STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	12/22/2016

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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 278 SS=D	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 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 medical record review, and staff interviews the facility failed to accurately code the Minimum Data Set for 2 of 18 sampled residents (resident #35 and #121). Findings included: 1. Resident #35 was admitted to the facility on	F 278	The Statements made on this Plan of Correction are not an admission to and do not constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and State regulations the facility has taken the actions set forth in	1/19/17

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

Electronically Signed | 01/20/2017

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F 278	Continued From page 1 09/13/16 with a diagnosis of urinary retention. The admission Minimum Data Set (MDS) dated 09/25/16, revealed the resident had an indwelling catheter and was always incontinent of urine. Medical record review revealed admission orders dated 09/13/16, to provide catheter care, and record catheter output every shift. During an interview on 12/22/16 at 8:57 AM, the MDS nurse stated Resident #35 had an indwelling catheter since admission on 09/13/16. The MDS nurse went on to say the admission MDS dated 09/25/16 was coded inaccurately. She indicated the incontinence status should have been coded as not rated due to the resident had an indwelling catheter. On 12/22/16 at 9:31 AM the Regional Clinical Reimbursement Specialist stated Resident #35 admission MDS dated 09/25/16 was coded inaccurately and should have been coded as not rated for incontinence status due resident had an indwelling catheter. On 12/22/16 at 9:37 AM the Administrator stated her expectations would be for the MDS for resident #35 to be coded accurately for incontinence when the resident had an indwelling catheter. 2. Resident #121 was admitted to the facility from the hospital on 10/07/16. Diagnoses included depression. The hospital discharge summary, dated 10/07/16 documented Resident #121's medication regimen included Cymbalta (antidepressant) 30 milligrams (mg) daily. Medical record review revealed a physician's order dated 10/07/16 for Cymbalta 30 mg daily.	F 278	this Plan of Correction. The Plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been corrected the date indicated. F-278 Accuracy of Assessment 1- A modification MDS was completed on 12-28-16 for resident #121 to reflect a diagnosis of depression in Section I. The patient no longer resides at this facility. Resident #35 had a modification MDS completed on 1-19-17 to reflect catheter use in section H 100A and not rated in section H0300 as patient is incontinent. 2. Any resident who has had an MDS completed could be affected. The MDS staff have audited the Diagnosis and the Coding of Diagnosis and patients who have a catheter who have had an MDS completed in the past 30 days and submitted a Modification MDS if error in coding section H or I was found. 3. The MDS Coordinator has educated the MDS nurses on accurate coding of Diagnosis in Section I and coding of catheter use (H100A) and incontinence in section H(0300A) on the MDS on 12-29-16 and 1-19-17. 4. Audits of accuracy of coding Section I and H of the MDS will be completed weekly x 4 weeks and then every two weeks x 3 months to provide monitoring. Results of Audits will be submitted to QAPI committee monthly x 3 months for ongoing trending and suggestions for	

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F 278	Continued From page 2 A pharmacy medication review dated 10/10/16 recorded Resident #121 received Cymbalta 30 mg daily for depression. The admission Minimum Data Set (MDS) dated 10/14/16, section I (Diagnoses) did not include the diagnoses of depression, but identified that Resident #121 received an antidepressant for the 7 days prior to the assessment reference date of the MDS. The Care Area Assessment indicated Resident #121 received a psychoactive medication (antidepressant) which was not a new medication for the Resident and that a care plan would be developed. The Care Plan dated 10/14/16 identified Resident #121 was at risk for adverse side effects regarding the use of a psychoactive medication (Cymbalta) for depression, with the goal that the Resident would be free from adverse effects regarding the use of Cymbalta thru the next review. Interventions included to monitor for side effects (sedation, hypotension episodes, anticholinergic symptoms like heart attack, insomnia, anorexia, and constipation, and to monitor the effectiveness of Cymbalta, report changes to the physician in behavior/mood state, or any negative outcome associated with the use of Cymbalta. The October 2016 Medication Administration Record (MAR), which was electronically signed by the physician, documented administration of Cymbalta 30 mg daily to Resident #121 beginning 10/08/16. An interveiw was conducted on 12/22/16 at 11:57 AM with Nurse #1, MDS Coordinator. Nurse #1 confirmed that she completed section I	F 278	improvement.	

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F 278	Continued From page 3	F 278		

(Diagnoses) on the admission MDS for Resident #121 and stated that when she completed that section, she reviewed the medical record for Resident #121 to include the hospital discharge summary, the history and physical, any available progress notes completed by clinicians (physicians, nurse practitioner and pharmacist) and the MAR. Nurse #1 stated when she reviewed these records for Resident #121, she did not see the diagnoses of depression on the MAR and therefore did not include the diagnoses on the admission MDS.

