STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(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 This was an MDS 3.0 Focused Survey. The survey was conducted May 26-28, 2015. Autumn Care of Fayetteville was not in compliance with applicable requirements of 42 C.F.R. Part 483, Health Standard Requirements for Long Term Care Facilities.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to conduct a significant change assessment for 1 of 3 sampled residents (Resident #5) who experienced a change in condition, when the resident returned from the hospital with an indwelling catheter and two unstageable deep tissue injuries. Findings included:	F 274	F274 This plan of correction will serve as the facility¿s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 5-28-15 survey and does not constitute an agreement or admission of	6/17/15

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

Electronically Signed | 06/16/2015

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F 274	Continued From page 1 Resident #5 had diagnoses that included diabetes. Record review revealed the resident had a fall on 04/12/2015 and was sent out to the hospital. Review of the Discharge Minimum Data Set (MDS), dated 04/12/2015, indicated the resident did not have an indwelling catheter, did not have any suspected deep tissue injuries and did not have any recent fractures. Resident #5 returned from the hospital on 04/17/2015, with diagnoses that included repair of a fractured hip, and urinary retention. An indwelling urinary catheter was in place due to the urinary retention and the admission skin assessment indicated the resident had suspected deep tissue injuries on both of his heels. On 04/24/15, the facility completed a combined Quarterly/5day assessment. The next MDS was a 14day assessment dated 05/01/2015, and then a 30day assessment was completed on 05/15/2015. On 05/27/2015 at 1:29 PM, Resident #5 was observed receiving treatment to his heels. The Treatment Nurse stated the resident ' s left heel was still considered a deep tissue injury but the right heel had slough and was an unstageable pressure ulcer. The indwelling urinary catheter was still in place. MDS Coordinator #2 was interviewed on 05/28/2015 at 12:11 PM. MDS Coordinator #2 indicated there had been a deterioration in Resident #5 condition when he returned with a fractured hip, an indwelling urinary catheter, and deep tissue injuries to both heels. She indicated a comprehensive assessment should have been	F 274	Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it¿s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 6/17/2015. For the Resident affected: A Significant Change MDS Assessment was completed on Resident #5 on 6/15/2015. For the Residents with the potential to be affected and measures put in place: Re-education was completed on 6/12/2015 by Regional MDS Nurse with both MDS coordinators related to the requirement of a significant change being completed timely and according to the RAI Manual if a resident has a decline or improvement in their status. Monitoring: An audit will be completed by MDS Coordinator or designee weekly for 3 months on all residents who have readmitted to facility in the previous week. During the audit MDS Coordinator or designee will confirm any resident who has been readmitted to the facility and determine if the resident¿s condition constitutes a significant change	

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F 274	Continued From page 2 completed when he returned from the hospital. During an interview on 05/28/2015 at 12:45 PM, the Director of Nursing and the Corporate Consultant indicated this resident had a significant change in status and a comprehensive assessment should have been completed.	F 274	assessment. Any resident, who is readmitted to the facility and meets the requirements of a significant change assessment, will have a significant change assessment completed per RAI guidelines. Audits will be monitored by Director of Nursing or Designee weekly time 4 weeks and then monthly for 2 months to ensure residents who have been readmitted to the facility and qualify for a significant change assessment, have a significant change assessment completed. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding significant changes will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		6/17/15

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F 278	Continued From page 3 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the current active diagnoses or bowel and bladder appliances for 6 of 8 residents (Residents #1, #2, #3, #5, #6 and #7) reviewed for accuracy of the Minimum Data Set. The findings included: 1. Resident #5 was readmitted to the facility with diagnoses of hip fracture and urinary retention. When the resident returned from the hospital on 4/17/2015, he an indwelling urinary catheter in place due to the urinary retention. a. Review of the combined Quarterly/5day Minimum Data Set (MDS) dated 04/24/15, indicated the resident did not have an indwelling	F 278	F278 This plan of correction will serve as the facility¿s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 5-28-15 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law,	

