STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

(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 000	INITIAL COMMENTS The surveyor entered the facility on 9/9/21 to conduct a complaint investigation and exited on 9/9/21. Additional information was obtained on 9/12/21, 9/13/21, and 9/15/21. Therefore the exit date was changed to 9/15/21. One of one allegation was substantiated. Event P3E011	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		9/20/21

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

Electronically Signed | 09/20/2021

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F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews for one (Resident # 1) of three sampled residents, the facility failed to consult with the physician when a resident was declining and orders had not been carried out per the physician's expectations. The findings included: Record review revealed Resident # 1 resided at the facility from 1/29/19 until his discharge to the hospital on 3/1/21. The resident had diagnoses of diabetes, hypertension, cardiomyopathy, coronary artery disease, vascular dementia with behavioral disturbance, anxiety disorder, hyperlipidemia, and failure to thrive. Review of the record revealed Resident # 1 had a MOST (Medical Orders for Scope of Treatment),	F 580	Corrective Action for Affected Resident Resident #1 was sent to ED on 3/1/2021. Identification of Other Like Residents An audit of each current resident's medical record has been conducted by the clinical team, to include the Director of Nursing, Assistant Director of Nursing, Unit managers and Wound Care Nurse to determine if MD notification was required. During the audit, all documentation to include diagnostic and laboratory results, progress notes and assessments, beginning 9/1/2021 was reviewed to determine if there was any need for MD notification. Audit revealed no further	

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F 580	Continued From page 2 which had originated on 1/31/19, for comfort measures. According to the form, the resident's RP (responsible party) had signed that the resident would not be transferred to the hospital unless comfort measures could not be provided at the facility. The form did reflect that the RP desired the resident have intravenous fluids if clinically indicated. Resident # 1's last quarterly minimum data set assessment, dated 2/25/21, coded the resident as severely cognitively impaired. The resident was also coded as totally dependent on staff for his hygiene, toileting, and eating needs. He was coded as needing supervision for transfers and walking. Review of nursing progress notes revealed an entry by Nurse # 3 on 2/23/21 at 10:36 PM noting Resident # 1 was sleeping more, had a decreased appetite, had a decline in his activities of daily living, and more malaise. The nurse noted therapy was working with the resident and the physician had ordered a decrease in his Depakote (a medication used for his behaviors). The nurse further noted the resident's responsible party was notified. On 2/26/21 Resident # 1's physician saw the resident and documented the following information. The resident had "very advanced dementia." The doctor was unable to communicate with him, but the resident seemed comfortable. The resident had some weight loss of unknown etiology and the doctor would do a further work up. The resident had been diagnosed with COVID in 2019. He also had had trouble in the past with maintaining weight due to his dementia. The doctor noted either the	F 580	issues related to MD notification. Measures Implemented to Prevent Reoccurrence The DON will educate all currently hired registered and licensed nurses regarding MD notification requirements. Education will completed for all nurses by 9/20/2021. to include any nurse that is on vacation or is on a leave of absence. All newly hired nurses, to include agency nurses, will receive education regarding MD notification requirements during orientation by the DON or ADON. Each current and future nurse will be educated on ensuring that MD is notified of any significant change in a resident's physical, mental or psychosocial state, accident or incident resulting in injury to a resident, the need to alter treatment significantly; resulting in discontinuing the treatment or initiating a new treatment, and of any decision related to transferring or discharging a resident from the facility. Monitoring and Maintaining Ongoing Compliance An audit of the 24 hour report, completed Stop and Watch tools and Change in Condition assessments will be reviewed five times a week in the clinical meeting by the entire clinical team to include the DON, ADON, Social Worker, MDS Nurse, Activities Director and Dietary Manager, for 12 weeks in order to identify any situations that require MD notification.	

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F 580	Continued From page 3	F 580	QAPI	

dementia or the history of COVID could be contributing to his issues. The physician noted he would leave new orders. One of the orders was for labs to be completed. This included a CMP (complete metabolic panel).

According to the record, the CMP was drawn on 2/26/21 at 2:30 PM.

