PRINTED: 11/25/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0.45000	D. WING		С
	ROVIDER OR SUPPLIER	345268	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET	09/26/2024
AUTUMN	CARE OF MARSHVILLE			MARSHVILLE, NC 28103	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 000	INITIAL COMMENTS		F 00	0	
	through 09/26/24. Th investigated NC0022 allegation resulted in			Past noncompliance: no plan of correction required.	
	Past non-compliance	was identified at:			
	CFR 483.10 at tag F5 (IJ)	580 at a scope and severity			
	CFR 483.12 at tag F6 (IJ)	600 at a scope and severity			
	CFR 483.24 at tag F6 (IJ)	678 at a scope and severity			
	CFR 483.25 at tag F6 (IJ)	684 at a scope and severity			
	The tags F600, F678 Substandard Quality	, and F684 constituted of Care.			
F 580	removed on 09/20/24 was conducted. Notify of Changes (In	began on 09/19/24 and was  A partial extended survey  jury/Decline/Room, etc.)	F 58	0	
SS=J	§483.10(g)(14) Notific (i) A facility must imm consult with the resid consistent with his or representative(s) who (A) An accident involve	cation of Changes. lediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which las the potential for requiring			
LABORATORY	I DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed 10/11/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		345268	B. WING			C 09/26/2024
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE			STREET ADDRESS, CITY, STATE, ZIP COL 311 W PHIFER STREET MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	mental, or psychosocy deterioration in health status in either life-the clinical complications (C) A need to alter treament due to advect the aneed to discontinue treatment due to advect the commence an ew form (D) A decision to transcribe the faciscommence and form the faciscommence and fa	ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or attention of greatening conditions or	F 54	30		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345268	B. WING		C 09/26/2024
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE		:	STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	, 33,23,23
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION
F 580	by: Based on record rev Director (MD) intervier notify the physician for significant change in Resident #1 was obsicongestion, difficulty to cough up phlegm. Practitioner (NP) wer Resident #1 had his in phlegm noted in his in Resident #1's vital sig pressure (BP) of 90/8 48 (normal range 60- (normal range between air, and respirations of the had audible congrextremely hot to touch practitioner (NP) wer Resident #1 was four pronounced decease of 3 residents reviews of condition.  The findings included Resident #1 was read 12/06/23. His diagnor mellitus (DM), anxiety failure (CHF), and dy swallowing).	iew, and staff and Medical ews, the facility failed to or a resident who had a condition. On 09/18/24 erved with audible swallowing, and was trying The MD or Nurse e not notified. On 09/19/24 mouth open with clear mouth and he was coughing. gns included a blood 36 (normal 120/80), pulse of 100), oxygen at 89% en 95% and 100%) on room of 12 (normal range 12-18). estion, and his skin was th. The MD or Nurse e not notified. At 5:00 AM and not breathing and was and at 6:15 AM. This was for 1 ed for notification of change	F 580	Past noncompliance: no plan of correction required.	
	assessment dated 07	rly Minimum Data Set (MDS) 7/01/24 indicated his			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	·	09/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	Continued From par cognition was intact care or behaviors of	. There was no rejection of	F 58	00		
	09/18/24 revealed F with eyes closed, ea questions when ask breath and there wa note also revealed t Resident #1's chest	al systems that no physical				
	conducted on 09/25 she was the direct of 09/18/24 and she divith him on first shift	ed Aide (MA) #1 was 1/24 at 10:40 AM. She verified 1/24 at 10:40 AM. She verified 1/25 at 1				
	09/25/24 at 10:05 A for Resident #1 on 0 PM. Nurse #3 explainurse however they covering the assign Nurse #3 also state from first shift, they refused his medicat verified she did go a approximately 3:25 #3 did not observe cough or congestion was still working as Resident #1 refused	urse #3 was conducted on M. Nurse #3 stated she cared 09/18/24 from 3:00 PM to 4:00 ined she was the wound care had a call out and she was ment until Nurse #1 arrived. d when she received report informed her that Resident #1 ions at noon. Nurse #3 and speak with Resident #1 at PM, and he was "fine". Nurse Resident #1 with increased n. Nurse #3 also stated she sisting with meal trays and d dinner on 09/18/24, however behavior, as he refused meals				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103		09/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	Continued From pagand medications at t		F 58	50		
	Assistant (NA) #1 or verified she worked through 09/19/24 at direct care NA for Ronotified Nurse #1 at roommate had required Resident #1 becaus #1 stated she obser and she could hear notified Nurse #1 at had his mouth open his mouth, and he wo Nurse #1 went to his anything. NA #1 indivith the resident that of his baseline. NA # went in to change his	ras conducted with Nursing in 09/24/24 at 3:01 PM. She from 09/18/24 at 11:00 PM 7:00 AM and she was the resident #1. NA #1 stated she 2:00 AM that Resident #1's rested her to come look at rested her to come but did not tell her rested she had not worked at often and she was not sure rested her look at 15:00 AM she rested her look at 15:00 AM s				
	on 09/23/24 for 09/14:28 AM she entered heard rales (fine crassounds that occur wasound like small clic during inspiration. Swhich included a blouse of 48, oxygen temperature of 96.1 previously refused to airway pressure (CF Assistant (NA) obse	note recorded as a late entry 9/24 by Nurse #1 revealed at d Resident #1's room and ockles, are abnormal breath when a person inhales and king, bubbling, or rattling) he checked his vital signs and pressure (BP) of 90/86, at 89% room air, and (axillary). Resident #1 had to have continuous positive PAP) on for the night. Nursing rved that Resident #1 wasn't e walked down to Resident				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345268	B. WING			C
	ROVIDER OR SUPPLIER	0.0230		STREET ADDRESS, CITY, STATE, ZIP CO 311 W PHIFER STREET MARSHVILLE, NC 28103	DDE	09/26/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 580	breathing. Code statuinitiated. EMS pronou	bserved that he wasn't is was validated, and CPR	F 5	580		
	on 09/24/24 at 11:30 was the nurse for Res 4:00 PM through 09/2 indicated she checke and observed Reside closed, even rise and distress noted. Nurse wanted his afternoon shook his head no. N she would be back la did not normally crush however she did crus due to him exhibiting up clear phlegm, and #1 verified these sym Resident #1. Resider concerns at that time check Resident #1's vindicated she left Resident #1's vindicated she left Resident #1 at 2:00 A eyes closed and exhi Nurse #1 stated she again at 3:30 AM, Reclosed and did not ap Resident #1 had his rivas noted in his mou	AM. Nurse #1 verified she sident #1 on 09/18/24 from 19/24 at 7:00 AM. Nurse #1 d on Resident #1 at 4:15 PM ent #1 resting with his eyes I fall of chest, and no efficient #1 if he medication and Resident #1 urse #1 told Resident #1, ter. Nurse #1 indicated she in Resident #1's medications with his 8:00 PM medications congestion, trying to cough difficulty swallowing. Nurse ent mormal for int #1 did not voice any and Nurse #1 she did not vital signs. Nurse #1				

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		345268	B. WING		09/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	1 00/20/2024
