STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to notify the responsible party (RP) for 2 of 3 sample residents (Resident #1 and Resident #2). Resident #1 who had a downgrade in diet, and Resident #2 who had a dental appointment. The findings included: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was mildly cognitively impaired and required extensive assistance with activities of daily living (ADLs). The resident was coded as being independent with eating, after setting up. Review of Resident #1's care plan dated 6/11/20 revealed Resident #1 had increased nutrition and hydration risk related to [MEDICAL TREATMENT], [MEDICAL CONDITION], and DM II. The goals were for Resident #1 to remain stable, consume a therapeutic diet, and show no signs and symptoms of dehydration. Interventions included encourage compliance with diet guidelines, monitor the need for increased nutrition, assist with meals, and provide supplements. Review of nursing note dated 6/29/20 revealed Resident #1 was coughing during meals, and his diet texture was changed to mechanical soft. Further review of the nursing note did not indicate Resident #1's family was notified of a change in the diet. A review of the Speech Therapist (ST) evaluation and plan of treatment dated 6/29/20 revealed Resident #1 had dysphagia, increased mastication timing and coughing episodes with meals. Further review of the documentation revealed a mechanical soft diet and nectar thick liquids were recommended. The treatment plan did not identify the RP was notified of the diet recommendation. A review of physician's orders [REDACTED].#1 was downgraded to mechanical soft. Further review of physician order [REDACTED].#1's diet was downgraded to pureed texture and nectar consistency. Review of the grievance log revealed a concern dated 7/7/20 on behalf of Resident #1 by his RP. The concern was regarding not being notified of a downgrade in the resident's diet. The concern form further revealed the staff would be in-serviced on notification of RP. An interview with Nurse #1 on 9/2/20 at 2:30 PM revealed Resident #1's diet was changed by ST to Puree on 7/3/20 due to resident holding food in his mouth. She stated she did not notify the RP of the new order. An interview with the Speech Therapist on 9/2/20 at 2:45 PM revealed Resident #1 was having a general decline. She stated his neck was in an upward position, thin liquids were running back to quickly, and he was unable to swallow or chew well enough due to his jaw muscles being tight. She stated she wrote an order for [REDACTED]. An interview with Nurse #2 on 9/3/20 at 3:00 PM revealed the nurse on the floor would notify families of new orders. She stated that Resident #1's RP was difficult to reach and sometimes they were unable to leave a message. She further stated she usually checked during the morning meeting to see if any follow up was needed such as family notification. She could not recall if she had contacted resident #1's RP with regards to the resident's downgraded diet. She stated she was aware that documentation was necessary for it to be considered done. An interview with the Director of Nursing (DON) on 9/3/20 at 11:55 AM revealed that the nurse noting the orders would notify the RP. She stated the Unit Managers would also notify families of new orders. An interview with the Administrator on 9/4/20 at 3:15 PM revealed that RP's should be notified of any changes. He further stated they have a clinical meeting Monday through Friday where they discuss if the nurse was not able to call the family, the unit manager would notify the family of new orders. He revealed he could not say what would be a reasonable time to notify families of changes. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively impaired and required extensive assistance with activities of daily living. Review of facility grievance log revealed a grievance filed on behalf of Resident #2 by Resident #2 family member (responsible party) on 6/16/20. The concern form stated that Primary Representative (PR) was not notified of Resident #2 dental appointment. The concern form further stated the PR called the facility and was put on hold with no one answering or hung up on him. Documentation of facility follow up to the PR concern was staff was educated on phone etiquette. If the needed staff member was busy at the time of call, the staff member answering the phone was to take the message and relay it to the staff member that was needed at the time of call. Resident #2 dental appointment was not addressed in the concern. Review of Resident #2 physician progress notes [REDACTED]. Review of transportation request form dated 06/15/20 revealed Resident #2 had a dental appointment evaluation to be performed by a specialist. The follow-up date was 07/07/20. Review of late entry progress note dated 06/22/20 stated an attempt was made to notify responsible party (RP) regarding plan to replace dentures and left voicemail to return call. An interview was conducted with Nurse #3 on 09/04/20 at11:00 AM revealed she was the Unit Manager. Nurse #3 stated that whoever initiated an order, the nurse or unit manager, would be responsible for notifying a resident's responsible party and the notification should be documented in the progress notes. Interview with the Social Worker on 09/04/20 at 3:50 PM revealed the Transportation Scheduler was responsible for notifying the responsible party of resident's upcoming appointments. An interview was conducted with the Transportation Scheduler on 09/04/20 at 4:05 PM. The Transportation Scheduler stated that she was responsible for notifying Residents responsible party of any residents upcoming appointments as she scheduled them and logged them. She indicated that she was unable to provide the log because she shredded them after use. An interview was conducted with the Director of Nursing (DON) on 09/04/20 at 11:15 AM. The DON stated that responsible party was to be notified of any changes or appointments and that whoever put in the order was responsible for notifying the responsible party.

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