STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

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E 000	Initial Comments An unannounced Recertification and Complaint Survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EPJV11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/25/22 through 4/28/22. Event ID #EPJV11 The following Intakes were investigated: NC00184071, NC00184511, NC00186050. 9 of the 9 complaint allegations were not substantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR. Findings included: Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.	F 641	How Corrective action was accomplished for those residents found to have been affected by the deficient practice: The MDS was corrected for Resident #31 on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) number. How the facility identified other residents having the potential to be affected by the same deficient practice: An MDS audit of all current residents was conducted by the MDS Nurse on 5/1/2022	5/13/22

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

Electronically Signed | 05/13/2022

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F 641	Continued From page 1 Record review indicated Resident #31 had a Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 11/12/15. The annual MDS assessment dated 12/03/21 was answered "No" to question A1500 which asked if Resident #31 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 4/27/22 at 2:12 PM with the MDS Nurse regarding PASRR documentation for Resident #31. The MDS Nurse stated the PASRR II documentation should have been completed when the Level II PASRR had been confirmed. She explained she was not working at the facility during that time and did not know why it was missed. An interview was conducted on 4/27/22 at 2:30 PM with the Administrator. The Administrator stated the MDS coding should have been completed for PASRR II residents on their annual MDS assessments.	F 641	to determine compliance with PASRR coding accuracy. All MDSs identified as not having the correct PASRR number coded on the MDS were corrected by 5/4/2022. Measures put into place to ensure that the same deficient practice does not recur: MDS Nurse received education on 5/1/2022 on coding accuracy for Section A of the MDS. The clinical team, which consists of: Social Worker, Director of Nursing, Unit Manager, MDS Nurse, Activities Director and Administrator received education on 4/5/2022, and again on 5/13/2022 on the process of the facility's social worker/ or designee communicating in the morning clinical meeting any new PASRR number issued to a resident. An audit of the medical record will be conducted each morning (Monday through Friday) during the facility's Morning Clinical Meeting by the Administrator/ or designee to ensure ongoing compliance with MDS coding accuracy for PASRRs. Facility's plan to monitor its performance to make sure that solutions are sustained includes: Audits will be reviewed in the facility's QAPI meeting monthly for three months. The facility's decision to extend the audits will be based on the findings of the audits.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		5/13/22

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F 644	Continued From page 2 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to make a referral for re-evaluation after a change in mental health status for 1 of 6 residents (Resident #62) reviewed for Pre-Admission Screening and Resident Review. Findings included: A review of the North Carolina Department of Health and Human Services, Division of Medical Assistance, Preadmission Screening and Annual Resident Review (PASRR) application, dated 10/28/17, revealed Resident #62's had no mental health diagnoses included on the application. Resident #62 had been given the determination of a PASRR Level 1 with no expiration date.	F 644	How Corrective action was accomplished for those residents found to have been affected by the deficient practice: A referral for re-evaluation for a PASRR level II request was submitted through NC Must by the facility's SW on 4/27/2022. How the facility identified other residents having the potential to be affected by the same deficient practice: An audit was conducted by the SW for all current residents to determine if additional residents needed a referral for re-evaluation for a PASRR level II request submitted. Applications were submitted	

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F 644	Continued From page 3 Resident # 62 was admitted to the facility on 12/04/20 with diagnoses which included post-traumatic stress disorder. A review of Resident #62's annual Minimum Data Set (MDS), dated 12/15/21, revealed Resident #62 was moderately cognitive impaired and had not been considered by the State Level II PASRR process to have a serious mental illness. The MDS indicated Resident #62 had diagnoses which included, in part, post-traumatic stress disorder. A review of Resident #62's Care Plan, last revised 03/25/22, revealed Resident #62 had been planned for a psychiatric disorder and having a mental illness/intellectual disability. During an interview with the Social Worker (SW) on 04/26/22 at 2:00 p.m., the SW stated she had been doing the PASRR tasks trying to catch up and had not submitted Resident #62 ' s changes yet. During an interview with the Administrator on 04/28/22 at 11:00 a.m., the Administrator stated he was aware of PASRR being updated and the staff is trying to catch them up. He stated he expected PASRRs are completed timely as per federal regulations.	F 644	through NC Must by 4/29/2022 for any resident identified as requiring a re-evaluation related to PASRR level II requests. Education was provided on 4/5/2022, and again on 5/13/2022 by the administrator to the Interdisciplinary Clinical Team, which consists of: The Director of Nursing, Social Worker, Unit Manager, Activities Director and MDS Nurse, on the requirements of identifying and communicating any mental health change, new mental health diagnosis, medications for the treatment of mental illness each morning, Monday through Friday, in the facility's morning clinical meeting; and that upon identifying such information, the SW/ or designee will immediately submit an application for a change of condition through NC Must for a PASRR level II request. Medical Record audits will be conducted by the administrator/ or designee in each morning clinical meeting for 90 days to ensure ongoing compliance. Facility's plan to monitor its performance to make sure that solutions are sustained includes: Audits will be reviewed in the facility's QAPI meeting monthly for three months. The facility's decision to extend the sudits will be based on the findings of the audits.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals	F 645		5/13/22

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F 645	Continued From page 4	F 645		

with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the

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F 645	Continued From page 5	F 645		

preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to include all mental health diagnoses on the Preadmission Screening and Resident Review (PASRR) Level I for 2 of 6 residents (Resident #12, and #55) reviewed for PASRR.

