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	345567	A. BUILDING ______ B. WING ______	C 03/13/2023

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AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(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 An unannounced complaint investigation was conducted on 03/09/23 with additional information obtained through 03/13/23 therefore, the exit date was changed to 03/13/23. Event ID# XIIN11.The following intakes were investigated: NC00197017, NC00197038, NC00197210, NC00199224, NC00199238, NC00199320 and NC00199294. 20 of the 20 allegations investigated resulted in no deficiency.	F 000		
F 684 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Director interview the facility failed to complete a thorough assessment after Resident #1 had an unwitnessed fall on 02/23/23 and landed on her right side before being transferred off the floor for 1 of 3 residents reviewed for falls. Resident #1 displayed or voiced no complaints of pain but was unable to bear weight on 02/24/23. An x-ray was ordered which showed an acute right intertrochanteric (type of hip fracture) fracture and Resident #1 was transported to the emergency room for evaluation and treatment on 02/25/23.	F 684	Resident #1 is no longer a resident of Autumn Care of Cornelius. All residents have the potential to be affected therefore on 3/14/2023, a review of all residents that had a fall within the previous 30 days were reviewed. The audit was conducted to ensure the facility had completed assessments on resident that had a fall. Any identified issues were corrected. On 3/15/23, the Director of Nursing educated all nursing staff on Post fall	3/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/29/2023

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.

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F 684 Continued From page 1

The Findings included:

Resident #1 was admitted to the facility on 02/22/23 with diagnoses that included fracture of left femur (thigh bone) and dementia.

Review of a fall risk assessment dated 02/22/23 indicated Resident #1 was high risk for falls.

Review of a care plan initiated on 02/23/23 indicated Resident #1 was at risk for falls related to decreased mobility, history of falls, recent hip fracture, and impaired cognition. The interventions included: bed in low position, call bell in reach, and nonskid socks.

The Admission Minimum Data Set (MDS) assessment dated 02/25/23 revealed that Resident #1 was severely cognitively impaired for daily decision making and was sometimes understood by others and sometimes understood what others were saying. The MDS further indicated that Resident #1 required limited assistance with transfers, pain reported rarely, and had one fall with major injury since admission. No fall history prior to admission was assessed during the assessment reference period.

An incident report dated 02/23/23 completed by Nurse #1 read in part, at 5:50 PM this Nurse was made aware by a Nurse Aide (NA) that Resident #1 was on the floor in her room. This Nurse went into Resident #1's room and observed her laying on the floor beside of the recliner chair on her right side, family member standing over her. Resident #1 was unable to explain why she was on the floor, she showed no signs of distress or pain at this time. Immediate action taken: resident

F 684

Physical assessments to include ROM, specifically ensuring an assessment is complete at the time of a fall prior to helping the resident up. Education was completed on 3/15/23. New staff will be educated upon hire, including new agency staff.

The Director of Nursing or designee will review all falls (5) five times per week for 12 weeks to ensure all residents who have falls are assessed, including Range of Motion, prior to being moved from the floor.

The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.
Compliance date is 3/24/2023

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Continued From page 2
was assessed for injuries, vital signs were obtained, and she was assisted back into her wheelchair. Injury type: no injuries observed at this time.

A Nurse's note dated 02/23/23 written by Nurse #1 read in part, on 02/23/23 at 5:50 PM this Nurse was made aware by a NA that Resident #1 was on was on the floor in her room. This Nurse went into Resident #1's room and observed her laying on the floor beside of the recliner chair on her right side. Resident was wearing yellow nonskid socks. There was a family member standing over her and her bed was in the lowest position. The call light was on the bed and was not activated. Resident #1 was unable to explain why she was on the floor or what she was attempting to do. She was assessed for injuries and obtained a small abrasion to her right elbow. She showed no signs of distress or pain at this time. Immediate action taken resident was assessed for injuries, vital signs were obtained, and she was assisted back into her wheelchair. Communication was left for Medical Doctor (MD) via communication book, Director of Nursing (DON) was notified, and Resident's family was present.