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F 580	a reason for not notin Nurse #1 explained states and the audible congestion or coughing was obstituted by vital signs which incled 90/86, pulse 48, oxygrespirations 12, and "tepid". Nurse #1 rensheet on him to help skin was extremely hid do not speak to Nurse #1 why she did not notif Practitioner (NP) at the didn't". She further explained to the speak to the same of the same of the speak to the same of the same	the coughing, audible gm. Nurse #1could not give ying the physician or NP. The returned to check on the AM and she could still hear on, but no difficulty breathing erved. Nurse #1 checked his uded: blood pressure (BP) gen level 89% on room air, his skin was clammy and noved his blanket and put a cool him off because his not to the touch. Resident #1 se #1 during this #1 stated she did not know by the physician or Nurse that time, she said, "I just explained when she returned I NA #1 exited Resident #1's	F 58		
	revealed the followin received/dispatched AM, and at patient at Impression was obvi emergency medical to Resident #1's root department (FD) and were already at beds reported Resident #7 at 5:15 AM this morn (LE) on scene report resuscitation (CPR) staff at their arrival. If at bedside, EMS creobtain patient inform	at 6:01 AM, on scene at 6:09 6:11 AM. Primary			

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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 580	obvious death. Resider (cessation of respira 4-lead electrocardic measures the heart and noted asystole system fails, causin in all pre-cordial lea of discoloration on tand posterior of pat to light. Per protoco without CPR and as	ge 7 The primary impression was ident #1 found supine in nt #1 found to be apneic ation) and without pulse. A ogram (ECG) (a test that 's electrical activity) performed (when your heart's electrical g your heart to stop pumping) ds. Mottling (blotchy patches the skin) noted in extremities ient's trunk. Eyes non-reactive II, due to extended downtime systole upon presentation, ated, and time of death noted	F 58	0	
	Medical Director (M He stated he would him or the Nurse Pr difficulty swallowing cough were first obserceived a call about change in condition difficulties, cough, of the also stated that the MD when a chat thought the nurse dipractice when she coindicated if Resident and he was having	vas conducted with the D) on 09/24/24 at 3:08 PM. have expected the staff to call factitioner (NP) when the actitioner (NP) when the analysis and served. The MD had not sut Resident #1 having a static that included swallowing congestion, or low vital signs. It was standard practice to call ange occurs. He stated he eviated out of the standard did not call a NP or MD. He at #1's vital signs were low, difficulty breathing he would sent to the hospital for			
	was conducted on (	e Director of Nursing (DON) 09/25/24 at 11:18 AM. She ould have applied oxygen due			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	I	03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	to Resident #1's oxygexpected Nurse #1 to	e 8 gen levels dropping, and she o notify the physician for a of a resident as soon as it	F 58	30		
	The Administrator wa jeopardy on 09/25/24	as notified of immediate 4 at 1:15 PM.				
		the following corrective mpletion date of 09/20/24.				
	Address how correct accomplished for tho been affected by the	se residents found to have				
	Resident #1 at 0428. axillary temperature 9 12, blood pressure 9 on room air. Nurse # difficulty swallowing, on the 3p-11p shift w monitoring. Nurse #1	e #1 obtained vital signs for Vital signs documented: 96.1, pulse 48, respirations 0/84, oxygen saturation 89% 1 identified congestion, and the presence of phlegm vith no follow up or ongoing failed to notify physician of e in condition during her shift.				
	Address how the factoresidents having the the same deficient pr	potential to be affected by				
	were interviewed by Services to ensure the conditions were acte	rent interviewable residents the Director of Social nat they felt any change in d upon timely by the staff ootification and to ensure				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	COMPLETED
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	ROVIDER OR SUPPLIER  CARE OF MARSHVILL	E	;	STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	1 33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 580	of care and treatme On 9/19/2024 a 30 onotes was reviewed Nursing for current of ensure that there working in condition care and treatment, notification.  On 9/19/2024 all stance before the were any condition including of care condition of care included the condition of care included the condition of care, respectively.  On 9/19/2024 the Source of care condition of care including timely treating the condition of care, respectively.  The same education development Coordinates are condition of care including timely treating the care including timely treating timely	day look back of progress by the Assistant Director of non-interviewable residents to ere no concerns related to or delay or withholding of including physician  aff were interviewed by the or designee to determine if cerns related to delay or related to a resident change in ohysician notification.  ures will be put into place or nade to ensure that the ll not recur:  taff Development Coordinator ed all staff on care services ion of change in condition, atment as ordered not porting any concerns and	F 580		
	directive of the Direct	•			

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		345268	B. WING _			C 09/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	<b>,</b>	03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	meeting by the Interd through Friday. Any r acted upon immediat Team includes the Ac Director of Nursing, A Staff Development Co Clinical Coordinator, Director of Rehabilita	wed in clinical morning isciplinary Team Monday legative findings will be ely. The Interdisciplinary lministrator, assistant Director of Nursing, bordinator, Wound Nurse, Director of Social Services,	F 5	80		
	the directive of the Di 9/19/2024.					
	9/23/2024 through 11	established by the n that beginning the week of /15/2024, the following steps I documented weekly for 8				
	weekly by the Director designee to ensure the addressed timely, that concerns, that facility Rights, that the facility changes in condition, medical concern the timely and notified the	sidents will be interviewed or of Social Services or nat resident concerns are at there are no unresolved is respecting Resident y is identifying resident if a resident has had a facility has addressed it e physician, and have no ne potential to be considered				

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	CARE OF MARSHVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 311 W PHIFER STREET MARSHVILLE, NC 28103		3/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	medical record review manager to identify at change in condition, a care or treatment, or a Rights, code statuses be reviewed. Any con addressed to include indicated.  Five staff members w Administrator or designare any concerns relain resident Change in withholding of treatment physician notification.  Facility Activity Report through Friday in Clinensure timely identification treatment if indicated, resident that is a full of potential neglect.  The Quality Improvementation were committee feel that full will be determined at Above responsibilities Ad-hoc QAPI completed.	e residents will have their yed weekly by a clinical my concerns related to any delay or withholding of any concerns with Resident is not being honored will also decrise will be immediately physician notification if will be interviewed weekly the gnee to determine if there ated to delay in identification Condition, delay or ent or concerns regarding will be reviewed Monday ical Morning Meeting to eation of Change in a of physician, prompt appropriate response for a code, timely identification of the entitle of the entitle auditing is necessary, at that time.	F 5	80		

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		345268	B. WING				C <b>26/2024</b>
	ROVIDER OR SUPPLIER			3′	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  MARSHVILLE, NC 28103		20/2027
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENC			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Jeopardy removal was verification and include their corrective action audits dated 09/19/24 revealed no issues will licensed nursing, nursiade staff regarding a reviewed and sign in interviews across all of verbalize that they had change in condition, econdition, and who to resident condition. Question and include the condition of the condition of the condition and who to resident condition.	ible allegation of Immediate is validated by onsite ided:  documentation to support in plan. The initial facility is were reviewed and iderented. Education to see aides and medication change in condition was sheets were provided. Staff departments were able to id received education on examples of change in notify of a change in	F	580			
