STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	04/16/2025

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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 04/14/25 through 04/16/25. The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID O5SO11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 04/14/25 through 04/16/25. Event ID# O5SO11. The 2567 was amended on 5/9/25 to reflect changes as result of IDR.	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 observations, record review, and staff and resident interviews, the facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #76). The findings included: Resident #76 was admitted to the facility on 08/11/22 with diagnoses that included chronic respiratory failure, history of stroke, hemiplegia and hemiparesis following a stroke, hypertension, and heart failure. Review of Resident #76's quarterly Minimum Data Set assessment dated 03/22/25 revealed	F 554	The facility failed to assess resident #76 ability to self- administer medications. Resident #76 had medications left at bedside without a self-administration assessment. The nurse on duty was educated by the Assistant Director of Nursing on 4/14/25 regarding not leaving medications at bedside. The facility completed an audit of all resident rooms on 4/14/25 to ensure no other medications were present at bedside. No further issues were identified. Self administration assessment conducted for resident #76 on 5-5-25. Resident #76 does not wish to self	5/9/25

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

Electronically Signed | 05/09/2025

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F 554	Continued From page 1 Resident #76 was cognitively intact with no delusions, behaviors, or rejection of care. Review of Resident #76's medical record revealed no documentation that Resident #76 had been assessed to self-administer medications. Further review of Resident #76's medical record revealed no care plan for self-administration of medications. An observation of Resident #76 on 04/14/25 at 10:51 AM revealed her to be in her room, sitting in her wheelchair watching television. On Resident #76's overbed tray was a medicine cup that contained 2 blue capsules, 1 pink capsule, 4 white tablets, and 2 beige tablets. An interview with Resident #76 on 04/14/25 at 10:52 AM revealed that Nurse #4 came in and gave her the medication but that she didn't want to take it right then, so Nurse #4 left the medicine cup and left the room. Resident #76 reported she thought the medicine cup included her potassium "and a bunch of other stuff". Resident #76 indicated she was unsure what other medications were in the cup. An interview with Nurse #5 on 04/14/25 at 10:59 AM revealed she was the nurse assigned to Resident #76 but that an orientee, Nurse #4, was the nurse that passed Resident #76's medications that morning. Nurse #5 reported that Resident #76 did not have a self-administration order, and that the medication should not have been left at her bedside. An interview with Nurse #4 on 04/16/25 at 10:24	F 554	administer her medications. Beginning 5/5/25 the Director of Nursing or designee assessed alert and oriented residents for self administration of medications. No residents chose to or met the criteria to self administer medications. On 5/5/25 education to all licensed nurses and certified medication aides was provided by the Director of Nursing or designee. Education included a resident must have a self administration assessment deeming them able to self administer medications to leave medications at bedside. Otherwise, medications may not be left at bedside. Licensed nurses, including agency licensed nurses and medication aides will not be permitted to work until education is completed. Newly hired licensed nurses and certified medication aides will be educated as part of the orientation process. Beginning the week of 5/11/25 The Director of Nursing or designee will audit 5 resident rooms to ensure there are no medications at bedside without a self administration assessment for 12 weeks. Audit findings will be reviewed by the facility Quality Assurance Performance Improvement committee monthly for 3 months and as needed.	

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F 554	Continued From page 2	F 554		

AM via telephone revealed she had worked at the facility for approximately 2 weeks. She verified she was the nurse assigned to Resident #76 on 04/14/25 and had given her medication that morning. Nurse #4 continued, stating she was unaware if Resident #76 had a self-administration order or if she had been assessed to safely administer her own medications. Nurse # 4 reported when she walked into the room, Resident #76 stated she was not quite ready to take her medications and would take them later so Nurse #4 left them on her overbed table. Nurse #4 reported she could not recall what medications had been given to Resident #76 on 04/14/25.

An interview with the Director of Nursing on 04/16/25 at 11:58 AM revealed she was not very familiar with Resident #76 but reported that she did not believe the facility had any residents who had the ability to self-administer medications. She reported for residents who wished to self-administer medications, the facility would complete an assessment to ensure the resident was safe to self-administer medications and would then obtain a physician's order which would indicate which medications the resident would be able to self-administer. She indicated without the assessment and the physician's order, no medications should be left at a resident's bedside.

