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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 000	INITIAL COMMENTS The survey team entered the facility on 08/14/24 to conduct an unannounced complaint investigation survey and exited on 8/14/24. Additional information was obtained offsite and a telephone exit conference was conducted on 8/16/24. Therefore, the exit date was changed to 08/16/24. The following intake was investigated: NC00219824. One (1) of the 2 complaint allegations resulted in a deficiency. Event ID# 9Q4Q11. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G). Noncompliance began on 07/21/24 and the facility came back in compliance effective 07/24/24.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Nurse Practitioner (NP) and staff interviews, the facility failed to prevent an accident when staff was assisting a resident with advanced Parkinson's disease (disorder of the central nervous system that affects movement) to the dining room in her wheelchair without the use of	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2024

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foot pedals. The resident was unable to "keep her feet up" while in her wheelchair without the assistance of her foot pedals which allowed her foot to drop, causing her shoe to fall off and her shoe to become stuck underneath the wheel of the wheelchair. This caused the wheelchair to stop abruptly and the resident to fall forward out of the wheelchair and hit her head on the floor. The resident sustained a large gash above her left eye and was transferred to the hospital for treatment. She received 11 stitches, and a hospital CT (computed tomography) scan revealed the resident had also suffered a small subarachnoid hemorrhage (bleeding in the space between your brain and the membrane that covers it) due to the fall. The resident was admitted to the hospital for further evaluation and treatment and was discharged back to the facility on 7/26/24 once the hematoma had resolved. This was for 1 of 3 residents reviewed for the prevention of accidents (Resident #1).

Findings Included:

Resident #1 was admitted to the facility on 5/12/22 with diagnosis that included Parkinson's disease, muscle weakness, and history of falling.

Review of quarterly Minimum Data Set (MDS) dated 6/10/24 revealed Resident #1 was cognitively intact and had been assessed as being dependent on staff for all activities of daily living, was a two-person assist for transfers, and required a wheelchair for mobility.

Review of nursing progress note dated 7/21/24 read in part: "Resident #1 was sent to the emergency department (ED) by emergency medical services (EMS) via stretcher. Nursing

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assistant (NA) #1 on hall was pushing resident in wheelchair down the hall towards the dining room for dinner. Nurse #1 was sitting at nurse's station charting when the incident occurred. NA #1 stated Resident #1 shoe came off and she did not see it and went over the shoe with the wheelchair and the resident fell face forward on the floor. Laceration above left eye observed. Compression dressing to area, EMS called, and vital signs (VS) taken. Staff remained with Resident #1 while awaiting EMS. Resident #1's daughter was notified of the incident and stated, "she was going to meet her mother at the hospital". The NP was notified of the incident as well as the unit manager (UM) and Director of Nursing (DON).

A telephone interview was conducted with Nursing Assistant (NA) #1 on 8/14/24 at 2:47 PM revealed she was familiar with Resident #1. She stated she had been working on the evening of 7/21/24 and was assigned to Resident #1. She revealed prior to her transporting Resident #1 to the dining room, she and another staff person had assisted Resident #1 from her bed to her wheelchair and did not apply her foot pedals. NA #1 stated when she returned to transport Resident #1 to the dining room, she had forgotten about the foot pedals and as they were moving, she realized she did not have her foot pedals on and asked Resident #1 to "hold her feet up". She revealed while transporting Resident #1 down the hall towards the dining room, her foot dropped, and her shoe fell off and became stuck underneath the wheel. She stated she was not aware Resident #1's foot had dropped or her shoe had fallen off and was stuck under the wheel until her wheelchair stopped abruptly, and Resident #1 fell forward from the wheelchair onto the floor. NA #1 revealed she stayed with

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Resident #1 and hollered for help from Nurse #1 who had been sitting at the nurse desk. She stated Nurse #1 assessed Resident #1, called 911, and applied a compress to a laceration above her left eye until the EMS came and then they took over treatment and transferred Resident #1 to the hospital. She revealed while Resident #1 was at the hospital she received stitches for the laceration above her left eye and a CT scan showed she had suffered a hematoma from the fall, so she was admitted for further treatment. NA #1 stated the Administrator and DON came to the facility that evening and she informed them of what happened, and they educated her on wheelchair and fall safety to include the use of foot pedals and the following day she reenacted for the DON how the fall occurred and continued to receive education and was also observed transferring residents, transporting residents, and making sure all residents had their correct adaptive equipment in place. She also stated that nursing staff had a list of all residents who require any type of adaptive equipment to include foot pedals and when they should be applied. She revealed she had seen Resident #1 being transported without her foot pedals before and was able to hold her feet up and she just didn't think about applying her foot pedals prior to transporting her.

