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 02/01/2019

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
E 000	Initial Comments There were no deficiencies cited as a result of this emergency preparedness investigation survey of 02/01/19. Event ID # 0V7K11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID # 0V7K11.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) related to a significant change as required within 14 days for 1 of 3 residents reviewed for activities of daily living (ADL) (Resident #63). The findings included: Resident #63 was admitted to the facility on 09/14/17 with diagnoses which included diabetes mellitus, neurogenic bladder.	F 637	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with state and federal requirements. Problem. Change of status MDS not completed	2/28/19

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

Electronically Signed | 02/22/2019

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 02/01/2019

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 637	Continued From page 1 During a comparative review of Resident # 63's Annual Assessment MDS dated 10/13/18 and Quarterly Review Assessment MDS dated 01/13/19, a total of 5 area of declines in ADL under Section G were identified: Locomotion on unit - from supervision to limited assistance Locomotion off unit - from supervision to limited assistance Eating - from limited assistance to extensive assistance Toilet use - from limited assistance to extensive assistance Personal hygiene - from limited assistance to extensive assistance Further review of Resident #63's MDS records revealed a Significant Change in Status Assessment (SCSA) was not completed within 14 days after the submission of 01/13/19 Quarterly Review Assessment MDS with 5 ADL areas having declines. During an interview conducted on 01/30/19 at 2:04 PM, MDS Coordinator #2 (MC #2) stated she was responsible for the completion and submission of Resident #63's MDS dated 01/13/19. She was not sure if there were 2 or more area of changes under Section G, a SCSA MDS would be required. MC #2 stated she would check with the corporate staff for clarifications. During a subsequent interview conducted on 01/30/19 at 5:38 PM, MC #2 stated she had clarified with corporate staff and acknowledged that after the 01/13/19 Quarterly Review Assessment MDS, the facility was required to complete a SCSA MDS within 14 days if there	F 637	when resident met criteria to have Change of status Corrective action for affected resident Resident #63 had change of status, as soon as it was identified and completed. No resident was negatively affected by this missed assessment. The plan of care was reviewed and modified as needed after the assessment was completed How will the facility identify other like residents that have the potential to be affected and what corrective action will be done? To identify other residents that have the potential to be affected the MDS Coordinators completed an audit on 2/21/19, using the facilities EMR ADL Index Report and Weight Summary Report, then cross-referenced these reports with completed MDS to ensure the last 30 days of MDS were correct and did not require a Significant Change Assessment. There were no negative findings. What will you do to prevent this from recurring or what systemic change will you implement? To prevent this from recurring on 2-6-2019 the Regional Reimbursement nurse provided education to the MDS Coordinators and Dietary Manager that included the definition of a Significant Change and Guidelines for Determining a Significant Change in a Residents Status from Chapter 2 of the RAI Manual. The	

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 02/01/2019

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 637	Continued From page 2 were 2 or more area of declines/improvements under Section G. She added it was an error for not submitting a SCSA MDS within 14 days after the 01/13/19 MDS assessment as Resident #63 had 5 area of declines in ADL. During an interview conducted on 02/01/19 at 10:07 AM, the Director of Nursing (DON) stated if there were 2 or more area of changes under Section G, she expected the MDS Coordinator to complete and submit a SCSA MDS within 2 weeks. It was her expectation for the MDS Coordinators to follow the Centers of Medicare & Medicaid Services (CMS) rules and regulations to complete MDS as required accurately and in timely manner.	F 637	remaining members of the IDT were in-serviced on the requirements of significant change assessments on 2/27/19. All new hired IDT members and employees with MDS assessment responsibilities will receive training on the requirement. Beginning the week of 2/25/19, the IDT will review all MDS' weekly whose ARD is scheduled during the time period of the weekly meeting by using the facilities EMR ADL Index Report and Weight Summary Report to determine if a Significant Change Assessment is needed or if the residents condition is a temporary variation in the residents status. If there are any negative findings, corrections will be made following the RAI guidelines. How will you monitor and maintain ongoing compliance? To monitor and maintain ongoing compliance the MDS Coordinators will audit 3 MDS assessments per week for 12 weeks to ensure that there were no significant change required. The facility employees 2 MDS Coordinators and each will be responsible for auditing the others assigned patient MDS'. These audits will begin the week of 2/25/19. If there were any negative findings, they will be corrected following the RAI guidelines. QAPI The results of the weekly findings will be discussed in the facilities Quarterly QAPI meeting. The QA committee will	

