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 06/07/2017

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 No deficiencies were cited as a result of the complaint investigation conducted on 06/07/2017. Event ID F4L211.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 272		7/1/17

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

Electronically Signed | 06/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 1 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review, resident observation, and staff interviews the facility failed to assess the use of physical restraints for 1 of 1 sampled resident (Resident # 102) Findings included: Resident #102 was admitted on 3/31/2017. Her admitting diagnoses included intellectual disabilities, chronic kidney disease, Hypertension and epilepsy. Her most recent Minimum Data Set (MDS) dated 6/6/2017 indicated he was severely cognitively impaired. He was totally dependent on staff with the assistance of 2 persons with all other activities of daily living, bed mobility and transfer. He was not coded as having a restraint. Resident #102 was observed on 6/5/2017 at 11:30 AM as having a vest/trunk restraints. An interview was conducted with Minimum Data Set (MDS) nurse #1 on 6/6/2017 at 11:51 AM. The MDS nurse stated the vest on the resident's wheelchair was being used as restraints due to	F 272	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 June 7, 2017 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 of42 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 its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of July 1, 2017.	

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F 272	Continued From page 2 safety concerns. The nurse stated she should have assess and coded section P of the MDS as the residents having a restraints. An interview with the Administrator (AD) was conducted on 6/6/2017 at 12:34 PM. The AD stated it was her expectation that the resident be assessed and be coded correctly accurately in the MDS for the use of restraints.	F 272	F 272 For affected resident: On 6/6/17 a significant correction assessment was done by MDS for the affected resident (#102) to accurately capture the use of a physical restraint and was re-submitted. Resident's (#102) care plan was updated to reflect the changes on 6/7/17 by MDS. For other residents with the potential to be affected: On 6/21/17 a facility audit was initiated and completed by the unit managers reviewing every resident for restraint use. No other residents were identified. The MDS department was re-educated on 6/22/17 regarding 483.20(b) (1) comprehensive assessments, to ensure accurate coding and assessing resident status on the MDS by the Administrator. Facility plan to prevent re-occurrence: A restraint audit tool will be completed by the DON, unit managers, or designee weekly for 2 months to ensure restraint assessments are completed accurately, thoroughly, and coded on the MDS. The restraint assessment audit tool will review new admissions and current residents identified with the potential for restraint use. The audits will be taken to monthly QAPI meeting for committee to deem compliance.	

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, resident observation, and staff interviews the facility failed to accurately	F 278	This plan of correction will serve as the facility's allegation of compliance with	7/1/17

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F 278	Continued From page 4 code the use of physical restraints for 1 of 1 sampled resident (Resident # 102), the facility also failed to code accurately the diagnosis of depression and the use of an antidepressant for 1 of 1 sampled resident (Resident # 21). Findings included: 1- Resident #102 was admitted on 3/31/2017. Her admitting diagnoses included intellectual disabilities, chronic kidney disease, Hypertension and epilepsy. Her most recent Minimum Data Set (MDS) dated 6/6/2017 indicated he was severely cognitively impaired. He was totally dependent on staff with the assistance of 2 persons with all other activities of daily living, bed mobility and transfer. He was not coded as having a restraint. Resident #102 was observed on 6/5/2017 at 11:30 AM as having a vest/trunk restraints An interview was conducted with Minimum Data Set (MDS) nurse #1 on 6/6/2017 at 11:51 AM. The MDS nurse stated the vest on the resident's wheelchair was being used as restraints due to safety concerns. The nurse stated she should have coded section P of the MDS as the residents having a restraints. An interview with the Administrator (AD) was conducted on 6/6/2017 at 12:34 PM. The AD stated it was her expectation that the MDS be coded correctly and accurately.	F 278	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 June 7, 2017 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 of42 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 its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of July 1, 2017. F-278 For affected resident: On 6/7/17 MDS modified the admission assessment for the 2/25/17 ARD date for affected resident (#21). On this same date, a significant correction was done by MDS for the affected resident (#21) to capture the use of an anti-depressant and the diagnosis of depression. Resident's (#21) care plan was updated to reflect the changes on 6/7/17 by MDS. On 6/6/17 a significant correction assessment was done by MDS for the affected resident (#102) to accurately capture the use of a physical restraint and was re-submitted.	

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F 278	Continued From page 5 2. Resident #21 was admitted on 2/18/2017. Her admitting diagnoses included atrial fibrillation, coronary artery disease, hypertension, gastro-esophageal reflux, depression, and hyperlipidemia. Her most recent Minimum Data Set (MDS) dated 2/25/2017 indicated she was cognitively intact. The MDS also indicated the resident was not coded for her diagnosis of depression (Section I) and no antidepressant medication (Section N). Clinical record review revealed admission physician orders dated 2/18/2017 for Citalopram Hydrobromide tablet 20 milligrams orally daily for depression. Review of the February Medication Administration Record (MAR) indicated the resident received the antidepressant every day during the MDS review period. During an interview on 6/07/2017 at 5:10 pm, the MDS Nurse #1 indicated it was an over-site that the diagnosis and the antidepressant had not been coded on the Admission MDS. She stated she should have coded the diagnosis and the antidepressant on the Admission MDS. During an interview with the Administrator (AD) was conducted on 6/6/2017 at 12:34 pm. The AD stated it was his expectation that the MDS be coded correctly and accurately.	F 278	Resident's (#102) care plan was updated to reflect the changes on 6/7/17 by MDS. For other residents with the potential to be affected: On 6/21/17 a facility audit was initiated and completed by the unit managers reviewing every resident for anti-depressant use and ensuring that if used a diagnosis of depression is present. No other residents were identified. On 6/21/17 a facility audit was initiated and completed by the unit managers reviewing every resident for restraint use. No other residents were identified. The MDS department was re-educated on 6/22/17 regarding 483.20(g) (j) assessment accuracy/coordination/certified, to ensure accurate coding and assessing resident status on the MDS by the Administrator. Facility plan to prevent re-occurrence: An anti-depressant/depression audit tool will be completed by the DON, unit managers, or designee weekly for 2 months to ensure anti-depressant/depression assessments are completed accurately, thoroughly, and coded on the MDS. The anti-depressant/depression assessment audit tool will review new admissions and current residents identified with the potential for anti-depressant use and diagnosis of depression.	

