STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted an annual survey and complaint investigation on 04/21/16 - 04/22/16. The complaint investigation was initiated by the Duplin County Department of Social Services on 03/31/16.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician for 2 of 5 residents (#4, #5) sampled of high and low blood pressure readings and holding Clonidine for low blood pressure readings without a physician order (#4) and low blood sugar readings (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 01/19/16 revealed: -Diagnoses included coronary artery disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease, atrial fibrillation, hypertension, anxiety, muscle weakness, and arthritis. -There was a physician's order to obtain blood pressure daily. A. Review of a subsequent physician order dated 03/15/16 revealed there was an order to check blood pressure daily and call if systolic greater than 160 or less than 90.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 1 Review of the Medication Administration Record (MAR) for February 2016 revealed: -There was a computer generated entry to check blood pressure every day; call if systolic blood pressure greater than 160 or less than 90. -On 02/18/16, the blood pressure result was documented as 173/98. -On 02/22/16, the blood pressure result was documented as 84/58. -On 02/28/16, the blood pressure result was documented as 167/100. -On 02/29/16, the blood pressure result was documented as 74/53. -There was no documentation in the MAR notes section that the physician was notified of the blood pressure results. Review of the MAR for March 2016 revealed: -There was a computer generated entry to check blood pressure every day; call if systolic blood pressure greater than 160 or less than 90. -On 03/01/16, the blood pressure result was documented as 70/50. -On 03/02/16, the blood pressure result was documented as 75/45. -On 03/05/16, the blood pressure result was documented as 182/102. -On 03/09/16, the blood pressure result was documented as 170/101. -On 03/14/16, the blood pressure result was documented as 181/112. -On 03/27/16, the blood pressure result was documented as 178/99. -On 03/28/16, the blood pressure result was documented as 169/89. -There was no documentation in the MAR notes section that the physician was notified of the blood pressure results.	D 273		

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D 273	Continued From page 2 Review of the MAR for April 2016 revealed: -There was a computer generated entry to check blood pressure every day; call if systolic blood pressure greater than 160 or less than 90. -On 04/01/16, the blood pressure result was documented as 83/54. -On 04/05/16, the blood pressure result was documented as 72/48. -On 04/07/16, the blood pressure result was documented as 71/50. -On 04/09/16, the blood pressure result was documented as 192/98. -On 04/16/16, the blood pressure result was documented as 180/95. -On 04/17/16, the blood pressure result was documented as 169/90. -On 03/18/16, the blood pressure result was documented as 165/70. -There was no documentation in the MAR notes section that the physician was notified of the blood pressure results. Interview with Resident #4 on 04/22/16 at 10:00 a.m. revealed: -The staff obtained her blood pressure every day. -The resident did not know if the physician was notified when her blood pressure was high or low. -The resident knew that her blood pressure was "really high" at times and "really low" at times, but the staff would always recheck the blood pressure if the reading was elevated or lower than normal. Interview with the Resident Care Assistant (RCA) on 04/22/16 at 12:00 p.m. revealed: -If the orders to obtain blood pressure had parameters to notify the physician, the staff should have been contacting the physician if the readings were greater than or less than the ordered parameter.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 3	D 273		

-The staff was supposed to document that the physician was called on the MAR notes section or on the charting notes.
-There was no documentation in Resident #4's record that the physician was notified for blood pressure readings being outside of the ordered parameters.

-Interview with a Medication Aide (MA) on 04/22/16 at 12:30 p.m. revealed:
-The MA checked Resident #4's blood pressure in the mornings and documented the result on the MAR.
-The MA would "sometimes" get the Personal Care Aide (PCA) to check Resident #4's blood pressure.
-If the blood pressure needed to be rechecked, the MA would document that result in the MAR notes and if she notified the physician, she would document that in the notes as well.
-Resident #4's blood pressure would be high sometimes, so the MA would recheck the blood pressure after Resident #4 received her morning medications.
-The MA notified the physician if the readings were "too high" or "too low" based on the ordered parameter.

Interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. revealed:
-The staff should have been following the physician order for checking blood pressures and notifying the physician if there were parameters.
-The staff should be contacting the physician via fax or telephone call if the blood pressure readings were high or low.
-The staff were expected to document the readings on the MAR and document any notification to the physician in the care notes.
-Resident #4's physician had asked the facility to

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D 273	Continued From page 4	D 273		

"take things to the physician's office that needed the physician's attention each week."
-The RCA was taking things to the physician's office that needed signatures or clarification, but the RCA would have to leave the information at the office and pick up the next week.

Attempted interview with the physician was unsuccessful as the physician's office was closed on 04/22/16.

B. Review of subsequent physician orders dated 03/15/16 revealed an order for Clonidine 0.1mg three times daily. (Clonidine is an antihypertensive medication used to treat high blood pressure.)

Review of the MAR for February, March, and April 2016 revealed an entry for Clonidine 0.1mg three times daily that was scheduled for 8:00am, 2:00pm, and 8:00pm.

Review of a fax communication to the physician dated 02/03/16 revealed that the medication aide (MA) "withheld Clonidine at 8pm. BP was 84/59."

Review of the Charting Notes for Resident #4 revealed:
-There was a note dated 02/03/16 that read "held Clonidine; B/P was 84/52."
-There was a note dated 03/02/16 that read "withheld Clonidine; B/P was 86/58."
-There was a noted dated 03/03/16 that read "withheld Clonidine; resident didn't want to take; B/P was 104/69."

Review of Resident #4's record revealed no physician orders to hold Clonidine.