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F 278	Continued From page 4 catheter. b. Review of the 14day MDS dated 05/01/15, indicated the resident did not have an indwelling catheter. c. Review of the 30day MDS dated 05/15/15, indicated the resident did not have an indwelling catheter. An interview was conducted with MDS Nurse #2 on 05/28/2015 at 11:46 AM. MDS Nurse #2 stated Resident #5 had returned from the hospital with the indwelling catheter and it was still currently in place. When asked why the Quarterly/5day, 14day and 30day assessments did not reflect the use of an indwelling urinary catheter, MDS Nurse #2 indicated the computer system had pre-populated the MDS with the information from the discharge assessment. She indicated it was an over-site on her part and she should have changed the bowel and bladder portion of the assessment to show a catheter was in use during the three assessment periods. During an interview on 05/28/2015 at 12:45 PM, the Director of Nursing and the Corporate Consultant indicated it was their expectation that the assessments would have accurate information and the catheter should have been coded on the 5day, 14day and 30day assessments for Resident #5. 2. Resident #1 was admitted to the facility on 03/09/2015 with two Stage 4 pressure ulcers and 2 unstageable pressure ulcers. Record review revealed Resident #1 had been to the wound clinic on 03/25/2015, was diagnosed	F 278	however, submits this plan of correction to address the statement of deficiencies and to serve as it¿s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 6/17/2015. For the Resident affected: The Quarterly/5day MDS dated 4/24/2015, 14day MDS dated 5/01/2015, and 30day MDS dated 5/15/2015 for resident #5 was corrected on 6/9/2015 to include the resident's indwelling catheter. The Quarterly MDS dated 4/15/15, was corrected on 6/10/2015 to include the MDRO of MRSA for resident #1. The Annual MDS dated 1/15/2015, for resident #2 was corrected on 6/10/2015 to include MRSA as a MDRO. The Annual assessment dated 3/5/2015 was corrected on 6/8/2015 to remove the diagnosis of a UTI from the Annual MDS for resident #3. The 14day MDS assessment dated 5/13/2015 and admission MDS dated 5/6/2015 were corrected on 6/11/2015 to include the stage one pressure ulcer for resident #6. The Admissions/5day MDS dated 4/28/2015 and 14day MDS dated 5/5/2015, were corrected on 6/10/2015 to include ESBL as a MDRO for resident #7. For the Residents with the potential to be affected and measures put in place are re-education was completed on 6/12/2015 by Regional MDS Nurse with both MDS coordinators related to the requirement of accurate Minimal Data Sets. This includes coding indwelling catheters, coding	

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F 278	Continued From page 5 with Methicillin-resistant Staphylococcus aureus (MRSA) in a wound and started on an antibiotic. MRSA is a contagious and antibiotic-resistant bacteria. Review of the Quarterly Minimum Data Set (MDS) dated 04/14/15, indicated Resident #1 was severely cognitively impaired. The MDS was not coded for Multidrug-Resistant Organism (MDRO), but it did indicate the resident received an antibiotic 7 of the 7 days of the assessment period. During an interview on 05/27/2015 at 3:45 PM, MDS Nurse #1 stated the antibiotic coded on the Quarterly MDS was given for the MRSA in Resident #1 ' s wound. On 05/28/2015 at 11:46 AM, MDS Nurse #2 stated she had coded the diagnoses portion of the MDS but had not coded the MRSA as a Multidrug-Resistant Organism because she didn ' t think the MRSA qualified as a MDRO. During an interview on 05/28/2015 at 12:45 PM, the Director of Nursing and the Corporate Consultant indicated MRSA was a Multidrug-Resistant Organism and should have been coded as such on Resident #1 ' s Quarterly MDS. 3. Resident #2 had diagnoses including anemia and dementia. Record review revealed Resident #2 had developed Methicillin-resistant Staphylococcus aureus (MRSA) in a wound on 01/09/2015 and was started on an antibiotic. MRSA is a contagious and antibiotic-resistant bacteria.	F 278	MDROs, and reviewing prepopulated information on all resident MDSs for accuracy. On 5/29/2015 the facility began auditing the last Minimal Data Set completed for residents who have a diagnosis of a MDRO, indwelling catheter, wound, and UTI to ensure accuracy of these areas of the Minimal Data Set. Identified significant errors will be corrected per the RAI manual. Monitoring: An audit will be completed by MDS Coordinator or designee weekly for 3 months on all residents who have a diagnosis of a MDRO, indwelling catheter, wound, and UTI. During the audit MDS Coordinator or designee will confirm any resident who has been diagnosed while in the facility or admitted to the facility with a MDRO, indwelling catheter, wound, and UTI. Audits will be monitored by Director of Nursing or Designee weekly times 4 weeks and then monthly for 2 months to ensure all resident Minimal Data Sets have been coded accurately related to a MDRO, indwelling catheter, wound, and UTI. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding accuracy of Minimal Data Sets will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 278	Continued From page 6	F 278		

Review of the Annual Minimum Data Set (MDS) dated 01/15/2015, indicated Resident #2 was not coded for Multidrug-Resistant Organism (MDRO), but it did indicate the resident received an antibiotic 7 of the 7 days of the assessment period.

During an interview on 05/27/2015 at 3:58 PM, MDS Nurse #1 stated the antibiotic coded on the Annual MDS was given for the MRSA in Resident #2 ' s wound. MDS Nurse #1 stated she had not coded the MRSA as a Multidrug-Resistant Organism because she didn ' t think they were the same thing.

During an interview on 05/28/2015 at 12:45 PM, the Director of Nursing and the Corporate Consultant indicated MRSA was a Multidrug-Resistant Organism and should have been coded as such on Resident #2 ' s Annual MDS.

