

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/28/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MARSHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE, NC 28103	
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E 000	Initial Comments	E 000		
	An unannounced COVID-19 Focused Survey was conducted on 1/26/2021 and offsite 1/27-28/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# GFX411.			
F 000	INITIAL COMMENTS	F 000		
	An infection control and complaint investigation survey was conducted from 1/26/2021 on-site and off-site 1/27-28/2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.			
F 580 SS=D	0 of 4 compliant allegations were not substantiated. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		2/22/21
	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/12/2021

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.

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F 580	<p>Continued From page 1</p> <p>treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews, staff, physician assistant (PA), nurse practitioner (NP), and physician (MD) interviews, the facility failed to notify a medical professional regarding a change in condition for 2 of 3 residents reviewed for</p>	F 580	<p>I. Resident #1 passed away on January 18, 2021. Resident #3 passed away on January 25, 2021.</p> <p>II. The Director of Nursing/designee will review the twenty-four hour report for the</p>		

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F 580	<p>Continued From page 2</p> <p>change of condition (Resident #1 and Resident #3).</p> <p>Findings included:</p> <p>1. Resident #1 was readmitted to the facility on 10/19/2017 with diagnoses to include heart disease and diabetes.</p> <p>A physician ' s order dated 10/19/2017 identified Resident #1 as being a "full-code" (full resuscitative efforts to be made in the event of a loss of pulse or breathing).</p> <p>The medical record documented Resident #1 tested positive for COVID-19 on 1/1/2021.</p> <p>The facility standing orders with a revision date 1/2021 were reviewed. Included in the standing orders for respiratory distress were COVID-19 oxygen standing order to "apply O2 PRN (as needed) to keep pulse oximetry greater than 90% by nasal cannula (tubing to deliver oxygen by nose), facemask (mask to deliver oxygen that covers the nose and mouth) or non-rebreather (a mask used in emergency situations to delivery high-concentration oxygen). Notify Physician if non-rebreather is needed."</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 1/2/2021 assessed Resident #1 to be moderately cognitively impaired. The MDS revealed Resident #1 was coded as not receiving oxygen (O2) during the look back period.</p> <p>A physician order dated 1/4/2021 ordered oxygen (O2) as needed (PRN) for Resident #1 to keep pulse oximetry greater than 90% (related to COVID) for 30 days.</p>	F 580	<p>last thirty days to ensure we have notified the resident (if appropriate), responsible party and physician of the following changes in condition: accident involving the resident which results in injury and has the potential for requiring physician intervention, changes in the resident's physical, mental or psychosocial status, if there is a need to alter treatment significantly, if the resident transfers or discharges from the facility, if the resident changes rooms or roommate assignment or if there is a change in resident rights. If we discover an instance that proper notification was not completed, it will be corrected immediately. This review will be started February 10, 2021 reflected back to January 12, 2021. The review will be completed by February 17, 2021.</p> <p>III. The Director of Nursing/designee will provide education to the licensed nurses and interdisciplinary team members on the regulatory expectations related to notification. The education will be completed by February 17, 2021.</p> <p>IV. Beginning February 11, 2021 the twenty-four hour report will be reviewed five times per week by the Administrator/Director of Nursing/designee to ensure we have notified the resident (if appropriate), responsible party and physician of the following changes in condition: accident involving the resident which results in injury and has the potential for requiring physician intervention, changes in the resident's physical, mental or psychosocial status, if there is a need to alter treatment significantly, if the resident</p>		

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F 580	<p>Continued From page 3</p> <p>A physician order for Resident #1 dated 1/10/2021 ordered O2 at 2 liters per minute by nasal cannula continuously.</p> <p>A nursing note dated 1/18/2021 at 9:42 AM and written by Nurse #1 documented that Resident #1 was "easily fatigued and short of breath ... (Resident #1) put into bed in upright position and changed (Resident #1 ' s) nasal cannula to a non-rebreather mask. Resident O2 level came up to 95% and (Resident #1) was more alert."</p> <p>A phone interview was conducted with Nurse #1 on 1/27/2021 at 10:39 AM. Nurse #1 reported she provided care to Resident #1 on 1/18/2021 when he was transferred back to his room on the 400 hall. Nurse #1 reported Resident #1 was confused, which was not his baseline before having COVID. Nurse #1 said Resident #1 had O2 and a nasal cannula and he was fatigued and confused. Nurse #1 stated she called the 100/300 hall nurse for report and then applied a non-rebreather mask to Resident #1 to improve his pulse oximetry. Nurse #1 was unable to recall the pulse oximetry results prior to applying the non-rebreather mask and no results were documented in the chart. Nurse #1 explained that she thought the application of a non-rebreather mask was a standing order and she did not need to notify the MD or physician ' s assistant. Nurse #1 explained she gave report to the Clinical Coordinator and to the oncoming shift at 3:00 PM, and if the MD or PA needed to be notified, the Clinical Coordinator would do it.</p> <p>Pulse oximetry results for 1/18/2021 (no times) were documented as 94% and 95% on the medication administration record.</p>	F 580	<p>transfers or discharges from the facility, if the resident changes rooms or roommate assignment or if there is a change in resident rights for six weeks. If we discover an instance that proper notification was not completed, it will be corrected immediately and reeducation to the responsible individual will be completed. Then the twenty-four hour report will be audited weekly for the same criteria for four weeks by the Administrator/Director of Nursing/designee. Lastly, the twenty-four hour report will be reviewed monthly for two months by the Administrator/Director of Nursing/designee for the same criteria. Results of these audits will be taken to the Quality Improvement Committee for review/further recommendations.</p>		

