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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 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). (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	F 272		8/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2017

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 _____	C 07/28/2017

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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 272	Continued From page 1 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 and staff interview, the facility failed to comprehensively assess residents in the areas of cognition and mood for 2 of 4 residents (Resident #3 and #4) reviewed for the Minimum Data Set. The findings included: 1. Resident #3 was admitted to the facility on 5/19/17. The admission Minimum Data Set (MDS) dated 5/26/17, indicated the resident had clear speech, could be understood and was able to understand others. The cognition and mood interviews of the MDS (Section C and Section D) had not been completed. The entry questions for both sections indicated the resident interview should have been attempted. During an interview on 7/27/17 at 9:30 AM, MDS Coordinator #1 specified that the Social Worker's assistant had signed for completing the cognition and mood interviews with the residents. MDS Coordinator #1 stated she was unaware the sections had not been completed until after the assessment period had passed, at which time it was too late to do the interviews. On 7/28/17 at 8:48 AM, the Social Worker's assistant was interviewed and stated she had been responsible for completing the cognition and mood interviews for this resident's assessment.	F 272	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The process that led to deficiency cited: Failure of facility social worker to complete section C and D on the MDS for 2 Residents. Resident #3 was discharged on June 24th 2017. Resident #4 had annual MDS completed on 06-18-17 with section C & D completed. The Care Plan team was educated on August 14th by the Regional Clinical Director and the Administrator on thorough completion of the MDS according to the instructions in the Resident Assessment Instruction manual. The Director of the MDS team will audit 3 MDS's weekly for 3 weeks then monthly for 3 months to ensure MDS completed thoroughly. The audits will be reviewed in the Monthly QAPI meeting to ensure compliance of thorough completion of the MDS according to the instructions in the	

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	345511	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 272	Continued From page 2 She stated she had trouble with the computer retaining the data she inputted. The Social Worker's assistant said, "I've told my supervisor and several ladies in MDS ..." When asked about other assessments she had done, the Social Work's assistant indicated the retention issue was random and said, "I had entered it and signed off for it but it was like it had not been done." She added, "I've tried on multiple computers here and it's the same situation no matter where I am." The Social Worker responsible for supervising the assistant at the time this MDS was completed, no longer worked at the facility. During an interview on 7/28/17 at 9:09 AM, the Administrator said she expected that all sections of the MDS be completed thoroughly according to the instructions in the Resident Assessment Instrument Manual. 2. Resident #4 was admitted to the facility on 6/15/16. The quarterly Minimum Data Set (MDS) dated 5/21/17, indicated the resident had clear speech, could be understood and was able to understand others. The cognition and mood interviews of the MDS (Section C and Section D) had not been completed. During an interview on 7/27/17 at 9:30 AM, MDS Coordinator #1 specified that the Social Worker's assistant had signed for completing the cognition and mood interviews with the residents. MDS Coordinator #1 stated she was unaware the sections had not been completed until after the assessment period had passed, at which time it was too late to do the interviews.	F 272	resident Assessment Instruction annual. Once the QAPI Committee determines the MDS are completed thoroughly then the Audit will occur randomly thereafter. The Administrator will be responsible for implementing the plan of correction.	

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	345511	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 272	Continued From page 3 On 7/28/17 at 8:48 AM, the Social Worker's assistant was interviewed and stated she had been responsible for completing the cognition and mood interviews for this resident's assessment. She stated she had trouble with the computer retaining the data she inputted. The Social Worker's assistant said, "I've told my supervisor and several ladies in MDS ..." When asked about other assessments she had done, the Social Work's assistant indicated the retention issue was random and said, "I had entered it and signed off for it but it was like it had not been done." She added, "I've tried on multiple computers here and it's the same situation no matter where I am." The Social Worker responsible for supervising the assistant at the time this MDS was completed, no longer worked at the facility. During an interview on 7/28/17 at 9:09 AM, the Administrator said she expected that all sections of the MDS be completed thoroughly according to the instructions in the Resident Assessment Instrument Manual.	F 272		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		8/14/17

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 _____	C 07/28/2017

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F 323	Continued From page 4 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician interview, and staff interviews for 1 of 3 sampled residents (Resident #3) with a history of falls, the facility failed to have two staff members during a transfer when using a mechanical lift. The fall from a sit-to stand mechanical lift resulted in the resident being transferred to the hospital, and a diagnosis of traumatic anemia. The findings included: Resident #3 was admitted to the facility on 5/19/17 with diagnoses that included peripheral vascular disease, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 5/26/17, indicated the resident required extensive, 2-person assistance for transfers, balance was unsteady, and she received an anticoagulant medication 7 of 7 days during the assessment period. The cognition portion of the MDS had not been completed.	F 323	Past noncompliance: no plan of correction required.	

