STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET , MARSHVILLE, North Carolina, 28103

(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
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/19/25 through 8/21/25. Event ID# 1D47E8-H1. The following intakes were investigated 2590748 and 2584473. 2 of the 5 complaint allegations resulted in deficiency.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #2). Resident #2 was prescribed a daily low-dose aspirin for stroke prevention. Nursing Assistant (NA) #1 rolled Resident #2 away from her during incontinence care, and Resident #2 fell out of bed sustaining a laceration to her forehead, which necessitated 8 sutures to close. The findings included: Resident #2 was admitted to the facility 2/21/2019 with diagnoses including epilepsy, stroke, and hypertension. Review of the medical record revealed a physician order dated 12/3/24 for aspirin 81 milligrams administered daily.	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET , MARSHVILLE, North Carolina, 28103

(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
F0689 SS = G	Continued from page 1 The quarterly Minimum Data Set (MDS) assessment dated 6/11/25 assessed Resident #2 to be severely cognitively impaired. The MDS documented limited range of motion on one side of her upper body and for both legs. The MDS documented Resident #2 required substantial assistance with bed mobility and was dependent on staff for transfers. A nursing note dated 8/1/25 at 6:40 AM written by Nurse #1 documented NA #1 called Nurse #1 to Resident #2's room, and she found Resident #2 on the floor beside the bed face down in a puddle of blood. Nurse #2 documented she performed an assessment on Resident #2 prior to assisting her back into bed with a mechanical lift. Nurse #1 documented Resident #2 had a laceration to the right forehead, approximately 4 inches long, as well as an abrasion to the left knee. The physician and resident representative were notified, and orders were received to send Resident #2 to the hospital. A phone interview was conducted with NA #1 on 8/20/25 at 8:58 AM. NA #1 described Resident #2 had no movement on the right side of her body and her right arm and leg were contracted due to a stroke and Resident #2 had no control of that side of her body. NA #1 explained she was providing incontinence care to Resident #2 on 8/1/25 at about 6:30 AM. NA #1 described that she was standing on the side of the bed near the door with Resident #2 turned towards her. NA #1 explained she walked around the bed to the other side near the window, and she rolled Resident #2 away from her (towards the door). NA #1 explained she was attempting to change the fitted sheet under Resident #2 and when she pushed the fitted sheet under Resident #2, the resident rolled off the bed and fell on the floor. NA #1 explained she went to get Nurse #1 to come assist. NA #1 reported she was aware that she should not have pushed Resident #2 away from her during care, because there was a risk she could roll off the bed. When asked why she left Resident #2 alone to get the nurse, NA #1 reported that there was no one else on the hall and she needed to get the nurse as quickly as possible because Resident #2 was bleeding. Nurse #1 was interviewed by phone on 8/20/25 at 9:38 AM. Nurse #1 reported she was in the medication room counting narcotics at the change of shift on 8/1/25 at about 6:30 AM, when NA #1 came to her and said, "Can you come help me?" Nurse #1 reported she followed NA #1 to Resident #2's room and found Resident #2 face down on the floor in a puddle of blood. Nurse #1 reported she assessed Resident #2 and cleaned the laceration to her forehead. Nurse #1 reported she asked NA #1 what	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET , MARSHVILLE, North Carolina, 28103

(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
F0689 SS = G	Continued from page 2 happened, and NA #1 told her she rolled Resident #2 away from her and Resident #2 rolled off the bed. Nurse #1 reported she contacted the physician and received orders to send Resident #2 to the hospital emergency room for evaluation, because the laceration was more than the facility could treat. Hospital records dated 8/1/25 for Resident #2 were reviewed. Resident #2 arrived at the emergency room with a laceration to her right forehead, as well as an abrasion to her left knee. A computed tomography (CT) scan of the neck did not show fracture. A CT scan of the head did not show any abnormalities. The 6-centimeter laceration to the right forehead was closed with 8 sutures. Resident #2 was admitted to the hospital for elevated lab results and tachycardia (a fast heart rate). Resident #2 returned to the facility on 8/4/25 with orders to remove the sutures to the right forehead laceration on 8/11/25. The Director of Nursing (DON) was interviewed on 8/20/25 at 3:47 PM. The DON reported NA #1 was changing Resident #2 and she rolled over the side of the bed. The DON reported she was not aware NA #1 pushed Resident #2 away from her during care, causing her to roll off the bed. The DON reported she expected residents to be turned correctly in bed during care to prevent them from falling out of bed. The facility submitted the following corrective action plan. · Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/1/2025, NA #4 was providing incontinence care to Resident #2. The fitted sheet on Resident #2's bed needed changed and NA #4 rolled Resident #2 away from her in order to tuck the fitted sheet onto the mattress. Resident #2 rolled from the bed and NA #4 was unable to stop Resident #2. NA #4 stated that she knew she would have turned Resident#2 towards her, but she did not. Resident #2 was noted to have a laceration to the right forehead requiring first aid outside of the facility. On 8/1/2025, NA # 4 received education on bed mobility and positioning as well as requesting assistance when turning a resident in bed as needed. On 8/1/2025 Resident #2's regular bed was changed to a wider bed with a perimeter defined mattress cover to define the edges of the bed and allow more surface area for turning and positioning per the Assistant Director	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET , MARSHVILLE, North Carolina, 28103

(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
F0689 SS = G	Continued from page 3 of Nursing and maintenance staff to allow more room for turning when in bed. · Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/1/2025 the Assistant Director of Nursing reviewed the falls for the last 30 days to ensure there were no other falls related to staff transferring or positioning with care. No other falls were identified. On 8/1/2025 the Director of Nursing or designee reviewed like residents in the facility for the need for a wider bed. No other residents were identified. · Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/1/2025 the Director of Nursing or designee educated all nurses and nursing assistants on turning and positioning residents when in bed/providing care to include moving the resident from the middle of the bed before rolling towards themselves. The education also included notifying the supervisor if the resident requires a larger bed. Any staff member that was unable to be educated on 8/1/2025 was educated by the Director of Nursing or designee prior to working their next scheduled shift. Newly hired staff/agency staff will be educated by the Staff Development Coordinator during orientation. · Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To monitor the effectiveness of the plan beginning 8/1/25 the Director of Nursing or designee will observe 6 random staff per week (Monday – Sunday on random shifts) x 8 weeks while providing bed mobility and resident care to ensure staff are properly positioning residents in the bed starting 8/1/2025. The Director of Nursing or designee will audit 6 like residents per week (Monday – Sunday on random shifts) x 8 weeks to ensure that staff are providing safe bed mobility during care starting 8/1/2025. This plan of correction was reviewed in our Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting which was held with the Interdisciplinary Team on 8/1/2025. The audit will be reviewed by the QAPI committee every month for two months to ensure the plan is effective. The plan of correction will be revised as needed. Alleged Compliance date: 8/4/2025	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET , MARSHVILLE, North Carolina, 28103

(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
F0689 SS = G	Continued from page 4 The plan of correction was reviewed and validated on 8/21/25, which included reviewing the education provided to nurses and nursing assistants, reviewing the initial audits of falls, reviewing the weekly audits, interviewing nurses and nursing assistants, and observation of Resident #2's wider bed with perimeter defined mattress cover. In addition, bed mobility for a resident was observed with 2 staff members. The corrective action plan date of compliance of 8/4/25 was validated.	F0689		