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 02/01/2019

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 637	Continued From page 3	F 637	determine the need for increase in the frequency based on the results of the findings. The facility DON is responsible for compliance The facility will be in compliance by 2/28/19	
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 interview the facility failed to accurately code the Minimum Data Set (MDS) in the area of discharge status for 1 of 3 sampled closed records (Resident #79). The findings included: Resident #79 was admitted to the facility on 12/07/18 with diagnoses including hip fracture among others. The 5-day admission MDS dated 12/14/18 also revealed Resident #79 had short and long-term memory problems and required extensive to total assistance for all activities of daily living. Record review revealed a progress note from the Social Worker dated 01/11/19 revealed Resident #79 was discharged home with family. Review of the discharge MDS revealed Resident #79 was discharged from the facility on 01/11/19 to the hospital.	F 641	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with state and federal requirements. Problem Inaccurate coding of MDS identified Corrective action for affected resident Resident #79 had modification of MDS to reflect accurate discharge location. How will the facility identify other like residents that have the potential to be affected and what corrective action will be done? To identify other residents that have	2/28/19

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 02/01/2019

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	Continued From page 4 During an interview with MDS Coordinator #1 on 01/30/19 at 6:16 PM, she stated the coding on the MDS for Resident #79 had been a mistake. She further stated this should have been coded as a discharge back home in the community and not to the hospital. During an interview with the Director of Nursing (DON) on 01/30/19 at 6:30 PM, she stated her expectations were for the MDS coding to be accurate.	F 641	potential to be affected the MDS Coordinators and DON completed an audit on 2/1/19 using the facilities Discharge Location Report and cross-referenced with all MDS' from discharged residents from 11/1/18-2/1/19 to ensure the last 90 days of discharges were coded correctly. What will you do to prevent this from recurring or what systemic change will you implement? To prevent this from recurring on 2-6-2019 the Regional Reimbursement Nurse provided and reviewed education to MDS coordinators that included copies of RAI Manual Coding Instructions A2100 OBRA Discharge Status. All new hired MDS Coordinators will receive training on this requirement. IDT was in-serviced on OBRA Discharge Status Coding Instructions on 2/27/19. Beginning the week of 2/25/19 MDS Coordinators will run the Facilities Discharge Location Report from the facilities EMR weekly. All residents discharged during the week will be audited with the IDT to ensure the MDS' discharge status is accurate. How will you monitor and maintain ongoing compliance? To monitor and maintain ongoing compliance the MDS Coordinators will audit 3 MDS□' weekly for accuracy for the next 12 weeks. This will begin the week of 2/11/19. The facility employs 2 MDS	

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 02/01/2019

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	Continued From page 5	F 641	Coordinators that are assigned a patient caseload. No Coordinator will audit their own work. Immediate corrections will be made with any negative findings. QAPI The results of the weekly findings will be discussed in the Quarterly QAPI meeting. The QA committee will determine the need for increase in the frequency based on the results of the findings. The facility DON is responsible for compliance. The facility will be in compliance by 2/28/19	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		2/28/19

