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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	311 W Phifer Street Marshville, NC 28103

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #2). Resident #2 was prescribed a daily low-dose aspirin for stroke prevention. Nursing Assistant (NA) #1 rolled Resident #2 away from her during incontinence care, and Resident #2 fell out of bed sustaining a laceration to her forehead, which necessitated 8 sutures to close. The findings included: Resident #2 was admitted to the facility 2/21/2019 with diagnoses including epilepsy, stroke, and hypertension.Review of the medical record revealed a physician order dated 12/3/24 for aspirin 81 milligrams administered daily. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #2 to be severely cognitively impaired. The MDS documented limited range of motion on one side of her upper body and for both legs. The MDS documented Resident #2 required substantial assistance with bed mobility and was dependent on staff for transfers. A nursing note dated 8/1/25 at 6:40 AM written by Nurse #1 documented NA #1 called Nurse #1 to Resident #2's room, and she found Resident #2 on the floor beside the bed face down in a puddle of blood. Nurse #2 documented she performed an assessment on Resident #2 prior to assisting her back into bed with a mechanical lift. Nurse #1 documented Resident #2 had a laceration to the right forehead, approximately 4 inches long, as well as an abrasion to the left knee. The physician and resident representative were notified, and orders were received to send Resident #2 to the hospital. A phone interview was conducted with NA #1 on 8/20/25 at 8:58 AM. NA #1 described Resident #2 had no movement on the right side of her body and her right arm and leg were contracted due to a stroke and Resident #2 had no control of that side of her body. NA #1 explained she was providing incontinence care to Resident #2 on 8/1/25 at about 6:30 AM. NA #1 described that she was standing on the side of the bed near the door with Resident #2 turned towards her. NA #1 explained she walked around the bed to the other side near the window, and she rolled Resident #2 away from her (towards the door). NA #1 explained she was attempting to change the fitted sheet under Resident #2 and when she pushed the fitted sheet under Resident #2, the resident rolled off the bed and fell on the floor. NA #1 explained she went to get Nurse #1 to come assist. NA #1 reported she was aware that she should not have pushed Resident #2 away from her during care, because there was a risk she could roll off the bed. When asked why she left Resident #2 alone to get the nurse, NA #1 reported that there was no one else on the hall and she needed to get the nurse as quickly as possible because Resident #2 was bleeding. Nurse #1 was interviewed by phone on 8/20/25 at 9:38 AM. Nurse #1 reported she was in the medication room counting narcotics at the change of shift on 8/1/25 at about 6:30 AM, when NA #1 came to her and said, Can you come help me? Nurse #1 reported she followed NA #1 to Resident #2's room and found Resident #2 face down on the floor in a puddle of blood. Nurse #1 reported she assessed Resident #2 and cleaned the laceration to her forehead. Nurse #1 reported she asked NA #1 what happened, and NA #1 told her she rolled Resident #2 away from her and Resident #2 rolled off the bed. Nurse #1 reported she contacted the physician and received orders to send Resident #2 to the hospital emergency room for evaluation, because the laceration was more than the facility could treat. Hospital records dated 8/1/25 for Resident #2 were reviewed. Resident #2 arrived at the emergency room with a laceration to her right forehead, as well as an abrasion to her left knee. A computed tomography (CT) scan of the neck did not show fracture. A CT scan of the head did not show any abnormalities. The 6-centimeter laceration to the right forehead was closed with 8 sutures. Resident #2 was admitted to the hospital for elevated lab results and tachycardia (a fast heart rate). Resident #2 returned to the facility on 8/4/25 with orders to remove the sutures to the right forehead laceration on 8/11/25. The Director of Nursing (DON) was interviewed on 8/20/25 at 3:47 PM. The DON reported NA #1 was changing Resident #2 and she rolled over the side of the bed. The DON reported she was not aware NA #1 pushed Resident #2 away from her during care, causing her to roll off the bed. The DON reported she expected residents to be turned correctly in bed during care to prevent them from falling out of bed. The facility submitted the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:On 8/1/2025, NA #4 was providing incontinence care to Resident #2. The fitted sheet on Resident #2's bed needed changed and NA #4 rolled Resident #2 away from her in order to tuck the fitted sheet onto the mattress. Resident #2 rolled from the bed and NA #4 was unable to stop Resident #2. NA #4 stated that she knew she would have turned Resident#2 towards her, but she did not