STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/06/23 through 2/09/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NURQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/06/23 through 2/09/23. Event ID#NURQ11. The following intakes were investigated: NC00197727, NC00192564 and NC00190215. 2 of the 8 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/3/23

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

Electronically Signed | 02/28/2023

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to (1)maintain drywall in good repair as evidenced by drywall that was scratched and peeling off the wall behind resident beds and adjacent walls in occupied resident rooms for (Room #301, Room #303, Room #304, Room #305, Room #306, Room #307, Room #308, Room #310, Room #311, Room #312, Room #313, Room #401, Room #402, Room #403, Room #405, Room #406, Room #601, Room #605, and Room #606), 2) ensure privacy curtains were free of stains (Room #305 and Room #310), and 3) and ensure a tube feeding pump, a tube feeding pole, and suction equipment were in clean and sanitary condition (Room #310) for 3 of 4 halls observed.	F 584	As of 3/3/23 Rooms 301, 303, 304, 305, 306, 310, 311, 312, 313, 405, 406, 601, 605 and 606 were patched, sanded and painted. Privacy curtains were replaced with clean curtains in 305 and 310, IV/Tube Feeding pole was cleaned and suction machine was removed, cleaned and placed in inventory as it was not needed for the resident. To identify other residents that have the potential to be affected a 100% Audit of all rooms in the facility was completed on 3/3/23 to identify any additional wall issues, privacy curtain soil levels, IV poles, and other nursing equipment. All areas of cleanliness concern were	

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F 584	Continued From page 2 Findings included: 1. During observations on 2/07/23 at 8:30 am through 10:30 am the following rooms had damaged drywall. a. Room #301 had a hole approximately eight inches long with multiple areas of peeled drywall on wall on the side of the door bed. The window bed area had an area measuring approximately 3.5 feet (ft) in length from the corner of the room to the window with exposed peeling drywall, hardened spackle with cracks, and without paint. b. Room #303 an area approximately 3 ft. in length above the head of the bed with cracked spackle areas without paint. c. Room #304 was observed with an area approximately 5 ft. by 5 ft. with dried, cracked spackle without paint, and multiple tears in the drywall surrounding the area. d. Room #305 with an area approximately 3 ft. x 3 ft behind the head of the bed with dried, cracked spackle without paint. e. Room #306 had an area approximately 3 ft. in length with unpainted area with multiple drywall tears and hardened areas of cracked spackle. f. Room #308 the door and windows beds were observed with an area above head of the bed, and along the side of the bed with multiple areas of torn drywall and dried spackle without paint. g. Room #310 door bed was observed with an open hole in the drywall above the head of the bed and an area of hardened spackle around the	F 584	identified and cleaned and walls in need of repair are placed in line to be repaired within 7 business days. To prevent this from recurring the Maintenance Director was in-serviced that any reported wall repairs must be repaired within 7 days. The housekeeping supervisor was in-serviced that all privacy curtains are to be laundered minimally every three months and/ or when visibly soiled. That it is the house-keepers responsibility to deep clean resident rooms at least once a month, and that all rooms and equipment shall be cleaned daily. Any new maintenance director or housekeeping supervisor will be oriented upon hire that walls are to be repaired within 7 days of being reported as damaged and that privacy curtains are to be cleaned every 3 months minimally and when visibly soiled. That all rooms are expected to be cleaned daily and deep cleaned minimally once a month. To monitor and maintain ongoing compliance the Administrator/designee shall complete weekly rounding with the Maintenance Director to review outstanding wall repair work-orders, and also identify any new wall repairs that have arisen weekly for 12 weeks.	

