DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( )	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345268	B. WING		C 03/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/08/2023
			3	311 W PHIFER STREET	
AUTUMN	CARE OF MARSHVILLE		I	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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	through 03/08/23. In	vas conducted from 02/27/23 take NC00198755 resulted y. Immediate Jeopardy was			
	(J) CFR 483.15 at tag F6 (J)	580 at a scope and severity 524 at a scope and severity 584 at a scope and severity			
	(J) CFR 483.25 at tag F6 (J)	586 at a scope and severity 589 at a scope and severity			
	The tags F684, F686 Substandard Quality	and F689 constituted of Care.			
		began on 12/31/22 and was . A partial extended survey			
	Four of the six compl deficiency.	aint allegations resulted in			
F 580 SS=J		jury/Decline/Room, etc.) ŀ)(i)-(iv)(15)	F 580		3/22/23
	consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical,			(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	
Electroni	cally Signed				03/25/2023

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345268	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	UTUMN CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	mental, or psychosoc deterioration in health status in either life-thr clinical complications; (C) A need to alter tre a need to discontinue treatment due to adve commence a new forr (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that compris- part, and must specify	ial status (that is, a a, mental, or psychosocial reatening conditions or ); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F	580			

Facility ID: 922952

If continuation sheet Page 2 of 71

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · /	LETED
						2
		345268	B. WING		03/	08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				311 W PHIFER STREET		
AUTUMIN	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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 2	F 58	30		
		is not met as evidenced	1.00			
	by:	IS NOT THE AS EVICENCED				
		iew and interview of the		*Resident #1 no longer resides i	n the	
		tant (PA), Nurse Practitioner		facility.		
	(NP), Wound Nurse F	Practitioner #1, and				
		failed to notify the medical		*On 3/2/2023 the facility complete		
		#1's sacral pressure ulcer		100% skin sweep for all current r		
		pint the wound was 11.5		No issues were identified. On 3/2		
		by 16 cm wide and failed to		the Director of Nursing/Designee		
	notify the medical sta			reviewed previously completed w		
		ness skin tear injury which he subcutaneous tissue		reports for the last 30 days for an declines or changes. There were		
	(tissue below the skir			wound declines or changes. On 3		
		g by 3 cm wide on 12/31/22		the Director of Nursing/Designee		
		viewed for pressure ulcer(s)		reviewed the previous 30 days of		
	and skin tear(s).			(electronic assessment tool in the		
				Electronic Health Record) Chang		
	Immediate jeopardy b	began on 12/31/22 for		Condition assessments for any m		
		aff failed to notify medical		physician notifications. There we		
		lower right leg injury at the		missed notifications identified.		
	time of hospitalizatior	n on 1/14/23 directly after				
		n the facility. The wound		*On 3/2/2023 the Director of Nurs	sing	
		uired pressure to control,		provided 1:1 education with the fa	-	
		proximate/unknown depth,		Designated Wound Nurse on not		
		proximate (close skin		to Medical Provider (MD/NP/Wou	,	
		eopardy continued on 1/9/23		for changes in condition including		
	when staff failed to no	•		deterioration of wounds, notificati		
		pressure ulcer deterioration eased in size and was		injuries at the time of injury, and protocol to ensure that proper pro		
		foul odor. Immediate		followed and in place. On 3/2/20		
		ed on 3/4/23 when the facility		Licensed Nursing Staff, including		
		ble allegation of immediate		staff were educated by the Nursi		
		e facility will remain out of		Administration Team on notificatio	-	
		e and severity level of D (not		Medical Provider for changes in o		
		potential for more than		including deterioration of wounds		
		not immediate jeopardy) for		wound protocol and location of w		
	-	e staff training and to ensure		protocol, immediate notification of	-	
	monitoring systems p	out in place are effective.		that cannot be treated per facility		
	1			protocol, description of the proble	bne me	

Facility ID: 922952

If continuation sheet Page 3 of 71

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3)	3 NO. 0938-039 DATE SURVEY
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(	COMPLETED
						С
		345268	B. WING		-	03/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 28103	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page	e 3	F 58	0		
	Findings included:			immediate need of	the situation.	
				Education of all Lice		
	a. On 2/28/23 at 9:50	am an interview was		including current ag	jency Licensed Nurses	
		/ound Nurse. The Wound		was completed on 3		
		s aware of Resident #1's		hired Licensed Nurs		
		l pressure ulcer wound on nd had not informed the		agency staff will be	educated by the Designee during the	
		NP, facility NP, PA, or		-	rocess on Notification	
		her stated she was not		to Medical Provider		
		l of any wound deterioration			changes in wounds,	
	over the weekend of	-		notification of injurie	-	
	On 2/28/23 at 10:26 a	am an interview was				
		irector of Nursing (DON).		*The Director of Nu		
		was asked by the Wound		audit Weekly Woun	-	
		dent #1's sacral wound on		weeks for deteriorat		
	-	staff. The DON stated, "if with a wound you would ask		notification beginnir	Designee will audit all	
		to the medical staff." The		incident reports to e		
		"not contacted medical staff			notification beginning	
		it's sacral wound decline and		3/6/2023. This aud		
		ement of treatment change."		times/week for twel		
					Designee will report	
	On 2/28/23 at 12:20 p				onitoring to the QAPI	
		ischarge Nurse. The		committee for review		
		s aware of the reported lent #1's sacral pressure			or the time frame of od. The Administrator	
		she had not reported to		is responsible for co		
	medical staff.					
	On 2/28/23 at 2:45 pr					
		e # 1. Nurse #1 stated she nd and provided sacral				
		d care to Resident #1 on				
	-	d noted the sacral wound				
		ed to the prior weekend.				
	The wound was "horr	ible" with black tissue and				
		was not reported to medical				
	staff. She stated the	change was not reported				

Facility ID: 922952

If continuation sheet Page 4 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345268	B. WING				C 108/2023
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 580	see the resident durin NP was not following, staff member covering On 2/28/23 at 11:03 at conducted with the fa she started her positio She stated she first sa for a medical visit and resident's wounds. On 3/1/23 at 10:30 ar conducted with the PH PA stated she saw Re assessed the residen nursing or aware that tear to the right leg ar evaluated. On 3/1/23 at 11:20 an conducted with Nurse assisted the Medication ulcer wound care and had opened, drainage and had foul odor on reported this to medic discharged to home at not stated why this ch b. A nursing note writt 12/31/2022 at 7:37 pr across the hall in ano (nurse aide) came to resident got a skin tea transferring resident in	Wound NP #1 was going to ig the week. If the Wound , she would call the medical g the weekend. am an interview was cility NP. The NP stated on at the facility on 1/6/23. aw Resident #1 on 1/10/23 d had not evaluated the in an interview was hysician Assistant (PA). The esident #1 on 1/6/23 and t but was not informed by there was a second skin nd the right leg was not in an interview was e #2. Nurse #2 stated she on Aide with sacral pressure l observed that the wound e changed to white purulent, 1/14/23 and had not cal staff. The resident was is planned. Nurse #2 had hange was not reported. ten by Nurse #1 dated in documented: "This nurse ther room when the NA this nurse and stated ar when they (were) nto her wheelchair. This	F	580			
	noted to the (right low	assess a large skin tear /er leg). Skin and noted to be pushed to the					

Facility ID: 922952

If continuation sheet Page 5 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345268	B. WING			_	03/	C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3	11 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			N	ARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	with Nurse #1. Nurse assigned to Resident her without the mecha her right lower leg on	d and unable to be an interview was conducted	F	580				
	stated she completed called the weekend m mail and left a messag (where to leave a mess Nurse #1 stated she h staff nor considered s Emergency Departme because the bleeding was applied, and she "that bad." Nurse #1 order or notice in the the treatment she initi	an incident report and edical staff on-call voice ge on the skin tear line ssage regarding skin tear). had not informed medical ending the resident to the ent at the time of accident had stopped after pressure did not think the wound was had not entered a physician obysician follow-up book for ated to the injury.						
	(NP). The NP stated the facility on 1/6/23. Resident #1 on 1/10/2 had not evaluated the stated there was a co and missing documen wounds. The NP stat was not available, she the Wound Nurse or W the resident's wound 1 1/4/23 wound NP #2 b	cility Nurse Practitioner she started her position at She stated she first saw 23 for a medical visit and resident's wounds. She mmunication breakdown tation regarding the ed when the Wound NP e wanted to be informed by Yound NP any changes to to follow up. She stated the by telehealth note was not in ther to review. She stated my should have been e before discharge on						

Facility ID: 922952

If continuation sheet Page 6 of 71

	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
	345268	B. WING				C / <b>08/2023</b>
ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CARE OF MARSHVILLE						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From page	6	F	580			
conducted with Woun was not available on suffered the injury to H stated she reviewed t Wound NP #2 who wa visit had not assessed (no documentation). On 3/1/23 at 10:30 an conducted with the PH PA stated she saw Re assessed the residem aware that there was leg and the right leg w	d NP #1. She stated she 12/31/22 when Resident #1 her leg. Wound NP #1 he resident's record and as covering by telehealth d the right lower leg skin tear n an interview was hysician Assistant (PA). The esident #1 on 1/6/23 and t but was not informed or a skin tear injury to the right vas not evaluated. Nor was					
conducted with the PH stated she was not inf right lower leg injury u was requested. The p she was not informed of the severity she wo notified or the residen Department when the The Administrator was jeopardy on 3/1/23 at The facility provided a immediate jeopardy re Credible Allegation of Identify those recipier are likely to suffer, a s	hysician. The Physician formed of Resident #1's until 1/4/23 when an order hysician further explained of its severity and because build have expected to be it sent out to the Emergency injury happened. s advised of immediate 6:21 pm. a credible allegation of emoval. Compliance on 3/4/23.					
	S FOR MEDICARE & I S FOR MEDICARE & I S DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER CARE OF MARSHVILLE SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page On 2/28/23 at 2:00 pm conducted with Woun was not available on suffered the injury to I stated she reviewed t Wound NP #2 who wa visit had not assessed (no documentation). On 3/1/23 at 10:30 an conducted with the PH PA stated she saw Re assessed the residem aware that there was leg and the right leg w she made aware of th On 3/1/23 at 12:40 pm conducted with the PH stated she was not informed of the severity she wo notified or the residem Department when the The Administrator was jeopardy on 3/1/23 at The facility provided a immediate jeopardy re- Credible Allegation of Identify those recipier are likely to suffer, a s	S FOR MEDICARE & MEDICAID SERVICES         SF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345268         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 6         On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she was not available on 12/31/22 when Resident #1 suffered the injury to her leg. Wound NP #1 stated she reviewed the resident's record and Wound NP #2 who was covering by telehealth visit had not assessed the right lower leg skin tear	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A BUILDI         345268       B. WING.         ROVIDER OR SUPPLIER       JA5268       B. WING.         CARE OF MARSHVILLE       ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIT TAG         Continued From page 6       F         On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she was not available on 12/31/22 when Resident #1 suffered the injury to her leg. Wound NP #1 stated she reviewed the resident's record and Wound NP #2 who was covering by telehealth visit had not assessed the right lower leg skin tear (no documentation).       On 3/1/23 at 10:30 am an interview was conducted with the Physician Assistant (PA). The PA stated she saw Resident #1 on 1/6/23 and assessed the resident but was not informed or aware that there was a skin tear injury to the right leg and the right leg was not evaluated. Nor was she made aware of the severity of the injury.         On 3/1/23 at 12:40 pm and interview was conducted with the Physician further explained she was not informed of Resident #1's right lower leg injury until 1/4/23 when an order was requested. The physician further explained she was not informed of its severity and because of the severity she would have expected to be notified or the resident sent out to the Emergency Department when the injury happened.         The Administrator was advised of immediate jeopardy on 3/1/23 at 6:21 pm.       The facility provided a credible allegation of immediate jeopardy removal.         Credible Allegat	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.       (X2) MULTIPLI A BUILDING         345268       B. WING         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PD PREFIX (PACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PD PREFIX (PACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PD PREFIX (PACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 6       F 580         On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she was not available on 12/31/22 when Resident #1 suffered the injury to her leg. Wound NP #1 stated she reviewed the resident's record and Wound NP #2 who was covering by telehealth visit had not assessed the right lower leg skin tear (no documentation).       On 3/1/23 at 10:30 am an interview was conducted with the Physician Assistant (PA). The PA stated she saw Resident #1 on 1/6/23 and assessed the resident but was not informed or aware that there was a skin tear injury to the right leg and the right leg was not evaluated. Nor was she made aware of the severity of the injury.       On 3/1/23 at 12:40 pm and interview was conducted with the Physician. The Physician stated she was not informed of Resident #1's right lower leg injury until 1/4/23 when an order was requested. The physician further explained she was not informed of its severity and because of the severity she would have expected to be notified or the resident sent out to the Emergency Department when the injury happened.      <	S FOR MEDICARE & MEDICAID SERVICES         9F DEFICIENCIES OF DEFICIENCIES       (x1) PROVIDERINGUPFLIERCLIA DERITIFICATION NUMBER:       (x2) MULTIPILE CONSTRUCTION A BUILDING         345268         STREET ADDRESS, CITY, STATE, ZIP CODE 311 W PHIFER STREET MARSHVILLE         CARE OF MARSHVILLE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         PREEX REGULATORY OR LSC DENTIFYING INFORMATION)       PREEX TAG         Continued From page 6       F 580         On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she was not available on 12/31/22 when Resident #1 stated she reviewed the resident's record and Wound NP #2 who was covering by telehealth visit had not assessed the right lower leg skin tear (no documentation).       F 580         On 3/1/23 at 10:30 am an interview was conducted with the Physician Assistant (PA). The PA stated she saw Resident #1 on 1/6/23 and assessed the resident but was not informed or aware that there was a skin tear injury to the right leg and the right leg was not evaluated. Nor was she made aware of the severity and because of the severity and the decause of the severity she would have expected to be notified or the resident set ut to the Theregoney Department when the injury happened.         The Administrator was advised of immediate jeopardy on 31/123 at 6:21 pm.         The facility provided a credible allegation of immediate jeopardy removal.         Credible Allegation of Compliance on 314/23. <td>S FOR MEDICARE &amp; MEDICAID SERVICES     OMB No       Dr GERICINNIES     (X) PROVIDERSUPLIERCIA INTERFICIENCIES     (V2) MULTIPLE CONSTRUCTION A BUILDING     (V2) MULTIPLE CONSTRUCTION A B</td>	S FOR MEDICARE & MEDICAID SERVICES     OMB No       Dr GERICINNIES     (X) PROVIDERSUPLIERCIA INTERFICIENCIES     (V2) MULTIPLE CONSTRUCTION A BUILDING     (V2) MULTIPLE CONSTRUCTION A B

Facility ID: 922952

If continuation sheet Page 7 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN C	ARE OF MARSHVILLE				11 W PHIFER STREET	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580 (	Continued From page	7	F	580				
H a a t r H v s t v o s t v o s t v o s t v o s t v o s t v o s t v o s t v o s t v o s t t t s t o s t t o s t t o s t t o s t t o s t t t o s t t o s t t o s t t o s t t o s t t o s t t t t t t t t t t t t t	change on 1/9/2023, - and failed to notify the the right lower leg inju- resulted in no medical Resident was hospital wound pressure ulcer sepsis. In addition, Re- by 2cm by 0.1 cm skir This wound deteriorat subcutaneous tissue a to become infected. All residents have the On 3/2/2023 the facilit sweep for all current r dentified. On 3/2/2023 the Direct reviewed previously ca- the last 30 days for ar changes. There were changes. On 3/2/2023 the Direct reviewed the previous (electronic assessment fealth Record) Chang assessments for any r notifications. There were dentified.	bund deterioration and 1/13/2023 and 1/14/2023 e physician of the severity of iry on 12/31/2022 which attention being provided. lized with an infected sacral stage 4 which resulted in esident #1 sustained a 7 cm in tear to the lower right leg. ed to expose bone and and had the high likelihood potential to be affected. ty completed a 100% skin esidents. No issues were ctor of Nursing/Designee ompleted wound reports for ny wound declines or no wound declines or no wound declines or no tool in the Electronic ge in Condition missed physician ere no missed notifications entity will take to alter the ure to prevent a serious n occurring or recurring, and						

Facility ID: 922952

If continuation sheet Page 8 of 71

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345268	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 281	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page		F 58	0			
	education with the fac	ctor of Nursing provided 1:1 cility Designated Wound to Medical Provider (Medical					
	Nurse Practitioner (NI	ractitioner (NP)/Wound P)) for changes in condition					
	injuries at the time of	n of wounds, notification of injury, and wound protocol protocol is followed and in					
	place. The facility wou	und protocol includes a					
		a picture of different types					
	options to implement	y and acceptable treatment for each.					
	On 3/2/2023 all Licen agency staff were edu	sed Nursing Staff, including ucated by the Nursing					
		on notification to Medical					
		und NP) for changes in					
		eterioration of wounds, ol and location of wound					
		each medication cart and at					
		on), immediate notification of					
	-	e treated per facility wound					
	protocol, description of the	e situation, per physician					
		d which is available 24					
	hours a day, 7 days p	er week. Education of all					
		ff including current agency completed on 3/3/2023.					
		sed Nursing Staff, including					
		ducated by the Director of ring the facility orientation					
	process on Notificatio	•					
	(MD/NP) for changes	in condition including					
		notification of injuries and the					
	wound protocol. The I Services notified the I	Regional Director of Clinical					
		ementation for new hires.					