F 600 SS=J	action plan was validader Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the neglect, misappropriation and exploitation as desincludes but is not limic corporal punishment, any physical or chemic treat the resident's medians.	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This aited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.	F	600			

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		345268	B. WING _			09/	26/2024
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE		STREET ADDRESS, CITY, STATE, ZIP COI 311 W PHIFER STREET MARSHVILLE, NC 28103				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	by: Based on record revi Practitioner (NP), and failed to protect a resi neglect when staff fail care and services for for neglect. Resident in condition on 09/18/ recognize the serious provide thorough and addition, Resident #1 and without a pulse o Cardiopulmonary Resi immediately administe pronounced deceases services (EMS) on 9/ residents reviewed for The findings included  This citation is cross in  1. F580  Based on record revie Director (MD) intervie notify the physician for significant change in or Resident #1 was obse congestion, difficulty services to cough up phlegm. Practitioner (NP) were Resident #1 had his re	is not met as evidenced  ew, and physician, Nurse staff interviews, the facility dent's right to be free from ed to provide necessary 1 of 3 residents reviewed #1 had a significant change 24 and the nurse did not ness, notify the physician or ongoing assessments. In was found not breathing n 09/19/24 and suscitation (CPR) was not ered. Resident #1 was d by emergency medical 19/24. This was for 1 of 3 r neglect (Resident #1).  ew, and staff and Medical ws, the facility failed to rra resident who had a condition. On 09/18/24 erved with audible swallowing, and was trying The MD or Nurse en not notified. On 09/19/24 mouth open with clear mouth and he was coughing.	F	6000	Past noncompliance: no plan of correction required.		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 311 W PHIFER STREET MARSHVILLE, NC 28103	CODE	03/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIA	DATE	
F 600	48 (normal range 60- (normal range between air, and respirations of the had audible congressive extremely hot to touch practitioner (NP) were Resident #1 was four pronounced decease of 3 residents reviewed of condition.  2. F678  Based on observation and Nurse Practitioner failed to ensure that Condition (CPR) immediately and faile effective system so stemergency situation and Nurse #1 was notified unresponsive, not breather the Nurse #1 verified Resident Nurse #1 did not verified resumed her nurse Nurse #1 was later in was a full code, Nurse without initiating a "costopped CPR when se #1 was pronounced demedical services (EM 1 of 3 residents reviewed)	16 (normal 120/80), pulse of 100), oxygen at 89% en 95% and 100%) on room of 12 (normal range 12-18). The MD or Nurse enot notified. At 5:00 AM and not breathing and was dat 6:15 AM. This was for 1 and for notification of change on, record review, and staff, er (NP) interviews the facility Cardiopulmonary	F 6	600			
	3. F684 Based on record revie	ew, staff interviews, Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345268	B. WING			C 09/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	343200	B. Wiito		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	26/2024
					11 W PHIFER STREET		
AUTUMN	CARE OF MARSHVILLE				MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	interviews, the facility thorough, and ongoin to intervene when Not the seriousness of a change in condition. code, was experience 09/18/24 with symptous audible congestion (a of stethoscope), and Nurse #1 did not obtainterventions into platon 09/19/24 Resider clear phlegm was not congestion continued Resident #1's vital sit pressure (BP) of 90/48 (normal range 60/89% (normal range 60/89% (normal range 60/89% (normal range 60/80% (normal range 60	d Medical Director (MD) y failed to provide complete, ng assessments, and failed urse #1 failed to recognize resident 's (Resident #1) Resident #1, who was a full ing a change in condition on oms of difficulty swallowing, able to hear without the use trying to cough up phlegm.	F	600			
	was conducted on 09	9/25/24 at 11:18 AM. The					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345268	B. WING _		09/26/2024			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	,	03/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 600	condition was observed #1's code status and neglect but a lack of Nurse #1. She indicated the physician vital signs and monitor the shift. The DON for #1 to notify the physic of a resident as soon verify a resident's confound without a pulse The Administrator was jeopardy on 09/25/24.	ician when a change of red, not checking Resident not initiating CPR was nursing competency of ted Nurse #1 should have a, should have been obtaining oring Resident #1 throughout urther also expected Nurse cian of a change in condition as it was observed and to de status immediately if e.	F 6	00				
	Address how correction accomplished for the been affected by the  On 9/19/2024 Nurse of change in condition failed to monitor Rescondition. Nurse #1 frode status and faile #1 with Advanced Dir #1 neglected to honor Address how the faciliary accomplished to the faciliary of the status and faile #1 with Advanced Dir #1 neglected to honor Address how the faciliary accomplished to the status and faile #1 with Advanced Dir #1 neglected to honor Address how the faciliary accomplished to the status accomplished to the status accomplished to the status accomplished for the status accomplishe	#1 failed to notify physician n of Resident #1. Nurse #1 ident #1 's change in ailed to verify Resident #1's d to initiate CPR for Resident rective of Full Code. Nurse or Resident #1's rights.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345268	B. WING				26/ <b>2024</b>	
	ROVIDER OR SUPPLIER		•	3	TREET ADDRESS, CITY, STATE, ZIP CODE 11 W PHIFER STREET IARSHVILLE, NC 28103	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 600	ensure they felt their in conditions were act and to ensure there were or withholding of care.  On 9/19/2024 Medicathe Assistant Director non-verbal residents is related to change in withholding of care.  On 9/19/2024 All staff Director of Nursing or there were any conce withholding of care or change in condition a resident rights, or cornot being provided as On 9/19/2024 A record of deaths was audited. There were no deaths identified that required Resuscitation.  On 9/19/2024 crash of that all appropriate edin working condition.  On 9/19/2024 the worfacility review of all confidents of the condition of the con	or of Social Services and oriented residents to rights were honored; change ted upon timely by the staff were no concerns with delay and treatment.  If records were reviewed by of Nursing for current to identify any concerns condition or delay or of were interviewed by of designee to determine if terns related to delay or of identification of resident and treatment, violation of the incerns with any code status of ordered.  The dreview of the last 30 days of by the Director of Nursing. The original of the condition	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345268	B. WING		,	C 9/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103		312012024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	≥ 18	F 60	00		
	reviewed employee fi ensure they have up	off Development Coordinator les for licensed staff to to date CPR certification to present at the time of the				
	event to review her e issues or disciplinary Compliance & Client	#1's agency was notified of mployee file for any previous action. The Director of Services of Convergence ated no previous issues or cumented.				
