STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF WAYNESVILLE	360 OLD BALSAM ROAD WAYNESVILLE, NC 28786

(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 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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 2 of 4 residents' (Resident #61 and Resident #9) identified as	F 278	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	10/14/16

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

Electronically Signed | 10/07/2016

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F 278	Continued From page 1 Level II PASRR residents. Findings included: 1 a. Resident #61 was admitted to the facility on 03/22/11 and diagnoses included non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, and schizophrenia. A review of Section A of the comprehensive assessment Minimum Data Set (MDS) dated 12/03/15 indicated Resident #61 was not coded as determined by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents which was provided on 09/13/16 during the entrance conference indicated Resident #61 was determined as Level II PASRR. On 09/15/16 at 9:14 AM an interview was conducted with the MDS Coordinator who stated it was her responsibility to code Section A of the comprehensive assessment MDS. The MDS Coordinator stated the comprehensive assessment MDS dated 12/03/15 should have been coded to reflect Resident #61 was Level II PASRR and was missed for coding. The MDS Coordinator stated the comprehensive assessment MDS dated 12/03/15 would require a modification to reflect Resident #61 was determined as Level II PASRR.	F 278	submitted to meet requirements established by state and federal law. F278 The MDS for affected residents #61 and Resident#3 were corrected on 9/13/16. On 9/13/16, a 100 % audit was conducted on all Level II PASRR residents to ensure accuracy for the remaining residents within the facility. All assessments for the remainder of Level II PASRR residents was accurate. All residents have the potential to be affected with inaccurate assessments related to their care and needs. All Resident Assessment Coordinators will complete the Point Click Care in-service instructional video titled " Data Entry for MDS 3.0". This will be completed no later than 10/14/16. The D.O.N/designee will audit various sections of the MDS for coding accuracy. The sample size of the audit will be 25 percent of MDS's submitted monthly. The results of the audit will be reported in quarterly QAPI meetings until 100 percent compliance is achieved for 6 months and ongoing as needed.	

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F 278	Continued From page 2	F 278		

On 09/15/16 at 9:25 AM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the comprehensive assessment MDS dated 12/03/15 would have been accurately coded to reflect Resident #61 was determined as Level II PASRR. The DON stated her expectation was that the MDS Coordinator would correct Resident #61's comprehensive assessment MDS to reflect Level II PASRR determination.

On 09/15/16 at 09:35 AM an interview was conducted with the Administrator. The Administrator stated it was his expectation that the Level II PASRR determination would have been accurately coded on Resident #61's comprehensive assessment MDS dated 12/03/15. The Administrator stated it was his expectation that the comprehensive assessment MDS dated 12/03/15 would be modified by the MDS Coordinator to accurately reflect Resident #61 was determined as Level II PASRR.

1 b. Resident #9 was admitted to the facility on 11/15/15 and diagnoses included non-Alzheimer's dementia, anxiety disorder, and manic depression (bipolar disease).

A review under Section A of the comprehensive assessment Minimum Data Set (MDS) dated 05/17/16 indicated Resident #9 was not coded as determined by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and a set of

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F 278	Continued From page 3	F 278		

recommendations for services to help develop an individual's plan of care.

A review of the facility's list of Level II PASRR residents which was provided on 09/13/16 during the entrance conference indicated Resident #9 was determined as Level II PASRR.

On 09/15/16 at 9:14 AM an interview was conducted with the MDS Coordinator who stated it was her responsibility to code Section A of the comprehensive assessment MDS. The MDS Coordinator stated the comprehensive assessment MDS dated 05/17/16 should have been coded to reflect Resident #9 was Level II PASRR and was missed for coding. The MDS Coordinator stated the comprehensive assessment MDS dated 05/17/16 would require a modification to reflect Resident #9 was determined as Level II PASRR.

On 09/15/16 at 9:25 AM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the comprehensive assessment MDS dated 05/17/16 would have been accurately coded to reflect Resident #9 was determined as Level II PASRR. The DON stated her expectation was that the MDS Coordinator would correct Resident #9's comprehensive assessment MDS to reflect Level II PASRR determination.

On 09/15/16 at 09:35 AM an interview was conducted with the Administrator. The Administrator stated it was his expectation that the Level II PASRR determination would have been accurately coded on Resident #9's comprehensive assessment MDS dated 05/17/16. The Administrator stated it was his

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F 278	Continued From page 4 expectation that the comprehensive assessment MDS dated 05/17/16 would be modified by the MDS Coordinator to accurately reflect Resident #9 was determined as Level II PASRR.	F 278		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to securely close and label frozen foods to prevent freezer burn for 3 boxes containing bags of frozen foods. The findings included: During an observation on 09/13/16 at 9:54 AM with the Food Service Director (FSD) the walk in freezer temperature was observed at 10 degrees below zero. The observation revealed 3 cases of food items that were opened to air and not sealed as follows: 1 bag containing frozen pork patty fritters was not securely sealed 1 bag containing burger patties was not securely sealed 1 case containing a bag of breaded yellow	F 371	This Plan of Correction constitutes my written allegation for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F371 No residents were affected by the alleged deficient practice. A 100 percent audit of all frozen products was conducted by the Dietary Manager on 9/13/16. All frozen food was/is stored , labeled, and dated correctly,; with interior bags sealed or tied tightly. In-service on properly stored, frozen products in the freezer was conducted by	10/7/16

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F 371	Continued From page 5 squash was not dated when opened and was not securely sealed. The FSD verified the yellow squash was opened and not sealed or dated and all the 3 bagged foods were opened and were frosted white colored. During an Interview on 09/15/16 at 4:26 PM the FSD revealed the cooks and the cook's aids were the staff responsible for stocking and pulling items from the freezers. The FSD further revealed that when an item in the freezer was opened by a staff they would have securely sealed the package and dated the box with the date of opening but would still go by the expiration date on the box. The FSD verified the boxes in the freezer were opened and the bags were open and the product appeared a white frosted color. The FSD stated it was his expectation that packages should be sealed and dated after opened. During an interview on 09/16/16 at 11:06 AM the Administrator it was his expectation that all packaged food items in the freezer were dated, labeled, and securely closed when opened.	F 371	the Dietary Manager on 9/20/16 to all dietary staff members. The Dietary Manager has created a checklist and log for all employees to sign when storing frozen products in the freezer. The log will require employees to sign off that all frozen products are dated and sealed according to the facilities policies and federal regulations. Audits of frozen products will be conducted twice weekly for 30 days to ensure all products are stored , labeled, and dated correctly,; with interior bags sealed or tied tightly. Random audits by Dietary Manager, or designee ; with corrective action taken as needed for any products that are not dated or sealed appropriately. The Administrator will conduct weekly audits x 6 weeks in conjunction with the Dietary Manager. Areas of concern will be addressed at the time of identification. Findings of these audits will be reported at the facilities quarterly QAPI meeting for a minimum of 6 months by the Dietary Manager.	