PRINTED: 07/19/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345553	B. WING		C 06/07/2017		
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 000 INITIAL COMMENT	-S	F 00				
complaint investigat 06/07/2017. Event 483.20(b)(1) COMP ASSESSMENTS (b) Comprehensive (1) Resident Asses must make a compresident's needs, st preferences, using to instrument (RAI) sp assessment must in (i) Identification an (ii) Customary rout (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and behat (vii) Psychological to problems. (ix) Continence.	Assessments Assessment Instrument. A facility rehensive assessment of a trengths, goals, life history and the resident assessment ecified by CMS. The include at least the following: and demographic information tine. In avior patterns. Well-being. Junctioning and structural Desis and health conditions. ritional status. s. rsuit.	F 27:		7/1/17		
(xv) Special treatme (xvi) Discharge (xvii) Document regarding the additi on the care area of the Minimum Dat	ents and procedures. planning. ation of summary information onal assessment performed as triggered by the completion		TITLE	(X6) DATE		

06/27/2017

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345553	B. WING _			06/0) 7/2017
NAME OF PI	ROVIDER OR SUPPLIER	l	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00/0	7172011
				1401 71ST SCHOOL ROAD			
AUTUMN	CARE OF FAYETTEVILL	E		FAYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI		(X5) COMPLETION DATE
F 272	Continued From page	e 1	F 2	272			
	assessment. The ass	ion of participation in sessment process must					
		and communication with					
	the resident, as well as communication with licensed and						
	non-license on all shifts.	ed direct care staff members					
	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						
	and staff interviews th	iew, resident observation, ne facility failed to assess straints for 1 of 1 sampled 102)		This plan of correction will facility's allegation of compl requirements of 42 CFR, Pa Subpart-B for long term car Preparation and submission correction is in response to	liance with art 483, e facilities. n of this plar	n of	
	admitting diagnoses i disabilities, chronic ki and epilepsy. Her mo	dney disease, Hypertension st recent Minimum Data Set		for the June 7, 2017 survey constitute an agreement or Autumn Care of Fayetteville the facts alleged or the corr	and does radmission of the truth rectness of t	not of h of the	
	cognitively impaired. staff with the assistan other activities of dail	7 indicated he was severely He was totally dependent on ice of 2 persons with all y living, bed mobility and coded as having a restraint.		conclusions stated on the s deficiencies. This plan of co prepared and submitted be requirements of42 CFR, Pa Subpart B throughout the ti	orrection is cause of the art 483,		
		observed on 6/5/2017 at		stated in the statement of d accordance with state and	eficiencies.		
		a vest/trunk restraints.		however, submits this plan address the statement of de	of correction	n to	
	Set (MDS) nurse #1 of The MDS nurse state	ducted with Minimum Data on 6/6/2017 at 11:51 AM. d the vest on the resident's used as restraints due to		to serve as its allegation of with the pertinent requirement dates stated in the plan of as fully completed as of Jul	compliance ents as of th correction ar	e ne	

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION B	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) 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 STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 272 F 275 F 276 F 277 F 2			345553	B. WING		l l	7/2017
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 FREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 272 F					1401 71ST SCHOOL ROAD	06/07/2017	
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 F 272 For affected resident: On 6/6/17 a significant correction assessment was done by MDS for the	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETION DATE