Finding included:

1. Resident #12 was admitted 09/18/2021 with diagnosis including type 2 diabetes mellitus. The Minimum Data Set (MDS) dated had diagnosis including psychotic disorder (other than

How Corrective action was accomplished for those residents found to have been affected by the deficient practice:

Referrals containing all mental health diagnoses for re-evaluation for a PASRR level II request was submitted through NC Must by the facility's SW on 4/27/2022 for both Residents #12 and #55. .

How the facility identified other residents having the potential to be affected by the same deficient practice:

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F 645	Continued From page 6 schizophrenia), and anxiety disorder. The MDS had Resident #12 coded as cognitively intact and needed extensive assistance. She also received an antipsychotic, antianxiety and an antidepressant for 7/7 days during the look back period. The comprehensive care plan dated 04/16/2022 had focus' of being on antipsychotic therapy daily due to delusional disorder and antianxiety therapy due to anxiety disorder. The diagnosis report had a diagnosis of delusional disorder dated 09/18/2021 and anxiety disorder dated 12/28/2021. The NCDHHS halted PASRR level II determination notification dated 04/21/2022 stated no further level I screen is required unless a significant change occurs with the individuals mental status which suggest a psychiatric disorder that is not dementia. The NC PASRR level I screen dated 04/15/2022 had Resident #12's disorder diagnosis listed as anxiety/panic disorder. The screen did not include the diagnosis of delusional disorder dated 09/18/2021. A Physician's order dated 04/23/2022 revealed an order for Risperdal Tablet 1 MG (risperidone) Give 1 tablet by mouth at bedtime, and Risperdal Tablet 0.5 MG (risperidone) 1 tablet by mouth in the morning. An interview with the Social Worker (SW) was conducted on 04/26/22 at 12:10 PM. The SW stated Resident #12 had a diagnosis of delusional disorder dated 09/18/2021 and anxiety disorder	F 645	An audit was conducted by the SW for all current residents to determine if additional residents needed a referral for re-evaluation for a PASRR level II request submitted as a result of missing mental health diagnoses not included on pervious application to PASRR. Applications were submitted through NC Must by 4/29/2022 for any resident identified as requiring a re-evaluation related to PASRR level II requests. Education was provided on 4/5/2022, and again on 5/13/2022 by the administrator to the Interdisciplinary Clinical Team, which consists of: The Director of Nursing, Social Worker, Unit Manager, Activities Director and MDS Nurse, on the requirements of identifying and communicating any mental health change, new mental health diagnosis, medications for the treatment of mental illness each morning, Monday through Friday, in the facility's morning clinical meeting; and that upon identifying such information, the SW/ or designee will immediately submit an application for a change of condition through NC Must for a PASRR level II request. Medical Record audits will be conducted by the administrator/ or designee in each morning clinical meeting for 90 days to ensure ongoing compliance. Facility's plan to monitor its performance to make sure that solutions are sustained includes: Audits will be reviewed in the facility's QAPI meeting monthly for three months.	

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F 645	Continued From page 7 dated 12/28/2021. The diagnosis for her delusional disorder should have been included with the mental health diagnosis on the screening tool for PASRR level II. An interview with the Administrator was conducted on 04/02/2022 at 11:04 AM. The Administrator stated the staff was educated on PASRR procedures. All new mental health diagnoses were expected to be included on the PASRR screenings to receive an accurate determination for proper placement of residents. 2. Resident #55 was admitted to the facility on 8/21/2020. His diagnoses included post-traumatic stress disorder (PTSD), dementia and major depressive disorder. The North Carolina PASRR Level I form for Resident #55 submitted 8/18/2020 included dementia and PTSD diagnoses. Major depressive disorder diagnosis was not included in the screening form. The North Carolina Department of Health and Human Services halted PASRR level II determination notification dated 08/18/2020 revealed no further Level I screening was required unless a significant change occurred with the individual's mental status which suggested a psychiatric disorder that was not dementia. An interview was conducted on 04/26/22 at 03:12 PM with the facility Social Services Coordinator (SSC). She indicated it was an error and Resident # 55's Level I PASRR paperwork should have included depression diagnosis when it was submitted to the State Agency.	F 645	The facility's decision to extend the sudits will be based on the findings of the audits.	

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F 645	Continued From page 8 An interview was conducted on 04/28/22 at 09:44 AM with the facility Administrator. The Administrator stated the depression diagnosis should have been included in Resident #55's PASRR screening submitted to the State Agency. He indicated going forward he would ensure all diagnoses were checked prior to submitting the screening paperwork.	F 645		