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F 278	Continued From page 6	F 278	The audits will be taken to monthly QAPI meeting for committee to deem compliance.	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 356		7/1/17

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F 356	Continued From page 7 (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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: Based on observation, record review and staff interviews the facility failed to post the current daily staffing hour sheet for 1 of 4 days of the recertification survey and separate out the actual Registered Nurse (RN) and Licensed Practical Nurse (LPN) hours on the daily staffing sheets for 64 of 68 days reviewed. The findings include: During initial tour on 06/04/17 at 5:00 PM, the daily staffing hour sheet posted was dated 06/02/17, and indicated there were 6 Licensed Practical Nurses/Registered Nurses on first shift, 4 Licensed Practical Nurses/Registered Nurses on second shift and 2 Licensed Practical Nurses/Registered Nurses on third shift. The daily staffing was not posted for 06/04/17. During an interview on 06/04/17 at 5:30 PM, the Lead Nurse #1 (LPN) on Unit 1 stated that she was not aware who was responsible for posting the daily staffing hour sheet.	F 356	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 June 7, 2017 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 of42 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 its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of July 1, 2017.	

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F 356	Continued From page 8 During an interview on 06/06/17 at 7:55 AM, the Director of Nursing (DON) stated that the weekend Charge Nurse was responsible for completing and posting the daily staffing hour sheet on Saturday and Sunday. The DON further stated that she was using the most current daily staffing hour sheet provided by the corporate office. On 06/06/17 at 3:00 PM, the nurse staffing information postings were reviewed for April 2017, May 2017, June 1, 2017, June 2, 2017 and June 7, 2017. It was noted that 64 of 68 postings reviewed did not separate the RN hours from the LPN hours worked. The hours were posted together. During an interview on 06/07/17 at 8:30 AM, the Administrator stated that it was his expectation that the daily staffing hour sheets be posted daily and actual Registered Nurse and Licensed Practical Nurse hours should be listed separately.	F 356	F-356 For affected residents: No residents were affected. For other residents with the potential to be affected: No potential for residents to be affected. Facility plan to prevent re-occurrence: On 6/8/17, the Regional Director of clinical services educated the facility's Administrator and Director of Nursing on the posting of daily staffing process per federal regulation which includes the separation of LPN and RN hours. The Director of Nursing, Administrator/designee will ensure daily staffing is posted daily for 2 weeks and weekly for 2 months. Monitoring tools will be taken to monthly QAPI meeting for committee to deem compliance.	
F 520 SS=C	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		7/1/17

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F 520	Continued From page 9 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observation, record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 07/21/2016 recertification survey. This was for one recited deficiency that was subsequently cited during the current recertification survey in the area of failure to post	F 520	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 June 7, 2017 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of	

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F 520	Continued From page 10 nurse staffing information. 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. The findings included: This tag is cross referenced to F 356: Based on observation, record review and staff interviews the facility failed to post the current daily staffing hour sheet for 1 of 4 days of the recertification survey and separate out the actual Registered Nurse (RN) and Licensed Practical Nurse (LPN) hours on the daily staffing sheets for 64 of 68 days reviewed. On 07/21/2016, the facility was cited for failure to maintain nurse staffing data for a minimum of 18 months. During an interview on 06/07/17 at 1:30 PM, the Administrator stated that he had been employed at the facility for two months and there had not been any problems related to the daily staffing hour sheets and was not brought to QAA. During an interview on 06/07/17 at 4:05 PM, the Administrator stated it is his expectation that the daily staffing hour sheets be posted daily and actual Registered Nurse and Licensed Practical Nurse hours are listed separate.	F 520	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 of42 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 its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of July 1, 2017. F-520 For affected residents: No residents were affected. For other residents with the potential to be affected: No potential for residents to be affected. Facility plan to prevent re-occurrence: On 6/8/17, the Regional Director of clinical services educated the facility's Administrator and Director of Nursing on the quality and assessment and assurance process on maintaining implemented procedures and monitoring of these interventions to prevent re-occurrence. On 6/8/17, the Regional Director of clinical services educated the facility's Administrator and Director of Nursing on the posting of daily staffing process per federal regulation which includes the separation of LPN and RN hours.	

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F 520	Continued From page 11	F 520	The Director of Nursing, Administrator/designee will ensure daily staffing is posted daily for 2 weeks and weekly for 2 months. Monitoring tools will be taken to monthly QAPI meeting for committee to deem compliance.	