Interview with Resident #4 on 04/22/16 at 10:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

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D 273	Continued From page 5	D 273		

a.m. revealed:
-Resident #4 did not recall refusing to take her blood pressure medication.
-The resident recalled refusing to take her "depression pill" before, but that was the only medication she had refused.

Interview with the RCM on 04/22/16 at 3:04 p.m. revealed:
-The MA should not be expected to make the determination to hold Resident #4's Clonidine.
-The MAs were expected to call the physician if the blood pressure was low.
-The RCM was going to contact the physician to obtain parameters for holding the Clonidine if Resident #4's blood pressure was low.

Interview with a MA on 04/22/16 at 3:50 p.m. revealed:
-The MA had held the Clonidine if Resident #4's blood pressure was low.
-The MA would hold the Clonidine if the blood pressure was below 90 because "it's just going to bottom out."
-The MA would then fax the physician to let the physician know that the Clonidine was held.

Interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. revealed:
-The staff should be contacting the physician via fax or telephone call if the blood pressure readings were too low.
-The MA was expected to document when the physician was notified, but the staff should not withhold medication without a physician's order.
-The MAs were not expected to make the decision to hold a medication without guidance from the physician.

Attempted interview with the physician was

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D 273	Continued From page 6 unsuccessful as the physician's office was closed on 04/22/16. 2. Review of Resident #5's current FL-2 dated 06/19/15 revealed the resident's diagnoses included diabetes mellitus type II, diabetic neuropathy, dementia, gastroesophageal reflux disease, hyperlipidemia, hypertension, coronary artery disease, renal insufficiency, insomnia, chronic pain syndrome, and history of alcoholism. Review of a physician's order dated 01/25/16 for Resident #5 revealed: -Novolog sliding scale insulin was to be administered twice daily based on blood sugar readings at 7:30 a.m. and 5:00 p.m. (Novolog is rapid-acting insulin that lowers blood sugar.) -The sliding scale parameter included an order to call the physician if blood sugar was less than 80 or greater than 400. Review of the March 2016 and April 2016 medication administration records (MARs) revealed: -There was an entry for Novolog sliding scale insulin to be administered twice a day at 7:30 a.m. and 5:30 p.m. -The entry for Novolog did not include the parameters for when the physician was to be notified of high or low blood sugars. -The resident's blood sugar was less than 80 on 2 occasions in March and April 2016. -The resident's blood sugar was 78 at 5:30 p.m. on 03/23/16. -The resident's blood sugar was 68 at 7:30 a.m. on 04/07/16. -There was no documentation the physician was notified on 2 of 2 occasions when the resident's blood sugar was <80. -The resident's blood sugar ranged from 68 - 299	D 273		

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D 273	Continued From page 7 from 03/01/16 - 04/21/16. Interview with the medication aide on 04/22/16 at 3:40 p.m. revealed: -She was not aware there was a parameter to call Resident #5's physician for high or low blood sugars. -A parameter did not show up on the electronic MAR. -She had not contacted Resident #5's physician regarding any low or high blood sugars. Interview with the Resident Care Manager (RCM) on 04/22/16 at 3:58 p.m. revealed: -The primary pharmacy entered orders into the electronic MARs. -The medication aide on duty was responsible for checking and approving orders from the pending screen on the MARs. -If there was a discrepancy, the medication aide should reject the order and contact the pharmacy. -He did not know why the blood sugar parameters to call the physician for Resident #5 were not included on the MARs. -The medication aide who checked the order must have overlooked it. -He would contact the physician about the blood sugar parameters. Interview with Resident #5 on 04/21/16 at 9:59 a.m. revealed: -He was diabetic and staff checked his blood sugar about 3 times a day. -His blood sugar was sometimes low in the mornings and they gave him orange juice and food. Attempt to contact the physician for interview during the survey was unsuccessful.	D 273		

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D 287	Continued From page 8	D 287		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure table service included non-disposable bowls in the dining room for residents and non-disposable spoons for residents who required feeding assistance. The findings are: 1. Observation of the lunch meal in the facility's front and back dining rooms on 04/22/16 at 11:45 a.m. through 12:45 p.m. revealed: -31 residents were seated at tables in the front dining room at 12:05 p.m. -15 residents were sitting at tables in the back dining room at 12:30 p.m. -Table service included one napkin, a non-disposable spoon, a fork, beverage containers and plates. -The dietary staff served all resident's dessert (peach crisp) and slaw in Styrofoam bowls. Interview with 6 residents during the lunch meal (front and back dining rooms) on 04/22/16 revealed the dietary staff always serve desserts	D 287		

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D 287	Continued From page 9 and fruit in Styrofoam bowls. Interview with 2 staff on 04/22/16 at 12:35 p.m. revealed: -Styrofoam bowls were used to serve all residents desserts and other food. -They were not aware of any residents biting the bowls or complaining about being served food in the bowls. Interview with the cook on 04/22/16 at 2:00 p.m. revealed: -The residents were served desserts and cold foods in Styrofoam bowls because there were not enough non-disposable bowls at the facility to serve all residents. -The small bowls were broken over time (last 6 months) and the facility has not replaced the bowls. Interview with the Dietary Manager on 04/22/16 at 2:30 p.m. revealed: -She ordered Styrofoam bowls to use for desserts, grits and cold foods. -She was not aware disposable tableware was not to be used at meals. -The facility did not have to get approval from their corporate office to order disposable tableware, but would need to get approval to order non-disposable tableware. -She did not know how long the facility had used Styrofoam bowls at meals. Interview with the facility's Executive Director on 04/22/16 at 2:45 p.m. revealed: -She was not aware the dietary staff were using Styrofoam bowls to serve residents at meals. -The facility has non-disposable bowls in storage and available for the residents. -She will have the dietary staff to stop using the	D 287		

