STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 An unannounced Recertification survey was conducted on 09/10/19 through 09/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WDLR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 09/10/19 through 09/13/19. Event ID# WDLR11. 2 of 2 complaint allegations were not substantiated.	F 000		
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 complete a Brief Interview of Mental Status for 1 of 17 sampled residents whose Minimum Data Set Assessments (MDS) were reviewed (Resident #17). The facility also failed to accurately code an MDS assessment for 1 of 17 residents whose MDS was reviewed (7). The findings included: 1. Resident #17 was admitted to the facility on 7/3/19 and had a diagnosis of dementia. Review of the Admission MDS dated 7/10/19 under Section C, (Brief Interview of Mental Status), each section read: "not assessed." An interview was conducted with the MDS Coordinator on 9/11/19 at 9:16 AM. The MDS Coordinator stated the social worker was	F 641	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a. Resident #7 was assessed by the Social Worker with use of the Brief Interview of Mental Status (BIMS) on 09/12/2019 on paper copy. 1b. Resident # 17□s documentation was noted by the MDS (Minimum Data Set) Coordinator and MDS was modified and resubmitted on 09/12/2019. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. 100% of all current residents were audited to ensure that each resident has a current BIMS score by the Social Worker	9/24/19

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

Electronically Signed | 09/20/2019

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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F 641	Continued From page 1 responsible for conducting the Brief Interview of Mental Status (BIMS) on the MDS. The MDS Coordinator further stated she did the other part of the Resident #17 ' s MDS and signed off on it. On 9/12/19 at 9:06 AM an interview was conducted with the Social Worker. The Social Worker stated she was on vacation at the time the MDS was completed for Resident #17. The Social Worker further stated in July 2019 corporate was making some changes and there was some confusion as to whether speech therapy was going to do some of the BIMS assessments or all of the BIMS for the MDS assessments. The Social Worker continued and stated when the MDS Coordinator did the MDS she put in "not assessed." On 9/12/19 at 9:22 AM the MDS Coordinator stated the BIMS had not been done and when she coded the MDS it was past the ARD (Assessment Reference Date) and she was not allowed to go back and do the BIMS. The MDS Coordinator further stated a BIMS had not been done since the Admission MDS was completed on 7/10/19. On 9/13/19 at 11:46 AM the Director of Nursing stated in an interview she was not aware the BIMS had not been done for Resident #17, but she would expect a BIMS to be done. On 9/13/19 at 12:11 AM the Administrator stated in an interview the BIMS should have been captured on the MDS and because someone was on vacation there should have been back-up. 2. Resident #7 was admitted to the facility on	F 641	on 09/13/2019. 2b. 100% of all submitted assessments within the last 30 days has been audited by the MDS Coordinator to note accuracy of the dressing on the MDS is coded correctly, completed on 09/20/2019. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. 1:1 education was completed with the Social Worker by the Administrator on 09/12/2019 on completion of BIMS during the ARD period for all Long Term Care Residents and MDS Coordinator will be back-up when not in facility to complete. 3b. 1:1 education was completed with the MDS Coordinator by the Regional Director of Clinical Services (RDCS) on 09/18/2019 on ensuring that all information that is coded on the MDS is verified during ARD period and prior to submission of assessment. 3c. Any newly hired staff in the Social Services Role and/or the MDS Coordinators Role will be educated on this information. 4. Indicate how the facility plans to monitor it□s performance to make sure that solutions are sustained: 4a. All resident□s within the ARD period requiring a BIMS assessment will be discussed in the clinical morning meeting by the Administrator/designee to ensure that each assessment has a BIMS assessment 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then weekly times 4 weeks. 4b. All resident□s within the ARD period requiring dressing documentation will be	

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F 641	Continued From page 2 2/25/19 and had a diagnosis of dementia with behaviors, dysphagia (difficulty swallowing), congestive heart failure (CHF) and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) Assessment dated 8/26/19 revealed the resident had severe cognitive impairment and required extensive assistance of 2 persons for bed mobility, transfers, toileting, personal hygiene and bathing. Dressing was coded as 7,2 which means dressing only occurred once or twice with the assistance of one person. On 9/12/19 at 9:16 AM an interview was conducted with the MDS Coordinator who stated she coded the MDS for Resident #7 dated 8/26/19. The MDS Coordinator was observed to review her documentation and stated the nursing assistant noted the resident ' s clothing was changed every day except for one day. The MDS Coordinator further stated dressing on the MDS was not coded correctly and should have been coded 3,3 (extensive assistance with 2 persons) and she would correct the error. An interview was conducted with the Director of Nursing (DON) on 9/13/19 at 11:45 AM. The DON stated it was her expectation the MDS be coded correctly. On 9/13/19 at 12:11 PM the Administrator stated in an interview he expected the MDS to be coded correctly.	F 641	discussed in the clinical morning meeting by the DON/designee to ensure that the coding is correct; this will be done 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then weekly for 4 weeks. 4c. Results of audit(s) will be presented for review monthly for 3 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented. 5. Date of completion : 09/24/2019.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		9/24/19