Facility ID: 922952

If continuation sheet Page 9 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		345268	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2020
				3	311 W PHIFER STREET		
AUTUMN	CARE OF MARSHVILLE				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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	Continued From page	9	F	580			
	Administrator, Director Director of Nursing, N Rehab, Director of Lif Social Services, Envir Admissions Director, Minimum Data Set (M Clinical Coordinator, a 3/2/2023. The IDT wa Immediate Jeopardy received on 3/1/2023 and necessary educa to be in compliance. The Director of Nursin Weekly Wound report MD/NP notification be The Director of Nursin incident reports to ena MD/NP notification be Alleged date of IJ rem The credible allegation removal was validated observation and nursin were done of nursing change notification, u protocol, and injury m assessment/evaluation care, wound changes and, and medical sta New nursing hires an receive the education Current and ongoing	n (IDT) which includes the br of Nursing, Assistant lurse Managers, Director of e Enrichment, Director of ronmental Services Director, Business Office Manager, IDS) Nurse, Wound Nurse, and the Medical Director on as updated regarding (IJ) citations the facility along with regulation, policy, tion that is needed in order ng/Designee will audit ts for deterioration and eginning 3/3/2023. ng/Designee will audit all sure appropriate treatment, eginning 3/6/2023. noval is 3/4/23. noval is 3/4/23. not fimmediate jeopardy d on 3/7/23. On 3/7/23 ing interviews of all shifts education for resident se of the wound care otification, for proper on of wound status and care e (including deterioration) iff involvement (notification). d contract staff would					

Facility ID: 922952

If continuation sheet Page 10 of 71

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE		
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMP	LETED	
		345268	B. WING				C 08/2023	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	03/	00/2023	
			311 W PHIFER STREET					
				MA	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 580	Continued From page	e 10	F 5	580				
	held by the Administra plans for improvemen	ator and Corporate and						
	03/04/23 was validate							
F 624 SS=J	Preparation for Safe/ CFR(s): 483.15(c)(7)	Orderly Transfer/Dschrg	F6	624			3/22/23	
	preparation and orien safe and orderly trans facility. This orientation form and manner that understand. This REQUIREMENT by:	e and document sufficient tation to residents to ensure sfer or discharge from the on must be provided in a t the resident can is not met as evidenced iews, family member, home			*Resident #1 no longer resides in the			
	failed to safely discha (Resident #1). The fa signed order for home home health agency of from the facility. Reside pressure wound of the malodorous drainage lower right leg that the deep, and she was all	aff interviews, the facility arge 1 of 3 residents to home cility failed to submit a the health services to the until 3 days after discharge dent #1 had an unstageable the sacrum with purulent and a large skin tear of the the family described as very ble to see "white meat that additionally, Resident #1 had			facility. *On 3/2/2023 the Social Services Director/Designee reviewed all residents that discharged home or to Assisted Living Facilities for the last 30 days to ensure the order for home care services were sent to the agency prior to discharge. One correction needed to be made.	6		
	and a skin tear of the was sent home with in supplies and incorrect Resident #1 was take family members immedischarged Resident recognized Resident				*On 3/2/2023 the Vice President of Soc Services for Saber Healthcare Group provided education to the facility Social Service Director on Discharge Planning Policy to include timely notification to outside agencies. Social Services Direct will confirm with outside agencies that discharge information has been receive and confirm start date of services. The	tor		

Event ID: SQEW11

Facility ID: 922952

If continuation sheet Page 11 of 71

							NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION	· · · ·	ATE SURVEY OMPLETED
							С
		345268	B. WING				03/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ΔΠΤΠΜΝ	CARE OF MARSHVILLE			311 V	V PHIFER STREET		
				MAR	SHVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 624	Continued From page	e 11	F 62	24			
	for at home.				ertified medication aides were edu	cated	
				to	o not send wound supplies home v	vith	
		began on 1/14/2023 when			esidents discharging. This was do	ne on	
		harged home with an			/3/23 by the Assistant Director of		
	<b>.</b> .	e wound of the sacrum with drainage, an unstageable			lursing.		
		e left heel, a skin tear of the		*	The Social Service Director/Design	nee will	
		arge skin tear of the lower			udit all planned discharges in mor		
		an order for home health			linical meeting to ensure proper		
		ct wound care supplies and			otification, communication and	- : -! -	
	instructions for wound	ed on 3/4/2023 when the			ocumentation is complete with out gencies as soon as the discharge		
		a credible allegation of			etermined 5 times a week for 12 w		
		removal. The facility will			he Social Service Director/Design		
	-	ance at a scope and severity			eport the results of the monitoring	to the	
		harm with the potential for			API committee for review and		
		arm that is not immediate ity to complete staff training			ecommendations for the time fram ne monitoring period. The Adminis		
		ring systems put in place			responsible for compliance.	aloi	
	are effective.						
	The findings included	:					
	Resident #1 was adm	nitted to the facility on					
		noses to include acute on					
		ilure, (an acute illness					
	affecting a patient wit	n chronic respiratory 0-19 virus infection, anemia					
		fusions), kidney disease					
		ıry, pain in right knee, 2					
		ers (ulcer extends into the					
		skin and can look like a					
		er) of the sacrum, deep sure injury that begins in the					
		bone and appears as dark,					
		of the right and left heel,					
		re and debility. A hospital					
		1/14/2023 documented					
	Resident #1 had an e	jection fraction					

If continuation sheet Page 12 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345268	B. WING			_		C 108/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
Δυτυμν	CARE OF MARSHVILLE			:	311 W PHIFER STREET			
//010					MARSHVILLE, NC 2810	)3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From page	9 12	F	624	1			
		percentage of blood leaving eartbeat) of 45% (normal						
	after rehabilitation ser plan was to provide R transition back to the interventions to involv	discharge to the community rvices. The goal for the care tesident #1 with a safe community with re home health agencies nunity support services						
	required extensive as dressing, hygiene, an assistance to transfer assessment indicated discharged to the con services.	/16/2022 assessed derately cognitively documented Resident #1 sistance with bed mobility, d bathing, and total and to toilet. The MDS Resident #1 was to be mmunity after rehabilitation						
		vas to float heels (elevate dated 12/27/2022 directed e betadine (a topical						
	the left heel that mean 6.5 cm, and the depth to be determined. The wound had no drainag improving.	ageable pressure wound on sured 7 centimeters (cm) by n of the wound was unable e note documented that the ge and no odor and was						
	A physician order date	ed 1/9/2023 directed for left						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE COMP	SURVEY LETED	
		345268	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			3	11 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE		N	MARSHVILLE, NC 2810	)3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	normal saline to clear alginate (an absorber wound healing) to the absorbent pad and ap A wound assessment documented the skin measure 7.1 cm by 1. wound was described acquired in-house wit amount of serosangui red wound bed, and r noted. The wound can including applying cal covering the wound w securing the dressing A wound assessment documented the skin that measured 7.2 cm wound was document amount of serosangui wound bed. Wound care orders da lower leg read to clea collagen powder (use healing), cover with a with gauze to secure A wound assessment documented Residen pressure ulcer of the cm by 16 cm. The dep to be determined due (dead, moist, stringy to documented a moder	to be completed daily with a the wound, calcium at dressing that promotes a wound bed, cover with an oply gauze to secure. dated 1/9/2023 tear to the left lower leg to .9 cm and 0.1 cm. the d as a trauma that was h a scant (very small) ineous (pink) drainage, a to odor to the drainage was re documented wound care cium alginate to the wound, <i>i</i> th an absorbent pad, and with gauze. dated 1/9/2023 tear on the lower right leg h by 3.5 cm by 0.1 cm. The ted to have a moderate ineous drainage with a pink ated 1/12/2023 for the right n with normal saline, apply d to promote wound bsorbent dressing, and wrap once daily. dated 1/9/2023 t #1 had an unstageable sacrum that measured 11.5 pth of the wound was unable to the presence of slough tissue). The note	F 624				

Facility ID: 922952

If continuation sheet Page 14 of 71

	-						FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´				(X3) DATE COMP	SURVEY LETED
		345268	B. WING _			_		C 08/2023
NAME OF F	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE					3		
				IV				0(5)
(X4) ID PREFIX TAG	DEPARTMENT OF HEALTH AND HUMAN SERVICES       FOR         CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO         TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE         ND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE         NAME OF PROVIDER OR SUPPLIER       345268       B. WING       03         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       311 W PHIFER STREET         AUTUMN CARE OF MARSHVILLE       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE			(X5) COMPLETION DATE				
F 624	Continued From page	e 14	F	624				
	noted the wound was	deteriorating.						
	1/12/2023 read to app (sodium hypochlorite water) to clean the wo antiseptic soaked gau with calcium alginate, dressing, and secure change was to be cor An email dated 1/11/2 (SW) to a home healt part: "Attached is the #1). She is scheduled Saturday, 1/14/2023. for nursing (medication as I have the signed of you." An interview was con- 2/28/2023 at 1:41 PM Resident #1 and her fit	bly an antiseptic solution and boric acid diluted in bound, then apply an lize to the wound bed, cover cover with absorbent with tape. This dressing mpleted daily. 2023 from the Social Worker h agency liaison read, in face sheet for (Resident I to be discharged on She will need home health on management)as soon orders, I will send them to ducted with the SW on I. The SW explained that family planned on her						
	home health agency I family members. The reached out to home them to the referral. was concerned about because of Resident (including transfers, to well as wound care) b home health would be #1's care. The family family member who w for transfers.	had been chosen by the SW reported that she had health on 1/11/2023 to alert The SW reported the family the discharge home #1's high care needs bileting, and bed mobility, as						

Facility ID: 922952

If continuation sheet Page 15 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345268	B. WING				C / <b>08/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	reported that she did wound and did not ref wound bed. The DON her experience with w she decided to chang medihoney to an antis she noticed an odor. nurse practitioner, wh #1's sacral wound but antiseptic solution to 1 she was not certain if notified the Wound Nu sacral wound had det reported the facility di wounds that home he Resident #1's sacral a could be managed at A physician discharge reviewed. The order of was to be discharged a home health evalua services. The facility discharge listed the equipment of which included a whe commode, shower ch A physician order data Resident #1 to be disc home health to evalua services. The follow-u Resident #1's primary well as medical equip	und Nurse to assess wound on 1/13/2023 vas deteriorating. The DON not measure the sacral member the status of the I explained that based on vounds and her judgement, e the wound care from septic wound care because The DON spoke to the o did not observe Resident t wrote orders for the be used. The DON reported the Wound Nurse had urse Practitioner that the eriorated. The DON scharged residents with alth managed, she felt and right lower leg wound home. e order dated 1/13/2023 was documented Resident #1 on 1/14/2023 and required tion for nursing and therapy summary dated 1/13/2023 ordered for Resident #1, elchair, walker, bedside air, and oxygen. ed 1/13/2023 ordered for charged on 1/14/2023 with ate for nursing and therapy	F	624			

Facility ID: 922952

If continuation sheet Page 16 of 71

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345268	B. WING				08/2023
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MARSHVILLE				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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 624	A certified medication interviewed on 3/1/20 reported she had assi Resident #1's dischar 1/14/2023. The CMA members were prese Resident #1 and obse care and asked her for CMA #1 listed the sup Resident #1's family r wound cleanser, med reported Resident #1' sacrum was large, for pus-like, red-brown dr she had not sent the lower right leg wound Nurse #2 was intervie AM. Nurse #2 reporte supervisor and had di the facility on 1/14/20 and CMA #1 performe #1 before she was dis explained wound care Nurse #2 reported the indicate they were go the hospital, nor did th with the pressure ulco reported she did not t be infected. Nurse #2 had received a call lat hospital requesting m records for Resident #	d in the physician order. assistant (CMA) #1 was 23 at 11:12 AM. CMA #1 isted Nurse #2 with ge from the facility on reported the family nt during wound care for erved the pressure ulcer or wound care supplies. oplies she had given to members: absorbent pads, ihoney and gauze. CMA #1 is pressure ulcer on the ul-smelling, and had a rainage. CMA #1 reported wound care supplies for the care. ewed on 3/1/2023 at 11:20 ad she was the weekend ischarged Resident #1 from 23. Nurse #2 explained she ed wound care on Resident scharged, and she had e to the family members. a family members did not ing to take Resident #1 to hey seem to be concerned er on the sacrum. Nurse #2 hink the wound appeared to c concluded by reporting she ter in her shift from the edication administration	F	624			
	dated 1/14/2023 note						

Facility ID: 922952

If continuation sheet Page 17 of 71

				LE CONSTRUCTION		O. 0938-039
		IDENTIFICATION NUMBER:	, <i>,</i>		· · ·	IPLETED
						С
	LAN OF CORRECTION IDENTIFICATION NUMBER: A. B 345268 B. W E OF PROVIDER OR SUPPLIER TUMN CARE OF MARSHVILLE 4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)	B. WING		0	3/08/2023	
NAME OF P	ROVIDER OR SUPPLIER	•	- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				311 W PHIFER STREET		
AUTUMN	CARE OF MARSHVILLE			MARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y 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) COMPLETIO DATE
F 624	Continued From page	e 17	F 62	24		
		•				
	appointments (for tre	atment of anemia) on				
	•					
		•				
		0 0				
	Discharge instruction	s dated 1/14/2023 without a				
		· · · ·				
		ne health agency on				
	1/1//2023.					
	The family member o	of Resident #1 was				
		ted Nurse #2 and the CMA				
	performed wound car	re and gave them scharge on 1/14/2023. The				
		ted she and her sister saw				
		re ulcer on her bottom and				
	decided they were go	bing to take Resident #1				
		al for evaluation because the				
	-	ery deep, smelled bad, had a				
		t needed to be evaluated by				
	a physician. The fam	ily member described the				

