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 _____	C 06/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to correctly transcribe a medication order which resulted in administration of an incorrect dose of medication and a resident received a medication daily instead of PRN (as needed) for 1 of 5 residents (Resident #5) sampled for unnecessary medications. The Findings include:	F 329	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of	6/20/16

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

Electronically Signed | 06/17/2016

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F 329	Continued From page 1 Resident #5 admitted to the facility on 05/04/16 with diagnoses that included hip fracture and essential tremors. Review of the most recent comprehensive minimum data set (MDS) dated 05/11/16 revealed that Resident #5 was cognitively intact and required extensive assistance of two staff members with bed mobility and toileting and required limited assistance of one staff member with transfers and dressing. The MDS further indicated that Resident #5 was occasionally incontinent of bowel and bladder. Review of a discharge instructions that accompanied Resident #5 to the facility dated 05/04/16 contained the following orders Primidone (used to treat/control tremors) 50 milligrams (mg) by mouth 3 tablets (150 mg) every day and Primidone 50 mg 2 tablets (100 mg) by mouth at bedtime. The discharge instructions also contained the following Cetirizine (used to treat/control allergies) 10 mg by mouth everyday as needed for allergy symptoms. Review of medication administration record (MAR) dated 05/01/16 through 05/31/16 revealed the following Primidone 50 mg by mouth in the morning the medication had been administered daily for 6 days. The facility did not provide the 150 mg by mouth daily as ordered. The MAR also revealed cetirizine 10 mg by mouth in the morning and had been administered daily for 6 days, instead of PRN as ordered. Interview with Resident #5 on 06/06/16 at 1:25 PM revealed that she took Primidone at home, resident #5 stated she took 3 tablets in the morning and only took her cetirizine when she needed it but not every day. Resident #5 stated that she was not aware that the facility had given her the incorrect dose of Primidone or had given her the cetirizine daily instead of as needed. Resident #5 stated that the staff just bring my	F 329	Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F329 Corrective Action for Resident Affected: The medication orders for Resident #5 were reviewed for accuracy by the Director of Nursing on 06-07-2016. No discrepancies were noted. Corrective Action for Residents potentially affected: All other resident's medication orders were reviewed for accuracy by Nursing Management and concluded by 06-13-2016. Any identified transcription discrepancies were immediately corrected. Inservicing of Licensed Nurses and Medication Technicians was concluded by 06-15-2016 by the Director of Nursing/Designee to include the eight rights of medication administration and the transcription of orders. Each nurse transcribed five orders into the training module of Point Click Care and had validation of accuracy completed by Nursing Management which was concluded by 06-15-2016. Medication pass observations were completed for each Licensed Nurse and Medication Technician by the Pharmacy Consultant and Nursing Management and concluded by 06-17-2016. Newly hired Licensed	

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F 329	Continued From page 2 medications to me and I take them. Interview with Nurse #1 on 06/06/16 at 1:40 PM confirmed that she was the nurse that transcribed the orders for Resident #5 into the electronic medical record on 05/04/16. Nurse #1 reviewed the discharge instructions and stated that she just did not see the part that read "3 tablets every day" next to the Primidone and did not see the "as needed" instructions next to the cetirizine. Nurse #1 stated that the facility had recent implemented a 3 check system for transcribing orders in the electronic medical record. Nurse #1 stated that after she transcribed the orders she placed the orders into a folder at the nurse's station and another nurse would check behind her and then a 3rd nurse would make the final check. Nurse #1 stated that there was no system for the 2nd or 3rd checks it was just whichever nurse had time to check the folder. Nurse #1 also stated that she was not aware that she had made the error in transcribing the orders until the surveyor pointed it out to her. Nurse #1 also stated that she had not received the education on the 3 check system that the facility recently implemented. Interview with the Director of Nursing (DON) on 06/06/16 at 2:02 PM revealed that the facility had recently implemented a practice of a 3 check system. The DON stated that once a nurse transcribed orders into the electronic medical record then the supervisor on the next shift would complete the 2nd check and the supervisor on the next shift would make the 3rd check and then the orders would come to her or the assistant DON for the final check. The DON stated that each nurse that checked the orders was to initial the orders to indicate the check had been completed. With Resident #5 orders there was no initials that indicated the 2nd or 3rd checks had been completed. The DON stated the particular	F 329	Nurses and Medication Technicians will have the same inservice and Medication Pass observations as part of their orientation process prior to transcribing orders or performing a medication pass. Systemic Changes: A triple check system to validate accuracy of the orders are in place and will be completed by the Licensed Nurse for any new order received daily. The Licensed Nurse will enter the order, print the order and the medication administration record and have a second nurse validate the accuracy of the order entry daily. Nursing Management will then complete a third check of the accuracy of the order daily. Any identified discrepancies will be corrected immediately and a Medication Error Report logged into the Electronic Health Record for review by the Administrator and the Quality Assurance Committee. Quality Assurance: Daily audits of new orders will be completed by Nursing Management to identify any deficiencies and validate immediate correction and follow up education of nurse making error in order to prevent deficient practice from reoccurrence. The Administrator and Director of Nursing will review any medication discrepancy during Risk Rounds to validate correction and follow up are completed. Audit will be trended by the Director of Nursing and submitted	

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F 329	Continued From page 3 orders for Resident #5 "just fell through the cracks." The DON also reviewed the education provided to the nursing staff on the 3 check system for checking orders and confirms that Nurse #1 was not listed on the in service sign in sheet. The DON stated that she expected the 3 step system to be used on all orders so that any errors can be caught before they reach the patient. Interview with the Medical Doctor (MD) on 06/06/16 at 4:42 PM revealed that he was aware of the errors with Resident #5 orders of Primidone and cetirizine. The MD stated that he did not feel there was any negative outcome to Resident #5. The MD also stated that he expected the staff to carry out the orders correctly and to follow all prescriptions as prescribed.	F 329	to Quality Assurance Performance Improvement Committee for ongoing monitoring and recommendations.	