assessed and be coded correctly accurately in the MDS for the use of restraints. 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		safety concerns. The have assess and coor the residents having An interview with the conducted on 6/6/20 stated it was her explassessed and be co	e nurse stated she should ded section P of the MDS as a restraints. Administrator (AD) was 17 at 12:34 PM. The AD ectation that the resident be ded correctly accurately in	F 27	F 272 For affected resident: On 6/6/17 a significant correction assessment was done by MDS for affected resident (#102) to accurate capture the use of a physical restra was re-submitted. Resident's (#102) plan was updated to reflect the charon 6/7/17 by MDS. For other residents with the potential affected: On 6/21/17 a facility audit was initial and completed by the unit manager reviewing every resident for restrain No other residents were identified. The MDS department was re-educa 6/22/17 regarding 483.20(b) (1) comprehensive assessments, to en accurate coding and assessing resistatus on the MDS by the Administrestratus on the MDS by the Administrestraint audit tool will be completed the DON, unit managers, or designed weekly for 2 months to ensure restrances are completed accurate thoroughly, and coded on the MDS restraint assessment audit tool will new admissions and current resider identified with the potential for restrance. The audits will be taken to monthly	nt and) care nges al to be ted s it use. Ited on sure dent ator. ee: eed by ee aint tely, The review nts aint	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345553	B. WING _		C 06/07/2017
	ROVIDER OR SUPPLIER CARE OF FAYETTEVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	1 00/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 278 SS=D	(g) Accuracy of Assemust accurately reflection (h) Coordination A registered nurse reach assessment with participation of health (i) Certification (1) A registered nurse the assessment is considered to the assessment must sith that portion of the assessment must sith at portion of the assessment who willfully and known (i) Certifies a materine resident assessment; or (ii) Causes another	essments. The assessment ect the resident's status. nust conduct or coordinate ith the appropriate th professionals. se must sign and certify that ompleted. who completes a portion of the gn and certify the accuracy of ssessment. cation and Medicaid, an individual owingly- al and false statement in a t is subject to a civil money than \$1,000 for each	F 2	78	7/1/17
	subject to a civil mo \$5,000 for each ass (2) Clinical disagree material and false si This REQUIREMEN	ment does not constitute a			
		view, resident observation, the facility failed to accurately		This plan of correction will serve as facility's allegation of compliance w	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDI	_		، ا	
		345553	B. WING				07/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
ALITURAN	CARE OF FAVETTEVILL	-		14	401 71ST SCHOOL ROAD		
AUTUMN	CARE OF FAYETTEVILL	E		F.	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page		F	278			
		cal restraints for 1 of 1			requirements of 42 CFR, Part 483,		
		sident # 102), the facility			Subpart-B for long term care facilities.	_	
		curately the diagnosis of			Preparation and submission of this pla		
		se of an antidepressant for 1			correction is in response to DHHS 256		
	of 1 sampled residen	t (Resident # 21).			for the June 7, 2017 survey and does reconstitute an agreement or admission		
	Findings included:				Autumn Care of Fayetteville of the truth		
	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				the facts alleged or the correctness of		
					conclusions stated on the statement of		
					deficiencies. This plan of correction is		
					prepared and submitted because of the	•	
					requirements of42 CFR, Part 483,		
	· · ·	7 indicated he was severely			Subpart B throughout the time period		
		He was totally dependent on			stated in the statement of deficiencies.	In	
		ice of 2 persons with all			accordance with state and federal law,	- 4-	
		y living, bed mobility and coded as having a restraint.			however, submits this plan of correction address the statement of deficiencies and the statement of deficiencies and the statement of the stat		
	transier. Tie was not	coded as flaving a restraint.			to serve as its allegation of compliance		
	Resident #102 was o	observed on 6/5/2017 at			with the pertinent requirements as of the		
	11:30 AM as having a				dates stated in the plan of correction a		
	3				as fully completed as of July 1, 2017.		
	An interview was con	ducted with Minimum Data					
	Set (MDS) nurse #1 of	on 6/6/2017 at 11:51 AM.					