Review of the CMP results revealed it was faxed to the facility on 2/27/21 at 1:02 AM. The resident's sodium level was noted to be a high panic level of 166 (normal sodium levels are 136-144). The resident's BUN (blood urea nitrogen) was 80 (normal 8-20), creatinine was 4.89 (.64-1.27), and his glomerular filtration rate was 12.8 which was noted on the lab report to indicate a level indicative of Stage 5 chronic renal failure.

There was a notation on the lab report that Nurse # 1 was called by the lab at 12:57 AM on 2/27/21 and informed of the high panic sodium level.

According to orders, on 2/27/21 at 2:00 AM Resident # 1 was ordered to receive 2 liters of .9 sodium chloride via intravenous infusion. The BMP was to be repeated following the completion of the second liter of fluid. The rate of infusion was 100 cc (cubic centimeters)/ hour. (This indicated the intravenous fluids should take 20 hours to infuse after initiation. At the time of the order, there were still 22 hours left in the day).

On 2/27/21 at 2:10 AM Nurse # 1 noted "IV attempted but unsuccessful."

There were no further nursing progress notes regarding what was done regarding the IV after

QAPI

This plan was reviewed and accepted by an AD Hoc QAA committee on 9/16/2021. The DON will report the results obtained trough monitoring to the QAPI committee for review and recommendations. The QAPI committee will review and make recommendations monthly for a total of 12 weeks, or longer if amended by the QAPI committee.

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F 580	Continued From page 4	F 580		

the 2:10 AM entry noting that attempts to start the IV were unsuccessful.

The Resident's February 2021 Medication Administration Record (MAR) included the order for the intravenous fluids. There was a check made by the order for intravenous fluids on 2/27/21 at 11:26 AM by Nurse # 2. There was no further documentation on the MAR regarding the IV fluids other than this one check mark.

Nurse # 1 was interviewed on 9/9/21 at 2:50 PM and reported the following. She could not recall what happened on her shift after the IV could not be started. She reported if a nurse was unsuccessful in starting an IV, then they were to get another nurse to try. If the second nurse was unsuccessful, then they were to notify the doctor.

Nurse # 2 cared for Resident # 1 from 7:00 AM to 3:00 PM on 2/27/21. Nurse # 2 was interviewed on 9/12/21 at 4:30 PM and reported the following. When she arrived Nurse # 1 had not been able to start the IV. The resident was in the bed at the time. She looked to see if she could find a place to start the IV, but the resident was combative. She only worked every other week-end and the resident did not know her. She felt that might be contributing to the issue. She therefore called the supervisor while thinking that the resident might respond to the supervisor (Nurse # 4) better. The supervisor could not find a place to start the IV, and decided they would administer the fluids via SQ (subcutaneous route) instead. The supervisor placed a butterfly needle in the resident's abdomen and started the fluids. She did not recall the time the fluids were started. She only recalled that it was in the morning on dayshift.

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F 580	Continued From page 5 The resident's facility physician was interviewed on 9/15/21 at 1:05 PM. The physician reported the following. The nursing staff did not call him again during the week-end of 2/27/21 and 2/28/21 after the order for the IV fluids was given. The physician stated they should have done so. With the sodium level high, the physician stated time was an important factor in getting the fluids started and he did not know until 3/1/21 about the delay in initiation orders. The physician also stated they should also have called if his status changed.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview for one (Resident # 1) of three sampled residents, the facility failed to carry out orders in a manner consistent with the physician's expectations and the resident's plan of care. The findings included: Record review revealed Resident # 1 resided at the facility from 1/29/19 until his discharge to the hospital on 3/1/21. The resident had diagnoses of diabetes, hypertension, cardiomyopathy, coronary artery disease, vascular dementia with behavioral disturbance, anxiety disorder, hyperlipidemia, and failure to thrive. Review of the record revealed Resident # 1 had a	F 658	Corrective Action for Affected Resident Resident #1 was sent to the ED of 3/1/2021. Identification of Other Like Residents An audit of each current resident's medical record was conducted by the clinical team, to include the director of Nursing, Assistance Director of Nursing, Unit managers and Wound Care Nurse. The facility wide audit was conducted by reviewing the 24 hour report, labs and order listing report from 9/12/2021 to current. All orders were reviewed to	9/20/21