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F 690	Continued From page 3 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and review of the facility policy, the facility failed to secure an indwelling urinary catheter to prevent excessive pulling or	F 690	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a. Resident #30 had a catheter	

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F 690	Continued From page 4 dislodgement of the catheter for 1 of 2 residents reviewed for indwelling urinary catheters (Resident #30). The findings included: The facility policy titled Catheter Care Urinary Male-Female revised on 7/2015 noted the purpose was to prevent infection of the resident ' s urinary tract along with daily visualization of the catheter site. The section titled Procedure #18 read: "Secure catheter utilizing a leg band." Resident #30 was admitted to the facility on 1/5/17 and had a diagnosis of neurogenic bladder. The most recent Minimum Data Set (MDS) Assessment (Annual) dated 7/23/19 revealed the resident had severe cognitive impairment, required extensive assistance with bed mobility and toileting and had an indwelling urinary catheter. Review of the physician ' s orders revealed an order dated 2/14/17 than read: "Anchor catheter tubing and check placement every shift." The resident ' s Care Plan dated 9/6/17 noted the resident had an indwelling catheter for urine retention related to neurogenic bladder. The interventions included the following: Assess/document for pain/discomfort due to catheter. Secure catheter. Report signs/symptoms of urinary tract infection. Routine catheter care. Provide privacy cover for drainage bag. On 9/12/19 at 1:00 PM Nursing Assistant (NA) #1 was observed to provide catheter care for Resident #30. The resident ' s catheter tubing was stretched over the left thigh and was not	F 690	anchor/strap applied to indwelling catheter to prevent pulling and dislodgement. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. 100% of all current residents with orders for indwelling catheter was audited by the Director of Nursing (DON) on 09/12/2019 to ensure that any resident with indwelling catheter had an anchor/strap to ensure that indwelling catheter was stabilized to prevent pulling and/or dislodgement. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. 1:1 education was completed by the DON on 09/12/2019 with NA#1 if noted that a resident(s) with an indwelling catheter does not have an anchor/strap with indwelling catheter to notify the nurse, immediately. 3b. 1:1 education was completed with Nurse #1 by the DON on 09/12/2019 if any resident(s) is noted to have an indwelling catheter to ensure that an anchor/strap is in place appropriately to prevent pulling and dislodgement. 3c. 100% of education was completed by the DON on 09/24/2019 with all clinical staff to ensure that all indwelling catheters are to have an anchor/strap present and/or attached appropriately on each resident with an indwelling catheter. 3d. All newly hired clinical staff will be educated by the DON/designee on proper use of and ensuring that all residents with an indwelling catheter has an anchor/strap	

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F 690	Continued From page 5 secured to the thigh. NA #1 was asked if the facility used a device to secure the catheter and the NA stated the resident used to have a device to secure the catheter but had not had one in at least several months. On 9/12/19 at 1:25 PM an interview was conducted with Nurse #1 who was assigned to Resident #30. The nurse was asked about a device to secure the catheter tubing for Resident #30 and the Nurse stated they did have a device to secure urinary catheter tubing and asked: "Does she not have one?" The Nurse stated she would apply the device to secure the resident ' s catheter. On 9/13/19 at 11:50 PM the Director of Nursing stated in an interview that some residents refused to wear the device to secure a urinary catheter but it was her expectation for Resident #30 to have the urinary catheter secured. On 9/13/19 at 12:16 PM the Administrator stated in an interview it was his expectation the staff understand the policy to care for a urinary catheter and the need to bring it to someone ' s attention to address immediately.	F 690	to secure catheter tubing from pulling and/or dislodgement. 4. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained: 4a. Any resident(s) with a indwelling catheter will be identified and reviewed/audited in the clinical morning meeting by the DON/designee. DON/designee will then physically identify and check that each resident with an indwelling catheter will have an anchor/strap attached 5 times per week for 4 weeks; then 3 times per week for 4 weeks; then weekly times 4 weeks. 4b. Results of audit will be presented for review monthly for 3 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented. 5. Date of Completion : 09/24/2019.	