Facility ID: 922952

If continuation sheet Page 18 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				11 W PHIFER STREET IARSHVILLE, NC 2810	3		
					,			0(5)
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDI         345268       B. WING         NAME OF PROVIDER OR SUPPLIER       B. WING         AUTUMN CARE OF MARSHVILLE       ID         PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         F 624       Continued From page 18 wound on the right lower leg to be very deep, and she was able to see "white meat that looked like a bone". The family member concluded by stating she and her sister did not take Resident #1 home but drove directly from the facility to the hospital emergency room.       F 6         The Emergency Room (ER) notes dated 1/14/2023 documented Resident #1 had been brought to the ER for evaluation, after discharge from the facility. The notes documented the family reported they were concerned that Resident #1 had an infected pressure ulcer of her sacrum. The diagnoses for Resident #1 included infected decubitus (pressure) ulcer, unstageable (full thickness tissue loss but is covered by extensive necrotic (dead) tissue). The admission note documented 3 different antibiotics were started and surgical consult was needed for pressure ulcer debridement (surgical removal of dead tissue). The right lower leg wound was					(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From page	9 18	F	624				
	she was able to see "	white meat that looked like a						
	she and her sister did but drove directly from	not take Resident #1 home						
	The Emergency Roor 1/14/2023 documente brought to the ER for from the facility. The r family reported they w Resident #1 had an ir sacrum. The diagnoss infected decubitus (pr (full thickness tissue II extensive necrotic (de note documented 3 di started and surgical c pressure ulcer debride dead tissue). The righ documented as a chro description. Blood cultures complet 1/14/2023 tested posit A wound culture of the obtained on 1/14/2023 growth of 2 different b An email dated 1/17/2 home health liaison to	ed Resident #1 had been evaluation, after discharge notes documented the vere concerned that fiected pressure ulcer of her ses for Resident #1 included essure) ulcer, unstageable oss but is covered by ead) tissue). The admission ifferent antibiotics were onsult was needed for ement (surgical removal of at lower leg wound was onic wound without further eted at the hospital on tive for 3 different bacteria. e sacral wound was 3 and showed positive						
		o the home health liaison 30 PM read, in part, "I just (Resident #1)."						

If continuation sheet Page 19 of 71

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
	345268	B. WING				C 108/2023
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
			3	311 W PHIFER STREET		
AUTUMN CARE OF MARSHVILLE			N	MARSHVILLE, NC 28103		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
by phone on 3/1/2023 a Health Administrator re health agency had not Resident #1 until 1/17/ services would not hav the home health agence A follow-up interview w on 3/1/2023 at 1:42 PM why she had not sent t health agency until 1/1 The SW returned at 2:2 discharge residents for indicated Resident #1's contacted by phone ca The SW explained the Resident #1 was hospit the orders were signed 1/13/2023, but she had get the signed orders se agency. The SW repor 1/14/2023.The SW report 1/14/2023.The SW	hinistrator was interviewed at 10:23 AM. The Home eported that the home received orders for 2023 and home health we been initiated until after cy received those orders. was conducted with the SW A. The SW was not certain the orders to the home 7/2023. 23 PM with a log of r January 2023. The log s family had been for January 2023. The log s family had been for 1/16/2023 by the SW. family told her that italized. The SW reported d by the physician on d left for the day and did not sent to the home health ted she had not worked on worted that because a hospital, the orders for er mind and she did not he received the email from n on 1/17/2023. The SW a safe discharge home for e home health referral. for was notified of n 3/1/2023 at 5:51 PM.	F	624			

Facility ID: 922952

If continuation sheet Page 20 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345268	B. WING			03	C / <b>08/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				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 PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	services was not subi agency until 3 days a facility. Resident #1 w without skilled home of unstageable pressure purulent odorous drai 1/17/2023 when the fa physician order to the family member recogn wound that needed m not be cared for at ho All residents discharg to be affected. On 3/2/2023 the Socia Director/Designee rev discharged home or to for the last 30 days to care services were set discharge. Any issues corrected. *Specify the action the process or system fai adverse outcome from when the action will b On 3/2/2023 the Vice Services for Saber He education to the facilit Discharge Planning P notification to outside Director will confirm w discharge information confirm start date of set	mitted to the home care fter discharge from the yould have been at home care nursing services for an e ulcer of the sacrum with nage from 1/14/2023 until acility sent the signed e home care agency. The nized this was a serious nedical treatment and could ome. ing home have the potential al Services viewed all residents that o Assisted Living Facilities o ensure the order for home ent to the agency prior to s were immediately e entity will take to alter the lure to prevent a serious n occurring or recurring, and the complete. President of Social ealthcare Group provided ty Social Service Director on Policy to include timely agencies. Social Services with outside agencies that a has been received and	F	624			

Facility ID: 922952

If continuation sheet Page 21 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345268	B. WING			C 03/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ΔΗΤΗΜΝ	CARE OF MARSHVILLE			3	311 W PHIFER STREET			
Actomit				ľ	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 624	Continued From page	21	F	624	ŀ			
	Administrator, Director Assistant Director of M Director of Rehab, Din Director of Social Ser Services Director, Ad Office Manager, Minir Wound Nurse, Clinica Medical Director on 3 updated regarding Im citations the facility re with regulation, policy that is needed in orde Beginning on 3/3/202 discharges will be rev clinical meeting, which Administrator, DON, A heads, to ensure prop communication, and o be made with any and indicated to ensure a of outside agencies w discharge date is dete Alleged date of IJ rem On 3/7/2023, the facili immediate jeopardy re following: " Review of the ed related to timely notifi and confirmation of th outside agency. " Interview with SV education provided an residents to home wit	h (IDT) which includes the br of Nursing (DON), Nursing, Nurse Managers, rector of Life Enrichment, vices, Environmental missions Director, Business mum Data Set (MDS) Nurse, al Coordinator, and the /2/2023. The IDT was mediate Jeopardy (IJ) beeived on 3/1/2023 along r, and necessary education er to be in compliance. 3 a review of all planned viewed during morning h is attended by the ADON and all department ber notification, documentation has been/will d all outside agencies as safe discharge. Notification vill occur as soon as ermined. hoval 3/4/23. ity's credible allegation for emoval was validated by the ucation provided to the SW cation of outside agencies, he information with the V and nursing staff to review and procedure for discharging						

If continuation sheet Page 22 of 71

			()(0)		OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345268	B. WING		C 03/08/2023
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	CARE OF MARSHVILLE			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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIO
F 624	discharges noted with	e 22 n correct process in place. completed by the facility.	F 624		
	The facility's date of t removal plan of 3/4/2 3/7/2023. Quality of Care CFR(s): 483.25	he immediate jeopardy 023 was validated on	F 684		3/22/23
	applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profe- practice, the compret- care plan, and the resident This REQUIREMENT by: Based on record revi- member, Physician A Practitioner (NP), and facility failed to identific complete and docume- of an injury to Reside sustained during a tra- injury was described measured 7 centimet 2.5 cm and approxim- required direct pressu- minutes to stop the bl- wound were not able was unable to be pull provide protection to was reported to the o	ndamental principle that Int and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of hensive person-centered sidents' choices. T is not met as evidenced iew and staff, family ssistant (PA), Nurse d Physician interviews, the fy the seriousness and ent a thorough assessment nt #1's right lower leg ansfer on 12/31/22. The as a deep skin tear which ers (cm) in length, width of ately 0.5 cm deep and ure with a towel for several leeding. The edges of the to be approximated (skin ed over the open wound to the healing wound). This		*Resident #1 no longer resides in the facility. *On 3/2/2023 the Wound Nurse, Assi Director of Nursing, and Clinical Coordinator completed head to toe sl assessments on all residents in the fa to include assessment of current wou Appropriate treatment orders are in p No issues were identified. On 3/2/202 the Director of Nursing/Designee reviewed all incident reports for the la days to ensure thorough assessment injury, Medical Provider (MD/NP/Wou NP) notification, treatment orders were obtained timely as indicated, and car- plans were up to date. No issues were	istant kin acility unds. blace. 23 ast 30 t of und re e

Facility ID: 922952

If continuation sheet Page 23 of 71

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVE	<u>3-03</u>
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>		COMPLETED	r
			A. BOILDING		с	
		345268	B. WING		03/08/202	22
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/202	
				311 W PHIFER STREET		
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	K5) ILETIO ATE
F 684	Continued From page	- 23	F 684	A		
1 004			F 004			
		ember described the injury sable to see "white meat		(electronic assessment tool in the Electronic Health Record) Chang		
		e". This deficient practice		Condition assessment for the las		
		sidents reviewed for quality		were reviewed by the Director of	-	
	of care (Resident #1)			to ensure MD/NP notification and	-	
				were obtained timely as indicated		
	Immediate ieonardy h	began on 12/31/22 when the		issues were noted.		
		fy the seriousness of an		Issues were noted.		
		s right lower leg and the		*On 3/2/2023 the Director of Nur	sina	
		ntion. Immediate jeopardy		provided one on one education v	•	
	was removed on 3/4/			facility Designated Wound Nurse		
		ble allegation of immediate		notification to Medical Provider for		
		he facility will remain out of		changes in condition including no		
		e and severity level of D (not		of injuries, obtaining orders timel		
		potential for more than		protocol, ensuring the medical pr		
		not immediate jeopardy) for		evaluates and an appropriate tre		
		e staff training and to ensure		order is in place as indicated. Th		
		but in place are effective.		Nurse was educated to follow up		
				Medical Providers to ensure eval		
	Findings included:			wounds has been completed whe	en they	
				are in the facility.		
	Resident #1 was adm	nitted from the hospital to the		Education for all Licensed Nurse	s and	
	facility on 12/14/22 a	cute on chronic respiratory		agency Licensed Nurses was co	mpleted	
	failure, (an acute illne	ess affecting a patient with		on 3/3/2023 regarding following f	acility	
	chronic respiratory in	sufficiency), COVID-19 virus		wound protocol, notifying Medica	d	
	infection, anemia (rec	quiring blood transfusions),		Providers of any abnormal asses		
	kidney disease with a	acute kidney injury, pain in		findings during routine dressing of	changes	
		pressure ulcers (ulcer		immediately to ensure timely eva		
		per layers of the skin and can		completed and any changes to tr		
		ater or blister) of the sacrum,		be implemented immediately as		
		a pressure injury that begins		and notification of Medical Provid		
		to the bone and appears as		new skin condition cannot be trea		
		skin) of the right and left		facility wound protocol. Education		
	-	rt failure and debility. A		provided to any newly hired Lice		
	hospital admission no			Nurses and agency Licensed Nu	rses prior	
		t #1 had an ejection fraction		to providing direct care.		
		percentage of blood leaving				
		eartbeat) of 45% recorded		*The Director of Nursing/Designe		
	on 11/22 (normal 50-	70%)		randomly audit eInteract Change	e in	

Facility ID: 922952

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	/EY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETE	D	
		0.45000			C		
		345268	B. WING		03/08/2	023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	CODE		
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 28103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE CO. O THE APPROPRIATE	MPLETIO DATE	
F 684	Continued From page	e 24	F 68	34			
				Condition assessments 5	5		
		ion Minimum Data Set		12 weeks to ensure Med			
		nented moderately impaired ent was dependent with all		(MD/NP/Wound NP) noti medical attention is recei			
		g. The resident required		are received timely. The			
	two-person assist for			Nursing/Designee will au			
		ion care plan had a focus		reports 5 times weekly fo			
		al skin breakdown and		ensure Medical Provider	-		
		ties of daily living. The		proper medical attention			
	transfer intervention v	was for mechanical lift.		orders are received time	-		
	An interview was con	ducted on 2/28/2023 at 4:24		Nursing/Designee will re the monitoring to the QA			
		she reported she had worked		review and recommenda			
		1 explained she was working		frame of the monitoring p			
	on the 100 hall, and t	he 300 hall NA (NA #4) had		Administrator is responsi	ble for		
		Resident #1's room. NA #1		compliance.			
		enting NA #5 and the two of					
		nt #1's room on the 300 hall. ident #1 was in bed with her					
		d on 3 pillows and NA #4 told					
		as not working to elevate the					
		I to move Resident #1 to a					
		ident #1's family member					
		uring this time. NA #1 left the					
	•	transfer Resident #1 to the					
		red that when she returned n, and Resident #1's family					
		ident #1 up on the side of					
		NA #1's report, Resident #1					
		t herself sitting on the side					
		rying out, "I can't take it."					
		NA #5 said, "I used to be an					
		dical technician), I know how esident #1)," and proceeded					
	to lift Resident #1 fror	, .					
		Resident #1's leg on the					
		nd causing a skin tear. NA					
		towel to hold on the open					
	area of the skin tear t	o top the bleeding and NA					

If continuation sheet Page 25 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE			
		345268	B. WING				C /08/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 684	Nurse #1 arrived in "ju NA #5 was interviewed NA #5 reported her fir of the facility was 12/3 assigned to train with was standing behind and NA #4 lifted Resid bed to the wheelchair Resident #1's leg scra the wheelchair. NA #5 NA #1 and NA #4 that and to push it back, b correct the position of reported the wound w bedsheet and held pr the nurse arrived alm NA #4 was interviewed and she reported she and assigned to Resid verbalized she was not transferred Resident and Resident #1 moved fr wheelchair but rements sustained a large skir and NA #1 was holdir the bleeding. A nursing note writter 12/31/2022 at 7:37 Pl across the hall in ano came to this nurse and tear when they (were	rse. NA #1 reported that ust a few seconds". ad on 3/7/2023 at 4:18 PM. rst time working on the floor 31/2022 and she was NA #1. NA #5 reported she the wheelchair and NA #1 dent #1 from the side of the the wheelchair and NA #1 dent #1 from the side of the t, and during the transfer, aped against the footrest of 5 reported she had alerted t the footrest was jutting out ut the other NAs did not t the footrest. NA #5 vas bleeding and she took a essure on the wound until ost 20 minutes later. ed on 3/1/2023 at 4:27 PM was working 12/31/2022 dent #1 on that date. NA #4 of in the room, when NA #5 #1 and she did not see om the bed to the nbered that Resident #1 had in tear on her lower right leg ing a towel on the leg to stop	F	684					
	Skin and subcutaneo	d to the (right lower leg). us tissue noted to be de of the wound and unable							