An interview with the Administrator on 04/16/25 at 12:38 PM revealed there were no residents in the facility that were currently able to self-administer medications. She stated that unless a resident had been assessed and the facility had obtained a physician's order indicating a resident was safe to self-administer

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F 554	Continued From page 3 medications, she expected her staff to remain in the residents' rooms and observe them taking their medications.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		5/9/25

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F 578	Continued From page 4 with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure the code status information was accurate throughout the medical record for 1 of 1 resident (Resident #10) reviewed for advanced directives. The findings included: Resident #10 was admitted to the facility on 12/11/24. A review of Resident #10's hospital discharge summary dated 12/11/24 indicated Resident #10 was a Do Not Resuscitate (DNR). A review of Resident #10's physician orders revealed an order for DNR dated 12/12/24. A review of the code status notebook kept at the nursing desk revealed Resident #10 did not have a DNR form in the book. On 04/15/25 at 10:44 AM an interview was conducted with Nurse #1 who explained that if she had to immediately determine a resident's code status, she would look in the resident's medical record on the computer but if the computer was not booted up at that time, she would look in the code status notebook kept at the desk. The Nurse reported if there was no	F 578	The Facility failed to ensure resident #10 code status was accurate throughout the medical record. Resident #10 still resides in the facility. On 4-15-25 the facility social worker contacted the responsible party to verify the resident's code status. The facility social worker then verified the code status was correct throughout the medical record. Resident #10 still resides in the facility. On 4-15-25 the facility completed an audit of all resident records to ensure code status was accurately documented throughout the record. No other issues were identified. Beginning 5/5/25 the administrator or designee educated licensed nurses, providers, and social workers on required documentation regarding a resident's code status must be accurate throughout the residents medical record. Licensed nurses, including agency licensed nurses will not be permitted to work until education is completed.	

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F 578	Continued From page 5 DNR form in the code status notebook then the resident was determined to be a full code. Nurse #1 looked in the code status notebook for Resident #10's DNR form and acknowledged the form was not in the book. The Nurse stated she would determine Resident #10 to be a full code. An interview was conducted with the Director of Nursing (DON) on 04/15/25 at 10:46 AM. The DON explained that if a resident was a DNR then there should be a DNR form in the code status notebook at the desk. The DON looked in the code status notebook for Resident #10's DNR form and acknowledged the form was not there. The DON stated the Social Worker was responsible for the advanced directives. During an interview with the Social Worker (SW) on 04/15/25 at 11:55 AM the SW explained that on admission the nurse verified the residents' code status, and their code status was also discussed in the morning clinical meeting the next day. She continued to explain that she was responsible for auditing the code status and the last audit she completed for DNR status was on 04/07/25. A review of the audit revealed Resident #10 was not listed on the audit. When the SW was asked why Resident #10 was not on the audit, she looked in the Resident's medical record and acknowledged the DNR status and stated she could not explain why the Resident did not populate to the audit because the list for the audit came directly from the residents' code status from their medical record. An interview was conducted with the Administrator on 04/16/25 at 12:23 PM. The Administrator stated that she was aware of the problem with Resident #10's code status not	F 578	New providers, SW or licensed nurses will receive the same education as part of the orientation process. Beginning the week of 5/11/25 the administrator or designee will audit 5 resident records per week to ensure code status documentation is accurate throughout the medical record for 12 weeks. Audit findings will be reviewed by the facility Quality Assurance Performance Improvement committee monthly for 3 months and as needed.	

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F 578	Continued From page 6 matching both in the medical record and the code status notebook. She indicated that not having the residents' code status match throughout the medical record could be a problem and that the facility would be putting new systems in place to prevent the discrepancy from occurring again. The Administrator reported that after researching the issue it was discovered that Resident #10 should have been a full code.	F 578		
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 §483.71 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:	F 880		5/9/25

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

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F 880	Continued From page 8 Based on observations, staff interviews and record reviews, the facility failed to clean and disinfect an individually assigned glucometer stored outside of the resident's room per manufacturer's recommendations for 1 of 1 resident observed to have their blood glucose level checked (Resident #13). The facility also failed to provide enhanced barrier precautions (EBP) during wound care by failing to wear a gown during wound care provided to 1 of 1 resident observed (Resident #39). The findings included: 1.The glucometer manufacturer's recommendations for cleaning and disinfecting of Resident #13's individually assigned glucometer recommended the Environmental Protection Agency (EPA)'s registered germicidal and disinfectant wipes that the facility used. The manufacturer's instructions noted, "The meter should be cleaned and disinfected after use on each patient." On 04/15/2025 at 11:27 AM Nurse #2 was continuously observed performing a glucometer check on Resident #13. The nurse obtained a glucometer from a plastic bag labeled with Resident #13's name from the medication cart drawer. She failed to clean and disinfect the glucometer prior to using it to obtain a fingerstick blood glucose monitoring reading. Nurse #2 performed the blood glucose monitoring for Resident #13 and placed the meter back into the plastic bag and stored it in the medication cart drawer without cleaning or disinfecting it. Upon interviewing Nurse #2 on 04/15/2025 at 11:34 AM about the cleaning and disinfecting	F 880	Resident #13 had no negative outcomes from the nurse not disinfecting the glucometer. Resident #39 had no negative outcomes as a result of the enhanced barrier precautions not being followed. The enhanced barrier precaution sign and order was verified in place by the assistant director of nursing. On 4/15/25 the Director of Nursing or designee disinfected all resident glucometers in the facility. On 5/7/25 an audit of all residents with wounds was conducted by the assistant director of nursing to ensure they have EBP orders, signage and appropriate PPE accessible. On 4/15/25 the Director of Nursing or designee educated all licensed nurses and medication aides on the facility policy for disinfecting glucometers. The director of nursing or designee educated the wound nurse and wound PA on enhanced barrier precautions policy. The director of nursing or designee educated all staff on enhanced barrier precautions policy. Anyone not educated by the alleged date of compliance will not work until education is completed. New licensed nurses, including agency licensed nurses and medication aides will be educated on glucometer disinfection and new hired staff will be educated on	