An interview with Nurse #1 was conducted on 03/09/23 at 4:05 PM who confirmed she was on duty on 02/23/23 from 7:00 AM to 7:00 PM. Nurse #1 stated around 5:30 PM, Medication Aide (MA #1) approached her to notify her that she had obtained the blood sugars for the residents who resided on the unit where she was working and needed Nurse #1 to administer their insulin. Nurse #1 indicated within a few minutes, she and MA #1 headed to the unit where MA #1 was working and a NA (she could not recall her name)

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F 684	Continued From page 3 motioned for her and MA #1 to hurry and hollered that a resident was on the floor. Nurse #1 stated she and MA #1 quickly approached Resident #1's room where Resident #1 was laying on the floor next to her recliner on her right side. Nurse #1 stated Resident #1's husband was standing in the room next to her. Nurse #1 described Resident #1 to be lying on the floor on her right side with her arm in front of her and her legs were towards the door of the room. Nurse #1 stated she had MA #1 obtain Resident #1's blood pressure and pulse. Nurse #1 then stated she rolled Resident #1 onto her bottom, noticed she had a cut on her right elbow and then "patted" her right hip to see if she was hurt. Nurse #1 confirmed she did not check for leg shortening, internal/external rotation, or determine if Resident #1 could bear weight. Nurse #1 revealed since Resident #1 was cognitively impaired and unable to identify any pain, she, MA #1 and a third person (she could not recall who) picked Resident #1 up and carried her to her bed which was located across the room from where she was found in the floor and placed back to bed. Nurse #1 stated she left the room, wrote a note in the provider notebook, and returned to her hall to care for the residents she was assigned. Nurse #1 indicated she did not return to Resident #1's room the remainder of her shift. MA #1 was interviewed on 03/09/23 at 4:50 PM and revealed she was assigned to Resident #1 on 02/23/23 from 7:00 AM - 7:00 PM. Around 5:30-5:40 PM, she had finished her first evening medication pass and obtained blood sugars for residents on her unit. MA #1 stated since she was not able to administer insulin so she left the unit to get Nurse #1 who was assigned to work another unit to administer the insulin. MA #1	F 684		

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F 684	Continued From page 4 stated as she and Nurse #1 returned to the unit a NA who she was unable to identify hollered for them and stated a resident was on the floor. MA #1 stated she and Nurse #1 quickly approached Resident #1's room. She stated when they entered the room Resident #1 was laying on her right side with her head near the recliner chair and her feet near the door of the room. MA #1 explained Resident #1 was unable to explain what had happened to her or how she ended up on the floor. MA #1 indicated Resident #1's family member was standing next to her when Nurse #1 placed Resident #1 on her back. MA #1 said Nurse #1 ask her to obtain vital signs and she did so. MA #1 further explained Resident #1 was not able to vocalize pain or injury and therefore Nurse #1, MA #1, and Resident #1's family member lifted her and carried Resident #1 back to her bed. MA #1 stated Resident #1 seemed ok and therefore she and Nurse #1 left the room. NA #3 was interviewed on 03/10/23 at 4:24 PM and confirmed that she worked on 02/23/23 from 7:00 AM to 7:00 PM and was caring for Resident #1. NA #3 stated she was gathering supper trays on the unit and a resident had asked her to go to the restroom. NA #3 indicated she had placed the resident on the toilet when she heard Resident #1's family member hollering very loudly for help. NA #3 said she stepped out of the room and asked Resident #1's family member what he needed, and he stated Resident #1 was on the floor. NA #3 explained she left the resident on the toilet and quickly proceeded to Resident #1's room. When she entered the room, she noticed Resident #1's legs extended out passed the doorway. NA #3 stated Resident #1's family member was saying that she needed to be picked up and began trying to lift her to a seated position	F 684		

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F 684	Continued From page 5	F 684		

with his hands behind her back and under her left leg. NA #3 said she told Resident #1's family not to touch her and she would get the nurse. NA #3 left the room and proceeded down the hall where she saw MA #1 and Nurse #1 walking down the hall and she summoned them to come to help. When MA #1 and Nurse #1 approached she told them Resident #1 was on the floor. NA #3 said once MA #1 and Nurse #1 were in the room she left the room to go back to the resident who was on the toilet. NA #3 stated sometime after Resident #1 fell she saw Resident #1 in her wheelchair with her family member pushing her in the hallway.

Nurse #2 was interviewed via phone on 03/09/23 at 11:32 PM and revealed she was the nurse assigned to care for Resident #1 on the night shift (7PM-7AM) on 02/23/23. Nurse #2 stated she was told in report that Resident #1 had fallen but had sustained no injuries and therefore did not further assess Resident #1 for injuries on her shift. Nurse #2 stated Resident #1 was in the bed all night with her family at her bedside.

Attempts to speak to NA #4 on 03/13/23 were unsuccessful. NA #4 cared for Resident #1 on 02/23/23 from 7:00 PM to 7:00 AM.