Facility ID: 922952

If continuation sheet Page 26 of 71

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/24/2023 RM APPROVEI NO. 0938-039	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED	
		345268	B. WING			C 03/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER	•	1		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUTUMN	CARE OF MARSHVILLE				311 W PHIFER STREET MARSHVILLE, NC 28103			
()(4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
F 684	Continued From page	e 26	F	684	4			
		Area cleaned with wound						
		antibacterial dressing)						
		l and (absorbent) pad placed n (gauze). Resident states						
		mily member) in the facility at						
		ified of skin tear by this						
	nurse. (On-call physic	cian) was notified via ar." The nurse documented						
	· · · · · · · · · · · · · · · · · · ·	pain at a level "5" (1-10						
		nost intense pain) of the						
	lower right leg at the	skin tear site.						
	Nurse #1 was intervie	ewed on 2/28/2023 at 2:37						
		ed she was assigned to						
		/2022 and was notified by						
	•	(NA) that Resident #1 had to her right lower leg during						
		reported she arrived at						
		ind found 3 NAs at the						
		nployees and 1 orienting #1 reported NA #1 was						
		esident #1's leg to stop the						
	bleeding from a "hecl	k of a large" skin tear on her						
		#1 reported she was told by						
	NA #1 that Resident wheelchair when she	was being transferred.						
		e did not think the skin tear						
		not require evaluation at the						
	hospital.							
		an interview was conducted						
	with Nurse #1. Nurse							
	U U	#1 on 12/31/22 when staff ut the mechanical lift and the						
		ower leg on the wheelchair						
	footrest. NA #1 inform	ned her the resident had cut						
	-	rrived NA #1 was holding a pressure on the resident's						
		due to the bleeding. There						

Facility ID: 922952

If continuation sheet Page 27 of 71

CORRECTION ROVIDER OR SUPPLIER CARE OF MARSHVILLE	IDENTIFICATION NUMBER:	A. BUILDING	G		IPLETED C
CARE OF MARSHVILLE	345268	B. WING			С
CARE OF MARSHVILLE	345268	B. WING			
CARE OF MARSHVILLE					8/08/2023
			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
(4) ID SUMMARY STATEMENT OF DEFICIENCIES			311 W PHIFER STREET MARSHVILLE, NC 28103		
ID         SUMMARY STATEMENT OF DEFICIENCIES           FIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL					
(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	27	F 68	84		
	r and the resident's leg, and	1.00			
	nutes of pressure to stop the				
	tated she completed an				
incident report and do	ocumented that				
	could be observed. Nurse				
	/ was 7 centimeters (cm)				
	and depth approximately 0.5				
	stated, "I placed a non-stick nd and covered with a large,				
	dry dressing and wrapped				
-	t." Nurse #1 stated there				
	ocol for placement of the				
dressing and "I made	the decision to place a				
	-				
voicemail line (on-call	physician phone line)."				
	•				
	-				
-	-				
-					
	,				
infection, and the drai	inage was a small amount of				
on 1/7/23 and 1/8/23.					
	a multi-disciplinary team by the Wound Nurse.It				
	non-stick dressing to wound. The leg wour centimeters open (wid approximate the edge and I had not conside the Emergency Depa had stopped. I called left a message on the voicemail line (on-call Nurse #1 stated she I the wound care to the not placed the injury i book. Nurse #1 state resident's right lower and the following wee The wound looked the measured), was withour infection, and the drai serosanguineous. Nu documented the reside she initialed the treat	dressing and "I made the decision to place a non-stick dressing to prevent adherence to the wound. The leg wound was approximately 2.5 centimeters open (wide), and I was unable to approximate the edges (place them together), and I had not considered sending the resident to the Emergency Department because the bleeding had stopped. I called the physician on-call and left a message on the skin tear notification voicemail line (on-call physician phone line)." Nurse #1 stated she had not initiated an order for the wound care to the resident's leg and she had not placed the injury in the physician notification book. Nurse #1 stated she completed the resident's right lower leg wound care on 1/1/23 and the following weekend 1/7/23 and 1/8/23. The wound looked the same size (had not measured), was without signs and symptoms of infection, and the drainage was a small amount of serosanguineous. Nurse #1 stated she had not documented the resident's wound observation; she initialed the treatment administration record on 1/7/23 and 1/8/23.	non-stick dressing to prevent adherence to the wound. The leg wound was approximately 2.5 centimeters open (wide), and I was unable to approximate the edges (place them together), and I had not considered sending the resident to the Emergency Department because the bleeding had stopped. I called the physician on-call and left a message on the skin tear notification voicemail line (on-call physician phone line)." Nurse #1 stated she had not initiated an order for the wound care to the resident's leg and she had not placed the injury in the physician notification book. Nurse #1 stated she completed the resident's right lower leg wound care on 1/1/23 and the following weekend 1/7/23 and 1/8/23. The wound looked the same size (had not measured), was without signs and symptoms of infection, and the drainage was a small amount of serosanguineous. Nurse #1 stated she had not documented the resident's wound observation; she initialed the treatment administration record	non-stick dressing to prevent adherence to the wound. The leg wound was approximately 2.5 centimeters open (wide), and I was unable to approximate the edges (place them together), and I had not considered sending the resident to the Emergency Department because the bleeding had stopped. I called the physician on-call and left a message on the skin tear notification voicemail line (on-call physician phone line)." Nurse #1 stated she had not initiated an order for the wound care to the resident's leg and she had not placed the injury in the physician notification book. Nurse #1 stated she completed the resident's right lower leg wound care on 1/1/23 and the following weekend 1/7/23 and 1/8/23. The wound looked the same size (had not measured), was without signs and symptoms of infection, and the drainage was a small amount of serosanguineous. Nurse #1 stated she had not documented the resident's wound observation; she initialed the treatment administration record	non-stick dressing to prevent adherence to the wound. The leg wound was approximately 2.5 centimeters open (wide), and I was unable to approximate the edges (place them together), and I had not considered sending the resident to the Emergency Department because the bleeding had stopped. I called the physician on-call and left a message on the skin tear notification voicemail line (on-call physician phone line)." Nurse #1 stated she had not initiated an order for the wound care to the resident's leg and she had not placed the injury in the physician notification book. Nurse #1 stated she completed the resident's right lower leg wound care on 1/1/23 and the following weekend 1/7/23 and 1/8/23. The wound looked the same size (had not measured), was without signs and symptoms of infection, and the drainage was a small amount of serosanguineous. Nurse #1 stated she had not documented the resident's wound observation; she initialed the treatment administration record

Facility ID: 922952

If continuation sheet Page 28 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE			
		345268	B. WING				C 08/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
			311 W PHIFER STREET						
AUTUMN	CARE OF MARSHVILLE								
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 684	was noted to be treated (there was no standin non-adherent dressin Resident #1's Treatm (TAR) revealed no ordor residents right lower I order was entered to place a non-stick dress cover with dry dressin Wound Nurse and sig electronically (docume Documentation of a te Nurse Practitioner (NI did not include an ass right lower leg skin teat The Wound Nurse no Wound NP #2's telefor Resident #1's sacral p both heels. There wa resident's skin tear of documented. On 3/1/23 at 2:00 pm with Wound NP #2, at On 2/28/23 at 9:30 ar conducted with the W Nurse stated she ass lower leg skin tear on physician the resident right lower leg but had measurement or cond received from the phy	ower leg after being to the wheelchair. The area ed per standing orders ig order for use of g to an injury). ent Administration Record ders for wound care to the eg until 1/4/23 when an cleanse with normal saline, ssing to the wound bed, and ng each day initiated by the gned by the Physician ented in the order). elehealth visit by Wound P) #2 completed on 1/4/23 sessment of Resident #1's ar. te dated 1/4/23 documented ealth visit to evaluate pressure ulcer wound and as no evaluation of the the right lower leg an interview was attempted nd she was unavailable. In an interview was found Nurse. The Wound essed Resident #1's right 1/4/23 and informed the t had a skin tear injury to her	F	684					

Facility ID: 922952

If continuation sheet Page 29 of 71

-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE				
		345268	B. WING				C 08/2023			
NAME OF PROVIDER O	R SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN CARE OF				3	311 W PHIFER STREET					
				Ν	MARSHVILLE, NC 28103					
	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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE			
cover w non-stic Wound asked V right low teleheal resident measur injury or physicia An orde Nurse to right low day as p signed a teleheal A review saw Re sacral w lower le On 3/1/2 conduct Resider sacral p tear. Th nursing tear to t evaluate at the fa	k dressing ini Nurse stated Vound NP #2 ver leg skin te th visit. The v 's right lower ed and docum n 1/9/23 and r in. r dated 1/4/23 o apply hydrog ver leg and co prescribed by electronically th visit). v of Resident sident #1 on 1/6/23 ressure ulcer ne PA stated s nor aware that he right leg and ed. The PA stated she right leg and ented a skin te ed 7.6 centim had a pink wo of serosangu	dressing (change from the tiated by Nurse #1). The she had not informed nor to evaluate the resident's ar during the 1/4/23 Wound Nurse dressed the leg injury each day and hented the condition of the eported findings to the 8 was initiated by the Wound gel in the wound bed on the over with dry dressing every the Physician and was by the Physician (after the #1's record revealed the PA I/6/23 and assessed her eels, and left leg. The right	F	684						

Facility ID: 922952

If continuation sheet Page 30 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARSHVILLE			3	11 W PHIFER STREET			
AUTUWIN				N	IARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	dressing was applied covered with an absor- gauze. The nursing ne wound assessment da Resident #1 was repo- lower leg. The Wound Nurse's ne documentated the res- tear by the Wound Nu- Resident #1's skin tea measured 7 cm length deep. There was mod drainage, wound bed level 3, and the wound physician was notified new order was obtain The Wound Nurse was 9:20 am. The Wound the physician by phon skin tear status on 1/S new treatment order to She had not asked the medical staff member skin tear. Nursing ass daily dressing change Wound Nurse assess dressing changes Mo measured and docum once a week. Resident #1's new ord Wound Nurse for the dated 1/9/23 was to p wound and cover with with rolled gauze. The	antimicrobial non-stick to the open wound, it was rbent pad, and wrapped with ote that correlated with ated 1/2/2023 documented orting "3" pain to her right note dated 1/9/23 sident's right lower leg skin urse. The entry documented ar to the right lower leg n by 3.5 cm wide by 0.1 cm lerate serosanguineous was pink, there was pain d was improving. The I of the wound status and a	F	684				

Facility ID: 922952

If continuation sheet Page 31 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/24/2023 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION			LETED
		345268	B. WING		_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 2810	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684		ated 1/12/2023 for the right n with normal saline, apply	F 684	1			
	collagen powder (use healing), cover with a with gauze to secure the Wound Nurse and	d to promote wound bsorbent dressing, and wrap once daily was initiated by d signed by the physician.					
	There was no further Resident #1's right lov	documentation about wer leg wound after 1/9/23.					
	the family visited on N resident had a large v The dressing was soil was informed, and the dressing. The family nursing about the dre	n an interview was mily member. She stated Aonday (1/2/23) and that the vound to the right lower leg. led and falling off. The nurse e Wound Nurse changed the member stated they asked ssing to the right leg, and it sident complained of pain in					
	at 12:09 PM. The fam and other family mem 12/31/2023 and the n family to step out of th transfer Resident #1 to the air mattress to the reported that when sh members returned to that Resident #1 had the wheelchair. The fa they asked for the wo lower leg to be remove skin tear, they told the needed to be evaluated	ras interviewed on 3/1/2023 hily member recalled she hbers were in the facility on ursing staff had asked the ne room so they could to a different bed and apply be bed. The family member he and the other family the room, they were told sustained a skin tear from amily member explained that und dressing on the right red and when they saw the be nurse that the wound ed at the hospital. The family e wound on the right lower					

Facility ID: 922952

If continuation sheet Page 32 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			:	311 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			MARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	"white meat that looke member reported the from the wound and the been unable to pull it and Resident #1 report The family member sat the physician had been and didn't feel that the assessed at the hosp On 2/28/23 at 10:26 at with the Director of Nu stated, "if there was at would ask the staff to staff. I would use nur orders only. Resident lower leg was not ass follow, nursing was ta initiating the wound the order from the Physic was not sure if the wor Nurse #1 for Resident the standing orders. about the lack of the N documentation of the She stated that all wo and measured each w and the Wound NP if Nurse completed all re through Friday and ass complete wound care DON stated that the re treated each day and order and the Wound report any decline in t she had not assessed leg injury herself and	Ind she was able to see ad like a bone". The family skin was pushed back away he nurse said she had not back over the open wound rted pain at the wound site. aid that Nurse #1 told them en notified of the skin tear e wound needed to be ital. In interview was conducted ursing (DON). The DON concern with a wound you reach out to the medical sing judgement for standing t #1's skin tear to the right igned to Wound NP #1 to king care of the skin tear by eatment and obtained an ian." The DON stated she bund treatment initiated by t #1's skin tear was part of The DON had no comment	F 684				

Facility ID: 922952

If continuation sheet Page 33 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT OF DEI AND PLAN OF CORI	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PROVID	ER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	E OF MARSHVILLE			3	11 W PHIFER STREET			
ACTORIN CAR				N	MARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	ntinued From page Physician.	33	F	684				
con stat tool Res had 1/10 Wo wou cha low med Wo the sho disc ther On con stat Res Wo she phy sen or a faci The had wou She cha cha low the sho disc the sho sho sho sho sho sho sho sho sho sho	ducted with the NF red she started her k the place of the F sident #1 on 1/10/2 I not evaluated the D/23. She was of t und NP was follow unds and was to be nges. She stated er right leg should dical staff and wan und Nurse or Wou resident's wound. uld have been eva charge on 1/14/23 re was a change. 3/1/23 at 12:40 pm ducted with the Ph ted she was not inf sident #1's right low und Nurse commu provided the wou sician stated the re t to the Emergency at least followed by lity from when the e Physician was no I not assessed/obs und. sident #1's hospital cumented the right proic wound withour	m an interview was P for the facility. The NP position here on 1/6/23 and PA. She stated she first saw P3 for a medical visit and resident's wounds on he understanding the ing all the residents' e notified of concerns and that the skin tear to the have been followed by ted to be informed by the nd NP of the changes to All the resident's wounds iluated by medicine before since it was significant and or an interview was hysician. The Physician formed of the severity of ver leg skin tear. The nicated her assessments and care order. The esident should have been y Department on 12/31/22 the medical staff in the injury occurred on 12/31/22. t aware that the NP or PA erved the right lower leg Precord dated 1/14/23 lower leg wound was a t further description.						