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D 287	Continued From page 10 Styrofoam bowls immediately and provide the non-disposable bowls. Observation made of the supper meal on 04/22/16 at 6:00 p.m. revealed all table service ware were non-disposables. 2. Observation on 04/22/16 at 12:15 p.m. in Resident #2's room revealed: -Resident #2 was lying in bed with the head of bed raised. -A personal care assistant (PCA) was sitting beside the resident's bed preparing to provide feeding assistance during the lunch meal. -The PCA used a plastic spoon to feed the resident a pureed meal. -The resident ate only 5-6 spoonfuls of the meal without problems. Review of Resident #2's current FL-2 dated 12/16/15 revealed: -Diagnoses including dementia and osteoarthrosis. -The resident was non-ambulatory. -The resident diet was low fat, no added salt and pureed. Review of Resident #2's care plan dated 02/17/16 revealed the resident required total assistance for feeding. Interview with the PCA on 04/22/16 at 12:30 p.m. revealed: -Resident #2 was totally dependent on staff for feeding. -The resident was always fed with a plastic spoon by staff. -Resident #2 was the only resident who received feeding assistance with the use of plastic utensils. -The PCA did not know why the resident was	D 287		

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D 287	Continued From page 11	D 287		

given a plastic spoon, she had always been fed with a plastic spoon.
-The resident's family used a plastic spoon to feed the resident at mealtimes
-The resident has never had any problems while being fed with a plastic spoon.
-Other staff members have never reported any problems using plastic spoons to feed the resident during mealtimes.

Interview with the cook on 04/22/16 at 2:00 p.m. revealed:
-He was aware Resident #2 was fed all meals with a plastic spoon.
-No other resident in the facility used plastic utensils at meal times.
-He did not know why Resident #2 was fed with a plastic spoon.
-He will discontinue the use of plastic utensils and provide non-disposable utensils immediately.

Interview with the facility's Dietary Manager on 04/22/16 at 2:30 p.m. revealed she was not aware Resident #2 was being fed with a plastic spoon, but will assure non-disposable utensils were used for all residents at meal times immediately.

Interview with the facility's Executive Director on 04/22/16 at 2:45 p.m. revealed she was not aware Resident #2 was being fed with a plastic spoon, but will make sure the dietary staff and the PCA's know immediately plastic spoons were not allowed except for temporary use in case of an emergency such as power outage.

Based on observation, record review and interviews, Resident #2 was confused and was not interviewable.

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D 310	Continued From page 12	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure therapeutic diets were served as ordered for 1 of 5 sampled residents (#7) on a mechanical soft diet. The findings are: Observation made on 04/21/16 at 12:10 p.m. in the facility back dining room revealed: -Resident #7 was sitting at a table eating lunch meal which consisted of fried fish (whole), fried potatoes, corn, slaw, bread, sliced peaches in syrup, tea and water. -The resident ate about 50% of meal including ½ of fried fish. Review of Resident #7's current FL-2 dated 01/11/16 revealed: -Diagnoses included cognitive communication deficit, lack of coordination and diabetes mellitus II. -The resident was intermittently disoriented. - An order for mechanical soft diet. Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 12/21/15.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 310	Continued From page 13 Record review revealed a current diet order dated 09/29/15 for mechanical soft foods (ordered for residents who have difficulty chewing, but are able to tolerate more texture than a pureed diet). Review of the diet list posted in the kitchen revealed Resident #7's ordered diet was not listed. Review of the list of diet orders obtained from the facility's Resident Care Director (RCD) revealed Resident #7's diet order was mechanical soft. Interview with the cook on 04/22/16 at 2:00 p.m. revealed: -The facility has therapeutic menus available online but a copy of the menus were not available for the dietary staff. -There was a list available in the kitchen with all resident's ordered diets. -The cook did not use the therapeutic diet menu, but knew how to prepare all the therapeutic diets. -To prepare the fried fish for mechanical soft diets, the fish was chopped in a food processor. -Resident #7's name was not on the diet list and he was not aware the resident had an order for a mechanical soft diet. -The RCD gave the cook a copy of the current diet list today with Resident #7 listed with a mechanical soft diet. Interview with the Dietary Manager on 04/22/16 at 2:30 p.m. revealed: -She had been the facility's Dietary Manager for "only a few weeks". -She was currently working as a medication aide and the Dietary Manager. -The spread sheet menus with all the facility's ordered diets was not kept in the facility but was available online.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 310	Continued From page 14 -She will talk to the facility's Executive Director (ED) about providing copies of therapeutic menus and keeping an update resident diet list in the kitchen. Interview with the facility's ED on 04/22/16 at 2:45 p.m. revealed: -She was not aware the kitchen staff did not have an updated diet list available in the kitchen. -The therapeutic diet spreadsheet was available online but not kept in the facility's kitchen. -The ED will print the facility menu spreadsheet and provide the spread sheet to the Dietary Manager and cook. Review of the facility's therapeutic menu (lunch menu for 04/21/16) for mechanical soft diet reveal the 2 ounce fish should be ground or finely chopped. Based on observation, record review and interview, Resident #7 was confused and was not interviewable.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 15	D 358		

review, the facility failed to assure medications were administered as ordered to 3 of 5 residents (#1, #4, #5) sampled including errors with two medications for anxiety (#4), medications for acid reflux, enlarged prostate, and a topical cream for diabetic neuropathy (#5), and a medication for hypothyroidism (#1). The findings are:

1. Review of Resident #5's current FL-2 dated 06/19/15 revealed the resident's diagnoses included diabetes mellitus type II, diabetic neuropathy, dementia, gastroesophageal reflux disease, hyperlipidemia, hypertension, coronary artery disease, renal insufficiency, insomnia, chronic pain syndrome, and history of alcoholism.