		d the vest on the resident's			F-278		
	_	used as restraints due to					
		nurse stated she should			For affected resident:		
	have coded section F				On 6/7/17 MDS modified the admission		
	residents having a re-	straints.			assessment for the 2/25/17 ARD date	or	
	An interview with the	Administrator (AD) was			affected resident (#21). On this same date, a significant correction was done	hv	
		17 at 12:34 PM. The AD			MDS for the affected resident (#21) to	Бу	
		ectation that the MDS be			capture the use of an anti-depressant	and	
	coded correctly and a				the diagnosis of depression. Resident's		
		•			(#21) care plan was updated to reflect		
					changes on 6/7/17 by MDS. On 6/6/17		
					significant correction assessment was		
					done by MDS for the affected resident		
					(#102) to accurately capture the use of		
					nhysical restraint and was re-submitted	1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345553	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	343333		STREET ADDRESS, CITY, STATE, ZIP CODE	06/07/2017
NAME OF T	KOVIDER OR OUT FEEL			1401 71ST SCHOOL ROAD	
AUTUMN	CARE OF FAYETTEVILL	Ē		FAYETTEVILLE, NC 28314	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 278	Continued From page	e 5	F 278	Resident's (#102) care plan was upda to reflect the changes on 6/7/17 by ME	
	admitting diagnoses i coronary artery disea gastro-esophageal re hyperlipidemia. Her r Set (MDS) dated 2/25 cognitively intact. The resident was not code depression (Section I medication (Section I	flux, depression, and most recent Minimum Data 5/2017 indicated she was a MDS also indicated the ed for her diagnosis of and no antidepressant N). revealed admission d 2/18/2017 for Citalopram 20 milligrams orally daily for of the February Medication d (MAR) indicated the antidepressant every day w period. In 6/07/2017 at 5:10 pm, the ted it was an over-site that antidepressant had not dmission MDS. She stated ed the diagnosis and the Admission MDS.		For other residents with the potential to 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 used a diagnosis of depression is pres No other residents were identified. Or 6/21/17 a facility audit was initiated an completed by the unit managers reviewery resident for restraint use. No other residents were identified. The MDS department was re-educated 6/22/17 regarding 483.20(g) (j) assessment accuracy/coordination/certified, to ensure accurate coding and assessing residents status on the MDS by the Administration of the MDS by the Administration of the MDS and the MDN, unit managers, or designee weekly for 2 months to ensure anti-depressant/depression assessmentare completed accurately, thoroughly, coded on the MDS. The anti-depressant/depression assessmental tool will review new admissions a current residents identified with the potential for anti-depressant use and diagnosis of depression.	if ent. d wing er d on ure nt r. pol

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						l	
		345553	B. WING_			06/	07/2017
	ROVIDER OR SUPPLIER CARE OF FAYETTEVILLI	≣		14	IREET ADDRESS, CITY, STATE, ZIP CODE 101 71ST SCHOOL ROAD AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 6	F2	278	The audits will be taken to monthly QAI meeting for committee to deem compliance.	PI	
F 356 SS=C	483.35(g)(1)-(4) POS INFORMATION	TED NURSE STAFFING	F3	356	1		7/1/17
	483.35 (g) Nurse Staffing Info (1) Data requiremen the following informat	ts. The facility must post					
	(i) Facility name.						
	(ii) The current date.						
	by the following categ	aff directly responsible for					
	(A) Registered nurses	3.					
	(B) Licensed practical vocational nurses (as	nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					
	(iv) Resident census.						
	(2) Posting requireme	nts.					
		ost the nurse staffing data n (g)(1) of this section on a inning of each shift.					
	(ii) Data must be post	ed as follows:					
	(A) Clear and readabl	e format.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345553	B. WING _				C 07/2017
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	,	
ALITLIMN	CARE OF FAYETTEVILL	E		1401	1 71ST SCHOOL ROAD		
AUTOMIN	CARE OF PATETIEVILL	E		FAY	ETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	2 7	F 3	556			
	(B) In a prominent pla residents and visitors	ace readily accessible to					
	The facility must, upo make nurse staffing of	posted nurse staffing data. In oral or written request, Italia available to the public of to exceed the community					
	(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 interviews the facility daily staffing hour she recertification survey Registered Nurse (RI	n, record review and staff failed to post the current eet for 1 of 4 days of the and separate out the actual N) and Licensed Practical n the daily staffing sheets for ed.		1 1 1	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 plar correction is in response to DHHS 2567 for the June 7, 2017 survey and does no constitute an agreement or admission of	n of 7 not	
	The findings include:			1	Autumn Care of Fayetteville of the truth the facts alleged or the correctness of t	n of the	
	daily staffing hour she 06/02/17, and indicate Practical Nurses/Reg 4 Licensed Practical on second shift and 2 Nurses/Registered N staffing was not poster During an interview of the 10/10/10/10/10/10/10/10/10/10/10/10/10/1	ed there were 6 Licensed istered Nurses on first shift, Nurses/Registered Nurses Licensed Practical urses on third shift. The daily		(conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. accordance with state and federal law, however, submits this plan of correction address the statement of deficiencies at to serve as its allegation of compliance with the pertinent requirements as of the	In n to and	
		as responsible for posting		(dates stated in the plan of correction ar as fully completed as of July 1, 2017.		