Facility ID: 922952

If continuation sheet Page 34 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING		_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 2810	13		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	34	F 684				
	The facility provided a immediate jeopardy re	a credible allegation of emoval.					
		nts who have suffered, or serious adverse outcome as ance.					
	accidental injury on 12 which resulted in a 7 tear to the lower right medical provider (MD no physician order for						
	lower right leg was re triage line voicemail p The resident's hospita documented that the	idental injury to Resident #1 ported on the physician per protocol as a skin tear. al record dated 1/14/2023 resident's injury to her right with tissue injury depth to					
	All residents have the	potential to be affected.					
	of Nursing, and Clinic head to toe skin asse the facility to include a	nd Nurse, Assistant Director al Coordinator completed ssments on all residents in assessment of current treatment orders are in e identified.					
	reviewed all incident r to ensure thorough as Provider (MD/NP/Woo treatment orders were	e obtained timely as ans were up to date. No					

Facility ID: 922952

If continuation sheet Page 35 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345268	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARSHVILLE				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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	tool in the Electronic I Condition assessment reviewed by the Direct MD/NP notification art timely as indicated. N Specify the action the process or system fail adverse outcome from when the action will b On 3/2/2023 the Direct education with the fact Nurse on notification of Director (MD)/Nurse I Nurse Practitioner (NI including notification of timely, wound protoco provider (MD/NP/Wood appropriate treatment indicated. The Wound follow up with Medica evaluation of wounds they are in the facility continue to complete and assigned License treatments and dressi orders. The facility wo description along with of altered skin integrit options to implement The NP will be educa physician group mana assessment and eval	t (electronic assessment Health Record) Change in t for the last 30 days were do orders were obtained o issues were noted. The entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete. The Medical Provided 1:1 contron of Nursing provided 1:1 contron of nijuries, obtaining orders of nijuries, obtaining orders of nijuries, obtaining orders of nurse was educated to 1 Providers to ensure has been completed when the Wound Nurse will weekly wound assessments and Nurses complete ing changes per physician ound protocol includes a the a picture of different types y and acceptable treatment for each. ted by the respective ager regarding proper uation of all residents to of wounds/skin integrity in order to prevent	F 6	584			

Facility ID: 922952

If continuation sheet Page 36 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345268	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	up with facility Wound no evaluation needs h Education for all Licen Licensed Nurses was regarding following fa notifying Medical Pro- assessment findings changes immediately is completed and any implemented immedia notification of Medica condition cannot be tr protocol. Education w hired Licensed Nurse Nurses prior to provid Education was compl Licensed Nursing Sta agency nursing staff of location of wound pro- medication carts and documentation of any notification of medica NP) regardless of day skin concerns for the proper follow up and a An Ad Hoc QAPI was Interdisciplinary Team Administrator, Director Director of Nursing, N Rehab, Director of Lif Social Services, Envit Admissions Director,	e in place to prevent /skin conditions and follow d Nurse/Designee to ensure have been missed. nsed Nurses and agency completed on 3/3/2023 cility wound protocol, viders of any abnormal during routine dressing to ensure timely evaluation changes to treatments be ately as indicated, and l Providers if a new skin reated with facility wound vill be provided to any newly s and agency Licensed ling direct care. eted on 3/3/2023 with all ff, including Licensed of wound protocol and tocol (in binder on at main nurses station), r skin integrity concerns, l provider (MD/NP/Wound v or time, notification of new Wound Nurse to ensure assessment is completed. completed with the n (IDT) which includes the or of Nursing, Assistant lurse Managers, Director of renmental Services Director, Business Office Manager,	F	684			
		IDS) Nurse, Wound Nurse, and the Medical Director on					

Facility ID: 922952

If continuation sheet Page 37 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:			· /	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE C		
		345268	B. WING		0:	3/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARSHVILLE			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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684 F 686 SS=J	3/2/2023. The IDT wa Immediate Jeopardy received on 3/1/2023 and necessary educat to be in compliance. Alleged date of IJ rem The credible allegatio removal was validated observation and nursi were done of nursing in-service signed rost proper assessment/er notification of change protocol, and medical documented resident residents for injuries. contract staff would re assignment. A Quali held by the Administra plans for improvement facility's immediate je 03/04/23 was validated Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the comprent resident, the facility m (i) A resident receives professional standard pressure ulcers and culcers unless the indi- demonstrates that the (ii) A resident with pre-	as updated regarding (IJ) citations the facility along with regulation, policy, tion that is needed in order noval 3/4/23. In of immediate jeopardy d on 3/7/23. On 3/7/23 ing interviews of all shifts education and the er was reviewed regarding valuation of wound care, s, use of the wound care staff involvement. A audit was completed of all New nursing hires and eceive the education before ty Assurance meeting was ator and Corporate and it were outlined. The opardy removal date of ed. event/Heal Pressure Ulcer (i)(ii) rrity re ulcers. hensive assessment of a nust ensure that- s care, consistent with ls of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent	F 6			3/22/23	

Facility ID: 922952

If continuation sheet Page 38 of 71

	OF DEFICIENCIES	MEDICAID SERVICES		דוסי ר	CONSTRUCTION	(X3) DATE	0.0938-03
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
			A. BOILDI				с
		345268	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2020
				3.	11 W PHIFER STREET		
AUTUMN	CARE OF MARSHVILLE			N	IARSHVILLE, 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 686	Continued From page	- 38		686			
1 000				000			
	new ulcers from deve	vent infection and prevent					
		is not met as evidenced					
	by:						
		iew and interviews with staff,			*Resident #1 no longer resides in the		
	Wound Nurse Practit	ioner (NP) #1, Physician			facility.		
	Assistant, Facility Nu	rse Practitioner, Physician,					
	and Family Member,			*On 3/2/2023 the facility completed a			
		es, consistent with the			100% skin sweep for all current resider		
		col, to promote healing and			No issues were identified. On 3/2/2023	3	
		e pressure areas Resident			the Director of Nursing/Designee		
		. Resident #1's Stage 2 iorated, increased in size			reviewed previously completed wound reports for the last 30 days for any wou	und	
	· ·	drainage, and eschar (dead			declines or changes. No issues were	ina	
	-	e month stay. Staff did not			identified. On 3/2/2023 all wound		
	consult with medical				physician orders for the last 30 days w	ere	
	drainage and deterior	ration of the wound. On the			reviewed by Director of Nursing/Desigr	nee	
	day of discharge, the	Family Member took			for appropriateness of treatment orders	6.	
		o the hospital where she			No issues were identified. On 3/2/202	-	
		a stage 4, open and infected			Braden Scale Skin Risk assessment w	ere	
		sacrum. The infection was			reviewed by the Director of		
		acility. This deficient practice			Nursing/Designee and updated if		
		nts reviewed for pressure			indicated. On 3/2/2023 Care Plans for identified skin risk were reviewed and		
	sores (Resident #1).				updated as indicated by the Director of	:	
	Immediate ieopardy ł	began on 1/9/23 for Resident			Nursing/Designee.		
		o address the resident's			· · · · · · · · · · · · · · · · · · ·		
		ssure ulcer deterioration.			*On 3/2/2023 the Director of Nursing		
	Immediate jeopardy v	was removed on 3/4/23			provided one on one education with the	e	
	when the facility impl				facility Designated Wound Nurse on		
		te jeopardy removal. The			notification to Medical Provider		
	-	t of compliance at a scope			(MD/NP/Wound NP) for changes in		
		D (not actual harm with the			condition including wounds/skin	~	
	-	n minimal harm that is not			tears/pressure injuries, obtaining order		
		for the facility to complete nsure monitoring systems			timely, following facility wound protocol ensuring the medical provider is notifie		
	put in place are effect				timely of new or deteriorating wounds,	u	
					evaluates and that an appropriate		
							1

Event ID: SQEW11

Facility ID: 922952

If continuation sheet Page 39 of 71

	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345268	B. WING			С
		345266	B. WING		03	8/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE			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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 686	Continued From page	a 30	F 68	6		
	686Continued From page 39The facility standing order revised 3/2021 documented "Wound Care Protocol, 1. Document wound assessments to include measurements and description of the wound. 2. Only wound nurse to stage wounds. 3. Place in problem book for follow up with PEC (on-call physician). The unstageable pressure ulcer wounds that are completely covered with nonviable necrotic (dead) tissue cannot be staged. Ulcers should be carefully evaluated for the presence of undermining, sinus tracts or tunning. A physician or wound care specialist should evaluate wounds that show signs and symptoms of infection. Debridement of ulcers with unstable devitalized tissue is necessary. Notify the medical doctor or wound consultant for debridement options (i.e., enzymatics, referral for sharp debridement)." Debridement is the removal of non-viable material, foreign bodies, and poorly healing			The facility wound protocol inclu description along with a picture of types of altered skin integrity an acceptable treatment options to implement for each. On 3/2/2022 Licensed Nursing Staff, including Licensed Nursing agency staff we educated by the Nursing Admini Team on notification to Medical for changes in skin condition includeterioration of wounds regardled or time, wound protocol location entering orders into the electron record (EHR). All education com 3/3/2023. All Certified Nurse Aid (C.N.A.s) including agency C.N. educated to report any identified integrity concerns to Licensed N Staff immediately. All education completed on 3/3/2023. All new Licensed Nursing Staff and Cert	of different d 3 all g vere stration Provider luding ess of day , and ic health opleted on des A.s were I skin lursing vly hired ified	
	facility on 12/14/22 ac failure, (an acute illne chronic respiratory in infection, anemia (rec kidney disease with a right knee, 2 Stage 2 extends into the deep look like a shallow cra deep tissue injuries (a in the muscle closest dark, non-blanchable heel, congestive hear hospital admission no	t #1 had an ejection fraction		<ul> <li>Nurse Aides, including Licensed and Certified Nurse Aide agency be educated by the Director of Nursing/Designee during the fact orientation process.</li> <li>*The Director of Nursing/Design audit Weekly Wound reports for beginning on 3/3/2023. The Director of Nursing/Designee audit all new treatment orders to wound protocol is followed and assessment by medical provider beginning on 3/3/2023. The Interdisciplinary Team will re- residents with current wounds in pressure injuries during the facil</li> </ul>	v staff will cility ee will 12 weeks ee will e ensure - eview all icluding	

Event ID: SQEW11

Facility ID: 922952

If continuation sheet Page 40 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/24/2023 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345268	B. WING				C / <b>08/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	L		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN	CARE OF MARSHVILLE				11 W PHIFER STREET IARSHVILLE, NC 28103		
				IVI	, 		045)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From page	<u>2</u> 40	E 4	686			
1 000	on 11/22 (normal 50-7			000	will be weekly for twelve weeks. The		
					Director of Nursing will report the res	ults	
	An admission nurses				of the monitoring to the QAPI commit for review and recommendations for		
	follows:	e ulcer assessment as			time frame of the monitoring period.		
	The right buttock had				Administrator is responsible for		
	centimeters (cm) x 3 bed was red.	.9 cm x 0.1 cm. The wound			compliance.		
		a stage two ulcer 4.9 cm x					
	3.5 cm x 0.1 cm. The						
	The right gluteal fold cm x 0.6 cm x 0.1 cm	had a stage two ulcer 0.4					
	admission).	(newly identified of					
		an order dated 12/14/22 was <s and<br="" normal="" saline="" with="">sing.</s>					
	Resident #1's admiss	ion Minimum Data Set					
	dated 12/16/22 docur						
		he resident was dependent aily living. The resident had					
		cers. The resident was					
	always incontinent of						
	resident required 1 st bed mobility.	aff member assistance for					
	A pressure ulcer risk	assessment scale					
	· ·	ion documented high risk					
	for pressure ulcer dev	/elopment.					
	Resident #1's admiss	ion care plan dated					
		for actual and potential skin					
		rventions were to provide , assess, and document the					
		ment and report changes to					
	the physician, turn an	d reposition as indicated,					
	and use pressure reli	eving devices.					

If continuation sheet Page 41 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLET		
		345268	B. WING				C 08/2023	
NAME OF PI	ROVIDER OR SUPPLIER	I	<b>I</b>	s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,		
				3	11 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			N	ARSHVILLE, NC 28103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	e 41 te dated 12/20/22 indicated	F	686				
	the pressure ulcer as was as follows: The right buttock had	a stage two ulcer 3.0 x 3.9						
	x 0.1 cm. The wound bed was red with no odor and drainage was a small amount of sanguineous (watery red). The wound was unchanged and							
	1.0 x 0.8 x 0.1. The wwere unchanged and							
	0.1. There was scant Wound bed was pink							
	x 0.1. The wound wa	had a stage 2 ulcer 0.4 x 0.6 is unchanged.						
	A white blood cell cou 12/21/23 (range 6 - 10							
	by the Wound Nurse the stage 2 pressure protein drink was add	ultidisciplinary note written dated 12/22/22 documented ulcers to the buttocks, a led to promote healing, and position. The Wound NP ow up on 12/27/22.						
	measured together ar	he buttock areas were nd described as a sacral 2. The wound bed was pink						
	assessed by the Wou measurement was 4.4 drainage. The Woun	nd NP #1. The 8 x 5.6 x 0.3 with no						
		NP #1 documented her initial						

Facility ID: 922952

If continuation sheet Page 42 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345268	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	assessment of Reside ulcer wound. The chi tissue in the wound a The wound was prese unstageable. Tissue with mild serous drair was 4.8 x 5.6 x 0.3. T as unavoidable. On 2/28/23 at 2:00 pr conducted with Woun saw Resident #1 for f sacral pressure ulcer. the same size as whe went on leave after th available for resident Arrangements were n care on 1/4/23. A multidisciplinary me documented by the W had an air mattress in The Wound Nurse no the Wound NP #2 tele resident's sacral pres Wound Nurse measu the evaluation. Meas and depth was undete amount of sanguineo had pink and yellow ti appearance and sloug odor. The wound had deteriorated with next the sacral bone. New apply hydrogel to the the sacral bone for im Autolytic debridement	ent #1's sacral pressure ef complaint was necrotic ind services were requested. ent on admission and depth was subcutaneous hage. The measurement The wound was documented in an interview was id NP #1. She stated she her first visit on 12/27/22 for . The ulcer was stable and en admitted. She stated she he 12/27/22 visit and was not care until 1/17/23. hade for telehealth wound eting on 12/29/22 /ound Nurse the resident in place. te dated 1/4/23 documented ehealth visit evaluated the sure ulcer wound. The red the sacral wound during urements were, 11.5 x 15 ermined. It had a small us drainage. The wound bed issue with a necrotic gh (dead skin tissue) with no d gotten significantly larger, rotic tissue and was close to y orders were received to wound, imaging to assess	F	686			

Facility ID: 922952

If continuation sheet Page 43 of 71

		ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED	
		345268	B. WING			03/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MARSHVILLE				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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 686	continue to follow. On 2/28/23 at 9:50 ar conducted with the W Nurse stated on 1/4/2 in Resident #1's sacra wound NP telehealth NP #2 by video. The (dead tissue in the wo changed to use hydro bed. Wound NP #2's note documented the sacra width 15 cm and dept subcutaneous (tissue wound bed had 80% serous drainage. The and deteriorating. Th significant with an inc percentage of necroti to rule out osteomyeli with normal saline, ap wound, place hydroge bed, and dry protectiv written. On 3/1/22 at 2:00 pm interview Wound NP a available. A Physician Assistant documented that Res ulcer wound was asse drainage with no odor bed. The wound order	ized and Wound NP #1 will In an interview was Yound Nurse. The Wound 23 there was a noted change al pressure ulcer wound. A visit was done with Wound wound had new necrosis bund bed). The order was bogel with silver to the wound ordered labs and a sacral dated 1/4/23 for al wound length 11.5 cm by th was 0.5 cm down to the below the skin) layer. The yellow/black tissue with mild the wound was unstageable the deterioration was rease in wound volume and c tissue. Labs were ordered tis. A new order to cleanse oply skin prep around the el with silver to the wound ve dressing each day was an attempt was made to #2 and she was not f (PA) note, dated 1/6/23, ident #1's sacral pressure essed and had small r and pink with yellow wound er was changed to	F	686	δ			
	bed. The wound orde							

