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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/23/25 through 1/24/25. Event ID# MN3611. The following intakes were investigated NC00226056 and NC00225919. 1 of 3 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F684 at scope and severity of G. Non-noncompliance began on 1/5/25. The facility came back in compliance effective 1/9/25.	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 and staff and physician interviews, the facility failed to complete and document ongoing comprehensive assessments for a resident after an unwitnessed fall and to have effective systems in place for communicating changes in condition. Resident #1 was severely cognitively impaired and had an unwitnessed fall from bed on 1/5/2025. Resident #1 was assessed by a nurse immediately after the fall, with no pain or injury noted at that time.	F 684	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/10/2025

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This was the only documented nursing assessment. During the 7:00 AM to 3:00 PM shift on 11/6/2025, a nurse aide observed Resident #1 wince when she was turned on her left side during care, and this was not reported to a nurse. On 1/6/2025, between 2:20 PM and 3:00 PM, the Physical Therapist (PT) and Occupational Therapist (OT) went to work with Resident #1, and she did not want to get out of bed and complained of pain in her lower right extremity after sustaining a fall over the weekend. OT #1 pulled back the covers and noted Resident #1's right lower extremity was externally rotated and flexed. OT #1 indicated this observation was reported to a nursing staff member who reported it to the Assistant Director of Nursing. No physical assessment was completed. On 1/6/2025, at approximately 6:00 PM, a family member reported to the nurse that Resident #1 was "hurting badly" and that Resident #1 would not allow the nurse to touch her leg. The physician was contacted and ordered an x-ray. The family member declined this and asked for Resident #1 to be sent to the hospital. Resident #1 was diagnosed with a closed right hip fracture, which required TFN surgery (trochanteric fixation nail, an orthopedic nail to stabilize the hip joint), and a right closed clavicle fracture that was non-operable. The failure occurred for 1 of 3 residents reviewed for professional standards (Resident #1).

The findings included:
Resident #1 was readmitted to the facility on 11/12/2024 and discharged on 1/6/2025 with diagnoses of atrial fibrillation, severe dementia, and emphysema with chronic obstructive pulmonary disease.

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The physician's order dated 11/20/2024 stated to administer Acetaminophen Extra Strength 500-milligram tablets by mouth. Give 2 tablets at 8:00 AM, 12:00 PM, and 8:00 PM for pain.

Review of the care plan dated 12/4/2024 revealed Resident #1 was at risk for falls due to muscle weakness. Interventions were to anticipate her needs.

Review of the quarterly Minimum Data Set dated 12/16/2024 revealed Resident #1's cognition was severely impaired. She required partial assistance to transfer from the chair to the bed and supervision to walk ten feet. She was incontinent with both bowel and bladder. She had the ability to understand and speak clearly and was understood by others. She received speech therapy, occupational therapy, and physical therapy during the review period.

Review of the Event Fall Report dated 1/5/2025 completed by Nurse #1 revealed that Resident #1 had an unwitnessed fall on the floor with no injury in her room. She had no pain after the fall. Range of motion was without pain. No rotation, deformity, or shortening of extremity was observed. Right and left upper extremities had a strong grasp, and right and left lower extremities had strong movement. Resident #1's monitoring was continued; there were no complaints of pain or discomfort.

Record review of the post-fall huddle dated 1/5/2025 indicated the fall was at 10:11 AM per Nurse #1 and the last time toileting was at 9:00 AM, and she was clean and dry at the time of the fall. Blood pressure was 122/60 with a pulse of 99 lying down, 124/63 with a pulse of 87 sitting up,

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and 124/64 with a pulse of 88 standing. The physician and responsible party were contacted.

During a telephone interview on 1/23/25 at 8:07 PM, Nurse #1 stated she was standing in the hall administering medications and at about 10:00 AM, NA #1 reported that Resident #1 was on the floor lying on her back. Nurse #1 asked Resident #1what she was doing, and she said she "wanted to go to bed." She indicated she was not in pain, and each extremity was moved without discomfort. Nurse #1 assisted Resident #1 to bed with the gait belt. The physician and the responsible party were notified by telephone. Resident #1 was monitored for pain, and each time she denied experiencing any pain. Her responsible party came and sat with her.