An interview was conducted with Nurse #1 on 8/14/24 at 2:07 PM revealed she was familiar with Resident #1. She stated she had been working on the evening of Resident #1's fall and was sitting at the nurse desk charting when she heard NA #1 down the hall asking for help. She stated when she started down the hall towards the dining room, she observed NA #1 with Resident #1 who was lying in the floor in front of her

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wheelchair, her shoe was off, and she was bleeding from a laceration over her left eye. She revealed she assessed Resident #1 who was alert and conscious with no complaints of pain and visible signs of injury other than the laceration above the left eye. Nurse #1 stated 911 was called and she applied a compress to Resident #1's laceration above her eye and then once EMS arrived, they took over care and transported Resident #1 to the hospital where she was admitted for treatment of the eye laceration and a hematoma. She revealed she spoke with NA #1 about what happened, NA #1 had stated she was transporting Resident #1 in her wheelchair to the dining room when she dropped her foot, and her shoe fell off. She stated when Resident #1's shoe fell off it became stuck underneath the wheel causing the wheelchair to stop abruptly and Resident #1 to fall forward out of the wheelchair and into the floor. Nurse #1 revealed when NA #1 was asked about Resident #1's foot pedals not being applied to her wheelchair, NA #1 stated she had seen Resident #1 being transported without her foot pedals before and she would hold her feet up, so it just slipped her mind, and she didn't think about applying them prior to transporting her. She stated immediately following Resident #1's fall, she notified the Administrator and DON who came to the facility that evening and began investigating the incident and all nursing staff were educated on wheelchair and fall safety, all resident adaptive equipment and they received an updated list of all residents with required adaptive equipment which included foot pedals, and this list would be updated anytime there was a change with the equipment, new order was added, or a new admission.

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Review of hospital discharge summary dated 7/26/24 read in part: "Admitted on 7/21/24, resident of local skilled nursing facility for the last 5 years, non-ambulatory, was being taken to the dining room via wheelchair and apparently fell from the wheelchair when her shoe came off. She sustained a significant left supraorbital ridge facial laceration (deep cut above left eye socket), contusion to her face and brought to the ED where she was found to have a small left frontal subarachnoid hemorrhage. Neurosurgery was consulted by telemedicine and recommend a follow-up CT scan in 6 hours which was stable. Resident #1 was admitted to the hospital. Resident #1 had advanced Parkinsonism with dysphagia. Resident #1 was discharged back to the skilled nursing facility in stable and improved condition. She is high risk for readmission given disease process. Resident #1 is an extremely high fall risk given her disease process and would always recommend one-to-one supervision with transfers and toileting. Sutures were placed 7/21/24 for left laceration, will need removal in 7-10 days from placement".

Review of nursing progress noted dated 7/26/24 read in part: "Resident #1 returned to facility via EMS via stretcher after being sent to ED on 7/21/24 for fall resulting in head injury. Resident #1 had laceration with sutures intact to left eyebrow and a scab to the left knee that was also intact. Small bruises in various stages to her upper extremities were healing. The principal problem and reason for admission to the hospital on 7/21/24 was a subarachnoid hemorrhage following injury which after monitoring at hospital and multiple CT scans had resolved. Resident #1 does have history of advanced Parkinson's disease and upon returning to the facility was at

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baseline for orientation. Resident #1 will continue to be monitored and antibiotic ointment to be applied to residents sutured laceration above left eyebrow, sutures to be removed in about 3-7 days (sutures placed on 7/21/24). Resident #1 was resting in bed with no complaint of pain or discomfort at this time".

Observation on 8/14/24 at 12:15 PM revealed Resident #1 inside of her room, sitting in her wheelchair waiting to be assisted to the dining room for her lunch meal. Resident #1 was also observed with her foot pedals and kickboard in place. Observations also revealed no issues with Resident #1 being transported to the dining room and assisted with her lunch meal by the Assistant Director of Nursing (ADON).

An interview was conducted with the ADON on 8/14/24 at 1:02 PM revealed she was familiar with Resident #1. She stated she was not working on the evening Resident #1 fell from her wheelchair but was notified of the fall the following morning by the DON. She revealed she was informed Resident #1 was being transported in her wheelchair to the dining room for supper and did not have her foot pedals on her wheelchair which caused her foot to drop, her shoe to come off becoming stuck under the wheel, and the wheelchair stopped abruptly causing Resident #1 to fall into the floor. The ADON stated she was informed that Resident #1 did sustain a laceration above her left eye and was sent out immediately to the hospital for treatment and hospital CT scan showed she had suffered a hematoma which cleared prior to her return. She revealed part of her responsibilities as the ADON was to provide training on resident safety while providing care to all nursing staff and newly hired staff, but that

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specific wheelchair safety and training was provided by therapy. She stated therapy would also be responsible for making sure an order was in place for residents with required equipment including foot pedals. The ADON revealed since Resident #1's fall, all staff had been educated on the importance of wheelchair and fall safety, also resident checklists for all adaptive equipment including foot pedals were updated to include how and when those should be applied. These checklists were provided to all staff and placed at the nurse station and the list would be updated with any changes, new orders, new admissions, and staff would be notified of the changes.