Facility ID: 922952

If continuation sheet Page 44 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARSHVILLE				11 W PHIFER STREET			
				Μ	IARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page No measurement was On 3/1/23 at 10:30 an	documented.	F	686				
	conducted with the PA Resident #1 on 1/6/23 resident's sacral press the sacral wound had odor and the wound w tissue and yellow slou wound order was cha gel with calcium algin ordered two days earl Wound NP #2 docum deteriorating and to th x-ray to assess for os blood count to assess stated she had not rea prior to changing the stated 1/6/23 was her On 2/28/23 at 2:45 pr conducted with Nurse provided wound care weekends. Nurse #1 1/7/23 and 1/8/23 she	A. The PA stated she saw B and assessed the sure ulcer. The PA stated minimal drainage with no vas unstageable with pink ugh. She stated the sacral nged to honey-based wound ate instead of the hydrogel lier. She was not aware that ented the sacral wound was he bone and had ordered an teomyelitis and a complete is for infection. The PA ad Wound NP #2's note dressing order. The PA 'last day at the facility. In an interview was e #1. Nurse #1 stated she to Resident #1 on the stated on the weekend of a noted the sacral wound						
	was black necrosis ar with drainage and odd to use a larger dressin had gotten larger. Nu aware there was a tel #2 who was following the Wound NP #2 was not contacted medica and had not documen The Wound Nurse no the Wound Nurse as	te dated 1/9/23 documented						

Facility ID: 922952

If continuation sheet Page 45 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE COMP	SURVEY LETED
		345268	B. WING					C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
AUTUMN	CARE OF MARSHVILLE				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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	Ξ	(X5) COMPLETION DATE
F 686	depth was 0.5 cm. The amount of serosangui wound bed appeared odor. The wound was resident had a pain le with 0 being no pain). No medical staff come documented. Lab results were collec complete blood count an elevated white bloo 6 - 10). An elevated wa an indicator of infection The radiograph taken showed a result dated osteomyelitis (bone in On 2/28/23 at 11:25 at conducted with the Fa She stated she starte took the place of the Fa She stated she starte took the place of the Fa She stated the Wound resident and she did nulless there was a ne mildly elevated white there was no concern x-ray did not show os She stated staff had n #1 was not available to 1/17/23.	<ul> <li>5 cm by width 16 cm and here was a moderate ineous drainage, and the yellow with slough and faint is deteriorating, and the evel score of 3 (0 to 10 scale The family was notified. munication was</li> <li>ected on 1/9/23 for a The 1/9/23 result revealed od cell count of 13.2 (range white blood cell count can be on.</li> <li>on 1/6/23 of the sacrum d 1/6/23 that reported no ffection).</li> <li>am an interview was acility Nurse Practitioner.</li> <li>d her position on 1/6/23 and Physician Assistant. She /10/23 for a medical visit d the resident's wounds.</li> <li>d NPs were seeing the not evaluate the wounds, eed. She stated there was a blood cell count lab, but that a for wound infection and the teomyelitis of the sacrum. not informed her Wound NP to consult from 12/31/22 to ent's record did not</li> </ul>	F	680	δ			
	document a nursing a	ent's record did not issessment of the sacral l condition or measurements						

If continuation sheet Page 46 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
AUTUMN	CARE OF MARSHVILLE				311 W PHIFER STREET MARSHVILLE, NC 2810	)3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	cleanse and wet to dr each day was written and signed by the Phy of the wound. On 2/28/23 at 9:50 ar conducted with the W Nurse stated she was resident's white blood She said the physicia She added the Nurse lab reports to whoeve wounds changed and would change the cou- stated she asked the wound because the w further. She stated, u was initiated when the infection. The Directo decided on 1/13/23 th resident's sacral wour antiseptic solution to a no physician order. On 2/28/23 at 10:26 a with the Director of Nr stated she was asked look at Resident #1's a second opinion for t 1/13/22 the Wound N Resident #1's sacral would she was not familiar w She stated that she co antiseptic for a deterior part of the standing of	der for antiseptic solution y dressing with the solution by the Director of Nursing ysician without observation an an interview was found Nurse. The Wound a not aware that the cell count was elevated. In was responsible for labs. Supervisor would provide r need the labs. She said if developed odor, then you urse of treatment. She DON to look at the sacral yound had deteriorated usually, an antiseptic solution ere was a concern for or of Nursing (DON) and she here was an odor to the had and started using clean and pack. There was an interview was conducted ursing (DON). The DON I by the Wound Nurse to sacral wound on 1/13/22 for treatment change. On urse asked me to evaluate wound and the DON said with the status of the wound. ould not recall if using an orating pressure ulcer was rder.	F	686				

Facility ID: 922952

If continuation sheet Page 47 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345268	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN	CARE OF MARSHVILLE				11 W PHIFER STREET			
				N	MARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	BELAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 47	F	686				
	On 2/28/23 at 11:25 a	im, the Facility Nurse						
	,	ed staff had not informed						
	her that the resident's and had odor and incl	wound had deteriorated						
		formed her that the nurses						
	changed the wound tr	-						
	cleanse and packed it she wanted to be info	t with gauze wet to dry and rmed of the wound						
		cility Nurse Practitioner						
		t for discharge on 1/13/23						
		d her wounds. The DON						
	•	unds' condition but not of ration. She observed a						
		bund taken on 1/14/23 from						
		I record. She stated there						
		communication and missing Wound NP #1 was not						
		to be informed by the nurse						
	of the changes to the	-						
	On 2/28/23 at 12:20 p							
		scharge Nurse. She stated						
	the Wound Nurse con changes and she was	informed that the sacral						
	-	orse. She stated there was						
		the resident's wound during						
		nange reported by the nurse ported to medical staff). She						
		rainage was a concern by						
	the nursing staff. The	e family would visit and						
		as an odor and drainage						
		al wound. She stated when ound during the week of						
		etting larger with yellow						
	slough. The resident	was noted to have declined						
	the last week of her a	dmission.						
	On 3/1/23 at 9:45 am	an interview was conducted						

Facility ID: 922952

If continuation sheet Page 48 of 71

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2023 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING _			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				31	11 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			M	ARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	with the DON. She si accompanied the Woo observed Resident #1 wound because of wo stated the Wound Nut the DON was asked t DON stated she had evaluated the depth in pressure ulcer had bla stated she made the of wound care order from treatment with calciur solution cleanse and The DON stated she was "The DON stated she was #1 instructed the Wou Wound NP consultant changes to the wound could be done by tele she was not aware th contacted medical sta wound had continued was to notify the Wou there were changes. physician signed off of her computer and had resident's sacral On 3/1/23 at 11:12 an conducted with the M MA stated she was as the day of discharge dressing to the resider wound and found that	tated that on 1/13/23 she und Nurse as requested and I's sacral pressure ulcer bund changes. The DON rse was new to her role and o look at the wound. The not measured the wound or for remembered if the ack eschar. The DON decision to change the m honey-based gel n alginate to antiseptic wet to dry with the solution. gave her assessment of Facility NP later. The Facility the resident's wound. The not aware that Wound NP and Nurse to contact the t's office if there were d so that an assessment health. The DON stated at the Wound Nurse had not aff that the resident's sacral to deteriorate, and the plan nd NP consultant's office if The DON stated that the on orders electronically from d not assessed the nd. The DON stated she her observation on 1/13/23 al wound.	F6	\$86				

Facility ID: 922952

If continuation sheet Page 49 of 71

		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCT			(X3) DATE COMP	SURVEY LETED
		345268	B. WING					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIF	CODE	-	
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN ( ACH CORRECTIVE A DSS-REFERENCED TO DEFICIE	CTION SHOULD B D THE APPROPRIA		(X5) COMPLETION DATE
F 686	care. She had not rep medical staff. On 3/1/23 at 11:20 an conducted with Nurse was present when the sacral wound dressing She was not concerne provided the supplies home. Nurse #2 state had opened, had black drainage. On 3/1/23 at 12:50 pr conducted with the Pl stated she was not av pressure ulcer wound physician stated she was nursing staff to report deterioration of a wou medical staff was req at least 5 days before stated she was not av medical staff assesson The physician stated pressure ulcer was av medical staff attention further stated the resi predict because of the On 2/27/23 at 1:40 pr conducted with Resid She stated the reside had a strong odor and concerns to the nurse wound was not treate day of discharge (1/14)	vas present for the wound orted her findings to h an interview was #2. Nurse #2 stated she MA changed Resident #1's g and provided assistance. ed about the wound and for wound care to take ed that the sacral wound k tissue, and had white h an interview was hysician. The physician vare of Resident #1's sacral deterioration. The would have wanted the changes and continued ind to the medical staff. The uired to evaluate all wounds discharge. The physician vare Resident #1 had no hent within this timeframe. she was not sure the voidable, but the lack of h was avoidable. She dent outcome was hard to e many other diagnoses. h an interview was ent #1's family member. nt had a sacral wound that	F 68	36				

If continuation sheet Page 50 of 71

		ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345268	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	straight to the hospital commented that befor the resident had never Resident #1's hospital resident was brought on 1/14/23 instead of discharge planned by was seen for complai buttock. The family fe addressed (at the fac foul smell coming from hospital physician ass resident had two lowed were prior and a new wheelchair. The butto open stage 4 pressur malodorous, had a lai (containing pus) drain surrounding. The diag infected decubitus uld The Administrator wa jeopardy on 3/1/23 at The facility provided a immediate jeopardy re Identify those recipier are likely to suffer, a sa result of noncomplia The facility failed to sa Resident #1's sacral p deteriorated and had developed sour odor, drainage, black eschar	<ul> <li>I." The family member re hospitalization for COVID er had a pressure ulcer.</li> <li>I record documented the to the hospital by the family being taken home as the facility. The resident nt about wound to the elt the wound was not ility). The family reported m the buttock wound. The sessment documented the er extremity wounds that wound from trauma in ock wound was a large, e ulcer that was rge amount of purulent hage, and had pitting edema gnosis was unstageable cer of the sacrum.</li> <li>s notified of immediate 6:22 PM.</li> <li>a credible allegation of emoval.</li> <li>hts who have suffered, or serious adverse outcome as ance</li> <li>eek medical attention for pressure ulcer that had</li> </ul>	F	686			

If continuation sheet Page 51 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345268	B. WING			03	C 3/08/2023
NAME OF P				STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN				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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Nursing had not follow and discontinued a pl wound care and initia treatment without mere (last completed 1/6/20 on 1/13/2023. The res an infected sacral wo (as staged by the hos sepsis. A review of th admission dated 1/14 cultures and wound of same organism for ini- All residents have the On 3/2/2023 the facili sweep for all current to identified. On 3/2/2023 the Direct reviewed previously of the last 30 days for an changes. No issues w On 3/2/2023 all woun last 30 days were rev Nursing/Designee for treatment orders. No On 3/2/2023 Braden 3 were reviewed by the Nursing/Designee and On 3/2/2023 Care Pla were reviewed and up Director of Nursing/De-	wed their wound protocol hysician order for sacral ted antiseptic solution dical evaluation/observation D23) of deteriorating wound sident was hospitalized with und pressure ulcer stage 4 upital) which resulted in e residents' hospital record /2023 documented blood ulture to be positive of the fection and sepsis. e potential to be affected. ty completed a 100% skin residents. No issues were ctor of Nursing/Designee completed wound reports for hy wound declines or vere identified. d physician orders for the iewed by Director of appropriateness of issues were identified. Scale Skin Risk assessment Director of d updated if indicated. ans for identified skin risk podated as indicated by the	F	686	6		

Facility ID: 922952

If continuation sheet Page 52 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		345268	B. WING			C 03/08/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
ΔΗΤΗΜΝ			:	311 W PHIFER STREET				
ACTOMIN	CARE OF MARSHVILLE				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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	adverse outcome from when the action will b On 3/2/2023 the Direct education with the fact Nurse on notification a Director (MD)/Nurse F Nurse Practitioner (NI including wounds/skin (Pls), obtaining orders wound protocol, ensu (MD/NP/Wound NP) it deteriorating wounds, appropriate treatment indicated. The facility description along with of altered skin integrit options to implement On 3/2/2023 all Licen Licensed Nursing age the Nursing Administr Medical Provider (MD changes in skin condit of wounds regardless protocol location (in b and at main nurses st into the electronic heat education completed All Certified Nurse Aict agency C.N.A.s were identified skin integrity areas, saturated dress to Licensed Nursing S education completed	n occurring or recurring, and e complete. ctor of Nursing provided 1:1 cility Designated Wound to Medical Provider (Medical Practitioner (NP)/Wound P)) for changes in condition n tears/pressure injuries s timely, following facility ring the medical provider s notified timely of new or evaluates and that an torder is in place as wound protocol includes a n a picture of different types y and acceptable treatment for each. sed Nursing Staff, including ency staff were educated by ration Team on notification to NP/Wound NP) for ition including deterioration of day or time, wound inder on medication carts tation) and entering orders alth record (EHR). All on 3/3/2023. des (C.N.A.s) including educated to report any y concerns (redness, open sings, odors from wounds) Staff immediately. All on 3/3/2023.	F	686				

Facility ID: 922952

If continuation sheet Page 53 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2023 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345268	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				11 W PHIFER STREET IARSHVILLE, NC 2810	)3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	and Certified Nurse A educated by the Direct during the facility orie Notification to Medica NP) for changes in co deterioration of wound Regional Director of C Director of Nursing or implementation for ne The Director of Nursir Weekly Wound report on 3/3/2023. The Director of Nursir new treatment orders followed and assessm (MD/NP/Wound NP) th Residents with current injuries (PI) will contin Interdisciplinary Team Review Meeting. An Ad Hoc QAPI was Interdisciplinary Team Administrator, Directo Director of Nursing, N Rehab, Director of Liff Social Services, Envin Admissions Director, Minimum Data Set (M Clinical Coordinator, a 3/2/2023. The IDT wa Immediate Jeopardy ( received on 3/1/2023	ide agency staff will be ctor of Nursing/Designee ntation process on al Provider (MD/NP/Wound ondition including ds and wound protocol. The Clinical Services notified the n 3/2/2023 on the ew hires. mg/Designee will audit ts for deterioration beginning mg/Designee will audit all to ensure wound protocol is nent by medical provider beginning on 3/3/2023. It wounds including pressure to be reviewed by the n during weekly Resident completed with the n (IDT) which includes the pr of Nursing, Assistant Jurse Managers, Director of re Enrichment, Director of ronmental Services Director, Business Office Manager, IDS) Nurse, Wound Nurse, and the Medical Director on	F	686				

Facility ID: 922952

If continuation sheet Page 54 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345268	B. WING _			C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MARSHVILLE			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 686	Alleged date of IJ rem		F 6	86		
F 689 SS=J	was validated on 3/7/ and nursing interview nursing education and roster was reviewed r assessment/evaluation changes, timely enter wound care standing involvement notification contract staff would re assignment. Current planned audits were r Assurance meeting w and Corporate and pla outlined. The facility's removal date of 03/04 Free of Accident Haza	23. On 3/7/23 observation s of all shifts were done of d the in-service signed egarding proper on of wound care and ing of orders, use of the order, and medical staff on. New nursing hires and eceive the education before and ongoing wound care eviewed. A Quality as held by the Administrator ans for improvement were immediate jeopardy /23 was validated. ards/Supervision/Devices (2)	F 6	89		3/22/23
	§483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on record revi physician, Nurse Prac the facility failed to en transferred safely (Re transferred to the whe the use of a mechanic	sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced		*Resident #1 no longer resides at the facility *On 3/2/2023 each Electronic Health Record (EHR) was reviewed by the Director of Nursing/Designee to ensur the Kardex and Care plans reflected th	е	