A telephone interview with Nursing Assistant (NA) 1 on 1/24/2025 at 10:08 AM revealed that on 1/5/2025 at 9:30 AM, she went into the room to remove Resident #1's breakfast tray. She was sitting in her wheelchair with her blanket on her lap watching television. NA #1 stated she continued her rounds, and when she returned at about 10:00 AM, Resident #1 was lying on the floor on top of her blanket. NA #1 asked Resident #1 how she got to the floor, and she said she wanted to lie down. She stated Nurse #1 was notified of the fall. Resident #1's blood pressure and pulse were taken, and all values were at Resident #1's baseline. Nurse #1 came into the room and asked Resident #1 if she was in pain, and she denied pain. Nurse #1 assessed the upper and lower extremities for movement, and then together they used the gait belt and contact assistance to help Resident #1 off the floor. Resident #1 was assisted to bed. NA #1 indicated she checked on Resident #1 often. She continued

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to deny any pain or injury.

During a telephone interview on 1/24/2025 at 8:15 AM, Nurse #2 revealed she had worked on 1/5/2025 during the 3:00 PM - 11:00 PM shift with Resident #1. She revealed she made her rounds, and Resident #1 had no complaints of pain. Resident #1's family was visiting and stayed with her into the evening. There were no complaints of pain during this shift.

A telephone interview on 1/24/2025 at 8:14 AM revealed that Nurse #3 indicated she worked on 1/5/2025 from 11:00 PM to 7:00 AM. Nurse #3 stated she did not remember Resident #1 and continued that she worked in various buildings. She stated that if she had a resident who had pain, she would assess and medicate as ordered. For some people, acetaminophen worked; if they were still in pain, she would call the doctor and report the excessive pain. She documented medications on the medication administration record, and if there was an event, she documented it in the notes.

A telephone interview on 1/24/2025 at 10:18 AM with NA #3 stated she worked on 1/5/2025 from 11:00 PM to 7:00 AM. She did not remember Resident #1 experiencing pain. She reported that she had provided incontinence care between 5:00 AM and 6:00 AM and Resident #1 did not report any pain at that time. She did not notice anything different during the incontinence care.

During an interview on 1/23/2025 at 2:18 PM, NA #4 indicated she cared for Resident #1 on 1/6/2025 during the 7:00 AM through 3:00 PM shift. Resident #1 was cleaned up for breakfast and she was fine. While she was lying flat, she

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had pulled herself up in bed and her brief was checked. She was not hungry for breakfast, and normally, she sat in the wheelchair at 9:00 AM. Resident #1 said, "No." She was left in bed. A therapist came in and said to leave her in bed. NA #4 told the Medication Aid that Resident #1 wasn't getting up as usual. Resident #1 had a better appetite at lunch. She didn't say she was in pain during the shift. Resident #1 sat in her bed with her eyes closed and never asked for pain medication.

An interview on 1/23/2025 at 2:32 PM with NA #6 indicated on 1/6/2025 assisted NA #4 with a brief change with Resident #1. During care, he noticed her leg was propped up on a pillow, and he did not notice anything unusual. He indicated he rolled her to her left side. Resident #1 didn't yell in pain at all; he noted she did wince. He stated he didn't see anything to report.

An interview on 1/24/2025 at 12:00 PM, Speech Therapist #1 stated she saw Resident #1 for swallowing and cognition. On the morning of 1/6/2025, she was at her baseline. Resident #1 was severely impaired and verbalized her wants, needs, and pain.
Record review of the Physical Therapist (PT) 1 note dated 1/6/2025 at 3:40 PM revealed in part, "Patient's skin intact before and after treatment. Patient stated she did not want to get out of bed today and complained of pain in her lower right extremity after sustaining a fall over the weekend. The Occupational Therapist #1 notified nursing of the patient's complaint of pain in her right lower extremity and the right lower extremity being externally rotated and flexed."

Record review of the Occupational Therapist

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(OT) 1 note dated 1/6/2025 at 4:35 PM revealed that she checked Resident #1's bilateral lower extremities for edema/swelling and noted that the right lower extremity was externally rotated at the hip and the right hip/knee was flexed. She attempted to straighten the right lower extremity, and the patient yelled out in pain with movement of the right lower extremity. She notified the medication technician, and the medication technician notified the Assistant Director of Nursing (ADON), and the ADON stated she documented in the book for the Nurse Practitioner to see Resident #1.

During the interview on 1/23/2025 at 1:08 PM, Physical Therapist #1 (PT) revealed that on 1/6/2025, between 1:30 PM and 2:00 PM, Resident #1 declined to get out of bed for therapy. Electric Stimulation (E-Stim) therapy (a type of electronic therapy used to stimulate the muscles with a mild electrical current for pain control and muscle strengthening) was applied to both thighs. She did not observe an injury to the right hip. She returned between 2:20 PM and 3:00 PM, accompanied by Occupational Therapist #1 (OT). Resident #1 stated she didn't feel good. OT #1 pulled the covers back and observed her right leg on a pillow with the knee bent and the hip externally rotating out from the body. The OT stated she went to touch the leg, but Resident #1 didn't want her leg touched.