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F 584	Continued From page 3 hole. h. Room #311 was observed with an area approximately 3 ft. x 2 ft. of hardened cracked spackle without paint behind recliner and multiple sections approximately 4 ft. in length behind the head of bed with cracked spackle without paint. i. Room #312 was observed with an area behind the head of bed measuring approximately 2 ft. in length with torn drywall and cracked spackle areas. j. Room #313 was observed with an area measuring approximately 6 ft. in length on the wall alongside the bed with cracked spackle without paint. k. An observation of Room 401 was conducted on 2/7/23 at 12:31 PM. The wall behind the bed revealed two areas of spackled dry wall. There was a large area of spackled dry wall at the head of the bed. l. An observation of Room 403 was conducted on 2/7/23 at 12:43 PM. There was a large area of spackled dry wall at the head of the bed. m. An observation of Room 406 was conducted on 2/7/23 at 12:45 PM. The wall behind the bed revealed two areas of spackled dry wall. There was a large area of spackled dry wall at the head of the bed. n. An observation of Room 402 was conducted on 2/8/23 at 4:02 PM. The wall behind the bed revealed two areas of spackled dry wall. There was a large area of spackled dry wall at the head of the bed.	F 584	The administrator/designee shall complete 10 random room inspections daily for cleanliness for 4 weeks, 5 random room inspections for 4 weeks, and 3 random room inspections for 4 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	

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F 584	Continued From page 4	F 584		

o. An observation of Room 405 was conducted on 2/8/23 at 4:06 PM. There was a large area of spackled dry wall at the head of the bed.

p. On 2/7/23 at 1:57 PM an observation of room 601 Bed A revealed the spackled drywall at the head of bed and the spackled drywall beside the door was marred. Bed B the spackled drywall at the head of bed was observed to be scratched.

q. On 2/8/23 at 3:45 PM an observation of room 601 Bed A revealed the spackled drywall at the head of bed and the spackled drywall beside the door were scratched. Bed B the spackled drywall at the head of bed was observed to be scratched.

r. On 2/8/23 at 3:47 PM an observation of room 605 Bed A revealed the spackled drywall at the head of bed and the spackled drywall beside the door were scratched. Bed B the spackled drywall at the head of bed was observed to be scratched.

s. On 2/8/23 at 3:50 PM an observation of room 606 Bed A revealed spackled drywall at the head of the bed was scratched.

t. Observations on 2/9/23 at 1:51 PM revealed the spackled drywall in rooms 601, 605 and 606 were in the same condition.

During an interview on 2/09/23 at 8:52 am the Maintenance Director revealed he had a list of rooms that needed repair, but he had not been able to complete the work on the rooms. He stated he started the repair but would get pulled to do something else and it was hard to get back to complete the work.

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During an interview on 2/09/23 at 11:18 am the Administrator revealed he spoke to the Maintenance Director but had not created a plan to complete the repairs to the rooms. He stated the repairs involved the resident to be out of the room for the completion of the work which made it difficult to complete the work.

2a. During an observation on 2/06/23 at 9:51 am in Room #310 the privacy curtain had dark brown stains and a white hardened substance on multiple areas of the curtain.

b. During an observation on 2/06/23 at 10:58 am and again on 2/09/23 at 12:00 pm the middle privacy curtain in room 305 had multiple dark brown hardened stains on the curtain.

During an interview on 2/07/23 at 2:04 pm the Housekeeping Supervisor revealed the privacy curtains were taken down once a month on the scheduled deep cleaning day and when visibly dirty. He stated the privacy curtains should have been removed and laundered when they were visibly dirty.

During an interview on 2/09/23 at 1:49 pm the Administrator revealed the housekeeping department was responsible to maintain clean privacy curtains and they were expected to be laundered when needed.

3. During an observation on 2/06/23 at 9:51 am in Room #310 the tube feed pump was observed to have multiple areas of hardened beige substance on the top and down the front of the feeding pump. The tube feeding pole had a dried beige substance down the pole and on all four legs of the pole. A suction machine was observed

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F 584	Continued From page 6	F 584		

on the bedside table near the head of the bed with a heavy dust build up on the machine and a dried brown substance on the top and inside of the suction canister.

