DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF DREXEL SITESTADDRESS, CITY, STATE JIP CODE 307 OAKLAND AVENUE MORGANTON, NC 28855 PREFIX PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PROVIDERS PROVIDES PROVIDERS PLAN OF CORRECTION PROVIDES PROVIDES PROVIDES PROVIDE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
AUTUMN CARE OF DREXEL AUTUMN CARE OF DREXEL MORGANTON, NC 2885 PROFICE ADDRESS, CITY, STATE 2P CODE MORGANTON, NC 2885 PROFICE ADDRESS, CITY, STATE 2P CODE MORGANTON, NC 2885 PROPRIETY TAG PROFICE ADDRESS BAN OF CORRECTION (EACH DEPICION OF US 180 INSTITUTIONS INCOMMITTION) Initial Comments An unannounced Recertification and Complaint Investigation Survey was conducted on 02/17/20 through 02/20/20. The facility was found in compliance with the requirement CFR 483-73, Emergency Preparedness. Event ID# LBAO11. F 000 An unannounced Recertification and Complaint Investigation Survey was conducted from 02/17/20 through 02/20/20. There were 5 complaint allegations investigated and they were all unsubstantiated. Event ID# LBAO11. F 641 SS=D CFR(s): 483-20(g) S483-20(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 accurately code 1 of 1 sampled resident reviewed for hospitalization utilizing the Minimum Data 3et (MDS) to reflect discharge status (Resident #99). Findings included: Resident #99 was admitted to the facility on 12/3/119 with diagnosis of pneumonia. A physician's order dated 01/07/20 indicated Resident #99 was to be discharged home on 01/10/200 with home health services, nursing, physical therapy and occupational therapy. A review of the physician's discharge summary A review of the physician's discharge summary A review of the physician's discharge summary REQUIREMENT STATUS PROVIDED TO SERVICE STATUS STATUS PROVIDED TO SERVICE STATUS STA			345222	B. WING _					
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG					307 OAKLAND AVENUE			1 02/20/2020	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	ADODATOR					TITLE	-	(X6) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/03/2020

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.

Electronically Signed

Facility ID: 922950

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345222	B. WING			C 2/20/2020	
NAME OF P	ROVIDER OR SUPPLIER	0.0222		STREET ADDRESS, CITY, STATE, ZIP CODE		2/20/2020	
TO UNIC OF T	TO VIDER OR GOLF EIER			307 OAKLAND AVENUE			
AUTUMN	CARE OF DREXEL			MORGANTON, NC 28655			
				<u>, </u>			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From page	e 1	F 64	1			
	Resident #99 was discondition on 01/10/20 The discharge MDS a	the practitioner indicated scharged to home in stable). assessment dated 01/10/20 on A, A2100 Discharge		modification was completed or #99 to accurately reflect the dishome on 02/18/2020. Administ in-serviced the MDS coordinate proper RAI guidelines for dischlocation on 02/20/2020.	scharge trator ors on		
	discharged to the cor	#99 was not coded as nmunity and was coded as		Because other resident assess			
	she was responsible Discharge Status on MDS dated 01/10/20. stated she knew that discharge to the com miscoded the dischar incorrect box. The MI would need to modify MDS dated 01/10/20	PM an interview was IDS Coordinator who stated for coding Section A, A2100 Resident #99's discharge The MDS Coordinator Resident #99 had been munity on 01/10/20 and rge status by checking the DS Coordinator stated she and submit the Discharge		have the ability to be affected to Administrator completed a MD location audit for discharges we six months on 02/20/2020. In coassure continued compliance, Administrator or Designee will discharge location on all discharge location on all discharge hocation on all discharge when completed for the next 3. The completion date for this Pour 103/05/2020. The results of the findings will discussed in the monthly QAP. The QA committee will determine the pound of the pound	S discharge ithin the last order to audit arge MDS 0 days. OC is be I meeting.		
	who stated her expect Coordinator would had discharge MDS dated Resident #99 was distinct The DON stated her of MDS Coordinator wo Discharge MDS dated Resident #99 was distinct to the DON of the DON	irector of Nursing (DON) ctation was that the MDS ave accurately coded the d 01/10/20 to reflect ccharged to the community. expectation was that the uld modify and submit the d 01/10/20 to reflect ccharged to the community.		need for an increase in the free based on the results of the find. The title of the person respons implementing the acceptable p correction is the Administrator.	quency lings. ible for lan of		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 307 OAKLAND AVENUE MORGANTON, NC 28655	E .	
(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)		
F 641	stated the MDS Coord submit the Discharge	e Administrator further dinator would modify and MDS dated 01/10/20 to sident #99 was discharged to	F6	41		