A. Review of Resident #5's current FL-2 dated 06/19/15 revealed an order for Protonix 40mg 1 tablet once daily. (Protonix is used to treat acid reflux.)

Review of physician's orders dated 02/15/16 revealed:
-There was an order to discontinue Protonix.
-There was an order for Zantac 150mg twice daily. (Zantac is used to treat acid reflux.)
-The order noted to start Zantac after the current supply of Protonix was completed.

Review of the February 2016 medication administration record (MAR) for Resident #5 revealed:
-Protonix 40mg was administered daily at 7:30 a.m. from 02/01/16 - 02/16/16.
-Protonix was documented as discontinued on 02/16/16.
-There was no entry for Zantac on the February 2016 MAR.

Review of the March 2016 MAR for Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 16	D 358		

revealed:
-There was no entry for Protonix 40mg.
-There was an entry for Zantac 150mg twice daily and it was scheduled to be administered at 7:00 a.m. and 7:00 p.m.
-The administration of Zantac was documented and started on 03/10/16 - 03/31/16.

Review of pharmacy dispensing records dated 01/01/16 - 04/21/16 for Resident #5 revealed:
-Thirty Protonix 40mg tablets were dispensed on 01/15/16.
-Thirty Protonix 40mg tablets were dispensed on 02/09/16.
-Sixty Zantac 150mg tablets were dispensed on 03/08/16.

Observation of medications on hand on 04/22/16 for Resident #5 revealed:
-The 30 day supply of Zantac dispensed on 03/08/16 was on hand.
-There were 13 of the 60 Zantac tablets remaining.
-There was no Protonix on hand.

Interview with a medication aide on 04/22/16 at 3:40 p.m. revealed:
-The Protonix had been discontinued for a couple of months.
-She stopped administering the Protonix because it did not pop up on the electronic MAR anymore because it was discontinued.
-She could not recall if any Protonix was returned to the pharmacy.

Interview with the Resident Care Manager (RCM) on 04/22/16 at 4:15 p.m. revealed:
-The medication aides were supposed to finish administering Protonix until the supply was exhausted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 17 -He did not know why staff stopped administering the Protonix prior to the supply being exhausted. -He would check the return records to see if or when the Protonix was returned to the pharmacy. No further information was provided by the facility. B. Review of Resident #5's current FL-2 dated 06/19/15 revealed an order for Flomax 0.4mg take 1 capsule at bedtime. (Flomax is used to treat enlarged prostate.) Review of physician's orders dated 03/23/16 revealed an order to start Flomax 0.4mg once daily ½ hour after supper. Stop if dizziness. Review of the March 2016 medication administration record (MAR) for Resident #5 revealed: -There was an entry for Flomax 0.4mg take 1 capsule every night at bedtime and it was scheduled to be administered at 8:00 p.m. -Flomax 0.4mg was documented as administered at 8:00 p.m. from 03/01/16 - 03/22/16. -There was a second entry for Flomax 0.4mg take 1 capsule daily (take 30 minutes before supper) and it was scheduled to be administered at 4:30 p.m. -Flomax 0.4mg was documented as administered at 4:30 p.m. (30 minutes before supper) instead of 30 minutes after supper from 03/23/16 - 03/31/16. Review of the April 2016 MAR for Resident #5 revealed: -There was an entry for Flomax 0.4mg take 1 capsule daily (take 30 minutes before supper) and it was scheduled to be administered at 4:30 p.m.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 18	D 358		

-Flomax 0.4mg was documented as administered at 4:30 p.m. (30 minutes before supper) instead of 30 minutes after supper from 04/01/16 - 04/20/16.

Interview with the Resident Care Manager (RCM) on 04/22/16 at 3:58 p.m. revealed:
-The facility's policy was the primary pharmacy entered orders into the electronic MARs.
-The medication aide on duty was responsible for checking and approving orders from the pending screen on the MARs.
-If there was a discrepancy, the medication aide should reject the order and contact the pharmacy.
-The order for Flomax appears to have been entered incorrectly.
-The medication aide who checked the order must have overlooked it.
-The RCM and the Resident Care Assistant try to check new orders for accuracy but they did not always check every order due to time constraints.
-He would contact the pharmacy and the get the order corrected on the MAR.

Attempt to contact the physician during the survey was unsuccessful.

Interview with Resident #5 on 04/22/16 at 3:50 p.m. revealed:
-He usually got the Flomax capsule before he ate supper.
-He denied any symptoms of dizziness.