Nurse #3 was interviewed via phone on 03/09/23 at 5:44 PM who confirmed that she cared for Resident #1 on 02/24/23 from 7:00 AM to 7:00 PM. She stated that in report she was made aware that Resident #1 had fallen on 02/23/23 and had no injuries. Nurse #3 stated that at some point during her shift the Physical Therapist (PT) went into work with Resident #1 and noticed that she was resistive to exercises on her right leg. Nurse #3 stated that she and the PT went in to

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F 684	Continued From page 6 check on Resident #1, Nurse #3 stated Resident #1 could not tell us or point to any area that would indicate she was in pain. When attempting to do exercises on the right lower extremity she would draw back and knowing that she had fallen the PT stopped her treatment and Resident #1 went back to sleep and rested well for about an hour. After about an hour Occupation Therapy (OT) went into work with Resident #1 and when the OT attempted to stand Resident #1, she would not bear any weight on her right leg. Nurse #3 stated the Nurse Practitioner (NP) was contacted and an order for Xray was obtained. Nurse #3 confirmed that both times that she and the therapist were in her room, Resident #1 had no signs of pain, no moaning or grimacing or guarding. She stated that when we would lift her right leg, she would pull it back towards the bed. Nurse #3 also confirmed that there was no external/internal rotation or leg shortening noted to Resident #1's right lower extremity. Review of a physician order dated 02/24/23 read, Xray to right femur, right knee, right tibia/fibula (bones in lower leg), and right hip and pelvis. MA #2 was interviewed via phone on 3/10/23 at 4:15 PM and revealed she was assigned to work with Resident #1 on 02/24/22 from 7:00 PM to 7:00 AM. MA #2 stated when she arrived on shift Nurse #3 notified her Resident #1 had fallen on 02/23/22 and there was an order to obtain x rays that evening. MA #2 recalled around 8:00 PM the X-ray company arrived to obtain the X-rays to Resident #1's hip and right lower extremity. MA #2 stated following the X-ray Resident #1 appeared to be restless she was moaning and grimacing from the movement required to obtain the X-ray and MA #2 administered Tylenol for	F 684		

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F 684	Continued From page 7	F 684		

discomfort. MA #2 stated the Tylenol helped her "simmer" down and she seemed OK the remainder of the shift. MA #2 stated when the technician arrived to obtain the X-ray, she gave them the correct fax number to fax the results to. MA #2 stated during her shift she did not see the results arrive via fax and therefore reported to Nurse #4 when she arrived on shift on 02/25/23 at 7:00 AM.

Nurse #4 was interviewed via phone on 03/09/23 at 5:07 PM who confirmed that she cared for Resident #1 on 02/25/23 from 7:00 AM until she discharged to the Emergency Room (ER). Nurse #4 stated that she had assisted in the admission process for Resident #1 on 02/22/23 and was aware that she had a surgical repair of a left hip fracture. During report on 02/25/23 she was told that Resident #1 had fallen at the same time the phone at the nurse's station rang and it was the Assistant Director of Nursing (ADON) asking if I had seen the Xray report for Resident #1. Nurse #4 stated she turned to the fax machine and pulled the report off the machine that had been faxed over at 5:31 AM and showed an acute right hip fracture. Nurse #4 stated she hung up with the ADON and immediately called the on-call provider and got an order sent to Resident #1 to the ER for evaluation and treatment. Nurse #4 stated that Resident #1 did not return to the facility.

The Xray Alert from the mobile Xray company dated 02/24/23 and reported via fax confirmation on 02/25/23 at 5:31 AM read in part, acute right hip intertrochanteric fracture.

A physician order dated 02/25/23 read, send Resident #1 to the ER post fall with right hip

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fracture.

The Nurse Practitioner (NP) was interviewed via phone on 03/09/23 at 5:41 PM who confirmed that when she arrived at the facility on 02/24/23 she learned of Resident #1's fall on 02/23/23 with no injury noted. The NP stated that due to Resident #1's advance dementia her examination was very limited. She stated Resident #1 was sitting up in her wheelchair in her room with her family at bedside and was pleasantly confused. She stated at the time she had no verbal or nonverbal signs of any pain or discomfort, she allowed me to listen to her heart and examine her lower extremities. After the examination the NP stated she had no concerns of any hip injury or fracture as the patient appeared at her baseline, she was anxious but the family at bedside indicated that was normal. The NP further stated she had discontinued her narcotic pain medication because she was not able to ask for it and scheduled Tylenol to cover any discomfort Resident #1 might have had from her left hip fracture that she was admitted with.

