345280 B. WING 04/28/2022 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
WWE OF PROVIDER OR SUPPLIER SIMMARY STATEMENT OF DEFICIENCIES SIMMARY STATEMENT OF DEFICIENCIES ITERET ADDRESS. CITY. STATE. 2P CODE (M1) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP PROVIDER SPLAN OF CORRECTION CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP CMMEL CMMEL CMMEL (M2) D SIMMARY STATEMENT OF DEFICIENCIES IP CMMEL C			B. WING		C 04/28/2022	
UNUTUR CARE OF RAEPORD RAEFORD, NC 28376 (24) D PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EFECIANCY UNIST & PERCENDED BY NULA REGULATORY OR USE DEMTFYING INFORMATION) D PRETX TAG PROVIDER'S PLANOF CORRECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE 0,000 COMMENT (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE 0,000 COMMENT (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE THE ADDEST IN COORDINATE OF APPROPRIATE STORE STORE TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE STORE TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE STORE TO THE APPROPRIATE DEFICIENCIES THE APPROPRIATE STORE TO THE APPROPRIATE DEFICIENCIES TO THE APPROPRIATE STORE TO THE APPROPRIATE APPROPRIATE APPROPRIATE STORE TO THE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROP	AME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PREFIX TAG (EACH OBFICIENCY MST BE PRECEDED BY FULL REDULTORY OR LSCIDENT FYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMMENT DEFICIENCY) E 000 Initial Comments E 000 E 000 Initial Comments E 000 An unannounced Recertification and Complaint Survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EPJV11 F 000 F 000 F 000 A recertification and complaint investigation survey was conducted from 4/26/22 through 4/28/22. Event ID #EPJV11 F 000 F 000 Solution for the 9 complaint allegations were not substantiated. F 641 Solutacy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Dreadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR. How Corrective action was accomplished for those residents found to have been affected by the deficient practice: The MDS was corrected for Resident #31 on 731/2022 to relife the Correct Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR. How the facility identified other residents having the potential to be affected by the same deficient practice: The MDS was corrected for the facility on S(29716 and most recently readmited on 328/21/9 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder. How the facility identified other r	ИТИМИ С	ARE OF RAEFORD				
An unannounced Recertification and Complaint Survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID #EPJV11 F 000 INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/25/22 through 4/28/22. Event ID #EPJV11 The following Intakes were investigated: NC00184071, NC00184511, NC00186050. 9 of the 9 complaint allegations were not substantiated. Same GF 641 Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REOUREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set forlings included: Findings included: Findings included: Findings included: Resident #31 was admitted to the facility on 5/12/22 to reflect the correct Preadmission Screening and Resident #31) reviewe (PASRR) number. Findings included: <td>PREFIX</td> <td>(EACH DEFICIENC</td> <td>Y MUST BE PRECEDED BY FULL</td> <td>PREFIX</td> <td>(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA</td> <td>E COMPLETIC</td>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETIC
Survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EPJV11F 000F 000INITIAL COMMENTSF 000A recertification and complaint investigation survey was conducted from 4/25/22 through 4/28/22. Event ID #EPJV11 The following Intakes were investigated: NC00184071, NC001840511, NC00186050. 9 of the 9 complaint allegations were not substantiated.F 641F 641Accuracy of AssessmentsF 641Ss=0CFR(s): 483.20(g)F 641& 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 code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.How Corrective action was accomplished for those resident practice: The MDS was corrected for Resident #31 on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.How the facility identified other residents having the potential to be affected by the same deficient practice:Findings included:Resident #31 was admitted to the facility on S/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How DS audit of all current residents was	E 000	Initial Comments		E 000		
A recertification and complaint investigation survey was conducted from 4/25/22 through 4/28/22. Event ID #EFJ.V11 The following Intakes were investigated: NC00184071, NC00184071, NC00186050. 9 of the 9 complaint allegations were not substantiated.F 641F 641F 641Accuracy of Assessments CFR(s): 483.20(g)F 6415/13/22§ 483.20(g)\$483.20(g)Seessments. 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 code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.How Corrective action was accomplished for those resident's due to corect Preadmission Screening and Resident Review (PASRR) number.Findings included:Resident #31 was admitted to the facility on 5/29/15 and most recently readmited on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How the facility is all current residents was		Survey was conducte 4/28/22. The facility w the requirement CFR Preparedness. Even	d on 4/25/22 through vas found in compliance with 483.73, Emergency t ID #EPJV11	F 000		
SS=DCFR(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 code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.How Corrective action was accomplished for those residents found to have been affected by the deficient practice:Findings included:The MDS was corrected for Resident #31 on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) number.Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How the facility identified other residents was		survey was conducte 4/28/22. Event ID #EI The following Intakes NC00184071, NC001 9 of the 9 complaint a	d from 4/25/22 through PJV11 were investigated: 84511, NC00186050.			
resident's status.This REQUIREMENT is not met as evidenced by:Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.How Corrective action was accomplished for those residents found to have been affected by the deficient practice:Findings included:The MDS was corrected for Resident #31 on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) number.Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How the facility identified other residents having the potential to be affected by the same deficient practice:	SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy	of Assessments.	F 641		5/13/22
(MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 31) reviewed for PASRR.affected by the deficient practice:Findings included:The MDS was corrected for Resident #31 on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) number.Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How the facility identified other residents having the potential to be affected by the same deficient practice: An MDS audit of all current residents was		resident's status. This REQUIREMENT by:	is not met as evidenced			
reviewed for PASRR.on 5/1/2022 to reflect the correct Preadmission Screening and Resident Review (PASRR) number.Findings included:New iew (PASRR) number.Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.How the facility identified other residents 		(MDS) assessment a	ccurately in the area of		affected by the deficient practice:	
Resident #31 was admitted to the facility on 5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder. How the facility identified other residents having the potential to be affected by the same deficient practice: An MDS audit of all current residents was					on 5/1/2022 to reflect the correct	
5/29/15 and most recently readmitted on 03/28/19 after hospitalization with multiple diagnoses that included psychotic disorder, schizophrenia, and mood disorder.having the potential to be affected by the same deficient practice:An MDS audit of all current residents was		Findings included:			-	
mood disorder. An MDS audit of all current residents was		5/29/15 and most rec after hospitalization w	ently readmitted on 03/28/19 vith multiple diagnoses that		having the potential to be affected by the	
			· • /			