C. Review of physician's orders for Resident #5 dated 10/07/15 and 03/16/16 revealed an order for a Compounded Cream (Topiramate, Meloxicam, Gabapentin, Lidocaine, and Prilocaine), apply 2 pumps topically to both feet 3 times a day. (This compounded cream has 5 different medications mixed together to help treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 19 diabetic neuropathy.) Review of the April 2016 medication administration record (MAR) for Resident #5 revealed: -There was an entry for the Compounded Cream (Topiramate, Meloxicam, Gabapentin, Lidocaine, and Prilocaine), apply 2 pumps topically to both feet 3 times a day. -The cream was scheduled to be administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -The cream was not documented as administered from 8:00 p.m. on 04/07/16 through 8:00 a.m. on 04/12/16 due to "med not in facility". Review of primary pharmacy dispensing records dated 01/01/16 - 04/21/16 revealed no compounded cream was dispensed during this time from the primary pharmacy. Observation of medications on hand for Resident #5 on 04/22/16 revealed one 240gram pump container with the Compounded Cream dispensed by an outside pharmacy on 04/11/16. Interview with a medication aide on 04/22/16 at 3:40 p.m. revealed: -The physician who wrote the original order for the Compounded Cream was no longer seeing the resident as a patient. -The facility faxed the resident's new physician to get a new order for the Compounded Cream. -The new physician wrote a new prescription for the Compounded Cream. -They have to get the Compounded Cream from an outside pharmacy because the primary pharmacy did not make the cream. -She thought there was some discrepancy with one of the ingredients of the cream and the outside pharmacy had to clarify with the new	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 20	D 358		

physician.
-The resident ran out of the previous supply before the new prescription was dispensed.
-She did not know if any information regarding the clarification or delay in getting the cream was documented.

Interview with Resident #5 on 04/22/16 at 3:50 p.m. revealed:
-He used the Compounded Cream for the nerve pain in his feet because he was diabetic.
-The cream helped with his nerve pain a lot.
-The facility ran out of his cream for several days about a week ago.
-He could tell when he was not using the cream because he had more pain than normal.

2. Review of Resident #1's current FL-2 dated 01/12/16 revealed:
-The resident's diagnoses included hypothyroidism, dementia, depression, acute pain, and weakness.
-There was an order for Synthroid 75mcg take 1 tablet daily. (Synthroid is used to treat hypothyroidism.)

Review of a physician's order dated 12/14/15 revealed an order to change Synthroid 88mcg to Synthroid 75mcg daily and check pulse daily.

Review of the December 2015 medication administration record (MAR) revealed:
-There was a computer printed entry for Synthroid 88mcg take 1 tablet daily and it was scheduled at 7:30 a.m.
-Synthroid 88mcg was documented as administered from 12/01/15 - 12/15/15.
-There was a new entry for Synthroid 75mcg take 1 tablet daily and it was scheduled to be administered at 6:00 a.m. with a daily pulse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 21	D 358		

check.
-Synthroid 75mcg was documented as administered from 12/16/15 - 12/31/15.
-The resident's pulse ranged from 56 - 76 from 12/16/15 - 12/31/15.

Review of the January 2016 and February 2016 MARs revealed:
-There was an entry for Synthroid 75mcg take 1 tablet daily and it was scheduled to be administered at 6:00 a.m. with a daily pulse check.
-Synthroid 75mcg was documented as administered from 01/01/16 - 02/29/16.

Review of the March 2016 MAR revealed:
-There was an entry for Synthroid 75mcg take 1 tablet daily and it was scheduled to be administered at 6:00 a.m. with a daily pulse check.
-Synthroid 75mcg was not documented as administered from 03/20/16 - 03/25/16 due to "med not in facility".
-There was a medication pass note dated 03/20/16 at 5:46 a.m. that "wrong MCG on cart, pt needs 75MCG, had 88MCG on cart. Call pharmacy to send correct MCG."
-There was a medication pass note dated 03/21/16 at 5:40 a.m. that "med was decreased, med has to come from pharmacy today".
-There was a medication pass note dated 03/23/16 at 5:45 a.m. that "med should come from pharmacy today".
-There was a medication pass note dated 03/24/16 at 6:04 a.m. that "waiting on pharmacy to deliver".
-There was a medication pass note dated 03/25/16 at 5:55 a.m. that "waiting on clarification from dr".
-Documented of the administration of Synthroid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 22 75mcg started back on 03/26/16 - 03/31/16. Review of a note faxed to the physician on 03/24/16 for Resident #1 revealed: -A medication aide wrote a note to the physician to please clarify Synthroid 75mcg or Synthroid 88mcg once daily. -The physician responded on 03/25/16 the order was Synthroid 75mcg once daily. Review of outside pharmacy dispensing records dated 12/01/15 - 04/22/16 for Resident #1 revealed: -Thirty Synthroid 75mcg tablets were dispensed on 12/14/15. -Thirty Synthroid 88mcg tablets were dispensed on 12/22/15. -Thirty Synthroid 88mcg tablets were dispensed on 01/23/16. -Thirty Synthroid 88mcg tablets were dispensed on 02/24/16. -Thirty Synthroid 88mcg tablets were dispensed on 03/22/16. -Thirty Synthroid 75mcg tablets were dispensed on 03/25/16. -Thirty Synthroid 75mcg tablets were dispensed on 04/19/16. Interview with the Resident Care Manager (RCM) on 04/22/16 at 1:00 p.m. revealed: -The medication aides were supposed to notify the RCM of any medication errors. -He was not aware there had been any problems with Resident #1's Synthroid. -The medication aides were trained to read the MARs and the medication labels and if they don't match, the medication aides were supposed to stop and clarify the orders. -He would check with Resident #1's outside pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 23 Another interview with the RCM on 04/22/16 at 2:30 p.m. revealed: -He contacted the outside pharmacy and the order dated 12/14/15 to change the Synthroid to 75mcg was faxed to the pharmacy on 12/14/15. -The pharmacy dispensed Synthroid 75mcg on 12/14/15. -The pharmacy did not take the previous order for Synthroid 88mcg out of the computer so when the monthly cycle fill came due, the 88mcg was dispensed in error. -The Synthroid 88mcg continued to be dispensed on the monthly cycle fill until the facility got a clarification order on 03/25/16. -The RCM found 2 bubble cards with the Synthroid 88mcg that were dispensed on 02/24/16 and 03/22/16 in their extra supply of medications. -None of the Synthroid 88mcg tablets from those 2 supplies had been used. -He thought staff may have been giving Synthroid 75mcg from previous supplies because the resident had been on 75mcg in the past. -He did not know if any Synthroid was returned to the pharmacy but he would check on it. Observation of medications on hand for Resident #1 on 04/22/16 revealed: -There was a supply of Synthroid 88mcg with all 30 tablets remaining in the bubble pack that were dispensed on 02/24/16. -There was a supply of Synthroid 88mcg with all 30 tablets remaining that were dispensed on 03/22/16. -There was a supply of Synthroid 75mcg with 2 of 30 tablets remaining that were dispensed on 03/25/16. -There was a supply of Synthroid 75mcg with all 30 tablets remaining that were dispensed on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 24 04/19/16. Interview with a medication aide on 04/22/16 at 4:30 p.m. revealed: -He was doing a routine cart audit in March 2016 when he noticed they had Synthroid 88mcg tablets in the cart but the MAR noted Synthroid 75mcg. -They only had Synthroid 88mcg on hand at that time to his knowledge. -He faxed the physician to clarify the discrepancy. -The clarified order was for Synthroid 75mcg so he pulled the 88mcg tablets to be sent back to the pharmacy. Interview with the Administrator on 04/22/16 at 4:50 p.m. revealed: -She was unaware of the discrepancy with Resident #1's Synthroid. -Resident #1 got her medications from an outside local pharmacy. -The previous RCM was supposed to be checking medications that came in from outside pharmacy. -They had problems with the previous RCM not checking the medications like she was supposed to. Medication return records for the Synthroid were requested but none were received by the end of the survey. Attempt to contact the physician during the survey was unsuccessful. Review of lab forms in Resident #1's record revealed: -The resident's thyroid stimulating hormone (TSH) level was 0.12 (reference range 0.358 - 3.740) on 08/03/15.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 25	D 358		

