STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

(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
E 000	Initial Comments An unannounced recertification/complaint survey was conducted on 01/26/20 through 01/30/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BVG311.	E 000		
F 000	INITIAL COMMENTS A recertification/ complaint/follow-up survey was conducted from 01/26/20 through 01/30/20. None of the five complaint allegations was substantiated.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 1 of 5 residents (Resident #64) observed during medication administration. Findings included: During a medication administration observation on 01/28/20 at 9:45 AM Nurse #5 was observed passing medications to Resident #64. Nurse #5 administered aldactone 12.5 mg (milligrams) and bumex 1 mg at the same time to Resident #64. Nurse #5 also administered Systane Balance Solution eye drops, 1 drop to each of Resident	F 759	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a.Resident # 64 was administered aldactone 12.5 mg and bumex 1 mg at the same time. Medication Administration times were changed by MD on 2/6/2020. Systane was administered to both eyes when order read left eye. Medication Administrattion education was provided to nurse #5. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. A 100 percent audit of orders was	2/11/20

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

Electronically Signed | 02/11/2020

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F 759	Continued From page 1 #64's eyes. 1a. During a medication reconciliation on 01/28/20 at 10:10 AM Resident #64's orders were reviewed. An order dated 06/25/19 revealed that bumex should be administered 30 minutes after the aldactone was administered. In an interview on 01/28/20 at 10:25 AM Nurse #5 verified that she administered the aldactone and bumex at the same time. She stated that she had not read the order through to the end which revealed the special instructions to wait 30 minutes before administering the bumex. In a follow-up interview on 01/29/20 at 2:19 PM Nurse #5 stated that medications should always be administered as ordered. In an interview on 01/29/20 at 4:35 PM the Interim Director of Nursing (IDON) stated that the goal error rate of medication administration was 0%, but that 5% or less was a more realistic number. He indicated that the facility had a lot of work to do and he considered this an opportunity for training, diligence, and accountability. 1b. During a medication reconciliation on 01/28/20 at 10:10 AM Resident #64's orders were reviewed. An order dated 04/16/19 revealed that one drop of the Systane Balance Solution eye drops was to be administered to the left eye. In an interview on 01/28/20 at 10:25 AM Nurse #5 verified that she had put the Systane eye drops in both of Resident #64's eyes and stated she had done that because Resident #64 preferred it that way. She stated that she had been aware of this preference but had not spoken to the physician to	F 759	conducted by DON/RDCS to ensure medication administration directions were clear and followed correctly on1/30/2020. 3. Address what measures will be put into place or systemic changes to ensure that the deficient practice will not occur: 3a. All new admits, readmit(s) physician orders will be reviewed during clinical morning meeting for administration accuracy of medication orders per DON/designees. 3b. 100% of all Licensed Nurses will be educated on appropriate medication administration. 3c. New Hires, Licensed Nurses, will be educated on orientation regarding proper administration of medications. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 4a. DON/designee will observe medication administration by nurses for compliance with policy. There will be documentation for 3 nurses per week for 12 weeks. Director of Nursing/or licensed designee will review the documentation by the nurses of any medications to ensure that appropriate follow up occurred and to identify any trends. 5. Date of completion will be completed by 02/12/2020.	

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F 759	Continued From page 2 clarify if the eye drops could be administered to both eyes. In a follow-up interview on 01/29/20 at 2:19 PM Nurse #5 stated that medications should always be administered as ordered. In an interview on 01/29/20 at 4:35 PM the Interim Director of Nursing (IDON) stated that the goal error rate of medication administration was 0%, but that 5% or less was a more realistic number. He indicated that the facility had a lot of work to do and he considered this an opportunity for training, diligence, and accountability.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a physician interview the facility failed to administer a medication to increase a resident's blood pressure per a physician's order on 1 of 5 residents (Resident #33) reviewed for unnecessary medications. Findings included: Resident #33 was admitted to the facility on 11/27/18. Diagnoses included, in part, hypotension (low blood pressure). The Minimum Data Set significant change assessment dated 11/20/19 revealed Resident #33 was severely cognitively impaired.	F 760	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a. Resident # 33's orders were clarified on 1/30/2020 by MD. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. 100% of current resident's with orders regarding parameters were reviewed by DON/RDCS and any noted discrepancies were addressed on 1/31/2020. 3. Address what measures will be put into place or systemic changes to ensure that the deficient practice will not occur:	2/11/20

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F 760	Continued From page 3 A nursing note written on 01/04/20 at 8:09 AM revealed the resident kept trying to get out of bed so the nursing assistant (NA) got him up into his wheelchair and sat him in front of the nurse's station. The note stated at 5:25 AM, the resident had an unwitnessed fall with injury to his left eyebrow. The resident was assessed for other injuries and there were none noted. The resident's vital signs (VS) were documented with a Blood Pressure (BP) 126/74 mm/hg (milligrams of mercury), heart rate (HR) 82 beats per minutes (bpm), respiration rate (RR) 20 breaths per minutes (bpm) and temperature was 97.5. The note indicated the resident was sent to the emergency room (ER) for further evaluation. The resident was transferred via emergency medical services (EMS) at 5:55 AM. A nursing note written on 01/04/20 at 11:08 AM (late entry) revealed, in part, at approximately 8:45 AM the resident returned to the facility from the hospital via stretcher and he was transferred to his bed by emergency medical services (EMS). Resident's report from the hospital was given to the nurse and the resident was reported as having hypotensive episodes while at the hospital. The nurse obtained the resident's blood pressure and it was noted to be 57/33 milligrams of mercury (mm/hg). The resident was difficult to arouse when calling his name and would only open his eyes. The nurse attempted 3 more times to get a blood pressure but was unable to get a reading. The on call physician assistant was notified and an order was obtained to send the resident back to hospital for evaluation following acute hypotensive episode at 9:40 AM. The resident was returned to the facility at 1:30 PM on 01/04/20.	F 760	3a. All new admits, readmit(s) physician orders will be reviewed in clinical morning meeting for administration accuracy of those medications from previous day. 3b. 100% of current orders will be reviewed to ensure that there are no noted parameter medication discrepancies by DON/RDCS on 1/30/2020. Physician was notified of any discrepancies noted. 3c. New Hires, Licensed Nurses, will be educated on orientation regarding proper administration of medications that require a parameter. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. DON/designee will audit all new admits, readmits and/or physician orders 5 times per week for 4 weeks; then 3 times a week for 4 weeks ; 1 time a week for 4 weeks. 4b.Results of the audits will be taken to QAPI committee monthly x 3 months for review and revision as needed. 5. Date of completion will be completed by 02/12/2020.	