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F 580	<p>Continued From page 4</p> <p>A review of the physician orders revealed no order for a non-rebreather mask.</p> <p>A review of the nursing notes revealed no notification of the physician of the application of the non-rebreather mask.</p> <p>A phone interview was conducted with Nurse #2 on 1/27/2021 at 1:03 PM. Nurse #2 reported she had provided care to Resident #1 on the COVID unit in the morning of 1/18/2021. Resident #1 was moved back to his old room "around lunchtime". Nurse #2 reported Resident #1 was using O2 by nasal cannula when he left the COVID unit and he was stable.</p> <p>The Clinical Coordinator/Assistant Director of Nursing (ADON) was interviewed on 1/27/2021 at 11:13 AM. The ADON reported she was working on a cart passing medications on 1/18/2021 and was also the Clinical Coordinator on that date. The ADON reported that the standing orders allowed for the application of a non-rebreather mask for residents who needed the extra oxygen. The ADON reported she had not notified the MD or the PA the non-rebreather mask had been applied to Resident #1 because she didn ' t think it was a change from his new baseline.</p> <p>A phone interview was conducted with the triage line for the on-call PA and MD. The Triage line reported a phone call had been received on 1/18/2021 at 1:41 PM and the ADON had called to report Resident #1 was moved to a new room on the 400 hall and he was "doing fine."</p> <p>Nurse #4 was interviewed by phone on 1/26/2021 at 10:55 PM. Nurse #4 reported she was the</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>Clinical Coordinator on 1/18/2021 for the 3:00 PM to 11:00 PM shift. Nurse #4 reported she had received report from the 7:00 AM to 3:00 PM shift that Resident #1 was not doing well and had a non-rebreather mask for O2 delivery. Nurse #4 stated she assumed because he had a non-rebreather mask applied earlier in the shift, the MD or PA had been notified of his change in condition.</p> <p>A phone interview was conducted on 1/26/2021 at 11:09 PM with nursing assistant (NA) #1 who was assigned to Resident #1 for the 3:00 PM to 11:00 PM shift on 1/18/2021. NA #1 reported she had been on the 400 hall performing vital sign checks on residents and she stopped by Resident #1 's room to check on him. The NA reported Resident #1 was not breathing and he did not respond when NA #1 called his name and shook him. NA #1 reported she got Nurse #3 and CPR (cardiopulmonary resuscitation) was started on Resident #1.</p> <p>Nurse #3 was interviewed by phone on 1/27/2021 at 9:46 AM. Nurse #3 reported she had been assigned to Resident #1 on 1/18/2021 for the 3:00 PM to 11:00 PM shift. Nurse #3 reported she had received report on Resident #1 's condition at change of shift and she had been told that he was using a non-rebreather mask and he was not doing well. Nurse #3 said she checked on Resident #1 and told the NA to "keep an eye on" Resident #1. Nurse #3 reported she had checked on Resident #1 and then went to administer medications to another resident. Approximately 5 minutes after checking on him, NA #1 called her to come to his room. Nurse #1 reported Resident #1 had no pulse and was not breathing. Nurse #3 stated the Clinical</p>	F 580			