An interview was conducted with the Director of Therapy on 8/14/24 at 3:08 PM revealed she was familiar with Resident #1 and had previously provided her with therapy services. She stated prior to Resident #1 fall she had not been required, ordered, or care planned to have her foot pedals always applied to her wheelchair. She revealed due to Resident #1 advanced Parkinson's disease she would have good days and bad days and depending on the day would determine her capability of being able to hold her feet up while being transported for short period of time. The Director of Therapy stated the following day after the fall, therapy assessed all wheelchair residents for foot pedal use, updated the resident adaptive equipment list to include application of foot pedals, provided copies of list to all nursing staff, and assisted with educating staff on wheelchair and fall safety and foot pedal applications. She revealed she also assisted the MDS nurses with updating each wheelchair resident's care plans to address how and when foot pedals should be applied.

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An interview was conducted with the Administrator and Director of Nursing on 8/14/24 at 3:31 PM revealed they were familiar with Resident #1. The Administrator stated on the evening of 7/21/24, she and the DON were notified by Nurse #1 about Resident #1's fall, the laceration to her left eye, and being sent out to the hospital for treatment. She revealed she and the DON went to the facility and began their investigation of the incident. The Administrator stated she and the DON received statements from Nurse #1 and NA #1 about the fall and were informed NA #1 was transporting Resident #1 in her wheelchair to the dining room when her foot dropped, her shoe fell off becoming stuck under the wheel, and the wheelchair stopped abruptly causing Resident #1 to fall into the floor. She revealed they were also informed NA #1 had not applied Resident #1's foot pedals to her wheelchair which allowed her foot to drop causing her to fall. The DON stated she began education on wheelchair, fall, and transfer safety with NA #1 that evening and the following day completed a reenactment of the incident and continued education with all staff. She revealed all wheelchair residents were assessed for foot pedals and the resident master adaptive equipment list was updated to include foot pedals and copies of list were made available to all staff and at each nursing station. The DON stated the resident list would be updated by therapy with any changes in equipment, new orders received, or with new admissions and MDS nurses would update resident care plans to reflect these changes. She revealed the facility began audits of wheelchair residents requiring foot pedals being applied to wheelchair 3x's week

A telephone interview was conducted with the

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Nurse Practitioner (NP) on 8/14/24 at 4:29 PM revealed she was familiar with Resident #1. She stated she was notified of Resident #1's fall and continued her treatment for the laceration above her left eye upon her return to the facility. She revealed prior to Resident #1 fall she had never written an order and was not aware of an order from therapy of Resident #1 being required to have her foot pedals applied while being transported in her wheelchair and on occasion had seen Resident #1 able to hold her feet up while being transported in the facility. She stated Resident #1 does suffer from advanced Parkinson's disease and it appeared the disease was progressing, and she would not be able to continue to follow commands as well or hold her feet up for a long period of time. The NP stated after Resident #1 fall, all staff, herself included, had been educated on wheelchair and fall safety, applications of foot pedals and adaptive equipment for residents and when and how those should be applied, and an updated list of all residents and their required adaptive equipment to include foot pedals was provided and a copy was placed at each nurse station. She revealed if a resident has a change with their equipment, new order, or a new admission then she or therapy would let the DON and the MDS nurses know so they could update the list and the resident care plan.

The facility provided the following Corrective Action Plan with a compliance date of 7/24/24:

The facility identified concern with providing supervision to prevent accidents for residents.

Address how corrective actions will be

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accomplished for those residents to have been affected by the deficient practices.

On 7/21/2024 Resident #1 was assessed by Nurse #1 and made comfortable on the floor because moving her could have caused more damage until her neck and spine were stabilized.

On 7/21/2024 first aid was provided for the laceration to her forehead and pressure was held to stop the bleeding by the Nurse #1.

On 7/21/2024 new orders were received to be sent to the Emergency Department for evaluation and treatment.

On 7/21/2024 Emergency Medical Services were called by nurses.

On 7/21/2024 Responsible Party was made aware of the fall and resident being transported to the Emergency Department.

On 7/21/2024, the Director of Nursing provided 1:1 education to the Certified Nursing Assistant #1 who was transporting the resident in wheelchair regarding the need for foot pedals during transport for any resident who is unable to hold their feet up when in w/c and that feet should be placed on pedals during transport.

On 7/22/2024 the Director of Nursing provided the Certified Nursing Assistant #1 who was transporting Resident #1 in the wheelchair without foot pedals, training on resident handling and proper body mechanics as well as the lift program skills check off.