(X3) DATE SURVEY COMPLETED	
C 06/07/2017	
00/01/2011	
(X5) COMPLETION TE DATE	
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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345553	B. WING _			C 06/07/2017		
	ROVIDER OR SUPPLIER	.E		STREET ADDRESS, CITY, STATE, ZIP CO 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 PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 520	staff, at least one of administrator, owner individual in a leader (g)(2) The quality as committee must: (i) Meet at least quare coordinate and evaluate identifying issues with assessment and assessme	ter members of the facility's who must be the to a board member or other ship role; and seessment and assurance of terly and as needed to uate activities such as the respect to which quality turance activities are seement appropriate plans of outfield quality deficiencies; formation. A State or the require disclosure of the mittee except in so far as lated to the compliance of the requirements of this faith attempts by the fand correct quality one used as a basis for the record review and staff of the compliance of the requirements of this one used as a basis for the record review and staff of the compliance of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff of the compliance of the record review and staff	F	This plan of correction will s facility's allegation of complia requirements of 42 CFR, Par Subpart-B for long term care Preparation and submission correction is in response to [ance with rt 483, e facilities. of this plan of DHHS 2567			
	This was for one rec subsequently cited d	ited deficiency that was		for the June 7, 2017 survey a constitute an agreement or a Autumn Care of Fayetteville	and does not admission of			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		` '	ATE SURVEY DMPLETED	
		345553	B. WING _			06/0	;)7/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00/0	7772011	
				1401 71ST SCHOOL ROAD				
AUTUMN	CARE OF FAYETTEVILL	E		FAYETTEVILLE, NC 28314				
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F 520	Continued From page	e 10	F 5	220				
F 520	nurse staffing information of the facility during to show a pattern of the an effective Quality A. The findings included. This tag is cross referobservation, record rethe facility failed to pohour sheet for 1 of 4 consumers and Licerhours on the daily stadays reviewed. On 07/21/2016, the famintain nurse staffing months. During an interview of Administrator stated that the facility for two rehours heets and was. During an interview of Administrator stated it daily staffing hour sheets.	tition. The continued failure wo federal surveys of record facility's inability to sustain ssurance Program. : renced to F 356: Based on eview and staff interviews out the current daily staffing days of the recertification out the actual Registered nsed Practical Nurse (LPN) ffing sheets for 64 of 68 acility was cited for failure to g data for a minimum of 18 In 06/07/17 at 1:30 PM, the hat he had been employed months and there had not elated to the daily staffing not brought to QAA. In 06/07/17 at 4:05 PM, the tis his expectation that the eets be posted daily and rese and Licensed Practical	F 5	the facts alleged or the correct conclusions stated on the state deficiencies. This plan of corre prepared and submitted because requirements of 42 CFR, Part 4 Subpart B throughout the time stated in the statement of deficience accordance with state and fed however, submits this plan of content of address the statement of deficit to serve as its allegation of correct with the pertinent requirements dates stated in the plan of correct as fully completed as of July 1. F-520 For affected residents: No residents were affected. For other residents with the posificated: No potential for residents to be facility plan to prevent re-occuron 6/8/17, the Regional Direct services educated the facility's Administrator and Director of Nother quality and assessment an assurance process on maintain implemented procedures and rof these interventions to prevent re-occurrence. On 6/8/17, the legional prevent re-occurrence.	ement of ection is use of the 183, period ciencies. I eral law, correction iencies at mpliance is as of the ection and 1, 2017.	In to nd e nd be		
				Director of clinical services edu facility's Administrator and Director Nursing on the posting of daily process per federal regulation includes the separation of LPN hours.	ector of staffing which			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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AUTUMN CA	ARE OF FAYETTEVILLE			FAYETTEVILLE, NC 28314				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE	
F 520 (Continued From page	11	F 5.		veeks and ing tools veeting for			