	Address what measu systemic changes madeficient practice will					
	or designee educated related to identification providing timely treats withholding care, facion resident rights, report	lity CPR policy, honoring ing any concerns oolicy and procedures with a				
	Development Coordir					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345268	B. WING			l	26/ <b>2024</b>	
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W PHIFER STREET MARSHVILLE, NC 28103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 600	across all shifts by the Coordinator with nurs Nursing department s	codes were conducted e Staff Development	F	600				
	notification of physicial treatment, follow up, a concerns of resident potential abuse will be morning meeting Mor	e in condition identification, an, validation of timely appropriate code response, right violations and any e reviewed in clinical aday through Friday. Any be acted upon immediately.						
	held by the facility lea							
		ity plans to monitor its sure that solutions are						
	9/23/2024 through 11	established by the n that beginning the week of /15/2024, the following steps I documented weekly for 8						
	conduct and follow up	nment or designee will o on a weekly Resident nsure that resident concerns , that there are no						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345268	B. WING _			C 9/26/2024		
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP COI 311 W PHIFER STREET MARSHVILLE, NC 28103		3/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 600	Resident Rights, that resident changes in has had a medical conditional resident by the Direct designee to ensure the addressed timely. The concerns, that facility Rights, that the facility Rights, that the facility changes in conditional medical concern the timely, and have not potential to be considered in condition, care or treatment, or Rights, code statuse be reviewed.  Five staff members of Administrator or designer any concerns relin resident Change in withholding of treatments, or concerns relin resident deaths or reviewed by the clinic resident 's code status without delay.	s, that facility is respecting to the facility is identifying condition and if a resident concern, has the facility esidents will be interviewed for of Social Services or hat resident concerns are at there are no unresolved y is respecting Resident ty is identifying resident ty is identifying resident at facility has addressed it concerns that have the dered abuse/neglect.  The residents will have their wed weekly by a clinical any concerns related to any delay or withholding of any concerns with Resident is not being honored will also will be interviewed weekly the ignee to determine if there ated to delay in identification in Condition, delay or ment, violation of Resident with code status not being	F6					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345268	B. WING _			C 09/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	<u> </u>	09/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	across all shifts to er response. Any idential addressed immediate.  Crash carts will be a Director of Nursing of appropriate equipmed.  Facility Activity Report through Friday in Cliensure timely identific. Condition, notification treatment if indicated resident that is a full potential neglect.  The Quality Improve the results of the audited recommendation we committee feel that fit will be determined.  Above responsibilities Ad-hoc QAPI completed.  Alleged Compliance.  Date of immediate jet.  On 09/25/24 the created Jeopardy removal waverification and inclusion.  The facility provided their corrective action audits dated 09/19/2	ector of Nursing or designee insure timely and appropriate fied concerns will be ely.  udited daily by the Assistant or designee to ensure that ent is present.  ort will be reviewed Monday inical Morning Meeting to fication of Change in in of physician, prompt in a propriate response for a code, timely identification of the will review ditts for further ekly for 8 weeks. Should the further auditing is necessary, at that time.  The swere discussed during eted on 9/19/2024.  Indicate the sylundada of the electric place of of the electric pla	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
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		345268	B. WING _			09/26/2024	
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	aide staff regarding a reviewed and sign in interviews across all overbalize they had regin condition, example and who to notify in the condition of a residen Performance Improved discussed with the Adnotes were reviewed.	se aides and medication change in condition was sheets were provided. Staff departments were able to ceived education on change is of change in condition, ne event of a change in at. Quality Assurance and ement (QAPI) meetings were dministrator and meeting	F	600			
F 678 SS=J	The facility's compliance date of 09/20/24 for the corrective action plan was validated on 09/26/24.  Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)  §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review, staff, and Nurse Practitioner (NP) interviews the facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered immediately and failed to operationalize an effective system so staff could respond to an		F	Past noncompliance: no plan o correction required.	ıf		
	Nurse #1 was notified unresponsive, not bre Nurse #1 verified Res Nurse #1 did not verif	as needed. On 9/19/24 If that Resident #1 was eathing and had no pulse. sident #1 was not breathing. If Resident #1's code status sing duties on another hall.					

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		345268	B. WING			09/	26/2024	
	ROVIDER OR SUPPLIER			3′	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  IARSHVILLE, NC 28103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 678	was a full code, Nurse without initiating a "co stopped CPR when s #1 was pronounced of medical services (EM 1 of 3 residents review The findings included Review of the facility's October 2023 indicate Activate the emergen The resident should rulf you are alone with the If someone is nearby, immediately.  In the event help is not retrieve emergency of return as soon as possible. If no AED is cycle of compressions minutes then recheck noted.  Continue CPR efforts arrives, an onsite phy instructs otherwise, olonger continue due to Resident #1 was read.	formed that Resident #1 e #1 then started CPR ode blue protocol." Nurse #1 he became tired. Resident leceased by emergency S) on 9/19/24. This was for wed for CPR (Resident #1).  : s CPR policy revised ed the following: cy response team: hot be left alone. the victim, call out for help. instruct them to dial 911  of available, call 911 and art prior to starting CPR, sible. as possible if one is a vailable, continue the s: Breaths for about two pulse and continue if none  until pulse is restored, EMS sician or nurse practitioner r until the team can no	F	678				

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		345268	B. WING				26/ <b>2024</b>
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 678	failure (CHF), and dy swallowing).  A physician order dat Resident #1 was a furth of the Scope of Treatment (document that allows treatment preference MOST form indicates full scope of treatment Resident #1.  Resident #1's care ploof 17/17/24, revealed a Advanced Directives/ has chosen full code  A nursing progress no AM by Nurse #1 reversion AM."  A nursing progress no on 09/23/24 for 09/19 nurse did resident row 800 hall before starting 200 hall. Walked in Reard rales (abnormated during inspiration. The BP:90/84, P:48, R:12 (auxiliary) resident procession of the resident rounding at the NA observed that Resident also observed the swalled of	ed 03/23/24 indicated Il code.  reveal a Medical Orders for MOST) form (a legal patients to outline their s and end-of-life care. No that a resident wishes the nt for saving their life) for  an, last reviewed/revised on focus that read: Category: 'Code Status Resident #1	F	678			

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	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103		312012024
(X4) ID PREFIX TAG				N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 678	A phone interview wa on 09/24/24 at 11:30 was the nurse for Re 4:00 PM through 09/explained at 5:00 AM was exiting Resident was not breathing. Sknew it was coming be sitting low at 4:28 AM not check his code at stated, "I don't know status, I thought he we (DNR)". She explained AM by NA #2 that Re NA # 2 proceeded to 911 and Nurse #1 stated CPR at appears at the cart. When Nur #1, she put the back resumed CPR at appears the cart to do CPR tubing, or a suction make did not ask for as members, nor did she protocol. She explain	is conducted with Nurse #1 AM. Nurse #1 verified she sident #1 on 09/18/24 from 19/24 at 7:00 AM. She I Nursing Assistant (NA) #1 #1's room and stated he he stated she told NA #1 she he cause his vital signs were I. Nurse #1 verified she did atus at 5:00 AM. She also why I didn't check his code was a Do Not Resuscitate de she was informed at 5:55 sident #1 was a full code. the nurses' station to call arted CPR, however she time later to retrieve the rese #1 returned to Resident board under him and roximately 6:00 AM. She body was warm to the touch. sident #1's room and Nurse of have anything on the such as an AED, oxygen, hachine. Nurse #1verified desistance from other staff de activate the code blue led she stopped performing ause she was tired. Law	F 67			