During an interview on 2/07/23 at 1:55 pm Nurse #1 revealed the housekeeping department was required to clean the tube feed pump, tube feed pole, and the suction machine during the daily cleaning of room 310. Nurse #1 stated the suction machine was no longer used and she would remove the machine from the room.

An interview was conducted on 2/07/23 at 2:10 pm with the Housekeeping Supervisor. He revealed all surfaces were to be cleaned every time the room was cleaned which included wiping down the suction machine and tube feed pole. The Housekeeping Supervisor stated the feeding tube pole should have removed from the room and taken outside to scrape the buildup off the legs and pole.

An interview with the Director of Nursing on 2/09/23 at 9:20 am revealed the housekeeping department was expected to clean the tube feed pump, tube feed pole, and the suction machine when they completed the daily cleaning of room #310.

During an interview on 2/09/23 at 1:49 pm the Administrator revealed the suction machine, the tube feed pump, and the tube feed pole was the responsibility of the nursing department. He stated nursing staff was expected to wipe spills when they occurred and was to notify the housekeeping department when the tube feed pole required additional cleaning.

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F 656	Continued From page 7	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		3/3/23

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F 656	Continued From page 8 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement a comprehensive care plan for 1 of 1 resident who received renal dialysis (Resident #43). The findings included: Resident #43 was admitted to the facility on 11/27/20 with diagnoses of end stage renal disease, renal dialysis, and diabetes mellitus. Review of the annual Minimum Data Set dated 12/7/22 revealed that Resident #43 was mildly cognitively impaired, required set up assistance with eating and was coded for receiving dialysis. Review of the physician order dated 12/21/21 revealed an order for Novasource renal, one time a day for weight loss. Review of the physician order dated 1/25/23 revealed an order for fluid restriction 1,200 cubic centimeters (cc) every day. Dietary to give 840cc q day. Nursing to give 660 cc q day. Nursing 1st shift to give-270cc, nursing 2nd shift to give 270cc, 3rd shift to give-120cc. Review of the physician's order dated 2/8/22	F 656	On 2/8/23 resident #43□s care plan was updated to reflect appropriate orders for fluid restrictions To identify other residents that have the potential to be affected on 2/28/23 a 100% audit of all nutritional care plans was completed by the Director of Nursing/Designee to ensure that all current nutritional fluid intake restriction orders matched the care-plan. To prevent this from recurring on 2/23/23 the MDS nurses were re-educated by administrator that any new nutritional fluid intake restrictions orders are to be care planned timely. Any new MDS nurses will be educated upon orientation of the expectation that all care-plans shall be updated with regard to fluid restriction intake orders. To monitor and maintain ongoing compliance the Director of Nursing/designee will audit all physician	

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F 656	Continued From page 9 revealed Resident #43 had a diet order as renal diet, regular texture. Review of Resident #43's medical record revealed no nutritional care plan that addressed fluid restrictions, or the nutritional interventions implemented to help him achieve his goal of fluid restrictions. An interview on 2/8/23 at 10:53 with Minimum Data Set (MDS) Nurse #6 revealed during their care plan meetings, they would put down Dialysis and the patient should have been care planned then. An interview on 2/9/23 at 12:14 PM the Administrator revealed the Minimum Data Set Nurse should have care planned the resident.	F 656	orders 5 days a week for any new fluid restrictions during clinical morning meeting and ensure that the care-plan is updated to reflect new order times 12 weeks. DON/Designee will review 10 random nutritional care plans to ensure that all nutritional fluid restriction orders match the care plan for 4 weeks, 5 random care plans for 4 weeks and 3 random care plans for 2 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a resident receiving dialysis had a physician's order for 1 of 1 sampled resident reviewed for receiving dialysis. (Resident #43). The findings included:	F 698	On 2/9/23 resident #43□s orders were updated to reflect current order for dialysis treatment. To identify other residents that have the	3/3/23