4. Resident #3 was readmitted on 6/17/2014 with active diagnoses which included chronic pain, hemiplegia affecting dominant side, CHF (Congestive Heart Failure), Chronic Obstructive Pulmonary Disease.

Review of Resident #3 most recent MDS was coded as an Annual assessment and was dated 3/5/2015 (observation dates 2/27/2015 through 3/05/2015). The assessment included a diagnosis of UTI (Urinary Tract Infection) in section I8000I. Record review indicated the Resident did not have documented symptoms, lab work, treatment or an active diagnosis of UTI in the past 30 days as required by the RAI (Resident Assessment Instrument). This diagnosis did not accurately reflect the Resident ' s condition during the

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F 278	Continued From page 7 observation look back period. During an interview with the facility MDS nurse #1 on 5/25/2015 at 11:45AM, the MDS nurse stated Resident #3 inaccurate diagnosis or UTI was " just an oversight. " An interview was conducted with the DON (Director of Nursing) on 5/28/2015 at 2:00PM regarding resident # 3. The DON expectation is that MDS assessments should be coded correctly. 5. Resident #6 was admitted on 4/29/2015 with active diagnoses which included Diabetes, CHF, Hypertension, Atrial Fibrillation and Anemia. Review of Resident #6 two most recent MDS were coded as the 14 day assessment dated 5/13/2015 (observation dates 5/07/2015 through 5/13/2015) and the Admission/5 day assessment dated 5/06/2015 (observation dates 4/30/2015 through 5/06/2015). Record review indicated the Resident had been admitted to the facility with one Stage I pressure ulcer, treatments had been ordered by the physician and were being administered to the Resident. The assessments, in section M0210 and M0300A, did not indicate the Resident had a pressure ulcer. The assessments did not accurately reflect the Resident ' s condition during the observation look back periods. During an interview with the facility MDS nurse #1 on 5/25/2015 at 11:45AM, the MDS nurse stated the wound on Resident #6 had not been included on the assessments because the skin assessments had not been completed during the look back periods.	F 278		

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F 278	Continued From page 8	F 278		

An interview was conducted with the DON (Director of Nursing) on 5/28/2015 at 2:00PM regarding resident #6. The DON expectation is that MDS assessments should be coded correctly.

6. Resident #7 was admitted on 04/21/2015 with active diagnoses which included ESBL (Extended-spectrum beta lactamase) urinary tract infection/complicated urinary tract infection, Escherichia coli bacteremia, healthcare associated pneumonia, and chronic anemia.

Review of Resident #7 two most recent MDS were coded as the 14 day assessment dated 5/05/2015 (observation dates 4/29/2015 through 5/05/2015) and the Admission/5 Day assessment dated 4/28/2015 (observation dates 4/22/2015 through 4/28/2015). Record review indicated the Resident had been receiving intravenous antibiotic medication while a resident for a diagnosis of an ESBL (Extended-spectrum beta lactamase) urinary tract infection/complicated urinary tract infection and healthcare associated pneumonia. The CDC (Centers for Disease Control) classifies ESBL as a MDRO (Multidrug-Resistant Organism). The assessments did not include a diagnosis of MDRO in section I1700 or ESBL in section I8000.

During an interview with the facility MDS nurse #2 on 5/25/2015 at 11:45AM, the MDS nurse stated she did not think Resident #7 had been diagnosed with a MDRO.

An interview was conducted with the DON (Director of Nursing) on 5/28/2015 at 2:00PM regarding resident #7. The DON expectation is

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F 278	Continued From page 9 that MDS assessments should be coded correctly.	F 278		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356		6/17/15

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F 356	Continued From page 10 Based on observation and staff interviews, the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months. Findings included: An unannounced survey was conducted at the facility 05/26/2015 through 05/28/2015. The nurse staffing data and resident census was prominently posted and readily accessible to residents and visitors for each day of the survey. Review of facility records on 05/28/2015 at 10:15 AM, revealed the facility had retained the posted staffing sheets for January through May 2015 but the posted staffing sheets for 2014 were not physically available. The Administrator was interviewed at 1:10 PM on 05/28/15, about the retention of records. The Administrator indicated there had been a misunderstanding and the posted staffing sheets for 2014 had accidentally been shredded. The Administrator said, " We should have kept those but we do have a daily staffing sheet located at each nursing station that is updated each shift and retained in a notebooks that has the same information. "	F 356	F356 This plan of correction will serve as the facility¿s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the 5-28-2015 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it¿s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 6/17/2015. For the Residents affected, the employee responsible for maintaining staffing sheets was in-serviced on 5/28/2015 the requirement to maintain the posted daily nurse staffing sheets for a minimum of 18 months. Monitoring: An audit starting 6/15/2015 will be completed by the administrator or designee weekly for four weeks then monthly for two months to ensure the staffing sheets are being maintained.	

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F 356	Continued From page 11	F 356	A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding maintaining staffing sheets will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	