STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 06/22/2023

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AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/19/23 through 6/22/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8UFB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/19/23 through 6/22/23. Event ID#8UFB11. The following intakes were investigated NC0020359 6 of the 6 complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the behavior section and failed to code the medication section on the Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for MDS accuracy. (Resident #34, and #39). Findings included: 1. Resident #34 was admitted to the facility on 7/26/19 with a diagnosis of dementia, psychotic disturbance, mood disturbance and anxiety. A nursing progress note dated 6/4/23 read in part; "Resident had been yelling mom for approximately one hour, several attempts to	F 641	*A modification of the Minimum Data Set (MDS) for Resident #34 was completed. It now reflects Resident #34's behavior of calling out. A modification of the MDS for Resident #39 was completed. It now reflects the Rifaximin as an antibiotic, it reflects that Tramadol was given and that the Quetiapine was given. These modifications were completed June 22, 2023. *A 30 day lookback of MDSs was completed by the MDS nurse on July 10, 2023 and validated by the Regional Clinical Reimbursement Specialist. The areas of antibiotics, opioids, and	7/14/23

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

Electronically Signed | 07/14/2023

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F 641	Continued From page 1 redirect without positive results." Resident #34's quarterly Minimum Data Set (MDS) assessment dated 6/4/23 revealed Resident #34 had not exhibited any behaviors during the assessment period. An interview was conducted on 6/22/23 at 12:07 PM with the facility's MDS Nurse. The MDS Nurse stated that she was responsible for coding resident behaviors on the MDS. The MDS Nurse stated that any behavior that is on the care plan would not need to be documented on the MDS if it is a continued behavior and not a change. The MDS Nurse stated only new behaviors would be coded on the MDS. The MDS Nurse stated that she would become aware of new resident behaviors during the facilities weekly meetings that she would attend, and she would also get a report about a new behavior being documented in the progress note. An interview was conducted with the facility's Director of Nursing (DON) on 6/22/23 at 12:55 PM who stated that if behaviors were present, then behaviors should have been coded on the MDS. 2-a. Resident #39 was admitted to the facility on 11/15/19 with re-entry from a hospital on 1/23/21. Her cumulative diagnoses included anxiety disorder, manic depression, bipolar disorder, psychotic disorder, and a neurocognitive disorder with Lewy bodies. Lewy body dementia is a disease associated with abnormal deposits of a specific protein in the brain. The deposits, called Lewy bodies, affect chemicals in the brain which can lead to problems with thinking, movement,	F 641	psychotropics was audited for accuracy. There were two issues noted that have since been modified. *The MDS nurse was reeducated on Section N and E by the Regional Clinical Reimbursement Specialist on July 12, 2023. *Each MDS completed will be audited by the Director of Nursing/designee for three months for accuracy. These audits will be reviewed by the Quality Improvement committee for further recommendation.	

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F 641	Continued From page 2	F 641		

behavior, and mood.

A review of Resident #39's physician orders included the following medications, in part:
--550 milligrams (mg) rifaximin (an antibiotic) to be given as one tablet by mouth two times a day related to cirrhosis of the liver (Start date 10/23/20).
--50 mg tramadol (an opioid pain medication) to be given as ½ tablet by mouth every 12 hours as needed for pain (Start date 10/13/21).
--200 mg quetiapine (an antipsychotic medication) to be given as one tablet by mouth every morning and at bedtime related to schizoaffective disorder, bipolar type (Start date 2/7/22; Discontinued 6/19/23).

Documentation on Resident #39's June 2023 Medication Administration Record (MAR) revealed the resident received rifaximin on 7 out of 7 days, tramadol on 5 out of 7 days, and quetiapine on 7 out of 7 days from 6/9/23 through 6/15/23.

A review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated 6/15/23 was conducted. The "Medications" section of the MDS assessment indicated Resident #39 received an antipsychotic, antianxiety, antidepressant, anticoagulant, and diuretic medication on 7 out of 7 days. However, the MDS did not indicate the resident also received an antibiotic (rifaximin) and opioid medication (tramadol) during the 7-day look-back period. While the Medications section of the MDS indicated Resident #39 received an antipsychotic medication on 7 out of 7 days during the look back period, the Antipsychotic Medication Review of this section inaccurately reported the resident

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did not receive an antipsychotic medication since her last assessment.