On 7/22/2024 Certified Nursing Assistant #1 who

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was transporting Resident #1 in the wheelchair without foot pedals, demonstrated how the incident occurred with the Director of Nursing and Unit Manager.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice

The Director of Nursing and Director of Rehabilitation audited all residents and identified those residents that were unable to propel self or hold their feet up during transport in wheelchairs and if they did not have pedals, they were provided for safety. This audit was completed on 7/22/2024.

On 7/22/2024 the Director of Nursing placed a list of residents who required foot pedals for transport in a wheelchair at each nurse's station.

On 7/22/2024 the Director of Nursing or Designee updated the Master Device list for each resident who required foot pedals for transport in wheelchair. The master device list is a running list with each resident name and room number and their required adaptive equipment.

On 7/22/2024 the Director of Nursing or Designee updated the care plans and resident profile for each resident identified to be at risk to include requiring foot pedals for transport in wheelchair.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 7/22/2024 the Director of Nursing or Designee educated all staff on when residents are unable to

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hold their feet up during transport in w/c and required foot pedals prior to transporting in wheelchair and a list of residents requiring foot pedals for transport in wheelchair is provided at each nurse's station. The care plan and resident profile were updated for those residents who require foot pedals for transport in wheelchair. This education was completed on 7/22/2024. Those staff who were not working were educated via phone, during this education staff were asked questions and feedback to obtain understanding of education and were included during observation audits at the facility. This education will be provided to new employees during orientation.

The Director of Nursing or Designee had all Licensed Nurses and Certified Nursing Assistant complete a safety and accident prevention quiz. These quizzes were completed by 7/23/204.

The Director of Nursing or Director of Rehabilitation will evaluate newly admitted residents, provide foot pedals if indicated, and notify MDS nurse who will update residents care plans, profile and the master device list and the nursing station list to reflect need of foot pedals during transport in wheelchair. The MDS nurse will also inform management of any updates to resident care plans regarding adaptive equipment and provide them and therapy with an updated master device list.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

The Administrator and DON discussed on 7/21/24 and determined to have ADHOC QAPI on

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 13	F 689		

7/22/24. ADHOC QAPI was held on 7/22/2024 with the Interdisciplinary team to discuss the incident with Resident #1 and educate the team on the interventions that were put into place to prevent further incidents. The Interdisciplinary Team discussed the incident and will monitor weekly for 8 weeks and take it to QAPI for the next 3 months for review and recommendations.

The Director of Nursing or Designee will complete an observation audit 3 times per week for 8 weeks then monthly x 1 to ensure that residents that unable to hold their feet up during transport in wheelchair have foot pedals on while being transported in a wheelchair.

Date of Compliance: July 24, 2024

On 8/14/24, the facility's corrective action plan effective 7/24/24 was validated by the following: Observations of residents in wheelchairs with foot pedals applied being transported in the facility with no issues or concerns noted. Nursing staff interviews revealed they had received education on fall safety, wheelchair safety when transporting resident, foot pedals and all adaptive equipment requirements and how and when to use them, accident prevention, notifying therapy or administration if foot pedals are needed, and reviewing the master resident adaptive equipment list to see what equipment each resident should have and how and when it should be applied. The updated master resident adaptive equipment list to include foot pedals was placed at each nurse station as a reminder. Therapy staff interviews revealed they would continue to assess residents for any wheelchair needs to include foot pedals and assist MDS nurses with updating the master resident adaptive equipment list and notifying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 08/16/2024

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nursing staff of the changes. MDS nurses received education on updating wheelchair resident care plans to include foot pedals, updating master resident adaptive equipment list anytime there was a change, new order, or new admission, and notifying therapy and administration of the change. Administrative staff interviews revealed they provided staff education and were completing weekly audits of wheelchair residents to assure foot pedals have been applied while being transported in their wheelchairs and also reviewing the master resident adaptive equipment list to assure it was reflecting the status of each resident and being updated when any changes, new orders, or new admission had occurred. Auditing tools were reviewed. Documents were reviewed from the facility Quality Assurance and Performance Improvement (QAPI) committee meeting minutes of the audit results. Review of Resident #1's revised care plan dated 7/22/24 revealed her risk for falls characterized by multiple risk factors related to her history of falls and Parkinson's disease. She had a goal to minimize risks for falls and injuries related to falls through the next review. Interventions for Resident #1 included staff education related to wheelchair pedals and transporting residents, 20 inch reclining high back wheelchair with 2-inch pressure relieving cushion, bilateral standard footrests, kick plate and rear anti-tippers, evaluate needs for adaptive equipment, educate/direct the use of assistive devices, and transfers with 2-person assist.

The facility's compliance date of 7/24/24 was validated.