Event ID: SQEW11

Facility ID: 922952

If continuation sheet Page 55 of 71

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED		
			A. BUILDING		с		
		345268	B. WING		03/08/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
				311 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			MARSHVILLE, NC 28103			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION (X5		
PRÉFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	THE APPROPRIATE DAT		
F 689	Continued From page	e 55	F 68	39			
	deep skin tear of her	right lower leg that the		correct transfer status. O	n 3/2/2023 the		
		ery deep, and the family		Director of Nursing review			
	-	see "white meat that looked		reports for the last 30 day			
		und required pressure to		resident were transferred	as specified in		
		and the edges of the wound		their plan of care. No iss	ues were		
		pproximated (skin was		identified.			
		ver the open wound to					
	provide protection to	the healing wound).		*On 3/2/2023 all Licensed			
		10/01/0000		and Certified Nurse Aides			
		began on 12/31/2022 when		agency Licensed Nursing			
		sferred unsafely by one NA nechanical lift, resulting in a		Certified Nurse Aides wer			
		cm skin tear of the lower		return demonstration by t Administration Team and	-		
	right leg that required			on transferring according			
	bleeding and could no			individualized plan of care			
	-	was removed on 3/4/2023		the facility Mechanical Lif	-		
	when the facility imple			accessing transfer status			
		te Jeopardy removal. The		or Care Plan. Education			
		of compliance at a scope		on 3/3/2023. All newly hir	ed Licensed		
		D (not actual harm with the		Nursing Staff and Certifie			
	potential for more tha	n minimal harm that is not		including agency nursing	staff will receive		
	immediate jeopardy)	for the facility to complete		this education with return	demonstration		
	-	nsure monitoring systems		during the facility orientat			
	put in place are effect	tive.		total lift transfers accordin			
	The findings included	ŀ		Mechanical Lift Policy and transfer status from Karde			
	Resident #1 was adm			*The Director of Nursing/I			
		noses to include acute on		randomly audit 3 staff me			
		ilure, (an acute illness		for 12 weeks to ensure pr	oper lift/transfer		
	affecting a patient wit			techniques.			
		-19 virus infection, anemia		The Director of Nursing/D			
		fusions), kidney disease		randomly question 5 staff			
		ıry, pain in right knee, 2 ers (ulcer extends into the		members weekly for 12 w and utilization of resident			
		skin and can look like a		plan and Kardex. The Dir			
		er) of the sacrum, deep		Nursing/Designee will rar			
		sure injury that begins in the		5 interviewable residents			
		bone and appears as dark,		weeks to ensure proper/s			

Facility ID: 922952

If continuation sheet Page 56 of 71

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/24/2023 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345268	B. WING _				C / <b>08/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MARSHVILLE			31	11 W PHIFER STREET		
AUTUWIN	CARE OF MARSHVILLE			М	ARSHVILLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	e 56	F	689			
	congestive heart failu admission note dated Resident #1 had an e (measurement of the the heart with each h 50-70%). The admission Minim assessment dated 12 Resident #1 to be mo impaired. The MDS a require total assistant The MDS documente range of motion of bo required a wheelchait was unable to perform transfers without staff	percentage of blood leaving eartbeat) of 45% (normal num Data Set (MDS) 2/16/2022 assessed oderately cognitively assessed Resident #1 to ce of 2 people to transfer. ed Resident #1 had limited oth lower legs and she r for mobility. Resident #1 m surface to surface			These audits will be conducted week twelve weeks. The Director of Nursing/Designee will report the resu the monitoring to the QAPI committee review and recommendations for the frame of the monitoring period. The Administrator is responsible for compliance.	Its of for	
	transfer total lift with 2 A review of the physic	cian orders revealed					
	The Kardex (a brief s needs available for re documentation system reviewed, and it was instructions included 2 people with the use A physical therapy ev physical therapist (PT assessed Resident # assistance of 2 people	the extensive assistance of					

If continuation sheet Page 57 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				311 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE		1	MARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	\$ 57	F 689				
	PT #1 reported she w Resident #1 during he reported Resident #1 weight for brief period 2-person extensive as PT #1 explained NA s to transfer Resident # transferring a residen assistance without a r person standing behin the gait belt to lift, with the resident to stabilize	ssistance to transfer safely. staff used the mechanical lift 1. PT #1 clarified t with 2-person extensive mechanical lift involved one nd the resident and using h another person in front of ze them and guide the					
	had limited range of n and required one pers transfer from the bed	sfer with one person would					
	3/6/2023 at 2:09 PM. Rehabilitation reporte treatment to Resident 12/31/2022. The Dire reported Resident #1	d she had provided t #1 once prior to					
	Occupational Therapi 2/28/2023 at 12:54 Pl Resident #1 was very 2-person assistance t lift. The COTA reporte to bear weight on her unable to pivot to tran	ducted with the Certified ist Assistant (COTA) on M The COTA reported that weak, and she required to transfer with a mechanical ed that Resident #1 was able legs to stand, but she was nsfer from the bed to the was unable to lift her legs to without extensive					

If continuation sheet Page 58 of 71

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345268	B. WING _			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARSHVILLE			31	11 W PHIFER STREET			
AUTOWIN				М	ARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	one person transferrir under her arms was v in serious injury. An incident report dat 12/31/2022 document skin tear to her lower wheelchair. The note family members were the incident, and the of were notified by a void a skin tear. A nursing note written 12/31/2022 at 7:37 Pl across the hall in anor came to this nurse an tear when they (were) her wheelchair. This r a large skin tear noted Skin and subcutaneou pushed to the right sid to be approximated. A cleanser, (non-stick, a applied to wound bed on top and wrapped in this area is sore. (Fan this time and was not nurse. (On-call physic (voicemail) of skin tea Resident #1 reported scale, 10 being the m lower right leg at the s Nurse #1 was intervie PM. Nurse #1 reporte Resident #1 on 12/31	e. The COTA reported that ing Resident #1 by lifting her ery unsafe and could result ed written by Nurse #1 on ted Resident #1 sustained a right leg after transfer to the documented Resident #1's at the facility and notified of on-call physician services ce mail that Resident #1 had by Nurse #1 dated M documented: "This nurse ther room when the NA d stated resident got a skin transferring resident into nurse into room and assess d to the (right lower leg). us tissue noted to be de of the wound and unable Area cleaned with wound antibacterial dressing) and (absorbent) pad placed in (gauze). Resident states hily member) in the facility at fied of skin tear by this tian) was notified via tr." The nurse documented pain at a level "5" (1-10 ost intense pain) of the skin tear site. wed on 2/28/2023 at 2:37 d she was assigned to /2022 and was notified by	F	89		2EFICIENCY)		
	PM. Nurse #1 reporte Resident #1 on 12/31 the nursing assistant	d she was assigned to						

Facility ID: 922952

If continuation sheet Page 59 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345268	B. WING			_		C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MARSHVILLE				11 W PHIFER STREET			
				M	IARSHVILLE, NC 2810	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Resident #1's room a	eported she arrived at nd found 3 NAs at the	F	689				
	bedside, 2 fulltime err staff member. Nurse a holding a towel on Re bleeding from a "heck lower right leg. Nurse NA #1 that Resident # wheelchair when she Nurse #1 went on to a were in the room, as orienting. Nurse #1 re transferred to the whe they had not used a m reported she did not t serious and did not re hospital. A follow-up interview #1 on 3/1/2023 at 3:0 she had called the Din right after the incident instructed by the DON and NA #5 to instruct techniques. Nurse #1 arrived to assess the dressing, the skin tha curled away from the she was unable to pu	apployees and 1 orienting #1 reported NA #1 was esident #1's leg to stop the a of a large" skin tear on her #1 reported she was told by #1 hit her leg on the was being transferred. explain that NA#1 and NA #4 well as NA #5 who was eported Resident #1 was eelchair by the NA #5 and mechanical lift. Nurse #1 hink the skin tear was equire evaluation at the was conducted with Nurse 2 PM. Nurse #1 reported rector of Nursing (DON) to report it and had been N to talk to NA #1, NA #4, them on proper transfer reported that when she wound and apply a t had been torn was dry and wound. Nurse #1 reported II the skin back over the s so dry. Nurse #1 estimated						
	An interview was con PM with NA #1, and s on 12/31/2022. NA #1 on the 100 hall, and the asked her to come to	being notified of the injury. ducted on 2/28/2023 at 4:24 he reported she had worked l explained she was working he 300 hall NA (NA #4) had Resident #1's room. NA #1 enting NA #5 and the two of						

Facility ID: 922952

If continuation sheet Page 60 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED			
		345268	B. WING		_	C 03/08/2023		
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
			3	11 W PHIFER STREET				
AUTUMIN	CARE OF MARSHVILLE		r	MARSHVILLE, NC 2810	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	NA #1 described Resi upper body supported her the bed control wa head and she wanted bed that worked. Resi was at the bedside du room to get the lift to to other bed. NA #1 shal to Resident #1's room member had sat Resi the bed. According to was unable to suppor of the bed and was or NA#1 described how EMT (emergency med to do this (transfer Re to lift Resident #1 fror wheelchair, bumping wheelchair footrest ar #1 reported she got a area of the skin tear to #4 went to get the nur Nurse #1 arrived in "ju NA #4 was interviewe and assigned to Reside explained NA #1 was that Resident #1's beat the head of the bed, a transfer her to anothe lift. NA #4 verbalized when NA #5 transferm not see Resident #1 r wheelchair but remen sustained a large skin	at #1's room on the 300 hall. ident #1 was in bed with her d on 3 pillows and NA #4 told as not working to elevate the to move Resident #1 to a ident #1's family member uring this time. NA #1 left the transfer Resident #1 to the red that when she returned h, and Resident #1's family dent #1 up on the side of NA #1's report, Resident #1 t herself sitting on the side ying out, "I can't take it." NA #5 said, "I used to be an dical technician), I know how esident #1's leg on the nd causing a skin tear. NA towel to hold on the open o top the bleeding and NA rse. NA #1 reported that	F 689					

If continuation sheet Page 61 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/24/2023 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345268	B. WING				C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				311 W PHIFER STREET			
AUTUMN	CARE OF MARSHVILLE			MARSHVILLE, NC 2810	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	≥ 61	F 689				
	NA #5 was interviewe	ed on 3/7/2023 at 4:18 PM.					
		rst time working on the floor					
	of the facility was 12/3						
		NA #1. NA #5 explained					
	•	to Resident #1's room					
		not work, and they were					
	going to transfer her t						
		nding behind the wheelchair 1 lifted Resident #1 from the					
		wheelchair, and during the					
		's leg scraped against the					
		chair. NA #5 reported she					
		d NA #4 that the footrest					
	was jutting out and to	push it back, but the other					
		ne position of the footrest.					
	-	ound was bleeding and she					
		held pressure on the wound					
		almost 20 minutes later.					
	-	Ifter the incident, they were transfer residents by Nurse					
	-	by stating she didn't return					
	to work at the facility						
	,	5					
	The family member w	as interviewed on 3/1/2023					
		nily member recalled she					
	-	bers were in the facility on					
		ursing staff had asked the					
		he room so they could					
		to a different bed and apply					
		e bed. The family member ne and the other family					
	· ·	the room, they were told					
		sustained a skin tear from					
		amily member explained that					
		ound dressing on the right					
	-	ved and when they saw the					
	-	e nurse that the wound					
	-	ed at the hospital. The family					

Facility ID: 922952

If continuation sheet Page 62 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345268	B. WING				/08/2023
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	leg to be very deep, a "white meat that look member reported the from the wound and t been unable to pull it and Resident #1 report The family member sat the physician had bee and didn't feel that the assessed at the hosp A wound assessment documented a skin te measured 7.6 centime cm and had a pink wo amount of serosangu note documented the normal saline, and an dressing was applied covered with an abso gauze. The nursing n wound assessment d Resident #1 was report lower leg. Wound care orders da lower leg read to cleat antimicrobial non-stic absorbent dressing, a secure once daily. The Wound Nurse wa at 11:48 AM. The Wo was also the staff dev she had provided oriet the NA went out onto training. The Wound I	e wound on the right lower and she was able to see ed like a bone". The family skin was pushed back away he nurse said she had not back over the open wound orted pain at the wound site. aid that Nurse #1 told them en notified of the skin tear e wound needed to be ital.	F	689	9		

Facility ID: 922952

If continuation sheet Page 63 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345268	B. WING				/08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	proper transfer techni where to find the infor for each resident in the Nurse explained she training with the NA # without notice the nex- the facility. The Wour assessed the right low The Wound Nurse rep considered sending F treatment of the wour The facility nurse prac- interviewed on 2/28/2 stated that the skin te should have been foll stated that the skin te should have been foll stated that the trauma skin tear to the right low The Physician (MD) w 12:40 pm. The MD r informed of Resident with its severity. The should have been ser Department on 12/31, the medical staff in the the skin tear. The Administrator wa Jeopardy on 3/1/2023 Identify those recipier are likely to suffer, a sa a result of noncomplia The facility failed to e transferred safely from by the use of the total transferred to the whe	ques, and they are shown rmation related resident care he kardex. The Wound was unable to do further 5 because she had quit at day and did not return to hd Nurse reported she had wer leg wound on 1/2/2023. Dorted that she had not Resident #1 out for further hd to the right lower leg. ctitioner (NP) was 3 at 11:03 AM. The NP ar to the lower right leg owed by medical staff. She a wound was a full-thickness ower leg. vas interviewed on 3/1/23 at eported she was not #1's right lower leg skin tear MD reported the resident ht to the Emergency /22 or at least followed by e facility due to the size of s notified of Immediate B at 5:51 PM. hts who have suffered, or serious adverse outcome as ance. nsure Resident #1 was n her bed to the wheelchair	F	68	9		

Facility ID: 922952

If continuation sheet Page 64 of 71

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345268	B. WING				C / <b>08/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MARSHVILLE				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		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	by 0.1 cm deep skin t This wound deterioral subcutaneous tissue to become infected. In high likelihood of a se when the resident wa total lift. All residents not trans their assessment or p affected. On 3/2/2023 each Ele (EHR) was reviewed Nursing/Designee to plans reflected the co On 3/2/2023 the Direct incident reports for th resident were transfer plan of care. Specify the action the process or system fai adverse outcome from when the action will b On 3/2/2023 all Licen Certified Nurse Aides Nursing staff and Cer educated with return of Nursing Administratio on transferring accord individualized plan of Mechanical Lift Policy status from the Karde of Nursing/Designee nursing department ir	ear of her right lower leg. ted to expose bone and and had the high likelihood n addition, there was the erious adverse outcome s not transferred using the afferred as determined by blan of care could be ectronic Health Record by the Director of ensure the Kardex and Care wrect transfer status. ctor of Nursing reviewed all e last 30 days to ensure rred as specified in their e entity will take to alter the lure to prevent a serious n occurring or recurring, and be complete. sed Nursing Staff and , to include agency Licensed tified Nurse Aides were demonstration by the n Team and/or Rehab staff ding to the resident's care according to the facility y and accessing transfer ex or Care Plan. The Director	F	689			