-The resident's TSH level was 1.38 while in the hospital on 12/09/15.
-There were no other TSH levels documented in the resident's record.

3. Review of Resident #4's current FL-2 dated 01/19/16 revealed:
-Diagnoses included coronary artery disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease, atrial fibrillation, hypertension, anxiety, muscle weakness, and arthritis.
-Medication orders included Buspar 15mg daily and Ativan 0.5mg three times daily.

A. Review of subsequent physician orders dated 03/15/16 revealed an order for Buspar 15mg twice daily. (Buspar is an anxiolytic medication used to treat anxiety).

Review of Resident #4's Medication Administration Record (MAR) for January and February 2016 revealed:
-There was an entry for Buspar 15mg twice daily that was scheduled for 8:00am and 8:00pm.
-Resident #4 was documented as administered Buspar 15mg twice daily from 01/19/16-01/31/16.
-Resident #4 was documented as administered Buspar 15mg twice daily from 02/01/16-02/29/16.

Review of Resident #4's MAR for March 2016 revealed:
-There was an entry for Buspar 15mg twice daily that was scheduled for 8:00am and 8:00pm.
-Resident #4 was documented as administered Buspar 15mg twice daily from 03/01/16-03/31/16.

Interview with the Resident Care Assistant (RCA) on 04/22/16 at 8:45 a.m. revealed:
-The Resident Care Manager (RCM) or the RCA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 358	Continued From page 26	D 358		

were responsible for reviewing physician orders and for sending the orders to the pharmacy if there medication changes.
-The RCA did not know what happened with the Buspar from the FL2 in January until the new order in March.
-The resident should have only received Buspar daily from 01/19/16 until the new order was written on 03/15/16.
-The RCA was going to get the order clarified with Resident #4's physician.

Review of a faxed physician communication from the RCA dated 04/22/16 revealed a note to "please clarify that patient is on Buspar 15mg twice daily."

Attempted interview with Resident #4's physician was unsuccessful due to the physician's office being closed on 04/22/16.

B. Review of subsequent physician orders dated 03/15/16 revealed an order for Ativan 0.5mg three times daily. (Ativan is a benzodiazepine used to treat anxiety.)

Review of the MARs for February, March, and April 2016 revealed:
-There was an entry for Ativan 0.5mg three times daily that was scheduled for 8:00am, 2:00pm, and 8:00pm.
-The MAR notes revealed documentation that from 03/08/16-03/15/16, Resident #4 did not receive Ativan 0.5mg because the "med not in facility."

Review of the 24 Hour Report staff communications revealed:
-On the 3pm-11pm shift on 03/08/16, there was a note that read, "Ativan not in facility; call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 27	D 358		

physician."
-On the 11pm-7am shift on 03/09/16, there was a note that read, "Physician called about Ativan; physician not in."
-On the 7am-3pm shift on 03/10/16, there was a note that read, "Call physician about Ativan."
-On the 7pm-7am shift on 03/13/16, there was a note that read, "Family will get Ativan prescription on Monday from physician."
-On the 11pm-7am shift on 03/14/16, there was a note that read, "Family will get Ativan prescription from physician; appointment moved to 10am on 03/15/16."
-On the 7am-3pm shift on 03/15/16, there was a note that read, "Faxed script to pharmacy for Ativan.
-On the 3pm-11pm shift on 03/15/16, there was a note that read, "Faxed script to pharmacy for Ativan."
-On the 7am-3pm shift on 03/16/16, there was a note that read, "Ativan in."

Review of the prescription history from the pharmacy revealed:
-There were ninety tablets of Ativan 0.5mg dispensed on 01/16/16.
-There were ninety tablets of Ativan 0.5mg dispensed on 03/15/16.

