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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE PO BOX 6208 STATESVILLE, NC 28677

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to administer a medication as ordered by the physician for one (1) of ten (10) sampled residents. (Resident #51) The findings are: Resident #51 was admitted to the facility on 5/25/11 with diagnoses that included dizziness, history of a cerebrovascular accident and abnormality of gait. The most recent Minimum Data Set (MDS) dated 6/4/11 specified the resident had no cognitive impairment, used clear speech, had the ability to express her ideas and wants and understood verbal content. Medical record review revealed a physician's order dated 5/25/11 for Meclizine (Antivert) 25mg (milligrams) by mouth every four hours as needed for vertigo. Review of nurses' entries specified the resident complained of dizziness and received Antivert when requested. The 6/11 Medication Administration Record (MAR) specified the resident had requested and	F 309	***Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal laws*** **F 309: Resident #52 experienced no negative outcomes. Antivert was obtained from back up pharmacy and administered 06/20/11 at 4:45pm. On 06/22/11 the Antivert order was changed from prn to a routine order: Antivert 25mg by mouth routinely 4 times per day: 06:30am, 11:30am, 4:30pm, and 9:30pm.** **LN#7 was re-inserviced 06/21/11 by the Director of Nursing for obtaining medications from the back up pharmacy and facility policy for borrowing medications inhouse.** **LN#7 and all other licensed nurses received inservice for obtaining medications from the back up pharmacy, and inhouse policy for borrowing medications, 07/18/11, by the regional nurse consultant.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: L Daniel Goodwin | TITLE: Admin Asst | (X6) DATE: 7/12/11

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 309	Continued From page 1 received 24 doses of Antivert between 6/9/11 through 6/19/11. Interview on 6/20/11 at 2:30 p.m. with Resident #51 revealed she did not feel well and complained of being "swimmy-headed" and "very dizzy." She stated that she suffered from dizziness and relied on medication (name not given) for relief and added that the medication was effective in relieving the symptoms of dizziness and stated, "I don't know what I'd do without it." During the interview Resident #51 stated that since her admission to the facility she had requested the medication for dizziness every four (4) hours as ordered by the physician and reported her last dose was on 6/19/11 in the afternoon. She specified that on the evening of 6/19/11 she experienced dizziness and requested her medication to the licensed nurse who told her she was out of her medication. She then added she had requested her anti-dizzy medication twice on 6/20/11 and was again told by the licensed nurse that the medication was unavailable. She stated that the licensed nurse administered her morning medications and told her that her anti-dizziness medication was unavailable. She stated she was not given an explanation for when she might receive her anti-dizziness medication. On 6/20/11 at 2:35 p.m. Licensed Nurse (LN) #7 was interviewed and reported the resident had requested water and complained of dizziness. LN #7 stated she was first made aware of Resident #51's complaints of dizziness at 1:00 p.m. and confirmed no medication to treat	F 309	**The Director of nursing and the quality assurance nurse audit 5 prn medication re-order forms weekly to monitor the date the medication was reordered against the date the medication arrived to the facility to ensure timely delivery of prn medications.** **The Director of nursing and the quality assurance nurse audit 5 reorder forms for prn medications weekly for 2 months, then audit 5 reorder forms monthly for 2 months to ensure timely arrival of prn medications.** **The Director of Nursing is responsible for compliance and reports findings to the quality assurance committee quarterly.**	

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F 309	Continued From page 2 dizziness had been administered to the resident. LN #7 offered no explanation why medication had not been administered to the resident. LN #7 opened her medication cart and revealed Resident #51 had no Antivert in the medication cart. She looked in additional storage bins of the medication cart and could not locate Antivert to administer to the resident. Observations made on 6/20/11 at 2:45 p.m. revealed LN #7 entered Resident #51's room and told the resident she was out of her Antivert medication and would have to wait until after 6:00 p.m. before the medication would be available. Resident #51 became upset, raised her voice to LN #7 and stated, "What am I supposed to do until then? I need it now." LN #7 offered no explanation to the resident and did not offer to call the physician. At 2:50 p.m. on 6/20/11 LN #7 was interviewed again and reported there was nothing she could do to obtain the medication before the scheduled 6:00 p.m. pharmacy delivery. LN #7 stated the resident would have to wait on the medication. LN #7 stated she was new to the facility and was unsure of what to do for the resident. On 6/20/11 at 2:55 p.m. the Director of Nursing (DON) was interviewed and reported the licensed nurse who was first made aware of Resident #51's request for the unavailable medication should have notified the back-up pharmacy to obtain the medication as soon as possible. On 6/20/11 at 3:10 p.m. the Certified Occupational Therapy Assistant (COTA) was interviewed and reported he had worked with	F 309		