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F 580	<p>Continued From page 6</p> <p>Coordinator for the shift, Nurse #4, and NA #1 came in to assist with CPR, as well as two other NAs in the building. Nurse #1 reported 911 was called and EMT (emergency medical technicians) arrived and took over CPR on Resident #1. Nurse #3 reported EMT performed CPR, but Resident #1 was unable to be revived and he died at 1/18/2021 at 6:18 PM.</p> <p>A phone interview was conducted on 1/27/2021 at 9:58 AM with the PA for Resident #1. The PA reported Resident #1 had been "fairly stable" since the diagnoses of COVID-19 and she had seen him on 1/15/2021 and he reported he was feeling better. The PA reported Resident #1 had difficulty maintaining his pulse oximetry levels and O2 was used to help him. The PA reported she had not been on-call on 1/18/2021 and did not receive notification a non-rebreather had been applied to Resident #1. The PA reported Resident #1 had a significant cardiac (heart) history and he was at risk for sudden cardiac death.</p> <p>The MD was interviewed by phone on 1/27/2021 at 11:03 AM. The MD reported if a non-rebreather mask was applied to a resident because of poor pulse oximetry results, she would expect to be notified. During a follow-up interview on 1/28/2021 at 9:57 AM, the MD reported she felt based on Resident #1 's poor health and co-morbidities, she did not think that notifying her or the PA would have changed the outcome for Resident #1 and he would have died regardless of interventions.</p> <p>The Director of Nursing (DON) was interviewed by phone on 1/28/2021 at 10:35 AM. The DON reported she was not certain why the MD or PA was not notified Resident #1 had a</p>	F 580			

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F 580	<p>Continued From page 7</p> <p>non-rebreather mask applied on 1/18/2021. The DON reported that the facility had implemented new standing orders for residents with COVID to include the application of a mask or non-rebreather mask if they required increased oxygen flow. The DON stated that due to the COVID outbreak in the facility, the nursing staff were faced with challenges on a daily basis and using nursing judgement to apply a non-rebreather mask was within their scope of practice. The DON reported it was her expectation that nurses notified the MD or PA of changes in a resident ' s condition.</p> <p>The Administrator was interviewed on 1/28/2021 at 11:13 AM by phone. The Administrator reported she did not know a reason why the MD or PA was not notified of the change in condition for Resident #1.</p> <p>2. Resident #3 was readmitted to the facility on 12/22/2018 with diagnoses to include dementia and hypertension.</p> <p>A physician order for Resident #3 dated 5/21/2019 stated, "DNR (do not resuscitate) comfort measures only."</p> <p>The most recent annual Minimum Data Set (MDS) assessment dated 11/24/2020 assessed Resident #3 to be severely cognitively impaired.</p> <p>The medical record documented Resident #3 tested positive for COVID-19 on 1/20/2021.</p> <p>A nursing note dated 1/24/2021 at 7:00 PM written by Nurse #4 was reviewed. The note documented that Resident #3 had increased confusion, restlessness and agitation and he was</p>	F 580			

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F 580	<p>Continued From page 8</p> <p>unable to understand verbal instructions. The note documented that a note had been left for the Nurse Practitioner (NP).</p> <p>A nursing note dated 1/25/2021 at 11:58 PM written by Nurse #4 documented that Resident #3 was very agitated. Nurse #4 documented she called the NP to notify her that Resident #3 was very agitated, and the NP gave orders for medications and lab work. The note further documented that medications were administered to Resident #3 and he was less agitated after the administration. Nurse #4 documented that she returned to Resident #3 ' s room to check his vital signs and he was without a pulse or respirations. Resident #3 ' s time of death was documented as 1/25/2021 at 5:13 PM.</p> <p>A review of the medical record revealed there was no documentation from the NP on 1/25/2021.</p> <p>Nurse #4 was interviewed by phone on 1/27/2021 at 10:55 PM. Nurse #4 reported that Resident #3 had refused his medications and he was more confused and agitated on 1/24/2021 and she had put a note into the NP book to notify the NP of the change. Nurse #4 reported she did not know if the NP saw the note. Nurse #4 was unable to state why she had not called the NP to report Resident #3 ' s change in condition.</p> <p>The NP was interviewed by phone on 1/27/2021 at 2:56 PM. The NP reported she had visited the facility on 1/25/2021 to see residents. Resident #3 was not on her list of residents to see and there was no note in the communication book to alert her that Resident #3 had a change in condition or he was experiencing increased confusion. The NP reported Resident #3 was on</p>	F 580			

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F 580	<p>Continued From page 9</p> <p>comfort care, but the family had expressed a desire to be with him in a compassionate care visit if he declined in condition. The NP explained that if a call had been placed to the on-call NP, a copy of the call would have been sent to her. The NP reported the on-call NP did not receive a call from the facility to notify the NP of a change in condition. The NP reported she would have expected a call from the nursing staff on 1/24/2021 to notify her of Resident #3 ' s change in condition.</p> <p>The Director of Nursing (DON) was interviewed by phone on 1/28/2021 at 10:35 AM. The DON reported she was not certain why the NP was not notified Resident #3 had a change in condition on 1/24/2021. The DON reported it was her expectation that nurses notified the MD, PA or NP of changes in a resident ' s condition.</p> <p>The Administrator was interviewed on 1/28/2021 at 11:13 AM by phone. The Administrator reported she did not know a reason why the NP was not notified of the change in condition for Resident #3.</p>	F 580			