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.

						<u>10. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDING		С	
		345280	B. WING			4/28/2022
	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP COD		4/20/2022
				1206 N FULTON STREET	-	
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 641	Continued From pag	e 1	F 64	1		
1 041		e i ited Resident #31 had a	F 04			
		ning and Resident Review		to determine compliance with coding accuracy. All MDSs ic		
		termination Notification dated		not having the correct PASRF		
	11/12/15.			coded on the MDS were correctly 5/4/2022.		
	The annual MDS ass	sessment dated 12/03/21				
		to question A1500 which		Measures put into place to er		
		1 had been evaluated by a		same deficient practice does	not recur:	
		letermined to have a serious				
	related condition.	intellectual disability or a		MDS Nurse received education		
				5/1/2022 on coding accuracy of the MDS. The clinical tear		
	An interview was cor	nducted on 4/27/22 at 2:12		consists of: Social Worker, D		
		Irse regarding PASRR		Nursing, Unit Manager, MDS		
		esident #31. The MDS		Activities Director and Admini		
	Nurse stated the PAS	SRR II documentation should		received education on 4/5/20	22, and	
	have been complete	d when the Level II PASRR		again on 5/13/2022 on the pr	ocess of the	
		She explained she was not		facility's social worker/ or des	•	
		/ during that time and did not		communicating in the mornin		
	know why it was mis	sed.		meeting any new PASRR nur		
	An interview was set	ducted on 1/27/22 at 2:20		to a resident. An audit of the		
		nducted on 4/27/22 at 2:30 trator. The Administrator		record will be conducted each (Monday through Friday) duri		
		ng should have been		facility's Morning Clinical Mee		
		R II residents on their annual		Administrator/ or designee to	• •	
	MDS assessments.			ongoing compliance with MD		
				accuracy for PASRRs.	0	
				Facility's plan to monitor its p		
				to make sure that solutions a	re sustained	
				includes:		
				Audits will be reviewed in the	facility's	
				QAPI meeting monthly for thr	•	
				The facility's decision to exter		
				will be based on the findings		
F 644	Coordination of PAS CFR(s): 483.20(e)(1)	ARR and Assessments	F 644			5/13/22