	6:10 AM. Resident #' at 6:15 AM by EMS. wrote the nursing not that occurred on 09/1	services (EMS) arrived at  I was pronounced deceased She further stated when she e on 09/23/24 for the events 9/24 she did not add the d Resident #1 did not have a				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			COMPLETED		
		345268	B. WING			C <b>09/26/2024</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	- 1	09/26/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 678	indicated she did not Resident #1 was a I was.  A phone interview was Assistant (NA) #1 or explained that at 5:0 in to change Reside touch, however he was breathing and had notified Nurse #1. Not she figured it was considered it was considered for Resident #1 of his chest which was resuscitation (CPR) to pass medications provided postmorter further stated at apprinformed Nurse #2 traway.  A phone interview work on 09/24/24 at 2:54 coming up the 100 mapproached at 5:55 #1 and was told that	he started CPR. Nurse #1 t know why she thought DNR, she just assumed he  as conducted with Nursing n 09/24/24 at 3:01 PM. NA #1 DO AM on 09/19/24 she went nt #1, he was warm to the vas unresponsive, not o pulse. NA #1 immediately A #1 stated Nurse #1 said oming due to his vital signs A #1 observed Nurse #1 #1's pulse and the rise and fall ere absent. Nurse #1 verified t breathing. NA #1 stated that art cardiopulmonary and she went to another hall . NA #1 explained she m care to Resident #1. NA #1 aroximately 5:55 AM she hat Resident #1 had passed  as conducted with Nurse #2 PM. Nurse #2 stated she was nall when she was AM by Nursing Assistant (NA) Resident #1 had passed	F 6					
	spoken to NA #1, sh on the 100/300 hund #2 that Resident #1 stated NA #2 jumpe he's a full code," as nursing station to ch Between 6:02 AM a	lained that after she had be was at the nurses' station dred hall and she informed NA had passed away. Nurse #2 d up and said, "oh my god she went towards the main beck the code status binder. and 6:06 AM she went to the beck the coded help and						

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 311 W PHIFER STREET MARSHVILLE, NC 28103	•	03/20/2024		
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F 678	emergency medical sway. Nurse #2 went in check on her resident hall. Nurse #2 explaint 100/300 hall for two or Resident #1's room a law enforcement and room. At that time Enthe building. Nurse # talking to law enforce copies of Resident # stated Nurse #1 did rwhen she was made Nurse #2 confirmed sway #1 perform CPR at a An interview was corn Assistant (NA) #2 on #2 verified she worke PM through 09/19/24 halls. NA #2 stated station when Nurse #1 passed away. She exand said, "oh my good went up the hall toward She looked in the Do and removed Reside he was a full code. Not that sheet to Nurse #1 the 800 hall to show code. She explained	she did not need help and services (EMS) were on the back to the 100/300 hall to the then went back to the 800 hed she went back to the or three minutes then went to at approximately 6:08 AM, I first responders were in the MS was at the side door of 2 recalled Nurse #1 was ement, and she went to make 1's paperwork. She further not call the code overhead aware of his code status. She did not observe Nurse ny time.	F	678				
	Nurse #1 to grab the call 911. NA # 2 proc call 911. After the cal to Resident #1's roor through the drawers	crash cart, and she would eeded to the nurse station to Il was completed, she went n where Nurse #1 was going of the crash cart saying she to do CPR with such as an						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345268	B. WING _			C <b>09/26/2024</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103		03/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 678	automated external of tubing, or a suction in ambu-bag was located cart unopened, it appress was under Resident. Nurse #1 the oxygend crash cart. She looked enforcement and the the hall. She indicated assignment. She was CPR prior to grabbin explained that she all facility and that was likely and that was likely and the following revealed the following revealed the following revealed the following revealed the following received/dispatched AM, and at patient at limpression was obvious to Resident #1's roor department (FD) and were already at beds reported Resident #1 AM this morning. FD scene reported that or resuscitation (CPR) staff at their arrival. Note that the staff at their arrival. In at bedside, EMS cree obtain patient informate facility staff. Resident facility paperwork. The obvious death, Resident (cessation of respirated-lead electrocardiog	defibrillator (AED), oxygen, machine. NA #2 stated the ed on the side of the crash peared that the backboard #1's back and she reminded tank was located beside the ed up and saw law first responders coming up ed she then went back to her is unaware Nurse #1 initiated go the crash cart. NA #2 so did medical records at the mow she was aware of tatus.  Services (EMS) report go: the call was at 6:01 AM, on scene at 6:09 to 6:11 AM. Primary ous death, at scene, services (EMS) crew directed in by facility staff. The fire police department (PD) ide. Per report from FD, staff was last known well at 5:15 and law enforcement on	F	578				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345268	B. WING _			C 09/26/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 678	in all pre-cordial lead of discoloration on the and posterior of paties to light. Per protocol, without CPR and asy CPR efforts not initiated 6:15 AM.  A phone interview was Practitioner (NP) on 0 stated he would expessatus immediately if with no pulse. The N speculate and say the initiated that Resident been different.  An interview with the was conducted on 00 stated Nurse #1 show #1's code status whe congestion, change i immediately after ver pulse. She also stated crash cart that the factoxygen is located right facility does not utilize.  The Administrator was jeopardy on 9/25/24 and The facility provided.	your heart to stop pumping) s. Mottling (blotchy patches e skin) noted in extremities ent's trunk. Eyes non-reactive due to extended downtime estole upon presentation, ted, and time of death noted as conducted with the Nurse 09/24/24 at 4:00 PM. He ect the nurse to verify code a resident was observed P stated he could not at if CPR was immediately at #1's outcome would have  Director of Nursing (DON) 0/25/24 at 11:18 AM. She alld have checked Resident an she observed increased an his oxygen levels, and ifying, he was without a d everything was on the cility keeps on it and the and the beside the crash cart. The e an AED.  Is notified of immediate at 1:15 PM.  the following corrective empletion date of 09/20/24.	F6	578				
	accomplished for tho been affected by the	se residents found to have deficient practice:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 501251	_			
		345268	B. WING			09/	26/2024
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  IARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 678	Continued From page	÷ 30	F	678			
	that Resident #1 was failed to verify Reside	o), NA #1 notified Nurse #1 unresponsive. Nurse #1 ent #1's code status and opulmonary Resuscitation					
	Address how the facil residents having the p the same deficient pra	potential to be affected by					
	of deaths was audited	rd review of the last 30 days d by the Director of Nursing. s or change in condition d Cardiopulmonary					
	wound nurse to ensur	carts were audited by the re that all appropriate art and in working condition.					
	facility review of all co	ound nurse completed a full ode status orders and care were no concerns, no					
	reviewed employee fi ensure they have up	aff Development Coordinator les for licensed staff to to date CPR certification to present at the time of the					
	Address what measur systemic changes ma	res will be put into place or ade to ensure that the				_	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345268	B. WING			C <b>09/26/2024</b>
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	<b>.</b>	03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 678	Continued From paç deficient practice wil		F 67	78		
		raff Development Coordinator and all staff on the facility esuscitation Policy.				