During an interview on 1/23/2025 at 1:30 PM, Occupational Therapist #1 (OT) stated that on the morning of 1/6/2025 at 10:30 AM, Resident #1 said she wanted to stay in bed. OT #1 applied the E-Stim to both of her upper arms and asked her why she didn't feel well. OT #1 checked her blood pressure, temperature, and pulse. When she

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returned to remove the E-Stim between 2:30 PM and 3:00 PM, OT #1 thought Resident #1's stomach looked distended, and she pulled the covers back. The right leg was on a pillow, and it was externally rotated with the knee bent. She touched the foot, and Resident #1 grimaced. She then went to the nursing desk and asked Medication Aide (MA) #1 to look at Resident #1's right leg and explained the deformity of the right leg. OT #1 stated she stayed in Resident #1's room and watched MA #1 speak to the Assistant Director of Nursing (ADON). OT #1 revealed she reported to the Rehabilitation Therapy Director what was observed and reported to MA #1. She mentioned she reported to the MA because she was the nursing staff on the hall.

During a telephone interview on 1/24/2025 at 10:45 AM, MA #1 stated that on 1/6/2025, Resident #1 wanted to stay in bed; this was not unusual. In the afternoon, a therapist came and stated that Resident #1 was in pain. MA #1 reported that Resident #1 was in pain to the ADON, and she medicated her with acetaminophen.

During an interview on 1/24/2025 at 12:25 PM, the Rehabilitation Therapy Director indicated that OT #1 reported the right externally rotated hip and the pain of Resident #1 to MA #1 on the medication cart, and that she had observed her report to the ADON. No other action was taken by the therapy department.

During a telephone interview on 1/24/2025 at 2:46 PM, the ADON revealed she was the nurse overseeing the hall for MA #1. MA #1 reported to her on 1/6/2025 at 3:00 PM that Resident #1 had pain and was medicated with acetaminophen.

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She revealed that chronic pain was not unusual for Resident #1. She entered the information in the physician's book for the following day. The ADON revealed during the morning report (1/6/2025) for Resident #1 that there was no report of pain during the night and no report that there was any bruise or change of condition that required an assessment. The ADON further stated had MA #1 reported there was a change in pain level or change in condition, then she would have assessed the change in condition. The ADON verbalized that MA #1 did not report OT #1 had observed the change of condition.

A follow-up telephone interview was conducted on 1/24/2025 at 3:16 PM with MA #1, who indicated that OT #1 stated Resident #1's leg was painful. MA #1 explained that OT #1 verbalized she was not getting her up to do therapy. MA #1 stated she reported to ADON that Resident #1 wasn't getting up today and that she had given her acetaminophen for pain. MA #1 stated she did not know there was anything wrong. MA #1 indicated she was not a nurse and did not do physical assessments.

During a telephone interview on 1/24/2025 at 8:15 AM Nurse #2 indicated she returned to work on 1/6/2025 for the 3:00 PM - 11:00 PM shift, and there was no reported severe pain from the previous shift. Nurse #2 stated that at about 6:00 PM, two family members came to visit Resident #1. One family member said that Resident #1 was hurting badly. She stated she went to assess, and Resident #1 said, "Don't touch my leg." She left the room to call the physician and got the x-ray order. She stated she went back to tell the family, and the family said to send her to the hospital. She stated she notified the physician

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and sent her to the hospital. Resident #1 did yell as Emergency Medical Services were putting her on the stretcher. Nurse #1 stated that each time Resident #1 was asked if she had pain, she denied or ignored the question.

A review of the Emergency Medical Services (EMS) report revealed paramedics arrived at the facility at 8:56 PM, and Resident #1 was assessed by EMS at 9:08 PM. Resident #1 was transported non-emergently to the emergency room and arrived at 9:23 PM. Documentation revealed Resident #1 was lying in her bed with cognition alert and oriented, with a Glasgow Coma Scale (GCS, a tool used to assess traumatic brain injury) intact. Resident #1 had a fall the previous day, and the complaint was right hip, right thigh, and right shoulder pain. The report stated, "While enroute, a baseline set of vitals were obtained with nothing remarkable of note. The patient was carefully monitored and assessed throughout transport. All subsequent vitals were concurrent with baseline." Vital signs and cognition were baseline. No pain medications were administered.