An interveiw was conducted on 12/22/16 at 12:00 PM with the regional clinical reimbursement specialists who stated that Resident #121's October 2016 MAR was electronically signed by the physician and recorded Resident #121 received Cymbalta daily due to the diagnoses of depression.

An interview with the DON on 12/22/16 at 12:35 PM revealed that the facility conducted risk round meetings to discuss new admissions, their medical record/medical history, and diagnoses. The DON stated that any part of a resident's medical history that needed clarification with the physician would be identified at that time and clarified. She stated that telephone and monthly orders were signed electronically by the physician. The DON stated that she expected the MDS Coordinator to identify any active diagnoses by review of hospital records, paperwork regarding a resident's medical history, and signed physician orders. The DON stated that a signed physician's order, which also included the MAR, that recorded the diagnoses was an indication of a diagnoses and should be included in section I of the MDS. The DON stated she expected the

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F 278	Continued From page 4 the MDS to accurately reflect active diagnoses.	F 278		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		1/19/17

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to follow isolation precautions for 1 of 1 resident (Resident # 179) on contact precautions due to diagnosis of Clostridium Difficile bacterial infection (C-diff). The findings included: A review of the facility policy titled Contact Precautions and dated June 2013, with revision date May 2015 was conducted 12/21/16. The policy indicated "It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illness easily transmitted by resident contact or contact with items in the resident's environment." The policy also stated, " ontact precautions may be considered for severe diagnosis, including Clostridium Difficile." Also included in the policy was the statement, "gloves should be removed prior to leaving the resident's room and hand hygiene should be performed immediately." Posted on the door of the resident was the sign entitled Contact Precautions which indicated "perform hand hygiene before entering and before leaving the room." A review of medical doctor (MD) orders revealed Contact precautions ordered for C-diff on 12/14/16. On 12/19/16 at 3:20 p.m. personal protection equipment observed outside of the door to the resident's room. There was not a sign posted on the door to inform staff or visitors of the isolation precautions. The edges of sign for isolation contact precautions was covered by box of gloves set on top of the plastic drawer container of	F 441	F-441-Infection Control 1. Resident #179 no longer resides in the facility 2.Any resident requiring isolation could be affected. There are currently 2 other residents in isolation. Resident's doors have the proper signage to indicate isolation. Laundry/Housekeeping staff and Licensed nurses and Certified Nurse Aides have been educated on signage, proper storage and removal of linen from an isolation room and Proper use of Personal Protective Equipment (PPE) including contact precautions by the Director of Nursing, Administrator and Housekeeping/Laundry Supervisor 12/21/16 -1/19/17. New hires will be oriented to infection control procedures for isolation/contact precautions during orientation. 3. The Director of Nursing, Administrator and Housekeeping/Laundry Supervisor have in-serviced housekeeping/laundry and Licensed nurses and Certified Nurses Aides on isolation/contact precaution signage and procedures for storage and removal of linens from isolation room and proper use of Personal Protective Equipment 12/21/16 thru 1/19/17. The Director of Nursing/Assistant Director of Nursing/Housekeeping Supervisor and Administrator will conduct visual audits 3 x	

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F 441	Continued From page 6 Personal Protection equipment located beside the door. It was observed on 12/20/16 at 3 p.m. that contact precaution isolation instruction sign was not posted on the door of the resident's room. On 12/21/16 at 8:27 a.m. a nurse was observed picking up the sign from under a box of gloves on top of the container of personal protective equipment and taped it to the door of the resident's room. Housekeeping staff member #1 was observed while in the resident's room at 8:25 a.m. on 12/21/16 wearing a gown, gloves, mask, and shoe covers. Housekeeping staff #1 observed as she gathered up dirty linens from designated bin in resident's room. The Housekeeping staff member removed the gown and deposited it in designated trash bin in resident's room. The Housekeeping staff member then carried the dirty linen out into the hallway where she removed gloves, mask, and shoe coverings and deposited them in a general trash bin in the hallway. On 12/22/16 at 8:20 a.m. Housekeeping staff member #2 observed cleaning resident's room while wearing gown, cloves, mask, and shoe covers. When finished, the gown and shoe covers were removed prior to exiting the room. The Housekeeper #2 wore gloves and mask out of the room where they were removed and placed into general use trash container. An interview was conducted with Director of Nursing (DON), who was the acting Infection Control Nurse on 12/22/16 at 12:00 p.m. The DON stated that employees attended mandatory in-service training for infection prevention and control upon hire. It was stated that the education was reviewed routinely on a quarterly basis. The education included types of isolation precautions, what should be done for each type	F 441	week of staff removing linens and use of Personal Protective Equipment for isolation rooms to validate proper procedure utilized and for isolation signage. 4.Audits will be conducted by Director of Nursing /Assistant Director of Nursing,Housekeeping/Laundry Supervisor and Administrator 3 x week for 4 weeks and then weekly x 3 months. Audits will be submitted to QAPI monthly for ongoing monitoring, trending and recommendations	