	Development Coord staff upon first shift v	a will be provided by the Staff inator or designee to agency worked and all new hires fective 9/19/2024 per ctor of Nursing.				
	across all shifts by the Coordinator with nurn Nursing department	c codes were conducted ne Staff Development rsing department staff. staff includes Registered ractical Nurses and Certified				
	by a member of the effective 9/23/2024   Interdisciplinary Tea Coordinator, Director Enrichment Director Services, Food Serv Business Office Coo Manager. These me Team have been ed	udits will be completed daily Interdisciplinary Team per the Administrator. The m includes Medical Records r of Social Services, Life , Director of Environmental rice Director, Administrator, ordinator, and Central Supply mbers of the Interdisciplinary ucated on crash cart ce per the Administrator and				
		ility plans to monitor its e sure that solutions are				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		(	
		345268	B. WING			09/	26/2024
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE			3	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  IARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 678	Continued From page	e 32	F	678			
	9/23/2024 through 11	established by the n that beginning the week of /15/2024, the following steps I documented weekly for 8					
	shift per week by the designee across all sl	be conducted one random Director of Nursing or hifts to ensure timely and . Any identified concerns will iately.					
		dited daily by the Assistant designee to ensure that tis present.					
	the results of the audi recommendation wee	kly for 8 weeks. Should the orther auditing is necessary,					
	Above responsibilities Ad-hoc QAPI complet	s were discussed during ted on 9/19/2024.					
	Alleged Compliance of	date: 9/20/24					
	Date of immediate jed	opardy removal is 9/20/24					
	On 09/25/24 the credi Jeopardy removal wa verification and includ	-					
		documentation to support plan. The initial facility were reviewed and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345268	B. WING _			09/	26/2024
	CARE OF MARSHVILLE			31	TREET ADDRESS, CITY, STATE, ZIP CODE  1 W PHIFER STREET  ARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684 SS=J	all staff departments or reviewed and sign in a interviews across all of completed and those that they had received procedures to take. Of discussed with the Adnotes were reviewed. Crash cart at the main at 12:35 PM revealed an ambu bag and bac numerous others supplied for an emergency.  The facility's date of Of action plan was validated Quality of Care CFR(s): 483.25  § 483.25 Quality of care is a further facility residents. Basical assessment of a resident that residents receive accordance with profession plan, and the residents received accordance with profession plants received accordance wit	ere noted. Education across regarding CPR was sheets were provided. Staff departments were staff were able to verbalize deducation and knew the API meetings were iministrator and meeting. An observation of the nursing station on 09/25/24 the cart to be stocked with exboard along with plies that would be required.  19/20/24 for the corrective ated on 09/26/24.  The care in a care provided to be denoted on the comprehensive dent, the facility must ensure treatment and care in the essional standards of the ensure person-centered sidents' choices.  The interest is not met as evidenced.		578	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345268	B. WING				C 26/2024
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 11 W PHIFER STREET IARSHVILLE, NC 28103	03//	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	09/18/24 with sympto audible congestion (a of stethoscope), and Nurse #1 did not obtainterventions into place On 09/19/24 Resident clear phlegm was not congestion continued Resident #1's vital sign pressure (BP) of 90/8 48 (normal range 60-89% (normal range broom air, respirations and temperature 96.7 did not obtain anothe 5:00 AM when Resident pulse. Nurse #1, w #1's full code status, resuscitative efforts a medications. At 5:55 aware of Resident #1 initiated Cardiopulmo Emergency medical sat 6:00 AM, arrived at was pronounced dece for 1 of 3 residents recondition (Resident #1 The findings included Resident #1 was read 12/06/23. His diagnost	ing a change in condition on the soft difficulty swallowing, able to hear without the use trying to cough up phlegm. In vital signs or put the to relieve the congestion. It is that his mouth open, and he was coughing. It is given in the congestion of the congestion of the congestion of the congestion. It is that his mouth open, and he was coughing. It is given in the congestion of the co	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345268	B. WING				26/ <b>2024</b>
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE		•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W PHIFER STREET MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
F 684	(Bilateral Positive Airy breathing machine the delivering pressurized HS (hour of sleep) and Note if resident does  Chart review did not rescope of Treatment (#1.  Resident #1's quarter assessment dated 07 cognition was intact who rejection of care of the complete of th	ed 03/23/24 indicated II code.  ed 08/21/24 to apply Bi-pap way Pressure-a noninvasive at helps people breathe by drair into their airways) every dremove in the morning. In not wear.  eveal a Medical Orders for MOST) form for Resident  If Minimum Data Set (MDS) //01/24 indicated his without behaviors. There was rebehaviors coded.  In last reviewed/revised on focus that read he had the espiratory status/difficulty history of respiratory failure. Unded for staff to ort abnormal breathing elevate head of bed to resident comfort level, as oxygen as ordered. Another to vascular congestion and by which placed him at risk the to medication use. The diffor staff to administer difformity and the staff to administer difference of the staff to administer difformity or possible	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345268	B. WING _			C <b>09/26/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	<b>I</b>	03/20/2024
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	of any changes, as no /responsible party cho status, necessary pro	I for staff to notify physician	F6	584		
	with eyes closed, eas questions when asked breath and there was note also revealed that Resident #1's chest/p	sident #1 was lying in bed ily arousable and answering d. He denied shortness of no cough observed. The at during physical exam of ulmonary and systems that no physical				
	conducted on 09/25/2 verified she was the c #1 on 09/18/24 and N concerns with him on	dication Aide (MA) #1 was 44 at 10:40 AM. MA #1 direct care MA for Resident A #1 did not observe any first shift (7A-3P). She talkative and did not voice				
	(MAR) for medication 09/19/24. 09/18/24-re medications. All 8:00 signed as being admi were documented as on 09/19/24. Treatme	PM medications were nistered. No medications having been administered and administration record PAP on 09/10/24, 09/13/24,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345268	B. WING _				C <b>26/2024</b>
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE			STREET ADDRESS, CITY, STATE, ZIP COE 311 W PHIFER STREET MARSHVILLE, NC 28103	)E	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 684	o9/25/24 at 10:05 AM for Resident #1 on 09 PM. Nurse #3 explair nurse however the fa was covering the ass arrived. Nurse #3 also report from first shift. and speak with Resid 3:25 PM, and he was observe Resident #1 congestion. Nurse #3 working assisting with refused dinner, howe behavior, he refused times.  A nursing progress no on 09/23/24 for 09/19 nurse did patient rour before starting medic. Walked in Resident # (abnormal breath sou person inhales and so bubbling, or rattling) of checked vitals BP:90 room air, T:96.1 (axill refused to have CPAF (Certified Nursing Ass (patient) rounding at 1 hundred hall. CNA ob #1) wasn't breathing. the resident's room a patient wasn ' t breath validated, and CPR ir death at 6:15 AM. Po	se #3 was conducted on I. Nurse #3 stated she cared I/18/24 from 3:00 PM to 4:00 I. ded she was the wound care cility had a call out and she ignment until Nurse #1 Io stated when she received Nurse #3 verified she did go ent #1 at approximately "fine." Nurse #3 did not with increased cough or also stated she was still In meals and Resident #1 Iver that was not a new meals and medications at  Interpretation of the inject of the policy It is room and heard rales Inding at 4:28 AM on 800 hall Interpretation of the night. CNA Is is stant of the eight Is is served that pt. (Resident Interpretation of the eight Interpretation of the eight Is is room and heard rales Is is a company to the property of the policy Is place on for the night. CNA Is is stant of the eight Is is room and heard rales Is is a company to the property of the policy Is place on for the night. CNA Is is stant of the eight Is is room and also observed that Interpretation of the eight Is in the policy of the place on	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
