interview 4 residents per week for 12 weeks to ensure they are receiving snacks per their request. The Director of Nursing/Designee will interview 3 staff members weekly for 12 weeks to ensure they know the code to the nourishment room. Results will be taken to QAPI for review and revision as needed for the next 3 months. Date of compliance: 03.12.2024	

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 809	Continued From page 12 An interview conducted with the Administrator on 02/14/24 at 2:40 PM revealed she expected there to always be snacks available for residents. The Administrator further revealed nursing staff should know the codes for the nourishment rooms and dietary should be stocking enough for residents as well. The Administrator indicated nursing staff could have asked the Director of Nursing or Unit Managers for the codes to the nourishment rooms.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure items stored ready for use were labeled and dated and failed to remove expired food items in 1of 1	F 812	*Preparation and submission of this POC is required by state and federal law. The POC does not constitute an admission for purposes of general liability, professional	3/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 812	Continued From page 13 walk-in cooler and 1 of 2 nourishment rooms (First Floor). These practices had the potential to affect food served to residents. Findings included: a. An observation and interview were conducted on 2/11/23 at 9:15 AM with Dietary Cook #1 in the walk-in cooler revealed eleven sandwiches, six grilled cheese sandwiches, tomato soup in a container with saran wrap on top, and four cups of lima beans which were unlabeled and not dated. The Dietary Cook believed the sandwiches and grilled cheese sandwiches were made the day prior but was unsure when they had been prepared and needed to be discarded. The Dietary Cook was unable to determine when the other items had been prepared. Observations further revealed leftover roasted potatoes with the expiration/discard date of 02/09/23. Dietary Cook #1 stated the dietary staff member that puts the food item in the walk in the cooler was responsible for labeling and dating the container and the roasted potatoes should have been discarded. b. An observation and interview with Nurse Aide (NA) #1 were conducted on the first floor in the nourishment room on 02/11/24 at 10:00 AM revealed a carton with 18 eggs with no resident ' s name or date, two opened 8-ounce cartons of milk with no resident ' s name or dated opened, an opened 8 ounce bottle of nutritional drink which was not labeled with a resident ' s name or dated, and two wrapped sandwiches that were not labeled or dated. Nurse Aide #1 stated dietary staff checked nourishment rooms daily, but nursing staff had been educated to label items in the refrigerator with resident names and dates.	F 812	malpractice or any other court proceeding. Step 1- Dietary Manager immediately discarded all food that was expired and not dated in the kitchen. Dietary Manager immediately discarded the egg carton, unlabeled food and opened containers in the nourishment room. Step 2- All residents have the potential to be affected, the Dietary Manager completed 100% audit of the kitchen to ensure no food was expired and all food was labeled and dated on 02.14.24. Dietary Manager completed a 100% of the nourishment rooms to ensure all food was labeled, dated and unopened on 02.14.2024. Step 3- To prevent this from happening again, The Director of Nursing/Designee will educate all staff that no personal food is to be stored in the nourishment room refrigerators, do not put opened containers back in refrigerator and that any residents food is to have residents name of item and date. This education was completed on 02.16.2024. The Dietary Manager will educate all kitchen staff on the policy of procurement of food, to discard expired items and to place a sticker on sandwiches and date the sticker. This education was completed on 02.16.24.The Regional Director of Clinical Services educated the Dietary Manager on food procurement, labeling and dating items in the kitchen on 02.16.2024. Step 4- To monitor and maintain	