Record review of the hospital emergency report dated 1/6/2025 revealed Resident #1 had a right closed clavicle fracture, non-operable, and a closed right hip fracture. Orthopedic surgery was consulted. On 1/7/2025, Resident #1 underwent TFN surgery (trochanteric fixation nail, an orthopedic nail to stabilize the hip joint) to the right hip.

During an interview on 1/24/2025 at 4:50 PM, the Director of Nursing stated that in the electronic medical record software for event reporting, there was a box that needed to be triggered to

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schedule the post-monitoring after a fall, and that did not happen. The therapist did not communicate directly with the nurse the urgency of the situation, which resulted in a delay in treatment.

A telephone interview on 1/24/25 at 1:29 PM with the Medical Director indicated that it was possible for a person to have a fracture and not experience pain. He was notified of the fall on 1/5/2025, and there was no injury or severe pain. He stated that if the resident had neurological changes or uncontrolled pain, he expected the resident would be sent out immediately.

The facility provided the following action plan with a completion date of 1/9/2025.
1. Corrective action for residents(s) affected by the alleged deficient practice:
Upon discovery of the occurrence facility implemented the following quality assurance measures: On 1/6/2025 Resident #1 was assessed for pain with new orders received to obtain x-rays and ultimately sent to the ED per family request. 1/7/2025 Right intertrochanteric femur fracture open reduction internal fixation with long intramedullary nail was completed.
.
2. Corrective action for residents (s) with the potential to be affected by the alleged deficient practice: To identify other residents with this same issue: on 1/7/2025 the Assistant Director of Nursing reviewed current residents who have the potential to transfer without assistance to ensure proper interventions are in place. All alert and oriented residents were interviewed regarding the presence of pain and needs being met with no negative findings. Non-interviewable residents

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were assessed for signs and symptoms of pain with no negative findings. 1/7/2025 Staff Development Coordinator completed a 30 day look back of current resident's pain scale to ensure any pain had been treated and treatment was effective. Non alert residents were observed by a licensed nurse for signs and symptoms of pain. No other residents were identified.

3. Measures/Systemic changes to prevent recurrence of deficient practice. To prevent this from recurring: on 1/7/2025 all staff were interviewed to identify if there were any concerns of residents reporting pain that had not been assessed by a licensed nurse as well as if there were any concerns of abuse to include neglect with no negative findings. On 1/8/2025 the Director of Nursing or designee educated all staff on reporting acute changes in condition of residents to include use of the STOP & WATCH tool. On 1/8/2025 all licensed nurses were educated on initiating post fall monitoring in the electronic health record, pain assessments, acute changes, head to toe assessments and physician notification of changes.

4. Monitoring procedure was started on 1/8/2025 to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and sustained: To monitor and maintain ongoing compliance: Beginning 1/8/2025 the Director of Nursing or designee will review the record of all residents that have had a fall to ensure a proper assessment has been completed and pain is being monitored/treated Monday through Friday for 8 weeks. The Director of Nursing or designee will also complete a follow up head-to-toe assessment of any resident that has had a fall upon being notified.

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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 684	Continued From page 12 The date of correction was 1/9/2025. All above responsibilities were discussed during Ad hoc QAPI completed on 1/8/2025. The corrective action plan was validated on 1/24/2025 by reviewing the education provided to the staff and reviewing the audits of assessment sheet. Staff were interviewed and they confirmed that they received an education on use of the Stop and Watch tool, correctly initiating the post fall monitoring in the electronic health record, pain assessments, acute changes, head to toe assessments and physician notification of changes. The facility's corrective action plan was validated as completed 1/9/2025. Monitoring every resident fall for pain and follow up on any acute pain will be audited daily Monday through Friday for 8 weeks. On Mondays, a review of the weekend will be completed as well to ensure no acute pain was unidentified or followed up on. The Quality Improvement Committee will review the results of the audits for further recommendation weekly for 8 weeks. Should the committee feel that further auditing is necessary, it will be determined at that time. The corrective action plan was validated on 1/24/2025 by reviewing the education provided to the staff and reviewing the audits of assessment sheet. Staff were interviewed and they confirmed that they received an education on use of the Stop and Watch tool, correctly initiating the post fall monitoring in the electronic health record, pain assessments, acute changes, head to toe assessments and physician notification of changes. The facility's corrective action plan was validated as completed 1/9/2025.	F 684		