	0.45000	D. MINIC			С	
	345268	B. WING _		•	9/26/2024	
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
ALITUMNI CARE OF MARCUS			311 W PHIFER STREET			
AUTUMN CARE OF MARSH	TILLE		MARSHVILLE, NC 28103			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
4:00 PM through indicated she chand observed R closed, even risk distress noted. It wanted his after shook his head normally did not however she did due to him exhibit up clear phlegm #1 stated the sy administering Remedications were said Resident # that time and she vital signs. Nurs #1's room to admedications. Nur Resident #1 at 1 audible congest observed such a his eyes closed. #1 at 2:00 AM a closed and conticongestion. Nur Resident #1 agains eyes closed distress. Nurse having had his rooted in his more was not normal did not notify the (NP) of the coughlegm. Nurse # notifying the phy	page 38 or Resident #1 on 09/18/24 from 109/19/24 at 7:00 AM. Nurse #1 ecked on Resident #1 at 4:15 PM esident #1 resting with his eyes and fall of chest, and no lurse #1 asked Resident #1 if he moon medication and Resident #1 inc. Nurse #1 indicated she crush Resident #1's medications, arough this 8:00 PM medications of thing congestion, trying to cough and difficulty swallowing. Nurse imptoms she observed when esident #1 his 8:00 PM e abnormal for Resident #1. She is did not check Resident #1's er #1 indicated she left Resident innister other residents their rese #1 explained she checked on 0:50 PM and she could still hear on, but no difficulty breathing was as gasping. He was resting with Nurse #1 checked on Resident ind he was resting with his eyes nued to exhibit audible se #1 stated she checked on in at 3:30 AM, Resident #1 had and did not appear to be in #1 described Resident #1 as mouth open, clear phlegm was ith, and he was coughing which for Resident #1. She stated she physician or Nurse Practitioner thing, audible congestion, and except the properties of the physician or Nurse #1 explained check on Resident #1 at 4:28 AM except the properties of the physician or Nurse #1 explained check on Resident #1 at 4:28 AM	F6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345268	B. WING		C 09/26/2024
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	1 00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 684	observed such as gavital signs which incl 90/84, pulse 48, oxy respirations 12, and "tepid." Nurse #1 rer sheet on him to help skin was extremely I did not speak to Nur assessment, and sh Nurse #1 stated she notify the physician that time about Resi congestion, and low didn't." She further eto the 800 hall from 200 hall at 5:00 AM room and stated he checked for Resider	thing or coughing was asping. Nurse #1 checked his uded: blood pressure (BP) gen level 89% on room air, his skin was clammy and moved his blanket and put a cool him off because his not to the touch. Resident #1 se #1 during this e believed he was asleep. did not know why she did not or Nurse Practitioner (NP) at dent #1's coughing, audible vital signs, she said, "I just explained when she returned passing medications on the NA #1 exited Resident #1's was not breathing. Nurse #1 at #1's pulse and the rise and h were absent. Nurse #1	F 684		
	Assistant (NA) #1 or verified she worked through 09/19/24 at direct care NA for Ronotified Nurse #1 at roommate had reque Resident #1 becaus #1 stated she obser and she could hear Nurse #1 again at 3: having had his mouth his mouth, he was could the nurse immedwent to his room but	as conducted with Nursing n 09/24/24 at 3:01 PM. She from 09/18/24 at 11:00 PM 7:00 AM and she was the esident #1. NA #1 stated she 2:00 AM that Resident #1's ested her to come look at e he did not sound good. NA wed Resident #1 coughing, congestion. NA #1 notified 30 AM about Resident #1 h open, phlegm was visible in oughing, and she went and diately. She stated Nurse #1 did not tell her anything. NA dinot worked with the resident			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	(X3	(X3) DATE SURVEY COMPLETED	
		345268	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	ı	09/26/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	NA #1 explained at 5 change him and he was pulse. She immediated Resident #1's roomn interviewed.  A phone interview was on 09/24/24 at 2:54 for coming up the 100 happroached at 5:55 with an away. Nurse #2 explospoken to NA #1, shoon 100/300 hall with #2 that Resident #1 stated NA #2 jumped he's a full code," as Inursing station. Nurse checked the code stated the 800 nurses' stated NA she went to the 800 hall to deep and Nurneed help and emerge (EMS) were on the waste 100/300 hall to deep land the crash of Resident #1's room a responders, and fire assessing Resident areceiving CPR. At the door of the building, was talking to law en make copies of Resident waste 100/300 hall to law en make copies of Resident #1's room aresponders, and fire assessing Resident areceiving CPR. At the door of the building. Was talking to law en make copies of Resident waste 100/15 hall to law en make copies of Resident waste 100/15 hall to law en make copies of Resident waste 100/15 hall to law en make copies of Resident waste 100/15 hall to law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make copies of Resident waste 100/15 hall the law en make 1	as not sure of his baseline.  3:00 AM she went in to was not breathing and had no ely notified Nurse #1.  Inate was not able to be  as conducted with Nurse #2  PM. Nurse #2 stated she was all when she was AM by Nursing Assistant (NA) Resident #1 had passed ained that after she had awas at the nurses' station NA #2, and she informed NA had passed away. Nurse #2 I up and said, "Oh my god NA #2 went towards the main a #2 then stated NA #2 atus binder that was located ation and verified Resident etween 6:02 AM and 6:06 BOO hall to see if Nurse #1 rse #1 stated no, she did not gency medical services vay. Nurse #2 went back to heck on her residents then	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	, ,	E SURVEY IPLETED		
		345268	B. WING		09	C 9/ <b>26/2024</b>	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	•	1 03/20/2024	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Assistant (NA) #2 or verified she worked through 09/19/24 at not the hall where R stated she was sittin Nurse #2 told NA #2 away. NA #2 explair "oh my god, he's a f the hall towards the said she looked in the binder and removed indicated he was a she took that sheet down the 800 hall to full code. NA #2 expseveral times, "you' #2 told Nurse #1 to #2 went to call 911. nurses' station to caresponsible for med she was an NA, that Resident #1's code not been assigned to 9/18/24 to 9/19/24.  Emergency medical revealed the following received/dispatched AM, and at patient as Impression was obvi	onducted with Nursing in 09/24/24 at 11:44 AM. She on 09/18/24 from 11:00 PM 7:00 AM on the 100/300 hall, desident #1 resided. NA #2 ing at the nursing station when 22 Resident #1 had passed in hed she jumped up and said, full code," as NA #2 went up main nursing station. NA #2 in he Do Not Resituate (DNR) if Resident #1's sheet that full code. NA #2 then stated to Nurse #1 who was halfway to show her Resident #1 was a plained that Nurse #1 stated we got to be kidding me." NA grab the crash cart, and NA NA #2 proceeded to the sill 911. NA #2 explained she is lical records at the facility, and it was how she was aware of status. NA # 2 stated she had to Resident #1 at all from	F 68	·			
	nurses' station to caresponsible for med she was an NA, that Resident #1's code not been assigned to 9/18/24 to 9/19/24.  Emergency medical revealed the following received/dispatched AM, and at patient a Impression was obverned to Resident #1's root department (FD) and	all 911. NA #2 explained she is ical records at the facility, and it was how she was aware of status. NA # 2 stated she had to Resident #1 at all from  I services (EMS) reporting: the call was if at 6:01 AM, on scene at 6:09 at 6:11 AM. Primary vious death, at scene,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345268	B. WING			09/	26/2024