An interview was conducted on 6/22/23 at 11:33 AM with the facility's MDS Nurse. During the interview, the MDS Nurse was asked to review the Medications section of Resident #39's quarterly MDS assessment dated 6/15/23. The nurse confirmed this section did not report Resident #39 received either an antibiotic or an opioid medication during the 7-day look-back period. When asked, the MDS Nurse stated she was not aware rifaximin was an antibiotic or that tramadol was classified as an opioid medication. The nurse confirmed a medication classified as an antibiotic or as an opioid needed to be reported as such in the Medications section of the MDS. Upon further review of the 6/15/23 MDS assessment, inquiry was made as to the inaccuracy of the "Antipsychotic Medication Review" of this section. When asked, the MDS nurse reported she had the correct information on her reference sheet but made an error completing the Antipsychotic Medication Review. The MDS Nurse stated the Antipsychotic Medication Review should have reported an antipsychotic was received on a routine basis only, no gradual dose reduction (GDR) was attempted, and the date her physician documented a GDR as clinically contraindicated.

An interview was conducted with the facility's Director of Nursing (DON) on 6/22/23 at 11:50 AM. During the interview, concerns regarding the accuracy of the Medications section of Resident #39's MDS assessments were discussed. The DON stated, "I would agree they (the errors on the MDS) need to be corrected."

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2-b. Resident #39 was admitted to the facility on 11/15/19 with re-entry from a hospital on 1/23/21. Her cumulative diagnoses included anxiety disorder, manic depression, bipolar disorder, psychotic disorder, and a neurocognitive disorder with Lewy bodies. Lewy body dementia is a disease associated with abnormal deposits of a specific protein in the brain. The deposits, called Lewy bodies, affect chemicals in the brain which can lead to problems with thinking, movement, behavior, and mood.

A review of Resident #39's physician orders included the following medications, in part:
--550 milligrams (mg) rifaximin (an antibiotic) to be given as one tablet by mouth two times a day related to cirrhosis of the liver (Start date 10/23/20).
--50 mg tramadol (an opioid pain medication) to be given as ½ tablet by mouth every 12 hours as needed for pain (Start date 10/13/21).

Documentation on Resident #39's March 2023 Medication Administration Record (MAR) revealed the resident received rifaximin on 7 out of 7 days and tramadol on 3 out of 7 days from 3/9/23 through 3/15/23.

A review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated 3/15/23 was conducted. The "Medications" section of the MDS assessment indicated Resident #39 received an antipsychotic, antianxiety, antidepressant, anticoagulant, and diuretic medication on 7 out of 7 days. However, the MDS did not indicate the resident also received an antibiotic (rifaximin) and opioid medication (tramadol) during the 7-day look-back period.

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F 641	Continued From page 5 An interview was conducted on 6/22/23 at 11:33 AM with the facility's MDS Nurse. During the interview, the MDS Nurse was asked to review the Medications section of Resident #39's quarterly MDS assessment dated 3/15/23. The nurse confirmed this section did not report Resident #39 received either an antibiotic or an opioid medication during the 7-day look-back period. When asked, the MDS Nurse stated she was not aware rifaximin was an antibiotic or that tramadol was classified as an opioid medication. The nurse confirmed a medication classified as an antibiotic or as an opioid needed to be reported as such in the Medications section of the MDS. An interview was conducted with the facility's Director of Nursing (DON) on 6/22/23 at 11:50 AM. During the interview, concerns regarding the accuracy of the Medications section of Resident #39's MDS assessments were discussed. The DON stated, "I would agree they (the errors on the MDS) need to be corrected."	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide feeding assistance (Resident #54) for 1 of 5 residents who were dependent on staff for their activities of daily living needs (ADL) needs.	F 677	*Resident #54's care plan and kardex were reviewed to ensure her eating/nutrition status was accurately documented. This was completed by the Director of Nursing on July 10, 2023. Nurse Aide #3 was reeducated on kardex	7/14/23