Facility ID: 922952

If continuation sheet Page 65 of 71

SNATEMENT OF DERIGENCIES AND PLAY OF CORRECTION       (X1) PROVIETRE SUPPLIER DENTIFICATION NUMBER:       (X2) MULTIFIE CONSTRUCTION A BUILDING       (X3) DATE SUPPLY CONSTRUCTION SUBJECT ADDRESS, CITY, STATE, 2/P CODE 311 W PHIFER STREET MARSHYLLE, NC 28103         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2/P CODE 311 W PHIFER STREET MARSHYLLE, NC 28103       (X3) DATE SUPPLY CODE 311 W PHIFER STREET MARSHYLLE, NC 28103         (VALUE)       SUMMARY STATEMENT OF DEFICIENCIES TOD       IN WHIFER STREET MARSHYLLE, NC 28103       (X2) DATE SUPPLY CODES (X2) DATE SUPPLY SUMMARY STATEMENT OF DEFICIENCIES TOD       (X3) DATE SUPPLY SUMMARY STATEMENT OF DEFICIENCIES (X4) DEFICIENCY MUST BE PRECIDED OF VILL (X4) DEFICIENCY SUPPLY TOD       POSUDERS PLAN OF CORRECTION (X4) DEFICIENCY SUPPLY SUMMARY STATEMENT OF DEFICIENCIES (X4) DEFICIENCY SUPPLY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT SUMMARY STATEMENT SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT SUMMARY SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT SUMMAR			ID HUMAN SERVICES				FORI	M APPROVED D. 0938-0391
MALE UP REVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       MUME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       MUME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       MUME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       MATHEW FOR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       MALE OF MARSHVILLE, NC 2018       Vision     PERVISE     PROVIDERS PARANCE CORRECTION, HOULD BE     Colspan="2">Colspan="2"          Colspan="2" <td>STATEMENT O</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>, í</td> <td></td> <td></td> <td>(X3) DATE COMF</td> <td>E SURVEY PLETED</td>	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, í			(X3) DATE COMF	E SURVEY PLETED
INAME OF PROVIDER OR SUPPLIER       STREET ADDRESS: CITY, STREET ZARSP CODE         AUTUMN CARE OF MARSHVILLE       STREET ADDRESS: CITY, STREET ZARSP CODE         IN W PHIFER STREET       MARSHVILLE, NC 28103         OWID TAG       ISOURCEPT WATS FERENCE OF DEFICIENCES       PREFIX         (EACH DEFICIENCY WIDTS ERFORMATION)       ID RECOL DEFICIENCY       PREFIX         (EACH DEFICIENCY WIDTS ERFORMATION)       PREFIX       REACH CORRECTIVE ATTORN SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE       COMENTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE       COMENTION         J3/2023 to the Nursing Administration Team (RN Weekend Supervisor notified of this responsibility on 3/3/2023) to ensure no Nursing Staff work before the return demonstration has been validated. All verbal education was completed on 3/3/2023.       F 689         All newly hired Licensed Nursing Staff and Certified Nurse Aides, including agency nursing staff will be educated with return demonstration during the facility dechanical Lift transfers according to the facility Mechanical Lift transfers according to the Induking agency nursing staff will be reture of Nursing, Ausse Managers, Director of Social Services, Environmental Services Director of Nursing, Aussitant Director of Nursing, Nurse Managers, Director of Social Services, Environmental Services Director of So			345268	B. WING				-
Automa CARE OF MARSHVILLE     MARSHVILLE, NC 28103          (M) D PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH EDGREENT WAY STATEMENT OF DEFICIENCIES (EACH EDGREENT WAY STATEMENT OF DEFICIENCIES (EACH EDGREENT WAY STATEMENT OF DEFICIENCY REGULATORY OFLISCIENTIFYING INFORMATION)         PLEX PROVIDENT TAG         PROVIDENT PROVIDENT (EACH EDGREENT WAY STATEMENT OF DEFICIENCY REGULATORY OFLISCIENTIFYING INFORMATION)         PG 489         PROVIDENT PROVIDENT (EACH EDGREENT WAY STATEMENT OF DEFICIENCY TAG         PROVIDENT PROVIDENT (EACH EDGREENT WAY STATEMENT OF DEFICIENCY PROVIDENT PROVIDE	NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
Printing TVG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         CEACH CORRECTIVE ACTION BOULD BE CROSS-REFERENCE OF THE APPROPRIATE         COMMUNITIES DEFICIENCY)           F 689         Continued From page 65 3/3/2023 to the Nursing Administration Team (RN Weekend Supervisor notified of this responsibility on 3/3/2023).         F 689         F 689         F 689         F 689           All newly hired Licensed Nursing Staff work before the return demonstration has been validated. All verbal education was completed on 3/3/2023.         F 689         F 689         F 689           All newly hired Licensed Nursing Staff and Certified Nurse Aides, including agency nursing staff will be educated with return demonstration during the facility Mechanical Lift Policy and accessing transfer status from Kardex or Care Plan. The Regional Director of Clinical Services notified the Director of Nursing on 3/2/2023 on the implementation for new hires.         An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Std (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023 an the IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance.         Alleged IJ removal date 3/4/23.	AUTUMN	CARE OF MARSHVILLE						
<ul> <li>3/3/2023 to the Nursing Administration Team (RN Weekend Supervisor notified of this responsibility on 3/3/2023) to ensure no Nursing Staff work before the return demonstration has been validated. All verbal education was completed on 3/3/2023.</li> <li>All newly hired Licensed Nursing Staff and Certified Nurse Aides, including agency nursing staff will be educated with return demonstration during the facility orientation process on total lift transfers according to the facility Mechanical Lift Policy and accessing transfer status from Kardex or Care Plan. The Regional Director of Clinical Services notified the Director of Nursing on 3/2/2023 on the implementation for new hires.</li> <li>An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Life Enrichment, Director of Rehab, Director of Life Enrichment, Director of Nurse, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023. The IDT was updated regarding Immediate Jeopardy (Li) claitons the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance.</li> <li>Alleged IJ removal date 3/4/23.</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
On 3/7/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following: "Review of the education provided to the nursing staff and NA staff related to safe transfer	F 689	3/3/2023 to the Nursin Weekend Supervisor on 3/3/2023) to ensur before the return dem validated. All verbal e 3/3/2023. All newly hired Licens Certified Nurse Aides staff will be educated during the facility orie transfers according to Policy and accessing or Care Plan. The Re Services notified the I 3/2/2023 on the imple An Ad Hoc QAPI was Interdisciplinary Team Administrator, Directo Director of Nursing, N Rehab, Director of Lif Social Services, Envir Admissions Director, Minimum Data Set (M Clinical Coordinator, a 3/2/2023. The IDT wa Immediate Jeopardy of received on 3/1/2023 and necessary educa to be in compliance. Alleged IJ removal da On 3/7/2023, the facili immediate jeopardy of following: " Review of the ed	ng Administration Team (RN notified of this responsibility re no Nursing Staff work ionstration has been ducation was completed on sed Nursing Staff and , including agency nursing with return demonstration ntation process on total lift of the facility Mechanical Lift transfer status from Kardex gional Director of Clinical Director of Nursing on ementation for new hires. completed with the of (IDT) which includes the or of Nursing, Assistant lurse Managers, Director of ronmental Services Director, Business Office Manager, IDS) Nurse, Wound Nurse, and the Medical Director on as updated regarding (IJ) citations the facility along with regulation, policy, tion that is needed in order the 3/4/23. ity's credible allegation for emoval was validated by the ucation provided to the	F	689			

Facility ID: 922952

If continuation sheet Page 66 of 71

		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345268	B. WING		03/08/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
AUTUMN	CARE OF MARSHVILLE			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689 F 697 SS=E	education provided ar with transfer competer included. "Observation of tr mechanical lift. "Review of audits The facility's date of th removal plan of 3/4/20 3/7/2023. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu- provided to residents consistent with profess the comprehensive per and the residents' goa This REQUIREMENT by: Based on record revi interviews, the facility with pain relief for 1 of pain control (Residen members reported Re- and the facility failed to admission orders to p resulted in Resident # over the counter (OTC during her stay at the The findings included Standing orders for th	rsing staff to review nd procedure for transfers, ncies for each staff member ansfer of a resident with completed by the facility. he immediate jeopardy 023 was validated on agement. The that pain management is who require such services, sional standards of practice, erson-centered care plan, als and preferences. T is not met as evidenced ews, family, and staff failed to provide a resident f 3 residents reviewed for t #1). Resident #1's family esident #1 was having pain to initiate their standing rovide pain relief. This e1's family administering C) pain medication to her facility.	F 689	*Resident #1 no longer resides in the facility *3/22/23 the Director of Nursing completed a thirty day lookback of pain evaluations for all residents to identify other residents potentially being untreat for pain. There were no issues noted. *The Assistant Director of Nursing completed education with all licensed nursing staff, including agency License Staff and therapists regarding reporting pain to the nurse in timely manner.	any ated ed g
1	were reviewed. Incluc	led in the standing orders		Licensed nursing staff received educat	ion

Facility ID: 922952

If continuation sheet Page 67 of 71

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	IO. 0938-03		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	<b>MPLETED</b>		
		345268	B. WING			С		
	ROVIDER OR SUPPLIER	343280		STREET ADDRESS, CITY, STATE, ZI		3/08/2023		
			311 W PHIFER STREET		TOODE			
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 (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE		
F 697	Continued From page	e 67	F 69	7				
1 007		taminophen 1000 milligrams	FUE	regarding assessing for	nain standing			
		is needed for pain, with		orders for pain and notify				
		resident on the problem list		providers of any pain that	-			
	for follow-up by the cl	•		ineffectively managed. T				
				completed on 3/11/2023	All newly hired			
		nitted to the facility on		Licensed Nursing Staff a				
	-	noses to include right knee		including Licensed Nurs				
	pain and unstageable	e sacral pressure wound.		agency staff will be educ				
	A physician order dat	ted 12/13/2022 ordered		Director of Nursing/Designation facility orientation proces				
	diclofenac sodium ge				55.			
		dication) to be applied		*The Director of Nursing	/designee will			
	-	mee, every 8 hours as		conduct pain interviews	-			
	needed.			alert and oriented reside	-			
				twelve weeks to identify	-			
		ation administration records		unreported/unmanaged				
		23 revealed Resident #1 did ac sodium gel applied.		of Nursing/designee will and symptoms of pain fo	•			
		ac socium ger applied.		that are not able to com				
	The admission Minim	num Data Set (MDS)		weekly for twelve weeks				
	assessment dated 12	· · · ·		identified signs or sympt	•			
	Resident #1 to be mo	oderately cognitively		immediately. The 24 hou				
		locumented Resident #1 had		reviewed in clinical morr				
	-	on of both lower legs. The		times a week for twelve				
	MDS documented Re	esident #1 did not have pain.		potential issues with pair				
	A care plan dated 12	/14/2022 identified Resident		The Director of Nursing/ report the results of the				
	#1 had the potential t			QAPI committee for revi	•			
	Interventions for the c			recommendations for the				
		g for pain relief, administer		the monitoring period. T				
	medications as order	ed, assess for verbal and		is responsible for compli				
		ain, and provide education						
		/ members about pain						
	management.							
	The pain level summa	ary (record of pain						
	assessments for the	stay of a resident) for						
		ewed. On 12/27/2022 it was						
	noted that Resident #	#1 reported pain level "3"						

Facility ID: 922952

If continuation sheet Page 68 of 71

		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/24/2023 MAPPROVED ). 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					LETED	
		345268	B. WING			_	C 03/08/2023		
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
AUTUMN	CARE OF MARSHVILLE				11 W PHIFER STREET	_			
				M	ARSHVILLE, NC 2810	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	documented by the w 12/31/2022 she report documented by Nurse reported pain level "3 A review of the physic acetaminophen had b #1. Resident #1 was disc 1/14/2023. An interview was com- family member on 3/1 family member report and other family mem- pain in her buttocks fr had pain in her right of happened on 12/31/2 reported she had ask medications for Resid bring the pain medica family member was n remember specific da explained that becaus Resident #1 pain medica family members broug give to her. The famil acetaminophen helpe and allowed her to resi member reported that describe her pain but tear and the pressure family member report	eing the most intense pain) ound care nurse, on ted pain level "5" e #1, and on 1/1/2023 she " documented by Nurse #1. cian orders revealed no PRN been initiated for Resident harged from the facility on ducted with Resident #1's /2023 at 12:09 PM. The ed that Resident #1 told her ibers that she was having rom a wound, and that she calf from a skin tear that 023. The family member	F 6	97		DEFICIENCY)			
		is interviewed on 3/6/2023 and Nurse reported that							

Facility ID: 922952

If continuation sheet Page 69 of 71

DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MEDI	-				FORM	2: 04/24/2023 1 APPROVED 2: 0938-0391		
STATEMENT OF DEFICIENCIES (X1) P	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345268	B. WING		_	03/0	C 08/2023		
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE				
AUTUMN CARE OF MARSHVILLE		-	11 W PHIFER STREET MARSHVILLE, NC 2810	)3				
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
<ul> <li>F 697 Continued From page 69 Resident #1 had not report Wound Nurse reported she documenting that Resident on 12/27/2022.</li> <li>An interview was conducted 3/1/2023 at 3:02 PM. Nurse providing care to Resident sustained the skin tear to h Nurse #1 reported Resident her right leg was "a little so she had not told the physic was experiencing pain, and documenting a pain level of a level "3" on 1/1/2023. Nut the family asking for pain m Resident #1.</li> <li>Nursing assistant (NA) #4 w 3/1/2023 at 4:27 PM. NA # Resident #1 complained of reported to a nurse. NA #4 did not know if Resident #1 medications. NA #4 reported pain was primarily in her sa laying on her back.</li> <li>The facility physician was in 2:52 PM. The MD reported residents who experienced pain addressed by nursing standing orders or by callin</li> <li>A physical therapist (PT) w 3/6/2023 at 2:21 PM. The F Resident #1 reported pain ' the pressure ulcer. The PT therapy session, she would on her side to relieve press</li> </ul>	<ul> <li>a did not recall</li> <li>#1 had a level "3" pain</li> <li>d with Nurse #1 on</li> <li>#1 reported she was</li> <li>#1 on the night she</li> <li>er lower right leg.</li> <li>tt #1 had reported that</li> <li>re". Nurse #1 reported</li> <li>tian that Resident #1</li> <li>d she did not recall</li> <li>f "5" on 12/31/2023 or</li> <li>rse #1 did not recall</li> <li>nedications for</li> </ul> was interviewed on 44 reported that pain, and she had received pain ad that Resident #1's acrum when she was nterviewed 3/3/2023 at that she expected pain would have that staff with either the g for orders. as interviewed on PT reported that "in her bottom" from explained that after a t position Resident #1	F 697						

Facility ID: 922952

If continuation sheet Page 70 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/24/2023 APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	-	(X3) DATE SURVEY COMPLETED		
		345268	B. WING			03/	C 08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
AUTUMN	CARE OF MARSHVILLE			311 W PHIFER STREET MARSHVILLE, NC 2810	03			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	was not certain which report. The Director of Nursir on 3/6/2023 at 2:53 P was not aware of Res medicating her with a explained the facility I were signed by the M could initiate those st The DON expressed Resident #1 did not a why the resident did r	e pain to a nurse. The PT nurse had been given ng (DON) was interviewed M. The DON reported she sident #1's family members cetaminophen. The DON had standing orders that ID on admission and a nurse anding orders at any time. she was not certain why sk for pain medication, or not receive pain control standing orders to provide	F 69					

Facility ID: 922952

If continuation sheet Page 71 of 71