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 10/09/2018

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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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		10/13/18

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

Electronically Signed | 10/11/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to develop a comprehensive care plan to address the known behavior of Resident #3 entering the rooms of other residents without their permission for 1 of 1 residents reviewed. The findings included: Resident #3 was admitted to the facility on 11/1/17 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting left non-dominant side, heart disease, chronic obstructive pulmonary disease, depression, anxiety, and Alzheimer ' s disease. The plan of care for Resident #3 included the focus area of a self-care deficit. This area was initiated on 11/2/17 and most recently revised on 2/9/18. The interventions included a motorized wheelchair for Resident #3. A social service note dated 5/14/18 indicated Resident #3 utilized a power wheelchair to move throughout the facility. He was noted to be sociable with staff and other residents. This note stated, "[Resident #3] has a problem with inviting himself into others rooms to talk, but he feels he is being company to others". A social service note dated 5/21/18 indicated the Social Worker (SW) spoke with Resident #3 ' s family related to him "going into others rooms	F 656	The Care Plan for Resident #3 was updated on 10/9/2018 by the facility's Social Worker to address the known behavior of his desire to enter the rooms of other residents without their permission. Each Resident's Care Plan was reviewed on 10/11/2018 by the Interdisciplinary Team; includes the Director of Nursing, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Assistant Director of Nursing and Unit Manager #1 and Unit Manager #2 to ensure that any behavior was addressed in the Care Plan and that the Care Plan was Person-Centered. During the review, four resident care plans required updating. The following systemic changes that will be implemented to ensure that the deficient practice will not recur are 1. Review of the 24 Hour Report by the entire Interdisciplinary Team; which includes Director of Nursing, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Assistant Director of Nursing and Unit Manager #1 and Unit Manager #2 at least five days a week and 2. Review of all Concerns/Grievances by the entire Interdisciplinary Team at least five days a week. The Director of Nursing will ensure that any behaviors identified will be	

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F 656	Continued From page 2 without permission". The quarterly Minimum Data Set (MDS) assessment dated 7/24/18 indicated Resident #3 ' s cognition was moderately impaired. He was coded with no behaviors. Resident #3 required supervision of 1 staff for locomotion on and off the unit and he utilized a wheelchair. Resident #3 ' s comprehensive care plan was reviewed on 10/9/18 at 12:10 PM. This comprehensive care plan revealed no mention of Resident #3 entering the rooms of other residents without their permission. A phone interview was conducted with Nurse #1 on 10/9/18 at 12:01 PM. She indicated she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She reported Resident #3 frequently entered other resident rooms. She revealed sometimes Resident #3 entered other resident rooms without the resident ' s permission. Nurse #1 indicated that all of the staff were aware of this behavior and they monitored him closely to ensure he only entered other resident rooms after being invited in. An interview was conducted with Nurse #4 on 10/9/18 at 12:43 PM. She indicated she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She reported Resident #3 frequently entered other resident rooms. She revealed sometimes Resident #3 entered other resident rooms without the resident ' s permission. Nurse #4 indicated that all of the staff were aware of this behavior and they monitored him closely to ensure he only entered other resident rooms after	F 656	addressed in the respective Resident's Care Plan. The DON will provide education to all nurses on updating the Care Plan to reflect the needs of each resident. Education will be provided to all fulltime, part-time and PRN nurses by 10/13/2018. Any staff that do not receive education by 10/13/2018 will be required to receive the re-education prior to coming back to work. The DON will monitor the facility's performance to ensure that solutions are sustained by conducting an audit in which the 24 Hour report and Concern/Grievances are compared to each Resident's Care Plan. The audits will be completed five times a week for all residents with behaviors noted in the 24 Hour Report or a Concern/Grievance. The audits will be reviewed each week in the facility's Risk Meeting and Monthly in its Quality Assurance and Performance Improvement Meeting for a period of three months. The DON will bring the information to the QAPI meeting each month and to the Risk Meeting each week. The facility's decision to extend the audits past 90 days will be determined by the QAPI Committee based on the content of the audits.	

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being invited in.

A phone interview was conducted with Nurse #2 on 10/9/18 at 2:30 PM. She indicated she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She reported Resident #3 frequently entered other resident rooms. She revealed sometimes Resident #3 entered other resident rooms without the resident ' s permission. Nurse #2 indicated that all of the staff were aware of this behavior and they monitored him closely to ensure he only entered other resident rooms after being invited in.

A phone interview was conducted with Nurse #3 on 10/9/18 at 3:00 PM. She indicated she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She reported Resident #3 frequently entered other resident rooms. She revealed sometimes Resident #3 entered other resident rooms without the resident ' s permission. Nurse #3 indicated that all of the staff were aware of this behavior and they monitored him closely to ensure he only entered other resident rooms after being invited in.

An interview was conducted with Nursing Assistant (NA) #1 on 10/9/18 at 4:10 PM. She indicated she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She reported Resident #3 frequently entered other resident rooms. She revealed sometimes Resident #3 entered other resident rooms without the resident ' s permission. NA #1 indicated that all of the staff were aware of this behavior and they monitored him closely to ensure he only

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entered other resident rooms after being invited in.

An observation and interview were conducted with Resident #3 on 10/9/18 at 1:30 PM. Resident #3 was in his room seated in a motorized wheelchair. Resident #3 was alert and oriented. He indicated that he liked talking to people and preferred to be out of his room socializing throughout the day. Resident #3 reported he got bored if he was just sitting in his room.

An interview was conducted with the SW on 10/9/18 at 2:00 PM. She reported she was familiar with Resident #3. She stated he utilized a motorized wheelchair and traveled throughout the facility daily. She indicated Resident #3 was very social and he enjoyed talking to residents, staff, and visitors. The SW revealed she was aware that he frequently entered other resident rooms with or without their permission. She indicated she had spoken with Resident #3 on more than one occasion and educated him that he needed to be invited into another resident ' s room before entering. She stated she had also spoken with staff about this behavior and instructed them to monitor him and to redirect him if he was found in another resident ' s room without their permission.

This interview with the SW continued. The care plan for Resident #3 was reviewed with the SW. She confirmed the care plan had not addressed Resident #3 ' s behavior of entering the rooms of other residents without their permission. She revealed she was responsible for revising the care plans related to behaviors and she indicated she was going to update Resident #3 ' s care plan

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F 656	Continued From page 5 on this date (10/9/18). An interview was conducted with the Director of Nursing (DON) on 10/9/18 at 3:55 PM. She indicated she was familiar with Resident #3 and was aware he entered other resident rooms daily with or without their permission. She reported that the staff were aware of this behavior for Resident #3 and they monitored him closely to ensure he had permission to be in another resident ' s room. The DON indicated that she expected the comprehensive care plans to address behavioral issues of residents.	F 656		