STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 000	INITIAL COMMENTS The survey team entered the facility on March 9, 2021 to conduct an unannounced complaint investigation. Additional information was obtained offsite on March 10, 2021 through March 12, 2021. Therefore, the exit date was March 12, 2021. 1 of the 2 complaint allegations were substantiated resulting in deficiencies. Event ID# 8PPX11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		4/9/21

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

Electronically Signed | 04/01/2021

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interviews, the facility failed to notify the responsible party about a fall with head injury for 1 of 2 residents reviewed for notification (Resident #1). The findings included: Resident #1 was admitted to the facility on 08/27/19 with diagnoses that included anemia, coronary artery disease, hypertension, diabetes, Alzheimer's disease, depression, and muscle weakness. Resident #1's quarterly Minimum Data Set (MDS) assessment dated 02/28/21 revealed she was	F 580	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATES ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUE OF REQUIRMENTS UNDER STATE AND FEDERL LAW. CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: On January 29, 2021 Resident #1	

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F 580	Continued From page 2 moderately cognitively impaired, required extensive assistance with activities of daily living, was not ambulatory and had no use of restraints. Further review of the MDS revealed Resident #1 had no behaviors and one fall since her last assessment. Resident #1's care plan initiated 09/18/19 and revised on 12/14/20 revealed Resident #1 was at risk for falls related to decreased mobility, poor safety awareness and weakness. The goal was to have no preventable injuries from falls through the next review. Interventions included increase care rounds, place call bell in reach, blood work and medications as ordered, and therapy evaluations. An interview with a personal care aide (PCA) #1 on 03/10/21 at 3:01 PM revealed she had gone into Resident #1's room 01/28/21 just before dinner to assist with feeding her when she observed her on the floor next to the wall. She stated she called for a nurse to help. She further stated Resident #1's forehead started to swell, and the Nurse Practitioner (NP) came to the room to assess Resident #1. The PCA indicated Resident #1 had a little bump on her forehead. The Nurse Practitioner's progress note dated 01/28/21 revealed that she was called to Resident #1's room on 01/28/21 to assess Resident #1 after a fall out of bed. The NP progress note revealed Resident #1 had a raised area to her forehead and had no signs of pain. The documentation indicated a neurological assessment was performed and ice was applied to Resident #1's forehead. An interview with the NP on 03/10/21 at 3:31 PM	F 580	sustained a fall, NP was on site and aware of incident. NP accessed the resident. Responsible Party of resident was notified on 2/4/21. CBC, CMP as well XRAY of Shoulder, Pelvis, Hips, Knees and Head Set CT was ordered. OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECITVE ACTIONS TAKEN: Beginning April 2,2021, current residents with changes in condition will have notification to Residents Representative. Look back for changes in conditions for all residents was completed on April 2, 2021. Systematic Change Implemented: Beginning 3/24/21 all Licensed Nurses will be re-educate on resident representative notification. Staff to notify for injuries requiring medical evaluation and possible intervention, the family or representative will be contacted immediately. If unable to contact family or representative, continued attempts will be made for 24 hours. For injuries requiring medical evaluation and possible interruption, the physician will be contacted immediately. If unable to reach the physician within 1 hour, the medical director will be notified. Education was completed by DON and designee. Policy and procedures were reviewed as well as importance of notifying responsible party of any changes regarding resident. Completion on	

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F 580	Continued From page 3 revealed she was called to Resident #1's room to assess her after staff observed her to be on the floor. The NP stated Resident #1 had a raised area on her forehead and ice was applied. She further stated Resident #1 was at her baseline neurologically. The NP indicated that she normally calls the resident's family if there was a major injury after a fall. The nurse will notify the family if there was not a major injury. She stated she did not realize Resident #1's family had not been notified of the fall until she was called into a meeting in February 2021. Nursing progress notes revealed there was no documentation of Resident #1's family being notified of her having a fall on 01/28/21. Further review of the nursing progress notes revealed there was no documentation of Resident #1 having a fall on or around the date of 01/28/21. An interview with Nurse #1 on 03/11/21 at 2:25 PM revealed she was assigned to Resident #1 on 01/28/21. The NP was tending to Resident #1 who was found on the floor in her room. Nurse #1 stated she had a very hectic shift and did not call Resident #1's family to notify them she had fallen. She further stated the NP told her she would call Resident #1's family. An interview the Nurse #2 on 03/12/21 at 9:56 AM revealed she was working another unit and was called to assist when Resident #1 fell. She stated she did not call Resident #1's family and that she was only there long enough to assist with getting Resident #1 off the floor and back into her bed. The incident report dated 1/28/2021 completed by the Director of Nursing (DON) #1 revealed no notification of Responsible Party.	F 580	4/2/2021. Effective 4/2/210 all new employees and agency staff will be educated on resident representative notification. MONITORING: Beginning 4/2/21 the Director of Nursing or designee will review all residents who have a significant changes in conditions utilizing the 24 Hour report since the last morning meeting. The DON or designee will investigate all resident incidents/accidents. Beginning 4/2/21 the DON or Designee will document data during the morning clinical meeting for Responsible Party Notification. Monitoring will be conducted 5x weekly for 4 weeks, then 2x weekly for 4 weeks and weekly x 12 Result of the monitoring tools will be reviewed by Administrator or DON at monthly QAPI meeting. Completion Date of 4/9/21	