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 812	Continued From page 14 NA #1 indicated these food items should not be in the refrigerator and she discarded them. An interview conducted with Dietary Aide #2 on 02/13/24 at 9:45 AM revealed Dietary Cooks were responsible for checking items in the kitchen and Dietary Aides were responsible to check nourishment rooms daily. Dietary Aide #2 further revealed she did not know why items in the nourishment room were not labeled. The interview further revealed dietary staff checked the nourishment rooms twice a day and discarded expired and unlabeled items but had not checked the nourishments rooms that morning. An interview conducted with Dietary Manager (DM) on 02/13/24 at 9:50 AM revealed dietary staff checked the nourishment rooms twice a day and were educated to discard any food items that were not labeled or dated. The DM indicated all food items in the walk-in cooler should have been labeled and discarded appropriately. An interview conducted with the Administrator on 02/14/24 at 2:40 PM revealed she expected dietary staff to label all dietary items and discard any expired food items as well.	F 812	compliance The Dietary Manager will audit the nourishment room 3 times per week for 12 weeks to ensure no expired, opened personal food or undated items is stored in the refrigerator. The Dietary Manager will audit the kitchen 3 times per week to ensure no food is expired and all food is labeled for 12 weeks. Results will be taken back to QAPI for review and revision as needed for the next 3 months. Date of Compliance: 03.12.24	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		3/12/24

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 867	Continued From page 15 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 867	Continued From page 16	F 867		

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 867	Continued From page 17 assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey that occurred on 07/07/22 and follow-up and complaint investigation survey that occurred on 09/21/22. This was for one deficiency cited in July 2022 in the area of infection control and one deficiency cited in September 2022 in the area of maintain a medication error rate of 5% or less and both were subsequently cited on the current recertification and complaint investigation survey	F 867	*Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Step 1- The Administrator and Director of Nursing/Designee re initiated the audit tools for F759 And F880 due to receiving those citations last survey. Step 2- The Administrator and Director of Nursing/Designee conducted 100% audit for all new areas on new Plans of	

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 867	Continued From page 18 of 02/14/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referred to: F880: Based on record review, observations, resident, and staff interviews, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy, when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure and did not doff her gloves, sanitize her hands, and don clean gloves after cleansing the hip wound and before applying the treatment to the wound for a resident (Resident #55). During the recertification and complaint investigation survey conducted on 07/07/22, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy during wound care treatment for 1 of 3 sampled residents reviewed. F 759: Based on observations, record reviews and staff interviews, the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 medication errors out of 32 opportunities resulting in a medication error rate of 6.25% for 2 of 4 residents (Resident #26 and Resident #76) observed during medication administration observation. During the follow-up and complaint investigation	F 867	Correction for F880 and F789 to ensure the facility was in compliance. Step 3- The RDCS educated the Administrator, Director of Nursing and Department Heads on following QAPI process to maintain on going compliance, education was completed on 02.16.2024. New Plans of Correction were written by the Regional Director of Clinical Services for facility to implement. Step 4- The Administrator/Designee will audit all of the audits for POC's weekly for 12 weeks to ensure that audits are completed and facility remains in compliance. The Administrator will conduct an AD Hoc QAPI weekly for 12 weeks on infection control and medication errors to ensure facility remains in compliance. Results of audits will be submitted to the QAPI committee for the next three months for further reviews and recommendations. Date of Compliance: 03.12.2024	

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 867	Continued From page 19 survey conducted on 09/21/22, the facility failed to administer the correct dosage for 3 medications and omission of 2 medications. These errors constituted 5 out of 28 opportunities, resulting in a medication error rate of 17.86% for 2 of 5 residents observed during medication administration. During an interview on 02/14/24 at 2:38 PM with the Administrator, she reported her quality assurance team met monthly and included the Medical Director, pharmacist, registered dietician, and all the department heads who attend monthly. She reported they currently had Process Improvement Plans (PIPs) addressing abuse and said they would be adding PIPs for infection control and medication compliance. The Administrator stated she felt like repeat tags were due to oversight and human error.	F 867		
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,	F 880		3/12/24

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

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F 880	Continued From page 20	F 880		

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 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