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F 441	Continued From page 7 of isolation, and proper disposal of waste and dirty equipment and linens. During the interview the DON stated that a breech in isolation procedure had been observed on 12/21/16 and that education had already been conducted with housekeeping and nursing staff members. The DON stated that it was the expectation that whenever a resident has isolation precautions in place that a sign should be posted on the door. It is also expected that the sign should be visible. The DON also stated the expectation that the gown, gloves, mask, and shoe covers be removed prior to exiting the room and disposed of in designated trash bins.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		1/19/17

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F 520	Continued From page 8 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2015. This was for one recited deficiency that was originally cited in November 2015 on a recertification survey and subsequently recited in December 2016 on the recurrent recertification survey. The deficiency was in the area of infection control. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F441 Infection Control: Based on observations, record reviews, and staff interviews the facility failed to follow isolation precautions for 1 of 1 resident (Resident # 179) on contact precautions due to diagnosis of Clostridium Difficile bacterial infection (C-diff). During the recertification survey of November 30, 2015 the facility was cited for failure to implement isolation precautions for 1 of 1 resident's diagnoses with Methicillin Resistant Staphylococcus Aureus (MRSA) in a wound on his left foot (Resident #134). On the recurrent recertification survey the facility was cited again failure to follow isolation precautions for 1 of 1 resident (Resident #179 on	F 520	F-520-Quality Assurance 1. Resident #179 no longer resides in the facility. Housekeeping/Laundry staff and Licensed Nurses and Certified Nurse Aides were in-serviced on proper handling and removal of linens from isolation rooms and proper use of Personal Protective Equipment and sinage 12/21/16 - 1/19/17. 2. Any resident requiring isolation could be affected. There are currently 2 other residents in isolation/contact precautions. Residents have proper signage affixed to their door indicating isolation precautions and Licensed nurses, Certified Nurses Aides and Housekeeping and Laundry staff have been in serviced in isolation/contact precautions and proper removal of linens and use of Personal Protective Equipment and signageby Director of Nursing/Assistant Director of Nursing/Housekeeping/Laundry Supervisor and Administrator 12/21/16 thru 1/19/17. 3.The Director of Nursing/Assistant Director of Nursing /Housekeeping/Laundry Supervisor and Administrator have in-serviced Licensed Nurses, Certified Nurses Aides and	

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F 520	Continued From page 9 contact precautions due to diagnosis of Clostridium Difficile bacterial infection. During an interview with the Director of Nursing (DON) and the Regional Vice President of Operations (RVP) on 12/22/16 at 12:45 PM revealed that their quality assurance (QA) committee met quarterly and they have sub meetings monthly. Those monthly meetings consisted of the Administrator, the DON, Social Worker (SW), and Nursing Assistant (NA) and they discussed issues within the facility and tired to figure out ways to improve on them, we also try to determine root cause of the particular problem. Once we figure out ways to improve on those issues we monitor the feedback and make any necessary changes that we feel we could improve upon. The DON stated that recently they had identified an issue with the meal delivery system, they met as a team and come up with strategies and were able to rearrange the seating arrangement in the dining room and the response was all positive. The DON stated she was continuing the audits from last year survey including the audit for infection control. The DON also stated that to improve the infection control program at the facility they sent staff to the Statewide Program for Infection Control and Prevention (SPICE) training and further stated that they cover infection control during orientation and routinely throughout the year. The DON stated that these new issues would definitely require education and daily monitoring through frequent rounds. The DON further stated that when a resident was placed on isolation all families are notified and explained why the resident is on isolation and what type of isolation was required.	F 520	Housekeeping/laundry staff on proper signage for isolation room and procedure for removal of linens from isolation/contact precaution rooms and proper use of Personal Protective Equipment from 12/21/16 thru 1/19/17. the Administrator conducted education to the Department Managers and Quality Assurance Performance Improvement committee on the QAPI process on 1/4/17. In-service included the overall makeup of the committee, ongoing monitoring and the goals of the committee and identification of systems/deficiencies that need correction. The facility's Policy and Procedure was utilized as a reference tool for in-service. Review of the Annual Survey and subsequent Plan of Corrections were reviewed with the committee by the Administrator. 4. The Director of Nursing/Assistant Director of Nursing, Housekeeping/Laundry Supervisor or Administrator will conduct an audit weekly x 3 months for proper storage and removal of linen from isolation/contact precaution rooms,sinage and proper use of Personal Protective Equipment. Audits will be submitted to QAPI committee monthly x 3 months for ongoing trending, monitoring and recommendations. The Administrator will monitor completion of audits and findings and assure review by the QAPI committee.	