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F 580	Continued From page 4 The facility grievance log for February 2021 revealed a grievance was filed by the family of Resident #1 on 02/08/21 for failure of the facility to notify the family after Resident#1 had a fall with injury. The documentation of the grievance revealed it was reported to the Social Worker, NP, and Administrator. Further review of the grievance revealed the facility in-serviced staff and had a meeting with Resident#1's family which resulted in a request from the family for a complete workup for Resident #1 to include blood work and X-Rays. An interview on 03/09/21 at 12:36 PM with Resident #1's family revealed the family was very upset that the facility did not call them and tell them that Resident #1 had fallen. An interview with the DON #2 on 03/12/21 at 10:19 AM revealed that part of the procedure for falls was for the nurse to notify the DON, NP, and the family. She stated she was aware Resident #1's family was not contacted. She further stated the nurse should call the resident's family when the resident had a fall with injury.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		4/9/21

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F 684	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record reviews, family, staff and Nurse Practioner (NP) interviews, the facility failed to do neurological checks (to rule out bleeding in the brain) after an unwitnessed fall out of bed which resulted in a bump on the forehead for 1 of 2 residents reviewed for falls (Resident #1). Findings included: Resident #1 was admitted to the facility on August 27, 2019 with diagnosis that included transient cerebral infarction, coronary artery disease, hypertension, Alzheimer's disease, depression, and muscle weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated February 28, 2021 revealed Resident #1 was moderately cognitively impaired. Resident #1 had adequate, hearing and vision, and was non-verbal. Resident #1 required extensive assistance with activities of daily living (ADL) and one previous fall since admission. Resident #1's physician's orders included an order for Aspirin 81 mg (milligrams) daily for coronary artery disease dated 8/28/19. Record review of Resident #1's hard chart and electronic medical record revealed there was no documentation related to Resident #1's fall of 1/28/2021 and/or neurological checks. During an interview on March 10, 2021 at 3:01 pm, with personal care aide (PCA) revealed that she was the first person to find Resident #1 after the fall. She stated Resident #1 was laying on the floor against the wall with a bump on her forehead. NA #1 stated the NP and Nurse # 2	F 684	THE PREPARATION AND SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSION STATED ON THIS STATMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW/ CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: On 2/4/21 Information regarding Residents fall on 1/28/21 was entered into Residents medical record. We are unable to complete neurological checks at this time. OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN: Current residents with falls are at risk. On April 2, 2021 a 30 day look back for Residents with falls with head injuries will be completed for 100% of current residents, to ensure neurological checks have been completed and information placed into medical record regarding falls. Completed on 4/2/21. Results of the audit were reviewed in QAPI on 4/29/2021.	

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F 684	Continued From page 6 assessed Resident #1. An interview with the NP on March 10, 2021 at 3:31PM revealed she was called to Resident #1's room to assess her after a fall out of bed. The NP stated Resident #1 had a raised area on her forehead and ice was applied. She further stated she instructed the staff to put ice on her forehead and then again later in the evening. The NP stated there were no obvious injuries except the bump on her forehead and her neuro assessment was without changes. Resident #1 was at her baseline neurologically. During an interview on March 12, 2021 at 9:56 am Nurse #2 revealed that she was working the night of the fall but on a different hall. When she heard a nurse aide yell, she went to help. Nurse #2 came into Resident #1's room and assisted the NP in evaluating Resident #1 for injuries. She indicated there were no obvious injuries, so they put the resident back to bed. As Nurse #2 left to go back to work on her assigned hall, Nurse #1 entered the room and resumed care. Nurse #2 stated she did not do neurological checks for the resident during the night, she was not assigned to Resident #1's room. During an interview on March 11, 2021 at 2:24 pm, Nurse #1 stated on the evening of the fall she worked 7:00 pm to 11:00 pm. She indicated that she started neurological checks and documented them on a piece of paper. At 11:00 pm, when her shift was over Nurse #1 handed the paper with the neuro checks to a staff member; however, she could not recall who it was. During an interview on March 11, 2021 at 2:54 pm with Nurse Aide #1 she stated she worked the	F 684	Beginning on 3/24/2021 DON/designee started re-education for Licensed Nurses concerning the requirement of completing neurological checks with all falls with head injury witnessed or non witnessed, for all non-interviewable residents and completing necessary documentation regarding falls. Completion date 4/2/2021 SYSTEMATIC CHANGES IMPLEMENTED: Beginning 4/2/21 DON and the Interdisciplinary team will review in morning clinical meeting all Incident/Accident Reports, Witness Statements and Incident/Accident Investigations. MONITORING: Beginning 4/2/21 the monitoring will consist of audit tool for Neurological checks that will be used daily in clinical meeting. Monitoring will be conducted 5x weekly for 4 weeks, the 2x weekly for 4 weeks and weekly x 12 weeks. On 4/29/2021 the Director of Nursing will report the findings of the monitoring tool at the monthly QAPI meeting. to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period. Completion date of 4/9/21	

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F 684	Continued From page 7	F 684		

night of Resident #1's fall and stated no one gave her a piece of paper with neurological checks on it. She did know Resident #1 fell and was taking vital signs and watched her throughout the night.

During an interview on March 11, 2021 at 3:00 pm with Medication Technician #1 indicated that she worked 11pm to 7am on the evening Resident #1 fell. She stated nobody gave her a paper with neurological checks for Resident #1, and she was not aware of the fall until it was mentioned later into her shift.

During an interview on March 12, 2021 at 10:09 am, the Director of Nursing (DON) stated with all unwitnessed head injuries, nurses were required to initiate the Neurological Check protocol. She stated once the fall occurred, the nurses should have put an Incident Report into the computer which would generate a neurological check list in the electronic medical record. She stated that some nurses still document on paper and the paper checks would be scanned into the medical record. The DON stated she was unable to locate any neurological checks for the day of the fall or any days after the fall for Resident #1's unwitnessed fall.