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F 677	Continued From page 6 Findings included: 1. Resident #54 was admitted to the facility on 2/17/21 with a diagnosis which included vascular dementia, cerebral infarction due to embolism, hemiplegia, weakness, and dysphagia. Review of Resident #54's annual Minimum Data Set dated 4/18/23 revealed that she was severely cognitively impaired and required extensive assistance with eating. The Care Area Assessment worksheet dated 4/18/23 read in part; Resident #54 received a regular, mechanical soft with thin liquids diet daily requiring assistance with meals. A review of Resident #54's care plan dated 4/18/23 included a focus are for self-care deficits with an intervention which required extensive one person feeding assistance. Review of Resident #54's Kardex form (a desktop file system that gives a brief overview of each patient and is updated every shift), revealed a care area for Eating/Nutrition that indicated extensive one person feeding assistance for eating. On 6/21/23 at 8:26 AM Resident #54 was observed sitting upright in bed and was eating toast independently. At 8:35 AM an interview and second observation were conducted with Resident #54 who was eating oatmeal with her fingers. Her silverware was wrapped in a napkin secured by an adhesive wrap. Nurse Aide (NA) #3 entered Resident #54's room to assist the other resident in the room and was asked if Resident #54 received assistance with eating. NA #3 stated, "no she is fine, unless something had	F 677	utilization and the kardex's content. Nursing Aide #3 also was reeducated on how to properly set up a tray. The education was done by the Staff Development Nurse on July 11, 2023. *The Director of Nursing completed an audit of all current resident kardexes to ensure that the level of assistance for eating was accurately documented. This audit was completed July 10, 2023. No issues were noted. *The nursing department staff were reeducated regarding proper meal tray set up as well as where and how to access each resident's kardex. The nursing staff were also reeducated on reporting changes in the level of assistance needed for activities of daily living (ADLs) to licensed staff. This education was completed by our Staff Development Nurse on July 14, 2023. *Newly admitted residents and readmissions will have their kardex audited to ensure the appropriate level of meal assistance is reflected. The 24 hour clinical report will be audited Monday through Friday to identify any changes in the level of assistance needed for eating. An audit will be completed of five random staff member to ensure each person is aware of the kardex, is using the kardex and that they can identify the resident's level of eating assistance. An audit of three random residents that require assistance with eating will be complete to ensure proper assistance is being provided. Auditing will be done weekly for twelve weeks by the Director of Nursing/designee. Results will be taken	

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changed." Resident #54 did not receive assistance with her breakfast meal.

An interview was completed with NA#3 on 6/21/23 at 8:43 AM who stated that she had worked at the facility for almost a year and had worked with Resident #54 a couple of times. NA #4 stated that she had never assisted Resident #54 with feeding assistance. NA #3 was asked how she would know if a resident needed assistance with eating and she stated Resident #54 eats by herself, but she would know if a resident needed assistance by being told by another NA or Nurse. NA #3 was asked if there were any other methods to know if a resident needed assistance and she stated that she would walk the hall and look at the residents. NA #3 was how she sets up a meal tray and she stated that she would set the tray down and open the juice and put a straw in the juice. NA #3 was informed that Resident #54 did not have her silverware opened and she stated that she had forgotten to open her silverware but eventually Resident #54 would eat with her hands. NA #3 was asked if she would check a resident Kardex (a desktop file system that gives a brief overview of each patient and is updated every shift) and NA #3 stated she would do that only for transferring needs but not for specific care.

An interview with NA #1 was conducted on 6/21/23 at 5:23 PM who stated that Resident #54 required one on one assistance with feeding. NA #1 stated that Resident #54 will hold her food in her mouth and needs reminders to swallow her food.

A joint interview was conducted with the Administrator and the Director of Nursing on

to the Quality Improvement Committee for further recommendations.

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F 677	Continued From page 8 6/22/23 at 12:55 PM. The Administrator stated that it was her expectation if a resident is care planned as needing assistance with meals, they should be getting assistance.	F 677		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		7/14/23

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including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 10 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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F 867	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification dated 11/4/21 for one deficiency in the area of Activities of Daily Living (ADL) for dependent residents. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is crossed referenced to: F677 - Based on record review, observation and staff interviews the facility failed to provide feeding assistance (Resident #54) for 1 of 5 residents who were dependent on staff for their activities of daily living needs (ADL) needs. During the recertification survey of 11/4/21 the facility failed to provide personal care for 2 of 3 residents related to incontinence care and nail care. An interview was conducted with the Administrator on 6/22/2023 at 12:55 PM. The Administrator stated although ADL care had been cited on the last annual survey on 11/4/21 it was for a different ADL concern. The Administrator stated that when we have a citation, we will write a Plan of Correction (POC) for that concern and work through it and conduct our auditing until the Quality Improvement (QI)committee determines it	F 867	*The Quality Assurance Process was reevaluated by the Administrator and the Director of Nursing on July 11, 2023 including monitoring for F641 and F677. The Administrator and the Director of Nursing reviewed the Federal Regulations for these F tags also on July 11, 2023. *On July 11, 2023 the Administrator audited our Quality Assurance and Performance Improvement Committee minutes for the past six months to identify any needs for additional monitoring. No areas were found to need additional monitoring. *The Administrator has been reeducated by the Regional Vice President of Operations concerning the Quality Assurance and Performance Improvement Program Policy. The Director of Nursing was reeducated by the Administrator concerning the Quality Assurance and Performance Improvement Program Policy. Both were educated on July 11, 2023. *The Regional Vice President of Operations or Regional Director of Clinical Services will review the Administrator's Quality Assurance and Performance Improvement Committee minutes monthly for three months to ensure systems and processes are being monitored and proper follow up is completed. If any discrepancies are noted, further action will be implemented by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(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 867	Continued From page 12 is no longer necessary.	F 867		