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F 309	Continued From page 3 Resident #51 on 6/20/11 from 9:00 a.m. to 9:45 a.m. He specified she complained of not getting her Antivert on a regular basis. He stated he notified LN#7 on 6/20/11 after the therapy session of the resident's complaints and confirmed LN #7 stated she would look into the matter concerning the medication. On 6/20/11 at 3:30 p.m. the Administrator reported the back-up pharmacy had been contacted to obtain Resident #51's Antivert at 3:00 p.m. that day. He also added the resident would be given the medication as soon as it arrived to the facility. On 6/21/11 at 9:20 a.m. interview with Resident #51 revealed she had received her Antivert on 6/20/11 in the afternoon and felt much better. On 6/21/11 at 4:50 p.m. LN #8 assigned to care for Resident #51 on 6/19/11 from 3 p.m. to 11 p.m. was interviewed. She reported she had administered the resident's last dose of Antivert on 6/19/11 and noted the medication had been re-ordered because the "sticker" on the medication package had been removed indicating a request had been made to pharmacy. On 6/22/11 at 8:00 a.m. the Administrator was interviewed and reported that the original pharmacy request sheet revealed Resident #51's Antivert was re-ordered on 6/17/11 at 2:05 p.m. He stated the pharmacy cut-off time was 2:00 p.m. and the order was not filled. He confirmed the medication was not delivered to the facility on 6/17/11 and would not have been delivered until 6/20/11. The Administrator said he was unaware LN #7 told the resident on 6/20/11 she would	F 309		

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F 309	Continued From page 4 have to wait until after 6:00 p.m. to receive her Antivert medication she had requested. He confirmed LN #7 should have notified the back-up pharmacy to obtain the Antivert medication after the resident's first request for the unavailable medication.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to use the chair alarm as care planned for one (1) of three (3) residents reviewed for falls. (Resident #58) The findings are: Resident #58 was readmitted on 05/02/11 following hospitalization for a hip fracture. An annual MDS dated 05/22/11 indicated Resident #58 was able to make her needs known and had moderately impaired cognition. The annual MDS revealed Resident #58 required extensive assistance for transfer/toilet use, and did not walk in her room. Further review of Resident #58 ' s the medical record revealed she received Physical Therapy Services five (5) days a week beginning 05/02/11 and continued through	F 323	**F323: Resident # 58 alarms are applied as scheduled. All nursing staff was inservice regarding proper use of safety devices by the director of nursing 07/07/11.** **Further, the Licensed nurses were inserviced for scheduling of safety devices and updating care plans by the regional quality assurance nurse on 07/18/11.** **2 100% audits for visual checks of safety devices have been completed by the Director of nursing and quality assurance nurse to ensure proper application of scheduled devices. All safety devices are scheduled and checked every shift by staff. A 100% audit was completed by the regional quality assurance nurse for safety devices scheduling and placement in the care plan, 07/14/2011.** **The director of nursing reviews all incidents daily to monitor safety device applied and alarming .**	

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F 323	Continued From page 5 06/23/11. The Care Area Assessment (CAA) Summary for falls, completed with the annual MDS, stated Resident #58 had a fall in April which resulted in a right hip fracture. The CAA Summary further stated Resident #58 had a pad alarm on her wheelchair and a personal alarm on her bed. The CAA summary also listed medications which increased her risk for falls and identified her as at risk for additional falls and injuries. A care plan dated 5/2/11 identified Resident #58 as at risk for falls due to cognitive impairment, a history of falls, and poor safety awareness. Interventions included a personal alarm to bed and chair, a pad alarm to wheel chair, antiroll back brakes on wheel chair, and call light within reach. A nurse's note dated 05/31/11 stated Resident #58 attempted to put herself on the toilet after breakfast and was found lying on her left side on the bathroom floor. Resident #58 reported pain on her right side and right elbow and was sent out of the facility for evaluation. No injuries were noted. The licensed nurse noted the personal alarm was in place and functioned properly on Resident #58's wheel chair, but indicated the resident was able to remove the clip from her clothing. The licensed nurse further documented she initiated a pad alarm to the seat of Resident #58's wheel chair. The facility's event investigation follow-up dated 06/01/11 revealed Resident #58 had a fall while attempting to transfer herself from her wheel chair on to the toilet and was found on the floor. The document noted the resident had a personal alarm and self	F 323	**The at risk committee meets weekly to review incidents and update care plans and ensures scheduling of safety devices is complete.** **The director of nursing is responsible for compliance and reports findings to the quality assurance committee quarterly.**	

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F 323	Continued From page 6	F 323		

locking brakes in place on her wheel chair at the time of the incident. In addition, it was noted the pad alarm was "reapplied" to Resident #58's wheelchair.