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 323	Continued From page 5	F 323		

The Care Plan, most recently updated on 6/14/17, indicated the resident was at risk for falls and decreased mobility.
Record review revealed lab work drawn on 5/31/17 which indicated the resident had a hemoglobin of 9.6 grams per deciliter (g/dL) with a Reference Range of 11.7-15.5g/dL. Hemoglobin is a protein molecule in red blood cells that carries oxygen from the lungs to the body tissues.

Record review revealed a Resident Mobility Transfer Profile, completed by Physical Therapy on 6/5/17, which indicated the resident was to be transferred with a sit-to-stand mechanical lift.

A physician order dated 6/12/17 indicated the resident's Coumadin 2 milligrams (mg) medication was to be held and the facility was to check the resident International Normalized Ratio (INR) on 6/14/17 and notify the physician. (The INR is a test used to determine the clotting tendency of blood.)

On 6/14/17 the INR was 2.5. The physician was notified and an order was received to restart the Coumadin at 2mg and recheck the PT/INR on 6/22/17.

A nursing note dated 6/21/17 at 4:24 PM indicated the resident had a fall. The note stated, "Resident was being transferred from w/c [wheelchair] to bed with sit-to-stand [lift] and slipped out of the bottom landing on her buttock in an upright position." The note also indicated the resident had not hit her head but was complaining of pain of "7" on a scale of 1 to 10. It also indicated the resident had skin tears on both hands. Neuro checks were started. Vital Signs at

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 323	Continued From page 6	F 323		

the time of the fall were Blood Pressure (BP) 141/83, Pulse 83, Respirations 18, and Temperature 97.4

The incident report dated 6/21/17 at 4:24 PM, specified that the physician was notified on 6/21/17 at 4:35 PM, one-on one training was done with a staff member and the resident was placed on total lift status until a complete assessment by physical therapy could be completed.

Record review revealed a Resident Mobility Transfer Profile, completed by Physical Therapy on 6/21/17 which indicated the resident was to be transferred with a total passive mechanical lift.

On 6/22/17, the physician was notified that Resident #3's INR was greater than 8. The physician examined the resident that day and gave orders to hold the Coumadin and repeat the INR on 6/23/17.

A Nurse's Note on 6/23/17 at 8:04 AM, stated the resident's Vital Signs were BP 113/65, Pulse 70, Respirations 18, Temperature 98.2.

A Nurse's Note on 6/23/17 at 12:12 PM indicated Resident #3's INR was greater than 8, and the nurse notified the resident's physician, who was in the facility at the time. The physician gave orders for Vitamin K 2.5mg [to promote blood clotting] to be administered orally and to check INR in 24 hours again.

A Nurse's Note on 6/24/17 at 8:04 AM specified the resident reported her pain was "0" out of 10, and Vital Signs were BP 95/58, Pulse 66, Respirations 18, and temperature was 98.3.

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 7	F 323		

A Nurse's Note on 6/24/17 at 2:41 PM indicated the nurse spoke to the on-call physician, reported the resident's INR was 7.1 and that the resident had extensive bruising over the left upper side of the body. The on-call physician was also informed the resident had a recent fall. There were no new orders.

On 6/24/17 at 5:30 PM, the regular attending physician called the facility, said he had spoken to Resident #3's family member and gave orders to send the resident to the hospital for evaluation.

The hospital Emergency Department dated 6/24/17 was reviewed. It revealed Resident #3 had bleeding into the muscle tissue, had a hemoglobin of 5.9g/dL and was admitted to the hospital with a diagnosis of traumatic anemia.

During an interview on 7/26/17 at 4:09PM, the Director of Nursing (DON) stated the she went in to see the resident immediately after the fall. The DON indicated the resident had been transferring with the sit-to-stand lift but her knees became weak and she just slid down. The DON stated she re-educated staff and took the mechanical lift out of service until it could be inspected. An immediate intervention was to use the total lift as the resident stated she just got weak. She also indicated the bruising on the left upper chest and left arm did not start to become evident until the day after the fall. The only injury noted on 6/21/17 were two skins tears to the resident hand and arm.

