STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 A complaint investigation survey was conducted from 9/14/21 through 9/17/21. Event ID# FJ1011. One of the 20 complaint allegations was substantiated resulting in deficiency.	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- (A) A change in room or roommate assignment	F 580		9/24/21

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

Electronically Signed | 10/06/2021

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F 580	Continued From page 1 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 and staff interviews, the facility failed to notify resident's Responsible Party of pressure ulcer changes for 2 of 2 residents reviewed for pressure ulcers. (Resident #3 and 4). Findings included: 1. Resident #3 was admitted to the facility on 05/28/21 with diagnoses that included stroke, hypertension, frailty, and general deconditioning. Resident #3 was discharge to hospital on 07/23/21. Record review of Change in Condition (CIC) Evaluation dated 06/30/21 revealed that Resident #3 was identified to have a pressure ulcer to sacrum. The pressure ulcer was measured approximately 2 centimeters (cm) in diameter	F 580	#1 Corrective action for affected resident Resident # 3 is no longer at the facility. The responsible party for resident # 4 was notified and updated on the current status of her pressure ulcer on 9/20/2021 by the ADON. #2 How will the facility identify other like residents On 9/24/21, the Director of Nursing/designee completed a 30 day look back of any residents with a change in condition related to pressure ulcers to ensure that both the MD and the	

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F 580	Continued From page 2 with a necrotic (black) middle. The nurse notified Resident #3's Responsible Party (RP) of new pressure ulcer, treatment, and consult for wound physician. Record review of the admission Minimum Data Set (MDS) dated 07/02/21 revealed that Resident #3 was cognitively impaired, had an indwelling catheter, and required extensive assist for transfers, dressing, personal hygiene, and toileting. Resident #3 was coded for an unstageable pressure ulcer. Record review of weekly wound assessment dated 07/02/21 revealed the pressure ulcer had increased in size and measured 3.0 x 3.0 cm in size with pink wound bed. The family notification section was not completed. Record review of weekly wound assessment dated 07/05/21 revealed the pressure ulcer had increase in size and measured 3.7 x 4.3 x 0.1 cm with yellow wound bed. The treatment order was changed by the wound physician. The family notification section was not completed. Record review of weekly wound assessment dated 07/12/21 revealed the pressure ulcer had increased in size and measured 11.0 x 15.0 x 0.1 cm and was described as deteriorating with necrotic (dead cells/tissue) wound bed. The family notification section was not completed. Record review of weekly wound assessment dated 07/19/21 revealed pressure ulcer had increased in size and measured 11.5 x 16.0 x 0.1 cm in size and was described as deteriorating with necrotic wound bed. The treatment order was changed by the wound physician. The family	F 580	responsible parties were notified of any change. A 30 day look back was also performed on any resident with changes in condition to ensure the MD/responsible parties were notified. #3 What will you do to prevent this from recurring To prevent this from recurring, licensed nursing staff have been reeducated on the expectation that the MD and responsible party will be notified for any change in condition according to the policy. This education was completed by the Director of Nursing on 9/21/2021. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. #4 How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor any resident change	

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F 580	Continued From page 3 notification section was not completed. Record review of Wound Evaluation and Management Summary report revealed that the wound physician performed a bedside debridement (removal of damaged tissue) for Resident #3's pressure ulcer on 07/05/21, 07/12/21, and 07/19/21. During a telephone interview on 09/16/21 at 9:37 am the wound physician revealed the facility was responsible to notify Resident #3's RP of the pressure ulcer progress. During a telephone interview on 9/14/21 at 2:20 pm Resident #3's RP revealed that the facility did not notify her of the increase in size and description of the pressure ulcer. The RP stated that she did not receive an update of the wound until Resident #3 was at the hospital. During an interview on 09/15/21 at 10:05 am Nurse #3 revealed that notification for pressure ulcer change was documented on the weekly wound assessment, CIC, or a nursing progress note. Nurse #3 was unable to state why Resident #3's RP was not notified of pressure ulcer changes. During an interview on 09/15/21 at 11:00 am Nurse #2 revealed that the floor nurse was responsible to notify the RP of change in pressure ulcer and document the information in a nurse progress note. She reported that the wound physicians do not notify RP on pressure ulcer changes. Nurse #2 stated that she believed the RP was notified however the floor nurse did not document the information as required. Nurse #2 was not able to state why Resident #3's RP	F 580	of condition in general and changes related to pressure ulcers to ensure that both the resident's MD and responsible party were notified. This will be documented 5 x a week for 14 days during the morning clinical meeting and then weekly for 10 weeks with a completion date of 12/17/21. Date of compliance: 9/24/2021 #5 QAPI The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will reviewed monthly for 100% compliance for 3 months.	