Facility ID: 922954

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345280		B. WING			C 04/28/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 644	Continued From page	2	F	644				
	pre-admission screer (PASARR) program u of this part to the may avoid duplicative test includes:	nate assessments with the ning and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination						
	from the PASARR lev PASARR evaluation r	rating the recommendations rel II determination and the report into a resident's nning, and transitions of						
	all residents with new serious mental disord related condition for l a significant change i	ng all level II residents and ly evident or possible er, intellectual disability, or a evel II resident review upon n status assessment. is not met as evidenced						
	Based on record rev facility failed to make after a change in mer residents (Resident #	iew and staff interviews, the a referral for re-evaluation ntal health status for 1 of 6 62) reviewed for ning and Resident Review.			How Corrective action was accomplish for those residents found to have been affected by the deficient practice: A referral for re-evaluation for a PASRI level II request was submitted through	२		
	Findings included:				Must by the facility's SW on 4/27/2022			
	Health and Human S Assistance, Preadmis	Carolina Department of ervices, Division of Medical ssion Screening and Annual SRR) application, dated			How the facility identified other residen having the potential to be affected by the same deficient practice:			
	Resident Review (PASRR) application, dated 10/28/17, revealed Resident #62's had no mental health diagnoses included on the application. Resident #62 had been given the determination of a PASRR Level 1 with no expiration date.				An audit was conducted by the SW for current residents to determine if addition residents needed a referral for re-evaluation for a PASRR level II requires submitted. Applications were submitted	onal iest		

Facility ID: 922954

If continuation sheet Page 3 of 9

PRINTED: 05/26/2022

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	יסיד וו או (אַי)	E CONSTRUCTION	(X3) DATE SURVEY		
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			
				с			
		345280	B. WING		04/28/2022		
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	CARE OF RAEFORD			1206 N FULTON STREET			
				RAEFORD, NC 28376			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIC		
F 644	Continued From page	e 3	F 64	4			
		dmitted to the facility on		through NC Must by 4/29/2022 for	any		
	12/04/20 with diagnos	ses which included		resident identified as requiring a	-		
	post-traumatic stress	disorder.		re-evaluation related to PASRR lev			
	A review of Resident	#62's annual Minimum Data		requests. Education was provided 4/5/2022, and again on 5/13/2022			
		15/21, revealed Resident		administrator to the Interdisciplinar	-		
		cognitive impaired and had		Clinical Team, which consists of: T			
		by the State Level II PASRR		Director of Nursing, Social Worker,			
	•	rious mental illness. The		Manager, Activities Director and M			
		ent #62 had diagnoses rt, post-traumatic stress		Nurse, on the requirements of iden and communicating any mental he			
	disorder.	n, post-traumatic stress		change, new mental health diagno			
				medications for the treatment of me			
	A review of Resident	#62's Care Plan, last revised		illness each morning, Monday thro	ugh		
		esident #62 had been		Friday, in the facility's morning clini			
		atric disorder and having a		meeting; and that upon identifying			
	mental illness/intellec	ciual disability.		information, the SW/ or designee w immediately submit an application			
	During an interview w	vith the Social Worker (SW)		change of condition through NC M			
		o.m., the SW stated she had		a PASRR level II request. Medical			
		R tasks trying to catch up		audits will be conducted by the			
		d Resident #62 ' s changes		administrator/ or designee in each			
	yet.			morning clinical meeting for 90 day ensure ongoing compliance.	/s to		
	During an interview w	vith the Administrator on		ensure ongoing compliance.			
	•	n., the Administrator stated		Facility's plan to monitor its perform	nance		
	he was aware of PAS	SRR being updated and the		to make sure that solutions are sus			
		them up. He stated he		includes:			
		e completed timely as per		Audito will be reviewed in the facilit	hulo		
	federal regulations.			Audits will be reviewed in the facilit QAPI meeting monthly for three mo	-		
				The facility's decision to extend the			
				will be based on the findings of the			
F 645 SS=D	PASARR Screening f CFR(s): 483.20(k)(1)		F 64	5	5/13/22		
	§483.20(k) Preadmis	sion Screening for					
	individuals with a me						