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 880	Continued From page 21 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 review, observations, resident, and staff interviews, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy, when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure and did not doff her gloves, sanitize her hands, and don clean gloves after cleansing the hip wound and before applying the treatment to the wound for a resident (Resident #55). The Treatment Nurse only doffed her right glove, sanitized her right hand, and donned a clean glove on her right hand after removing the soiled dressing from the resident's hip wound, did not doff her gloves after cleansing the wound, did not sanitize her hands, and did not don clean gloves before proceeding to apply the treatment to the hip wound and covering the wound with a clean border gauze dressing. This occurred for 1 of 3 residents reviewed for wound care. The findings included: The facility's policy entitled Hand Hygiene/Handwashing Policy which is part of their Infection Control Policies and Procedures last revised on 05/03/23 under "Procedure" read in	F 880	* Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Step 1- Resident #55 was evaluated by the wound physician on 02.15.2024 and no s/s of infection were noted. The wound nurse was educated on 02.16.2024 by the Director of Nursing on infection control policy and ensuring proper procedure is followed during wound care to include changing gloves after removal of dressing and hand washing. Step 2- To identify like residents the Director of Nursing/Designee will assess all residents with pressure wounds for s/s of infection, this audit was complete on 02.15.2024. No s/s of infection were identified. Step 3- To prevent this from happening again, the Director of Nursing/Designee will educate all licensed nurses on infection control policy and ensuring	

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	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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(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 880	Continued From page 22 part: 3. Perform hand hygiene: a. Before and after having direct contact with residents. b. After removing gloves. d. After contact with body fluids or excretions, mucous membranes, non-intact skin and/or wound dressings. 5. Hand Rub Method: a. Apply a palm full of the product in a cupped hand, covering all surfaces. b. Rub hands palm to palm. c. Right palm over left dorsum with interlaced fingers and vice versa. d. Palm to palm with fingers interlaced. e. Backs of fingers to opposing palms with fingers interlocked. f. Rotational rubbing of left thumb clasped in right palm and vice versa. g. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa. h. Once dry, your hands are clean. A wound observation was made on 02/13/24 at 9:30 AM on Resident #55 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse washed her hands with soap and water and donned a clean pair of gloves and proceeded to remove the resident's wound dressing and treatment with her right hand. She walked over to the sink and doffed her right-hand glove, sanitized her right hand, and placed a clean glove on the right hand, walked back over to the resident and cleansed her wound with wound cleanser-soaked gauze.	F 880	proper procedure is followed during wound care to include changing gloves after removal of dressing and hand washing. This education was completed on 02.14.2024. Step 4- To monitor and maintain compliance the Director of Nursing/Designee will audit wound care on 3 residents per week for 12 weeks to ensure proper infection control procedure is followed. Results will be taken to QAPI for review and revision as needed for the next 3 months. Date of Compliance: 03.12.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 880	Continued From page 23	F 880		

The Treatment Nurse then without doffing her gloves, sanitizing her hands, or donning clean gloves, proceeded to trim and apply the treatment to the wound bed. After applying the treatment, the Treatment Nurse doffed her gloves, sanitized her hands, donned clean gloves, and applied the border gauze dressing to the left hip wound.

An interview on 02/14/24 at 12:21 PM with the Treatment Nurse revealed she did not realize she had not taken her gloves off and sanitized her hands and applied clean gloves after cleansing the wound. She stated she should have doffed her gloves, sanitized her hands, and donned clean gloves prior to applying the treatment to Resident #55's wound. The Treatment Nurse stated she didn't realize it was not appropriate to just cleanse one hand since she had not touched anything dirty with her left hand but said she had touched the resident's skin and should have sanitized both hands. She further stated she was nervous about being watched and just didn't think through the process.

An interview on 02/14/24 at 12:36 PM with the Director of Nursing (DON) revealed she expected the Treatment Nurse to follow the policy and procedure of Hand Hygiene/Handwashing at the facility. The DON stated it was best practice to remove both gloves and sanitize both hands and apply clean gloves to both hands and was not sure why she had not followed that procedure during wound care for Resident #55.