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F 580	Continued From page 4	F 580		

was not notified of pressure ulcer changes.

During an interview on 09/15/21 at 12:40 pm the Assistant Director of Nursing (ADON) revealed the floor nurse was responsible to notify the RP of change in wound size or description, new orders, and update if stable or declined after weekly wound rounds. The ADON stated the floor nurse documented notification of the RP in a nurse progress note or the weekly wound assessment.

2. Resident #4 was admitted to the facility on 03/15/19 with diagnoses that included diabetes, end stage renal disease with dependence on renal dialysis, epilepsy, stage 2 pressure ulcer to sacrum, and stroke.

The most recent Minimum Data Set (MDS) dated 07/10/21 indicated Resident #4 was cognitively intact. She required extensive assistance for ADLs, turning, repositioning, and transfers. Resident #4 was coded for stage 3 and stage 4 pressure ulcers present on admission/reentry.

Record review of the weekly wound assessment dated 04/16/21 revealed the pressure ulcer increased in size from previous assessment and measured 8.5 x 10.2 x 1.7 centimeters (cm) with tunneling (passageway under the skin) of 2.0 cm and 5% bone exposed. The family notification section was not completed.

Record review of the weekly wound assessment dated 04/23/21 revealed the wound increased in size from previous assessment and measured 8.5 x 10.1 x 1.8 cm with tunneling of 2.4 cm and 5% bone exposed. The treatment was changed by the wound physician. The family notification section was not completed.

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F 580	Continued From page 5	F 580		

Record review of the weekly wound assessment dated 06/08/21 revealed the wound increased in size from previous assessment and measured 8.0 x 12.0 x 1.4 cm with tunneling of 2.0 cm and 10% bone exposed. The wound was described as unable to progress to a healing phase. The family notification section was not completed.

During an interview on 09/15/21 at 10:05 am Nurse #3 revealed that RP notification for pressure ulcers was documented on weekly wound assessment, CIC, or in a nursing progress note. Nurse #3 was unable to state why Resident #4's RP was not notified of pressure ulcer changes.

During a telephone interview on 09/16/21 at 9:37 am the wound physician revealed the facility was responsible to notify Resident #4's RP of the pressure ulcer progress.

During a telephone interview on 09/14/21 at 1:38 pm Resident #4's RP revealed she had received pressure ulcer updates weekly, but she had not received any updated information for several months.

During an interview on 09/15/21 at 11:00 am Nurse #2 revealed the floor nurse was responsible to notify Resident #4's RP weekly on pressure ulcer progress and document the notification in a nursing progress note or CIC. Nurse #2 reviewed record and was unable to provide nursing notes or CIC for notification of pressure ulcer updates to RP. Nurse #2 was unable to state why Resident #4's RP was not notified of the pressure ulcer changes.

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F 580	Continued From page 6 During an interview on 09/15/21 at 11:11 am Nurse #1 revealed that notification of change in condition has not been identified as problem at the facility and that the floor nurse had updated the resident RPs on pressure ulcer progress. During an interview on 09/15/21 at 12:40 pm the Assistant Director of Nursing (ADON) revealed the floor nurse was responsible to provide weekly updated pressure ulcer information to resident RP that included improvement, decline, stability, and treatment change. During an interview on 09/15/21 at 12:59 pm the Administrator revealed that notification of change in condition was completed by nursing and documented in a nursing progress note or a CIC.	F 580		