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F 880	Continued From page 9 process for glucometers, she stated, "I think they get cleaned once a day unless they are visibly soiled. I think they are cleaned on nightshift because I know I don't do it." On 04/15/2025 at 12:36 PM an interview with the Unit Manager for Resident #13 was conducted. When asked about the cleaning and disinfecting process for glucometers, she explained the nurses were supposed to clean and disinfect the glucometer using an EPA registered disinfectant in accordance with the manufacturer's instructions prior to performing blood glucose monitoring and after completion even if the resident had their own glucometer. The Unit Manager stated that the facility used one of the wipes recommended by the glucometer manufacturer. The Assistant Director of Nursing who served as the Staff Development Coordinator and Infection Preventionist was interviewed at 12:38 PM on 04/15/2025. She revealed that the nursing staff received recent glucometer cleaning and disinfecting education, and Nurse #2 attended the training. During this session and upon hire, each nurse was instructed to clean and disinfect the glucometer prior to and after each use of the glucometer using the wipe that the manufacturer recommended. At 12:44 PM on 04/16/2025, the Director of Nursing revealed during interview that the nurses were just retrained to clean and disinfect glucometers "before and after use of the glucometer." One EPA registered disinfectant towelette was used to clean the glucometer and another towelette was used to disinfect it after use. Then the glucometer was to be air dried.	F 880	enhanced barrier precautions during the orientation process. Beginning the week of 5/11/25 the Director of Nursing or designee will audit 5 licensed nurses or medication aides per week for 12 weeks to ensure they are properly cleaning glucometers. The director of nursing or designee will audit 5 residents with wounds weekly for 12 weeks to ensure enhanced barrier precautions are in place and properly used. Audit findings will be reviewed by the facility Quality Assurance Performance Improvement committee for 3 months and as needed.	

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F 880	Continued From page 10	F 880		

An interview with the Administrator was conducted on 04/16/2025 at 1:20 PM and revealed that the facility policy was for the nurse to clean and disinfect the glucometer using an EPA registered disinfectant in accordance with the manufacturer's instructions prior to and after use. The Administrator explained that Nurse #2 didn't use the glucometer on any other resident and received training less than one month prior to observation on 04/15/2025.

2. A review of the facility policy for Transmission-Based Precautions and Isolation Policy last revised on 03/20/2025 revealed four types of precautions including Enhanced Barrier Precautions (EBP). EBP were indicated for high contact care activities for a resident with a chronic wound.

A continuous observation of wound care on 04/16/2025 at 10:40 AM was conducted and revealed that the Wound Care Physician Assistant (PA) nor the Wound Care Nurse donned a gown for wound care provided to Resident #39. The PA measured and debrided the unstageable pressure ulcer to Resident #39's sacral area, and the Wound Care Nurse provided cleaning, treatment and dressing to the sacral wound as ordered.

An interview was conducted with the Wound Care Nurse at 11:03 AM on 04/16/2025 and revealed that if Resident #39 was on EBP, she would have used mask, gloves and gown. When asked if she thought that Resident #39 should be on EBP she stated that she wondered that this morning and that the resident had been on EBP.

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F 880	Continued From page 11	F 880		

When the PA was interviewed at 11:03 AM on 04/16/2025, she stated that Resident #39 used to be on EBP, but someone took down the sign. When asked if she thought Resident #39 should be on EBP, she stated that she wondered about it and, "Yeah." The PA revealed that today the wound was now Stage 3.

On 04/16/2025 at 11:10 AM, the Assistant Director of Nursing (ADON who served as Staff Development Coordinator and Infection Preventionist was interviewed and revealed that EBP with gown and gloves would be used if there was any drainage. She explained that EBP would be used for any chronic wound, and a closed surgical incision would not need EBP. The ADON stated that she would expect Resident #39 to be on EBP and reported that Resident #39 has had the sign, but it isn't there right now. She explained that she conducted audits every so often due to one resident on another hall removing his post EBP sign.

An interview with the Director of Nursing (DON) was conducted at 11:19 AM on 04/16/2025 that any type of chronic wound would have EBP using gown and gloves. The DON stated that an unstageable wound or Stage 3 pressure ulcer should have EBP.