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F 658	Continued From page 6 MOST (Medical Orders for Scope of Treatment) as part of his plan of care. The form had originated on 1/31/19 and was for comfort measures. According to the form, the resident's RP (responsible party) had signed that the resident would not be transferred to the hospital unless comfort measures could not be provided at the facility. The form did reflect that the RP desired the resident have intravenous fluids if clinically indicated. Resident # 1's last quarterly minimum data set assessment, dated 2/25/21, coded the resident as severely cognitively impaired. The resident was also coded as totally dependent on staff for his hygiene, toileting, and eating needs. He was coded as needing supervision for transfers and walking. Resident # 1's care plan, last reviewed on 2/21/21, revealed the facility identified the resident had increased hydration and nutrition needs due to his dementia. One of the goals for Resident #1 was that he be free of dehydration and electrolyte abnormalities. Staff were directed on the care plan to monitor the resident for signs of dehydration. Review of nursing progress notes revealed an entry by Nurse # 3 on 2/23/21 at 10:36 PM noting Resident # 1 was sleeping more, had a decreased appetite, had a decline in his activities of daily living, and more malaise. The nurse noted therapy was working with the resident and the physician had ordered a decrease in his Depakote (a medication used for his behaviors). The nurse further noted the resident's responsible party was notified.	F 658	ensure that each was processed and initiated in a timely manner. The MD was to be notified of any negative findings. The DON ensured compliance with audit by 9/20/2021. No negative findings were revealed by audit. Measures Implemented to Prevent Reoccurrence The DON will educate all currently hired registered and licensed nurses regarding the expectation that all clinical services provided meet professional standards by ensuring all orders are processed and initiated in a timely manner, and that panic lab values are reported to MD immediately. Education will be completed for all nurses by 9/20/2021 to include any nurse that is on vacation or leave of absence. All newly hired nurses, to include agency nurses, will receive education regarding the requirement that all clinical services meet professional standards, to include lab collection requirements, during orientation by the DON or ADON. Each current and future nurse will be educated on ensuring that all orders are processed and initiated within a timely manner and any failure or delay must be reported to the MD immediately. Monitoring and Maintaining Ongoing Compliance An audit of the 24 hour report and order listing report will be reviewed five times a week in the clinical meeting by the entire clinical team, to include the DON, ADON,	

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F 658	Continued From page 7 On 2/26/21 Resident # 1's physician saw the resident and documented the following information. The resident had "very advanced dementia." The doctor was unable to communicate with him, but the resident seemed comfortable. The resident had some weight loss of unknown etiology and the doctor would do a further work up. The resident had been diagnosed with COVID in 2019. He also had had trouble in the past with maintaining weight due to his dementia. The doctor noted either the dementia or the history of COVID could be contributing to his issues. The physician noted he would leave new orders. One of the orders was for labs to be completed. This included a CMP (complete metabolic panel). According to the record, the CMP was drawn on 2/26/21 at 2:30 PM. Review of the CMP results revealed it was faxed to the facility on 2/27/21 at 1:02 AM. The resident's sodium level was noted to be a high panic level of 166 (normal sodium levels are 136-144). The resident's BUN (blood urea nitrogen) was 80 (normal 8-20), creatinine was 4.89 (.64-1.27), and his glomerular filtration rate was 12.8 which was noted on the lab report to indicate a level indicative of Stage 5 chronic renal failure. There was a notation on the lab report that Nurse # 1 was called by the lab at 12:57 AM on 2/27/21 and informed of the high panic sodium level. According to orders, on 2/27/21 at 2:00 AM Resident # 1 was ordered to receive 2 liters of .9 sodium chloride via intravenous infusion. The BMP was to be repeated following the completion	F 658	Social Worker, MDS Nurse, Activities Director and Dietary Manager in order to identify any failure or delay in following MD orders. The audit will be conducted for a period of 12 weeks. The DON or designee will ensure the MD is notified of any negative findings during the audit. QAPI This plan was reviewed and accepted by an Ad Hoc QAA committee on 9/16/2021. The DON will report the results obtained through monitoring, to the QAPI committee for review and recommendations. The QAPI committee will review and make recommendations monthly for a period of 12 weeks, or longer if amended by the committee.	