Interview with the RCA on 04/22/16 at 8:45 a.m. revealed:
-The issue with the Ativan being out of the facility was that the pharmacy needed a prescription.
-It took a while to get orders signed from the physician, so the facility took a folder with orders that needed to be signed to the physician office weekly.

Interview with Resident #4 on 04/22/16 at 10:00 a.m. revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 28 -There have been times when several medications were not in the facility. -The resident was unable to recall which medications the facility did not have other than the Ativan. -The resident's family member had to go to the physician's office to get a prescription for the Ativan about "a month or so ago." Interview with the RCM on 04/22/16 at 3:04 p.m. revealed: -If there was a five day supply of the medication left, the MAs were told to reorder the medication from the pharmacy. -If the medicine was ordered before 5:00 p.m., the medicine would be in the daily drop off which was at 3:00-4:00am. -If the medicine was ordered after 5:00 p.m., the medicine would arrive in the daily drop off for the next day. -The expectation was when a new "bubble pack" was received, the MA was to go ahead and get a new prescription or at least start calling the physician for the new order. Interview with the ED on 04/22/16 at 4:28 p.m. revealed: -When the MAs see that there were seven full days of the medication, the MAs were to reorder the medication. -With narcotics, the staff was having to get a new prescription after one week of the medication had been given, but then the pharmacy started the cycle fills. -The cycle fills worked well for the staff because they do not run out unless a prescription is needed. Attempted interview with the physician was unsuccessful as the physician's office was closed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 358	Continued From page 29 on 04/22/16.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow up on medication review recommendations for 4 of 5 residents (#1, #4, #5, #6) sampled for review related to medications for acid reflux (#5), labwork for thyroid levels (#1), medications for anxiety (#6), and labwork for comprehensive metabolic panel, complete blood count, magnesium, and Vitamin D levels (#4). The findings are: 1. Review of Resident #5's current FL-2 dated 06/19/15 revealed: -The resident's diagnoses included diabetes mellitus type II, diabetic neuropathy, dementia, gastroesophageal reflux disease, hyperlipidemia, hypertension, coronary artery disease, renal insufficiency, insomnia, chronic pain syndrome, and history of alcoholism. -There was an order for Protonix 40mg 1 tablet once daily. (Protonix is used to treat acid reflux.) Review of Resident #5's current medication review dated 02/12/16 revealed: -The pharmacist noted the resident had been taking Protonix for over 4 months and his gastrointestinal status was stable with no	D 406		

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	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

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D 406	Continued From page 30	D 406		

complaints.
-The pharmacist noted to re-evaluate the need to continue the Protonix.
-The pharmacist suggested to discontinue the Protonix when the current supply was completed.

Review of the physician's response to the recommendation and orders dated 02/15/16 revealed:
-There was an order to discontinue Protonix.
-There was an order for Zantac 150mg twice daily. (Zantac is used to treat acid reflux.)
-The order noted to start Zantac after the current supply of Protonix was completed.

Review of the February 2016 and March 2016 medication administration records (MARs) revealed:
-Protonix was documented as discontinued on 02/16/16.
-The administration of Zantac was documented and started on 03/10/16 - 03/31/16.
-No Protonix was administered until the Zantac was started on 03/10/16.

Review of pharmacy dispensing records dated 01/01/16 - 04/21/16 revealed:
-Thirty Protonix 40mg tablets were dispensed on 02/09/16.
-Sixty Zantac 150mg tablets were dispensed on 03/08/16.

Interview with the Resident Care Manager (RCM) on 04/22/16 at 4:15 p.m. revealed:
-They were supposed to finish administering Protonix until the supply was exhausted.
-He did not know why staff stopped administering the Protonix prior to the supply being exhausted.
-He and the Resident Care Assistant (RCA) were responsible for making sure any orders from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 31	D 406		

medication review recommendations were followed through.
-They must have overlooked it.

Refer to interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m.

Refer to interview with the Resident Care Assistant (RCA) on 04/22/16 at 3:25 p.m.

Refer to interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m.

2. Review of Resident #1's current FL-2 dated 01/12/16 revealed:
-The resident's diagnoses included hypothyroidism, dementia, depression, acute pain, and weakness.
-There was an order for Synthroid 75mcg take 1 tablet daily. (Synthroid is used to treat hypothyroidism.)

Review of Resident #1's previous medication review dated 11/25/15 revealed:
-The pharmacist noted the resident had a suppressed thyroid stimulating hormone (TSH) level of 0.12 in 08/2015.
-The pharmacist recommended a TSH level be checked on next facility lab day.

Review of a physician's response to the recommendation and orders dated 12/14/15 revealed:
-There was an order to change Synthroid 88mcg to Synthroid 75mcg daily and check pulse daily.
-There was an order to check TSH level in 1 month.

Review of lab forms in Resident #1's record revealed:

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	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 406	Continued From page 32	D 406		

-The resident's thyroid stimulating hormone (TSH) level was 0.12 (reference range 0.358 - 3.740) on 08/03/15.
-The resident's TSH level was 1.38 while in the hospital on 12/09/15.
-There were no other TSH levels documented in the resident's record.

Review of Resident #1's most current medication review dated 02/10/16 revealed the pharmacist noted he could not locate the recheck of the TSH level.

Interview with the RCM on 04/22/16 at 2:30 p.m. revealed:
-He and the Resident Care Assistant (RCA) were responsible for following up on the recommendations by the pharmacist.
-He could not locate another TSH level on file for Resident #1.
-He just called the physician's office and they did not have another TSH level on file.
-He did not know why the TSH level was not done and he would check with the physician about getting another TSH level drawn.