On 7/ 27/17 at 9:15 AM, Resident #3's attending physician was interviewed. He stated the facility immediately informed him about the fall on

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 323	Continued From page 8	F 323		

6/21/17 and he examined the resident the next day. The physician stated he wanted to be sure there was no head injury and no broken bones. He also stated that after the resident was sent out to the hospital on 6/24/17, he had called the hospital and spoken to the Emergency Department physician because this resident had a number of pre-existing conditions. He stated the hospital physician informed him there was no bleeding into the abdominal cavity, just the muscle tissues. He also stated the facility had kept him informed of the resident's status in the days after the fall.

Nursing Assistant (NA) #1, who was with the resident during the transfer and fall on 6/21/17, was interviewed on 7/27/17 at 12:58 PM. NA #1 said Resident #3 wanted to go to bed so she was transferring her with the mechanical lift. The NA indicated that after the resident was in the air, she started to slip, "so I pushed her to the bed so if she did slip it would be on the bed." The NA stated the resident slid off the bed and onto the floor. When asked if there were any concerns with how she had transferred the resident, NA #1 said "maybe the sling wasn't as tight as it could have been."

At 1:48PM on 7/27/17, NA#1 and NA #2 demonstrated a transfer. She stated two staff were required for a transfer by mechanical lift. NA #1 manipulated the lift control and NA #2 stood by and indicated she was the "spotter" to ensure the resident's safety.
On 7/27/17 at 2:04 PM, NA #1 explained how she had transferred Resident #3. When asked if there had been a second staff member during the transfer, NA #1 said "Yes." but she could not remember who was with her.

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 323	Continued From page 9	F 323		

On 7/27/17 at 2:51 PM, the Administrator was interviewed about the second staff member present for Resident #3's transfer. The Administrator indicated NA #1 had done the transfer without a second staff member present even though the policy and all training specified that mechanical lift transfers required two staff.

Plan of correction: Improper transfer by certified nursing assistant using the sit to stand lift.
Date of event: 06/21/2017

Corrective action for resident affected: This resident no longer resides at this facility. It is the policy of this facility that there will always be two staff members present during the transfer, one present to support the resident and one present to manipulate the lift. Immediate action taken on 06/21/2017 the DON removed the lift/sling until inspection for proper function could be identified. The DON also provided counseling to CNA involved concerning following facility lift policy for mechanical lifts and always having two staff members present.

Corrective actions taken for resident potentially affected: On 06/22/2017 the DON reviewed incident reports for the past thirty days and those residents who were assessed to require the use of mechanical lift to determine if policy was followed. No other residents were identified to be affected. Dates of 06/21/2017 thru 06/23/2017 the DON performed reeducation for certified nursing assistants on the policy specific to using two person transfer for mechanical lift. The facility will continue to assess proper lift status for residents upon admission and status change. The assessment will be performed by physical therapy

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 _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

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F 323	Continued From page 10	F 323		

and will be documented on the resident mobility/transfer profile assessment form. The physical therapist will communicate information verbally and via the assessment to DON/designee. The DON/designee will continue to place the residents lift status inside their closet door and the assessment will continue to be scanned into the resident's electronic health record.

Systemic Changes: Beginning 06/26/2017 the DON/designee will perform visual observation audits specific to the mechanical lift use to ensure two person utilized during transfer with lift. These audits will be performed three times weekly for one month, and then weekly for three months.

Quality Assurance: The DON will submit circumstances of event and related audits to the QAPI committee July 11th, 2017 and monthly until determined substantial compliance sustained.

Effective date of compliance June 23rd, 2017.

As part of the validation process on 7/26/17 through 7/28/17, the plan of correction was reviewed including the re-education of staff and observations of transfers to or from wheelchairs using the mechanical lift. All transfers observed were completed correctly. Interviews with nursing assistants revealed they were retrained in the areas of transfers, falls, where to obtain the information of what type of transfer should be used for a resident and to always have two staff present when using a mechanical lift. A review of the monitoring tools revealed that the facility completed the audit of transfers as noted in their POC. All in-servicing of nursing assistants was completed on 6/23/17 including NA#1 who had

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 323	Continued From page 11 transferred Resident #3 on 6/21/17. A review of the audits revealed audits had been conducted two to three times per week between 6/26/17 and 7/24/17. The Administrator provided evidence the issue of transfers had been discussed in the Quality Assurance meeting that had taken place on 7/11/17 and the facility was monitoring falls for trends. The final correction date was 6/23/17.	F 323		