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 ______	C 03/16/2018

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 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 correctly code a pressure ulcer on the discharge Minimum Data Set (MDS) for 1 of 3 residents reviewed for accuracy of assessment (Resident #1). Findings included: Resident #1 was admitted to the facility 11/03/17 with diagnoses including neurogenic bladder, generalized muscle weakness, and essential tremors. A review of the most recent discharge MDS dated 02/22/18 revealed Resident #1 had moderately impaired cognition. Section M0300 was marked to indicated a stage 2 pressure ulcer was present during the assessment period. Review of the physician order summary report revealed wound care dressing changes every Monday, Wednesday, Friday, and as needed for an unstageable pressure ulcer with a start date of 02/19/18. Review of a progress note dated 02/19/18, the Nurse Practitioner (NP) identified a large unstageable wound during a physical exam. Review of the bi-weekly skin check dated 02/21/18 revealed an unstageable pressure ulcer.	F 641	Preparation and submission of this POC is required by state and federal law. This POC does constitute an admission for purposes of general liability, professional malpractice or other court procedures. The facility maintains, that all MDS assessments accurately affect the resident□s status. During the survey process it was identified that the MDS Coordinator did not use the most recent wound documentation in the resident EMR (Electronic Medical Record) to code section M0300. The MDS for affected Resident #1 was modified and retransmitted on 04/09/2018 to reflect an un-stageable wound within section M. A 100 percent audit was done on all residents with a Discharged MDS transmitted dating back to 12/01/2017. All residents that have been discharged from 12/01/2017 through present were audited to ensure the transmitted MDS was consistent with the physicians/ Nurse Practioner's most recent wound assessment. No other residents were identified as having inconstancies between the wound documentation and what was coded in Section M of the MDS.	4/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/10/2018

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.

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AUTUMN CARE OF WAYNESVILLE	**360 OLD BALSAM ROAD** **WAYNESVILLE, NC 28786**

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F 641	Continued From page 1 During an interview on 03/16/18 at 4:31 PM, the MDS Coordinator explained she reviewed the weekly wound assessment dated 02/16/18 indicating a stage 2 pressure ulcer. She also explained weekly wound assessments were discontinued and Resident #1 was discharged 02/22/18. The MDS Coordinator revealed she did not know the pressure ulcer was identified unstageable on 02/19/18 and 02/21/18. She explained she did not review the NP progress note, the wound care orders, or the bi-weekly skin check. She explained the weekly wound assessment was reviewed for pressure ulcer information. She also revealed if the NP progress note, the wound care order, or the bi-weekly skin check were reviewed, she would have checked unstageable in section M0300, but she did not review those notes. During an interview on 03/16/18 at 5:22 PM, the Administrator revealed his expectations were for the MDS Coordinator to correctly code assessments to reflect the resident. He agreed Resident #1 had an unstageable pressure ulcer according to the wound care orders, the NP progress note, and the bi-weekly skin check during the MDS discharge assessment period.	F 641	All residents have the potential to be affected by inaccurate assessments related to their care and needs. All Resident Assessment Coordinators will complete an educational webinar focusing on data entry and accuracy for MDS 3.0. 'This will be completed no later than 04/13/18. The facility has partnered with a wound and skin specialist company to provide consistency with skin assessments and measurements. All clinical staff were inserviced by the facilities dedicated wound nurse on 4/17/18, with the focus being on resident repositioning, skin assessments, and proper communication to the wound nurse and IDT. The facility has added a skin/wound committee that will meet weekly. Committee members will include the Administrator, D.O.N., QA Nurse, wound nurse, and both MDS Coordinators. The facilities wound nurse will participate in weekly skin/wound rounds with the wound NP to ensure the assessment of the specialist is communicated to the committee. During the meeting the committee will audit the residents EMR to ensure that the resident/s identified with skin/wound issues have consistent care plans and MDS coding with the specialists assessments; when applicable. Any inaccuracies will be discussed with the committee and corrected during the meeting at which they were identified. This committee and meeting will be weekly and continue for the foreseeable	

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F 641	Continued From page 2	F 641	future but no less than a minimum of 12 months. The D.O.N. or designee will audit all discharged residents MDS Section M prior to discharge to ensure accuracy of what is being coded is consistent with the most recent skin/wound assessment in the residents□ EMR. Any inaccuracies of her findings will be addressed with the MDS Coordinator and corrected. Audits will continue until compliance is achieved for 3 months. DON will audit random MDS interviews and coding weekly x3 months. Results of the DON/designee findings will be presented at the facilities IDT quarterly QAPI to ensure compliance and identify any trends or patterns requiring corrections. D.O.N is responsible for implementing this POC.	