Facility ID: 922954

If continuation sheet Page 4 of 9

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/26/2022 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	ILTIPLE CONSTRUCTION DING			SURVEY LETED
		345280	B. WING		_	04/2	28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF RAEFORD			1206 N FULTON STREET			
	1			RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	Continued From page with intellectual disab		F 64	15			
	or after January 1, 19 (i) Mental disorder as (i) of this section, unlease authority has determine independent physical performed by a perso State mental health a (A) That, because of the condition of the individed the level of services period (B) If the individual re- services, whether the specialized services; (ii) Intellectual disability of authority has determine (A) That, because of the condition of the individed the level of services period intellectual disability of authority has determine (A) That, because of the condition of the individed the level of services period and (B) If the individual re- services, whether the specialized services for §483.20(k)(2) Exception (i) The preadmission se paragraph(k)(1) of this for determinations in the	and mental evaluation n or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or ty, as defined in paragraph n, unless the State or developmental disability ned prior to admission- the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or intellectual disability.					

If continuation sheet Page 5 of 9

	-	ND HUMAN SERVICES					RM APPROVE	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345280	B. WING				C 04/28/2022	
NAME OF PI	ROVIDER OR SUPPLIER	·	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF RAEFORD				06 N FULTON STREET AEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE	
F 645	to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nur- condition for which the the hospital, and (C) Whose attending before admission to to is likely to require less facility services. §483.20(k)(3) Definiting section- (i) An individual is con- disorder if the individual disorder defined in 48 (ii) An individual is con- disorder defined in 48 (ii) An individual is con- intellectual disability in intellectual disability in intellectual disability in a described in 435.101 This REQUIREMENT by: Based on record rev facility failed to include diagnoses on the Pre- Resident Review (PA) residents (Resident # PASRR. Finding included:	ing program under his section to the admission f an individual- to the facility directly from a hig acute inpatient care at the sing facility services for the he individual received care in physician has certified, he facility that the individual s than 30 days of nursing ion. For purposes of this insidered to have a mental ual has a serious mental 33.102(b)(1). Insidered to have an if the individual has an as defined in §483.102(b)(3) related condition as 0 of this chapter. T is not met as evidenced iew and staff interviews the	F	645	How Corrective action was accom for those residents found to have I affected by the deficient practice: Referrals containing all mental hea diagnoses for re-evaluation for a F level II request was submitted thro Must by the facility's SW on 4/27/2 both Residents #12 and #55	alth PASRR bugh NC		
	diagnosis including ty	/pe 2 diabetes mellitus. The /IDS) dated had diagnosis			How the facility identified other res having the potential to be affected same deficient practice:			