Observations of Resident #58 on 06/21/11 at 4:25 PM, 06/22/11 at 8:50 AM and 12:20 PM, and 06/23/11 at 10:00 AM revealed the personal alarm and seat pad alarm were in place and functioning when she was up in her wheel chair. Nursing assistants verified both alarms were functioning during care rounds and when getting Resident #58 out of bed to her wheel chair.

During an interview on 06/23/11 at 9:55 AM LN #1 revealed she cared for Resident #58 from 7:00 AM until 3:00 PM on 05/31/11. LN #1 stated a nursing assistant (NA) had noticed Resident #58's bathroom door was open while walking up the hallway and found the resident lying on the bathroom floor. LN #1 further stated the personal alarm did not sound and explained that Resident #58 was able to remove the clip for the alarm from her clothing. LN #1 indicated she added a seat pad alarm to Resident #58's wheel chair, in addition the personal alarm, immediately after the fall.

An interview was conducted with the Director of Nursing (DON) on 06/23/11 at 10:40 AM. The DON confirmed Resident #58's interventions for falls since the fall on 01/17/11 included a personal alarm and seat pad alarm when up in her wheel chair. The DON stated falls were discussed daily during the facility's morning meetings but could not provide any information regarding any additional interventions discussed for Resident #58 after her fall.

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a medication administration error rate of less the five percent (5%) by failing to give medications according to manufacturer's instructions and accepted professional standards of practice. During two medication passes, three errors were detected in a total of fifty-two opportunities resulting in a 5.8% medication administration error rate. (Residents #23 and #35). The findings are: 1. On 06/22/2011 at 4:33 PM Licensed Nurse (LN) #3 was observed crushing Crestor 10 milligram (mg) and Warfarin 7.5 mg tablets. LN #3 placed the crushed tablets into a medication cup, mixed them with apple sauce, proceeded to Resident #23's room and administered the medication to Resident #23. Following administration of the medication, several pieces of the tablets mixed with a small amount of apple sauce were observed remaining in the cup. Resident #23 was readmitted to the facility 02/14/2011 with diagnoses including Hypercholesterolemia (elevated cholesterol), Deep Vein Thrombosis/Embolism of the lower extremity, and long-term use of anticoagulants	F 332	**F 332: Resident #23 INR was 1.4 on 06/23/11.** **LN#3 was re-inserviced by the director of nursing for crushing medications, the 5 rights of administering medications and properly administering the full dose of medication. 06/22/2011.** **All other Licensed nurses and LN#3 were inserviced by the regional nurse consultant for properly administering entire dose of medication, 07/18/2011.** **The director of nursing and the quality assurance nurse observe LN# 3 for medication pass weekly times 2 weeks.** **Resident #35 Insulin was drawn into 2 separate syringes on 06/21/11 and administered according to manufacturer package insert.**	

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F 332	Continued From page 8 (Warfarin). Resident #23's medical record and June 2011 Medication Administration Record (MAR) revealed physician's orders for Crestor (cholesterol lowering agent) 10 milligram (mg) by mouth once daily, originally ordered 06/03/2004 and Warfarin 7.5 mg by mouth once daily, ordered 06/16/2011. Resident #23's finger-stick INR (International Normalized Ratio), utilized by the facility to measure effectiveness of Warfarin, completed 06/23/2011 revealed results of 1.4. A physician's notation in the medical record, dated 07/01/2010, stated Resident #23's INR was to be maintained between 1.3 - 1.6. On 06/22/2011 at 4:35 PM, LN #3 was interviewed and confirmed that several pieces of the Crestor and Warfarin remained in the cup. LN #3 stated usually Resident #23 would take only one bite of the apple sauce/medication mixture thus she did not offer/attempt to administer a second bite. LN #3 stated to ensure Resident #23 obtained full effects of the medication she (LN #3) should have attempted to give all the medication, as ordered. During an interview, 06/22/2011 at 4:45 PM, the Director of Nursing (DON) stated LN staff were expected to and responsible for administer Residents' entire dose of medication. On 06/23/2011 at 2:40 PM the facility pharmacy manager stated, in order to deliver the physician's intended dose and obtain the desired effects, it was important to give all the medication when administering crushed medications.	F 332	**The facility adopted an inhouse practice that all insulins are drawn into separate syringes for administration. All Licensed nurses are inserviced to the facility practice to draw insulin into separate syringes.07/18/11.** **The director of nursing and the quality assurance nurse audit 3 nurses on East and West units weekly times 2 weeks to ensure insulin is drawn into separate syringes.** **The director of nurses and the quality assurance nurse then audit 2 nurses preparing insulin administration 2 times a month for 1 month. The director of nurses and the quality assurance nurse then audit Licensed nurses randomly for preparation of insulin.** **The director of nurses is responsible for compliance and reports findings to the quality assurance committee quarterly**	