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE  11 W PHIFER STREET  MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 684	resuscitation (CPR) wastaff at their arrival. Nat bedside. EMS crew obtain patient informate facility staff. Resident facility paperwork. The obvious death. Reside facility bed. Resident (cessation of respiration 4-lead electrocardiog measures the heart's and noted asystole (wasystem fails, causing in all pre-cordial leads of discoloration on the and posterior of patients to light. Per protocol, without CPR and asystem fails, causing in all pre-cordial leads of discoloration on the and posterior of patients to light. Per protocol, without CPR and asystem fails. AM.  A phone interview was Medical Director (MD) He stated he would hobtain vital signs and the difficulty swallowing cough were first observed a call about change in condition the difficulties, cough, could he also stated that it the MD when a change thought the nurse devipractice when she dictindicated if his vital si	ed that cardiopulmonary vas not in progress by facility to facility staff were present or requested a firefighter to action and code status from #1 found to be full code on the primary impression was tent #1 found supine in #1 found to be apneic on) and without pulse. A tram (ECG) (a test that electrical activity) performed when your heart's electrical your heart to stop pumping) is. Mottling (blotchy patches the skin) noted in extremities in the strunk. Eyes non-reactive due to extended downtime stole upon presentation, ted, and time of death noted in the staff to to call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the call him or the NP when the staff to the staff to the call the standard that included swallowing the standard that included swallowing the standard that the standard the would have needed	F	684			

NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF MARSHVILLE  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  311 W PHIFER STREET  MARSHVILLE, NC 28103  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	C 09/26/2024 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF MARSHVILLE   STREET ADDRESS, CITY, STATE, ZIP CODE  311 W PHIFER STREET  MARSHVILLE, NC 28103   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  311 W PHIFER STREET  MARSHVILLE, NC 28103  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	DATE
A phone interview was conducted with the Nurse Practitioner (NP) on 09/24/24 at 4:00 PM. He stated he saw Resident #1 on 09/18/24 and he seemed to be in his normal state, alert and oriented to per, place, and time. He also stated he observed the resident as having no cough or shortness of breath. He indicated staff should have obtained vital signs and monitored Resident #1 and he would have expected the staff to call him or the Medical Director (MD) when the difficulty swallowing, audible congestion, and cough were first observed.  An interview with the Director of Nursing (DON) was conducted on 09/25/24 at 11:18 AM. She stated Nurse #1 should have applied oxygen due to Resident #1's oxygen levels dropping, she should have notified the physician, and she should have notified the physician, and she should have been obtaining vital signs throughout the shift. She also expected Nurse #1 to notify the physician for a change in condition of a resident as soon as it was observed.  On 09/25/24 at 1:15 PM the Administrator and DON were made aware of the Immediate Jeopardy.  The facility implemented the following corrective action plan with a completion date of 09/20/24.  Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:  On 09/19/24, Resident #1 was noted with abnormal vital signs at 4:28 AM per Nurse #1.  Nurse #1 identified congestion, difficulty	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345268	B. WING			C <b>09/26/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	<u> </u>	03/26/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE APF  DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 684	Resident #1's change interventions to import interventions to import Address how the fact residents having the the same deficient properties of the same deficient properties of the same deficient properties to ensure the conditions were acterincluding physician at there were no concern of care and treatment.  On 09/19/24 a 30 day notes was reviewed Nursing for current resure that there we change in condition care and treatment, notification.  On 09/19/24 all staff Director of Nursing of the the were any concern withholding of care and treatment, notification including properties of deaths was audited the the was no change required Cardiopulm.	In a led to further assess are in condition or implement rove Resident #1's condition.  It is is in condition or implement rove Resident #1's condition.  It is potential to be affected by the practice:  In a little be affected by the staff rotification and to ensure the erns with delay or withholding rot.  In a look back of progress by the Assistant Director of roon-interviewable residents to the reno concerns related to rot delay or withholding of including physician  If were interviewed by the rot designee to determine if the roters related to delay or related to a resident change in or obysician notification.  In a review of the last 30 days are delay or the last 30 days are in condition identified that roonary Resuscitation.  In a review will be put into place or	F 6	84			
		nade to ensure that the					

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345268	B. WING			C <b>09/26/2024</b>	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103		09/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	ue 45	F 68	34			
	or designee educate related to identificati providing timely trea	ff Development Coordinator and all staff on care services on of change in condition, tment as ordered not porting any concerns and ian.					
	Development Coord staff upon first shift v	will be provided by the Staff inator or designee to agency vorked and all new hires fective 09/19/24 per directive rsing.					
	physician, validation follow up will be revi	identification, notification of of timely treatment and ewed in clinical morning ough Friday. Any negative I upon immediately.					
		ility plans to monitor its e sure that solutions are					
	9/23/24 through 11/1	established by the m that beginning the week of 15/24, the following steps will ocumented weekly for 8					
	weekly by the Direct	esidents will be interviewed or of Social Services or that resident concerns are					

PRINTED: 11/25/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345268	B. WING	B. WING		1	26/ <b>2024</b>
NAME OF PE	ROVIDER OR SUPPLIER	0.0200			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	26/2024
	10112211 011 001 1 2.2.1				311 W PHIFER STREET		
AUTUMN (	CARE OF MARSHVILLE				MARSHVILLE, NC 28103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 46	F	684	1		
	addressed timely, that concerns, that facility Rights, that the facility changes in condition, medical concern the fitimely and notified the concerns that have the abuse/neglect.  Five non-interviewable medical record review	t there are no unresolved is respecting Resident y is identifying resident if a resident has had a facility has addressed it e physician, and have no be potential to be considered e residents will have their yed weekly by a clinical					
	change in condition, a care or treatment, or a	ny concerns related to any delay or withholding of any concerns with Resident a not being honored will also					
	Administrator or designare any concerns relation resident Change in	ent or concerns regarding					
	through Friday in Clin ensure timely identific Condition, notification treatment if indicated,						
	the results of the audi recommendation wee committee feel that fu it will be determined a	ekly for 8 weeks. Should the arther auditing is necessary,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345268	B. WING		0.	C 9/ <b>26/2024</b>
	ROVIDER OR SUPPLIER  CARE OF MARSHVILLE			51 <b>2</b> 51 <b>2</b> 52 <del>4</del>		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	On 09/25/24 the cred Jeopardy removal was verification and include The facility provided of their corrective action audits dated 09/19/24 revealed no issues willicensed nursing, nursing.	date: 09/20/24  pardy removal is 09/20/24  dible allegation of Immediate s validated by onsite led:  documentation to support plan. The initial facility	F 68	14		
	reviewed and sign in interviews across all of verbalize they had red in condition, example and who to notify in the condition of a resident Performance Improved discussed with the Acrontos were reviewed.  The facility's compliant	sheets were provided. Staff departments were able to ceived education on change s of change in condition, ne event of a change in t. Quality Assurance and ement (QAPI) meetings were dministrator and meeting				