The DON was interviewed via phone on 03/13/23 at 11:22 AM. The DON stated that at the time of Resident #1's fall on 02/23/23 she had only been the DON for three days. She stated that at the time of the fall she was not aware of the facility's policy and procedures regarding falls. The DON stated that she had since learned that following a fall of a resident the nurses would conduct a physical assessment to assess for any pain or visible injuries, the nurse should check all extremities and if the resident was not complaining of any pain, then range of motion should be conducted as well. The DON stated that "ideally a resident should not be moved off

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F 684	Continued From page 9 the floor until they are assessed by a nurse" she added that Resident #1's husband was attempting to move Resident #1 and had to be redirected to wait for the nurse. The Administrator was interviewed via phone on 03/13/23 at 12:32 PM who stated that when Nurse #1 went to assess Resident #1 he though that she did what she felt was best for resident at the time. He stated that he believed an assessment was done but "the thoroughness of the assessment was probably cut short due to the family member's" involvement. The Medical Director (MD) was interviewed via phone on 03/13/23 at 11:39 AM who stated that after a fall in the facility the staff should render first aid, return the resident to comfortable position, and then notify the provider of the fall. At the time a fall, the resident should be assessed by a nurse or medical provider ideally before they are moved off the floor, to including checking for bleeding, moving extremities to check for pain or discomfort or any other visible injuries. The MD stated if there was obvious injury like deformity to a hip then that would be addressed on the floor or at the site of the fall before attempting to move the resident. He further stated that Resident #1 was severely demented and the staff would rely on grimacing, moaning, or guarding as indicators of pain as Resident #1 was not able to verbalize her pain or discomfort.	F 684		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and	F 810		3/14/23

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F 810	Continued From page 10 appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide adaptive built-up utensils as ordered for 1 of 1 resident reviewed (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/27/23 with diagnoses that included Parkinson's disease. The admission comprehensive Minimum Data Set (MDS) was not completed. Review of a physician order dated 03/08/23 read; built up utensils for all meals. An observation and interview were conducted with Resident #3 on 03/09/23 at 1:04 PM. Resident #3 was sitting in her wheelchair next to her bed. Her lunch tray was in front of her. Resident #3 stated "I have eaten all that I want." Her meal tray was noted to have a regular spoon, fork, and knife. Resident #3 was observed to have eaten her dessert which was a piece of care and her mashed potatoes. Her two slices of roast beef remain untouched on her tray. Nurse Aide (NA) #1 and NA #2 were interviewed on 03/09/23 at 1:10 PM and both confirmed that they were the two NAs on the unit, and both were in a room assisting another resident out of bed when the lunch trays arrived at the unit. Both NA #1 and NA #2 confirmed that they did not	F 810	Resident #3 silverware was reviewed and in place on 3/14/23. All residents have the potential to be affected. On 3/13/2023, a review of all residents with adaptive built up utensils were reviewed to ensure equipment was available for use. No other deficient practice was observed. On 3/15/23, the Director of Nursing/Designee educated all nursing staff, department managers and dietary staff on proper tray setup to ensure resident who have orders with adaptive built up silverware as ordered. Education was completed on 3/15/23. New staff will be educated upon hire, including new agency staff. The Dietary Manager or designee will review 2 meal trays per day, (5) five times per week for 12 weeks to ensure adaptive built up silverware is available per physician's orders. The Dietary Manager will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 3/16/2023.	

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AUTUMN CARE OF CORNELIUS	**19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031**

(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 810	Continued From page 11	F 810		

assemble or deliver Resident #3's lunch tray and neither NA was aware of which staff member had assembled and delivered Resident #3's lunch tray. NA #1 and NA #2 were asked how the staff would know that Resident #3 required built up utensils and NA #1 replied "it is on the tray ticket" and then proceed to pick up a built-up spoon and fork that were wrapped in a napkin lying on a tray on top of the tray line (small kitchen area on each unit). NA #1 stated "these are Resident #3's and who ever delivered her tray just did not put them on the tray."

The Activity Director (AD) was interviewed on 03/09/23 at 4:02 PM who confirmed that she had assembled and delivered Resident #3's lunch tray. She stated that NA #1 and NA #2 were in a room assisting another resident and no one was there to deliver meal trays, so she started to do it. The AD stated she did not see the built up on the utensils on the tray ticket and was not sure if they were available on the tray line during the meal or not. Honestly, "I just did not see the built up utensils on the tray ticket."

The Assistant Director of Nursing (ADON) was interviewed on 03/09/23 at 4:32 PM who stated that all adaptive equipment including built up utensil were delivered to the unit when the meals arrived. She stated that it was the nursing staff responsibility to ensure that Resident #3's meal tray was put together and the correct adaptive equipment was delivered to the resident.

The Administrator was interviewed on 03/09/23 at 6:20 PM who stated that the NAs were responsible for ensuring that the meal tray correctly matched the tray ticket and that all adaptive equipment was included on the meal

Provider's Plan of Correction:

The Administrator is responsible for this plan of correction. Compliance date is 3/14/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING ______ B. WING ______	C 03/13/2023

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F 810	Continued From page 12 tray before it was delivered to the resident. He stated he believed it was an oversight on the AD part and she should have read the tray ticket before it was delivered to Resident #3.	F 810		