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F 698	Continued From page 10 Resident #43 was admitted to the facility on 11/27/20 and readmitted on 10/09/21 with diagnoses of end stage renal disease, and renal dialysis. Resident #43's care plan dated 11/27/20 noted he was on hemodialysis related to diagnoses of end stage renal disease. Staff were to provide diet as ordered, if resident has dialysis shunt, palpate for distal thrill and auscultate for bruit, monitor for bleeding, hemorrhage, sepsis, monitor skin around vascular access for, redness. Report to physician/Dialysis center: fever, chills, hypotension. Review of the annual Minimum Data Set (MDS) dated 12/07/22 revealed the resident as having moderately impaired cognition. The MDS coded Resident #43 as receiving dialysis. Resident #43's medical record was reviewed and revealed there was no physician order for dialysis. An interview with Nurse #2 on 2/09/22 at 9:57 AM revealed there was no order for his dialysis. She indicated the dialysis order for Resident #43 should be in computer. An interview with the Unit Manager Nurse #3 on 2/9/23 at 10:38 AM she indicated that technically Resident #43 had no physician order for his dialysis. The Unit Manager Nurse # 3 revealed the resident went out to the hospital on 10/7/21 and when he came back the new order should have been put in at that time. An interview with the Administrator on 2/09/23 at	F 698	potential to be affected on 2/28/23 an audit of all residents on dialysis was completed to ensure that they had current orders for dialysis treatment in their medical chart. To prevent this from recurring the DON/Designee re-educated all nurses on 2/28/23 to ensure that all new dialysis orders are properly transcribed into the medical record timely. All new nurses will be educated upon orientation of the expectation that new dialysis orders are to be transcribed to the medical record timely To monitor and maintain ongoing compliance the Director of Nursing/designee will audit all new admissions during clinical morning meeting 5 days week to ensure that all new admissions on dialysis have a matching order in their medical record times 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	

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F 698	Continued From page 11 12:14 PM revealed with a newly admitted resident the unit manager would take the orders off their hospital discharge orders and put into the resident record. He indicated the resident should have a dialysis order and they would get one for the resident.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		3/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 12 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to post accurate Daily Nurse Staffing Information that reflected the Daily Shift Assignment for licensed nurses for 6 out of 30 days. The findings included: A review of the Posted Nurse Staffing Information was conducted on 2/7/23 for the dates of 1/6/23 through 2/6/23. Comparison of the Posted Nurse Staffing Information with the Daily Shift Assignments revealed there was no Registered Nurse (RN) included on the Posted Nurse Staffing Information for the following days: 1/7/23, 1/8/23, 1/21/23, 1/22/23, 2/4/23, and 2/5/23. An interview was conducted with the facility staff scheduler on 2/7/22 at 3:29 PM. The scheduler stated there had been an RN Supervisor scheduled for 7 AM to 7 PM on the dates of 1/7/23, 1/8/23, 1/21/23, 1/22/23, 2/4/23, 2/5/23. She stated that she was not aware that the Posted Nurse Staffing Information should include the RN Supervisor. An interview was conducted with the Administrator on 2/8/22 at 4:02 PM. The Administrator stated he was not aware that the RN Supervisor had to be reflected on the Posted	F 732	No specific residents were identified to be affected by this deficient practice All residents have the potential to be affected by this deficient practice. To prevent this from recurring the On 2/28/23, the DON/Designee re-educated all nursing administrative nurses that the posted nurse staffing information should reflect all qualifying RN coverage available daily. All new nurse administrative nurses will be educated upon orientation of the expectation on how accurately post Nurse Staffing Information. To monitor and maintain ongoing compliance the Director of Nursing/designee will review all staff nursing postings in the morning clinical meeting 5 days a week to ensure that the information was posted correctly for 12 weeks The DON will report the results of the monitoring to the QAPI committee for review and recommendations for the time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

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F 732	Continued From page 13 Nurse Staffing Information since they were not part of the daily nursing hours. The Administrator further stated the Posted Nurse Staffing Information would be updated to reflect the RN coverage.	F 732	frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months.	