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of the second liter of fluid. The rate of infusion was 100 cc (cubic centimeters)/ hour. (This rate indicated the intravenous fluids should take 20 hours to infuse after initiation of the IV. At the time of the order, there were still 22 hours left in the current day).

On 2/27/21 at 2:10 AM Nurse # 1 noted "IV attempted but unsuccessful."

There were no further nursing progress notes regarding what was done regarding the IV after the 2:10 AM entry noting that attempts to start the IV were unsuccessful.

There was not a repeat chemistry lab on the resident's record for the dates of 2/27/21 or 2/28/21.

Nurse # 1 was interviewed on 9/9/21 at 2:50 PM and reported the following. She could not recall what happened on her shift after the IV could not be started. She reported if a nurse was unsuccessful in starting an IV, then they were to get another nurse to try. If the second nurse was unsuccessful, then they were to notify the doctor.

Nurse # 2 cared for Resident # 1 from 7:00 AM to 3:00 PM on 2/27/21. Nurse # 2 was interviewed on 9/12/21 at 4:30 PM and reported the following. When she arrived Nurse # 1 had not been able to start the IV. The resident was in the bed at the time. She looked to see if she could find a place to start the IV, but the resident was combative. She only worked every other week-end and the resident did not know her well. She felt that might be contributing to the issue. She therefore called the supervisor while thinking that the resident might respond to the supervisor (Nurse # 4)

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better. The supervisor could not find a place to start the IV, and decided they would administer the fluids via SQ (subcutaneous route) instead. The supervisor placed a butterfly needle in the resident's abdomen and started the fluids. She did not recall the time the fluids were started. She only recalled that it was in the morning on dayshift.

Nurse # 3 cared for Resident # 1 from 3:00 PM to 11:00 PM on 2/27/21. Nurse # 3 was interviewed on 9/13/21 at 2:00 PM and reported the following. Prior to the week-end of 2/27/21 and 2/28/21, Resident # 1 had been slowly declining over time. She knew his plan of care called for comfort measures. When she arrived on 2/27/21 the fluids were infusing and were still going when she left that night at 11:00 PM.

Nurse # 5 cared for Resident # 1 from 11:00 PM on 2/27/21 to 7:00 AM on 2/28/21. Nurse # 5 was interviewed on 9/9/21 at 3:35 PM and reported she could not recall anything about the resident for this shift.

Nurse # 4 cared for Resident # 1 from 7:00 AM to 11:00 AM. During the interview with Nurse # 4 on 9/9/21 at 2:30 PM. Nurse # 4 reported the following. She did not recall starting the IV fluids the previous day. She did recall the fluids finishing on her shift of 2/28/21 and she drew the lab and sent it to the hospital.

Nurse # 3 cared for Resident # 1 from 11:00 AM to 11:00 PM on 2/28/21. During the interview with Nurse # 3 on 9/13/21 at 2:00 PM, Nurse # 3 reported the following. She did not know when the IV fluids had been completed, but knew they had not been infusing when she came to work at

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11:00 AM on 2/28/21. There were no lab results on her shift for the lab work that had been done earlier on 2/28/21. She did not recall getting a message about problems with the lab being done as ordered.

The facility's current Director of Nursing (DON) was interviewed on 9/9/21 at 4:30 PM and reported the following. The DON stated she had checked on 9/9/21 and found that the chemistry lab, which was sent on 2/28/21, had been sent to the hospital in the wrong vial and therefore the hospital could not run the lab. Therefore, the 2/28/21 chemistry was not done.

The resident's facility physician was interviewed on 9/15/21 at 1:05 PM. He arrived Monday (3/1/21) to find that the repeat chemistry lab work was not available and therefore he did not have any current labs to assess the resident's status by and determine treatment. At that time he decided the best plan was to have the resident sent to the hospital where they could get the lab work done and the resident could be treated there.