Review of a physician's order faxed to the facility on 04/22/16 revealed:
-There was an order for Synthroid 75mcg daily, check pulse, hold for pulse <60 and call physician.
-There was an order to get TSH level now and every 6 months.

Refer to interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m.

Refer to interview with the Resident Care Assistant (RCA) on 04/22/16 at 3:25 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 33 Refer to interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. 3. Review of Resident #6's current FL-2 dated 03/09/16 revealed the resident's diagnoses included dementia, depression, and anemia. Review of Resident #6's most recent medication review from the summary report dated 02/12/16 revealed: -The pharmacist noted the resident was taking Vistaril 25mg 4 times a day and Xanax 0.5mg 4 times a day. (Vistaril and Xanax are used to treat anxiety.) -The pharmacist recommended to minimize some potential side effects from Vistaril to taper the resident down from 4 times a day to twice a day. Review of the physician's response to the recommendation dated 02/12/16 for Resident #6 revealed the physician agreed to decrease Vistaril to twice daily dosing. Review of Resident #6's record revealed: -There was no documentation of any order for Vistaril. -There was no documentation of any order for Xanax. Review of the February 2016 - April 2016 medication administration records (MARs) revealed: -There was no entry for Vistaril on the MARs. -There was no entry for Xanax on the MARs. Review of the yellow pharmacist note form in Resident #6's record revealed the pharmacist reviewed the resident's record on 02/10/16 and no recommendations were noted.	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 34 Interview with a medication aide on 04/22/16 at 5:40 p.m. revealed: -There was only one resident who took Vistaril and Xanax 4 times a day to her knowledge. -Resident #8 had orders to get Vistaril and Xanax 4 times a day. -Resident #6 had never taken Vistaril or Xanax to her knowledge. Review of medication review summary forms dated 02/12/16 revealed no recommendations for Resident #8. Review of the yellow pharmacist note form in Resident #8's record revealed the pharmacist reviewed the resident's record on 02/10/16 and noted the Vistaril needed to be decreased from 4 times a day to twice a day. Interview with the Executive Director (ED) on 04/22/16 at 5:50 p.m. revealed: -She just checked the electronic MAR records and Resident #6 had never taken Vistaril or Xanax. -It appeared the wrong resident's name was printed on the medication summary form. -The Resident Care Manager (RCM) and the Resident Care Assistant (RCA) were responsible for following up on the medication reviews. -She did not understand why Resident #6's physician signed the recommendation since the resident did not take those medications. -The physician's office was closed today. -Staff should have caught the error when they followed up on the physician's order based on the recommendation. -She would contact the pharmacist about the error in names on the summary report. -They would also contact Resident #8's physician regarding the recommendation.	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 35 Refer to interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m. Refer to interview with the Resident Care Assistant (RCA) on 04/22/16 at 3:25 p.m. Refer to interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. 4. Review of Resident #4's current FL-2 dated 01/19/16 revealed: - Diagnoses included coronary artery disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease, atrial fibrillation, hypertension, anxiety, muscle weakness, and arthritis. - Medication orders included Benicar 20mg daily, Mag Oxide 400mg daily, Omeprazole 20mg daily, and Vitamin D3 1,000units daily. Review of Resident #4's most recent medication regimen review dated 02/12/16 revealed: - The pharmacist noted the resident was taking medications that required laboratory monitoring. - The pharmacist recommend that baseline labs for a Comprehensive Metabolic Panel (CMP), Magnesium Level, Complete Blood Count (CBC), and Vitamin D level be obtained due to the resident receiving Benicar, Magnesium Oxide, Omeprazole, and Vitamin D. - The pharmacist recommendation was not signed by the physician. Review of Resident #4's record revealed: - No documentation the medication review recommendations had been sent to the physician for response. - There was no laboratory results for the CMP, Magnesium Level, CBC, and Vitamin D level.	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 36 Interview with Resident #4 on 04/22/16 at 10:10 a.m. revealed: - The resident did not recall having labs drawn recently. - She knew her physician had been drawing labs for the "blood thinner" she was taking, but that was the only labs she thought had been obtained. Interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m. revealed: - The review sheet would be in the record if it was faxed to the physician. - There was no pharmacy review sheet in Resident #4's record. Attempted interview with the physician was unsuccessful to the physician's office being closed on 04/22/16. Refer to interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m. Refer to interview with the Resident Care Assistant (RCA) on 04/22/16 at 3:25 p.m. Refer to interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. _____ Interview with the Resident Care Manager (RCM) on 04/22/16 at 3:04 p.m. revealed: - The RCM or the Resident Care Assistant (RCA) was responsible for sending the pharmacy review sheets to the physician for follow up. - The review sheet would be in the record if it was faxed to the physician. Interview with the RCA on 04/22/16 at 3:25 p.m. revealed:	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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D 406	Continued From page 37 - The pharmacy review sheets were to be sent to the physician for signature, and if the recommendation was for a new or changed medication, the review would be sent to the pharmacy once the physician signed. - The review sheet was considered an order, and would be in the resident's chart if it was faxed. - If the review sheet was sent via fax to the physician, the review would be in the chart with the physician's response to the recommendation. - The facility had a folder that was used to take orders and other paperwork that needed signatures to the physician's office weekly. Interview with the Executive Director (ED) on 04/22/16 at 4:28 p.m. revealed: - The pharmacy reviews were orders if the physician signed and dated the recommendation. - The RCM was responsible for getting the pharmacy reviews completed. - The pharmacy reviews were faxed to the physician.	D 406		