Facility ID: 922954

If continuation sheet Page 6 of 9

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·			OMPLETED
			7. DOILDING			С
		345280	B. WING			04/28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				1206 N FULTON STREET		
AUTUMN	CARE OF RAEFORD			RAEFORD, NC 28376		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 645	Continued From page	2.6	F 64	F		
1 045			F 04	-5		
		anxiety disorder. The MDS ded as cognitively intact and		An audit was conducted by	the SW for all	
		sistance. She also received		current residents to determ		
	an antipsychotic, anti			residents needed a referral		
		7 days during the look back		re-evaluation for a PASRR	level II request	
	period.			submitted as a result of mis	ssing mental	
				health diagnoses not includ		
		care plan dated 04/16/2022		application to PASRR. App		
		n antipsychotic therapy daily		submitted through NC Mus		
		order and antianxiety therapy		for any resident identified a re-evaluation related to PA		
	due to anxiety disord	er.		requests. Education was p		
	The diagnosis report	had a diagnosis of		4/5/2022, and again on 5/1		
		ated 09/18/2021 and anxiety		administrator to the Interdis		
	disorder dated 12/28/	•		Clinical Team, which consis		
				Director of Nursing, Social	Worker, Unit	
	The NCDHHS halted			Manager, Activities Directo		
		ation dated 04/21/2022		Nurse, on the requirements	, ,	
		I screen is required unless		and communicating any me		
		occurs with the individuals		change, new mental health medications for the treatme	•	
	mental status which s disorder that is not de			illness each morning, Mond		
		smenua.		Friday, in the facility's morr	• •	
	The NC PASRR level	I screen dated 04/15/2022		meeting; and that upon ide		
	had Resident #12's d	isorder diagnosis listed as		information, the SW/ or des		
	anxiety/panic disorde	r.		immediately submit an app	lication for a	
		clude the diagnosis of		change of condition throug		
	delusional disorder da	ated 09/18/2021.		a PASRR level II request.		
				audits will be conducted by		
	-	ated 04/23/2022 revealed an		administrator/ or designee		
		ablet 1 MG (risperidone) th at bedtime, and Risperdal		morning clinical meeting fo ensure ongoing compliance		
	· ·	idone) 1 tablet by mouth in				
	the morning.			Facility's plan to monitor its	performance	
				to make sure that solutions		
	An interview with the	Social Worker (SW) was		includes:		
		22 at 12:10 PM. The SW				
		had a diagnosis of delusional		Audits will be reviewed in the		
	disorder dated 09/18/	2021 and anxiety disorder		QAPI meeting monthly for t	three months.	

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	. 0938-039 SURVEY
	D PLAN OF CORRECTION				COMPL	
				C	;	
		345280	B. WING		04/2	28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN CARE OF RAEFORD				1206 N FULTON STREET RAEFORD, NC 28376		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 645	dated 12/28/2021. Th	ne diagnosis for her	F 64	The facility's decision to extend		
	delusional disorder should have been included with the mental health diagnosis on the screening tool for PASRR level II.			will be based on the findings of	the audits.	
	Administrator stated to PASRR procedures. A diagnoses were exper PASRR screenings to determination for pro- 2. Resident #55 was	2022 at 11:04 AM. The the staff was educated on All new mental health ected to be included on the				
	stress disorder (PTSI depressive disorder. The North Carolina P	D), dementia and major ASRR Level I form for				
		ed 8/18/2020 included diagnoses. Major depressive as not included in the				
	Human Services halt determination notificat revealed no further Lo required unless a sign with the individual's n	ition dated 08/18/2020 evel I screening was nificant change occurred				
	PM with the facility So (SSC). She indicated Resident # 55's Leve	I I PASRR paperwork should sion diagnosis when it was				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/26/2022 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345280	B. WING					C 28/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE	, ZIP CODE		
AUTUMN	CARE OF RAEFORD				206 N FULTON STREET RAEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 645	An interview was con AM with the facility Ac Administrator stated to should have been inco PASRR screening su He indicated going fo	ducted on 04/28/22 at 09:44 dministrator. The he depression diagnosis luded in Resident #55's bmitted to the State Agency. rward he would ensure all ked prior to submitting the	F	645				

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