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 02/01/2019

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 761	Continued From page 6 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to discard one unopened bottle of nitroglycerin sublingual tablets in 1 of 4 medication carts in the facility. Findings included: Resident #58 was admitted to the facility on 10/19/16 with diagnoses included heart failure, peripheral vascular disease, and Parkinson's disease. During medication storage check conducted on 01/30/19 at 5:51 PM, one unopened bottle of nitroglycerin 0.4 milligram (mg) sublingual tablets expired on December 2018 was found in the medication cart for 400 hall. Review of physician's orders dated 12/29/17 revealed Resident #58 had an ordered to take nitroglycerin 0.4 mg 1 tablet sublingually every 5 minutes as needed for angina - might repeat up to 3 times. This physician order was discontinued on 08/19/18. During an interview conducted on 01/30/19 at 5:58 PM, Nurse #1 stated that the expired nitroglycerin had been discontinued. When a medication was discontinued, the nurse who received the discontinuation order was supposed to pull the medication and returned it to the	F 761	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with state and federal requirements. Problem Expired medication located in the medication cart that was not removed after order was discontinued. Corrective action for affected resident? The expired medication found on the cart was removed immediately and returned to pharmacy. No residents were affected by this deficient practice How will the facility identify other like residents that have the potential to be affected and what corrective action will be done? All residents have the potential to be affected by this deficiency 100% medication cart audit was completed on 2/1/19 by ADON and QA	

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 02/01/2019

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 761	Continued From page 7 pharmacy. Nurse #1 acknowledged that the nitroglycerin was expired and needed to be pull from the cart. He had been instructed to check the medication cart for expired medications each shift and check expiration before administration to ensure proper storage. During an interview conducted on 01/30/19 at 6:08 PM, the Assistant Director of Nursing (ADON) acknowledged that the nitroglycerin was expired and should not be stored in the medication cart. She stated that the facility had a system in place to ensure all medications were properly stored, labeled, and free of expired medications. The DON explained the Quality Assurance (QA) nurse checked all the medication carts and storage rooms at least once per month or as needed. All the nurses were ordered to check their medication cart for time sensitive medications at least once daily and check the expiration date before administration. The ADON stated that the nitroglycerin order was no longer active and the expired nitroglycerin would never be used. She attributed the incident as a human error. During an interview conducted on 01/31/19 at 3:25 PM, the QA Nurse stated that she conducted weekly medication checks for all 4 medication carts and the 2 medication storage rooms to ensure proper storage, labeling and kept the facility free of expired medications. She added she missed pulling Resident #58's expired nitroglycerin when she did recent weekly medication checks as she thought the unopened bottle of nitroglycerin in the cart was still active and the medication was not expired. She further stated that she should have check the nitroglycerin.	F 761	Nurse. No further expired medications were found. What will you do to prevent this from recurring or what systemic change will you implement? In-service was conducted on 2/7/19 by the ADON to the licensed nursing staff as well as the Medication Aides. The topic of the In-service was Disposal and Destruction of discontinued Medication to ensure that medication that is not ordered, has expired, or been discontinued will be removed from the medication carts. All new hired Licensed Nurses and Medication Aides will receive training on the requirement. QA Nurse or Designee will perform audits on all Medication Carts weekly. The audits will begin the week of 2/25/19. DON or designee will utilize the facilities EMR Medication Order Listing report weekly that will show all medications that have been discontinued to ensure the medications have been removed from the med cart. How will you monitor and maintain ongoing compliance? Beginning the week of 2/25/19,the DON or designee will perform a complete audit of 2 medication carts weekly for 4 weeks, then 2 per week for 4 weeks then 1 per week for 4 weeks. Audits will focus on identifying any expired medications and to ensure all medications are dated and	

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 02/01/2019

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 761	Continued From page 8 During an interview conducted on 02/01/19 at 10:07 AM the Director of Nursing (DON) stated she expected all the medications to be stored and labeled properly and expired medications removed from the medication carts and storage rooms. She further stated it was her expectation for all the nurses to follow manufacturer's storage guidelines and facility's medication storage policies and procedures.	F 761	stored appropriately. QAPI The results of the audits will be discussed with the QAPI committee quarterly and further monitoring or increase in frequency will be determined by the QA committee based on the findings. The DON is responsible for compliance. Compliance date is 2/28/19	