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F 760	Continued From page 4	F 760		

A progress note written by the facility's physician on 01/07/20 revealed the resident fell from his wheelchair and was transferred to the ER on the morning of 01/04/20. At that time, his blood pressure was 80/55 mm/hg. He had a CAT (a computerized x-ray image) scan of the head and it showed no acute intracranial abnormality but moderate generalized volume loss and chronic small vessel ischemic changes. Despite his low blood pressure, the resident did not have any focal deficits and he was able to speak clearly and follow commands while in the ER. The resident ate and returned to the facility. The resident returned to the ER on 01/04/20 with hypotension and the ER triage recorded his blood pressure of 76/58 mm/hg. The progress note indicated the assessment and the plan was, after reviewing the recorded facility vital signs, the resident had a few readings of systolic blood pressure (SBP) less than 100 mm/hg. The note stated the physician would begin Midodrine (a medication to raise blood pressure) 2.5 milligrams (mg) every 6 hours when necessary for SBP less than or equal to 100 mm/hg.

A nursing note, written by Nurse #6, on 01/07/20 revealed the resident had an unwitnessed fall at 3:30 PM. The resident was noted to be assessed with no signs of injury. Resident was sitting near the nurse's station on the floor. Vital Signs included Blood Pressure (BP) 126/74 mm/hg, heart rate (HR) 82 beats per minute (bpm) and respiration rate (RR) of 20 breaths per minutes (bpm) and temperature of 97.8.

A physician's order written on 01/07/20 at 3:30 PM revealed an order for Midodrine 5 mg; give 2.5 mg every 6 hours as needed for systolic blood

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F 760	Continued From page 5	F 760		

pressure less than 100 mm/hg.

A review of the blood pressures on 01/07/20 revealed the following readings:

01/07/20	7:36 PM	80/40 mm/hg
01/07/20	7:38 PM	83/49 mm/hg
01/07/20	7:40 PM	80/48 mm/hg
01/07/20	7:43 PM	84/52 mm/hg
01/07/20	7:47 PM	88/52 mm/hg
01/07/20	7:50 PM	92/60 mm/hg
01/07/20	8:36 PM	52/36 mm/hg
01/07/20	9:00 PM	87/50 mm/hg
01/07/20	10:00 PM	52/36 mm/hg
01/07/20	11:00 PM	70/57 mm/hg

A review of the Medication Administration Record (MAR) for January 07, 2020, revealed the order for the Midodrine 2.5 mg was noted on the MAR but it was not signed off as given as evidenced by a nurse's initials on 01/07/20.

An interview was conducted with the Nurse #6 on 01/29/20 at 11:15 AM. Nurse #6 stated when a resident had an unwitnessed fall, the protocol was to complete neurological checks which included vital signs (VS) every 15 minutes for one hour, every 30 minutes for two hours and hourly for 4 hours and then every 8 hours for 72 hours. Nurse #6 stated the resident had an unwitnessed fall with no injury about 3:30 PM on 01/07/20 and she began the neurological checks, notified the physician and obtained an order from the physician to give the Midodrine 2.5 mg every 6 hours as needed for SBP less 100 mm/hg. Nurse #6 stated beginning at around 3:30 PM she took the resident's VS every 15 minutes for one hour and then every 30 minutes until right before her shift ended at 7:00 PM. Nurse #6 stated the

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F 760	Continued From page 6	F 760		

resident remained alert and out of bed most of the shift while she obtained the vital signs for the neurological checks. Nurse #6 stated the vital sign recordings in the computer system were entered all at once when she began to do her charting at 7:30 PM. Nurse #6 reviewed the MAR and confirmed that she did not give the resident the Midodrine medication as ordered. Nurse #6 stated the Midodrine medication should have been given according to the resident's blood pressures, but she could not provide an explanation as to why she did not administer it. Nurse #6 stated she could not be certain the fall earlier that day was as a result of a low blood pressure. She stated signs and symptoms of a low blood pressure could be confusion, fainting, and sleepy. Nurse #6 stated the resident was confused at baseline, talking and moving about the facility and was not sleepy. The resident was usually up most of the day, propelling self in the wheelchair around the facility. Nurse #6 stated she reported off to Nurse #7 at 7:00 PM on 01/07/20 regarding the resident's fall and she believed she told Nurse #7 about the new medication that was ordered for his low blood pressure, but she was not certain.

An interview with Nurse #7 was attempted via phone on 01/29/20 at 1:00 PM, but Nurse #7 could not be reached.

An interview was conducted with the resident's physician on 01/29/20 at 1:15 PM. The physician reviewed the 01/07/20 order for Resident #33 to receive Midodrine 2.5 mg on 01/07/20. The physician reported she recalled giving the order to administer the Midodrine if the SBP was at or below 100 mm/hg. The physician reported on 01/07/20 prior to the residents' fall there was no

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F 760	Continued From page 7 documentation that day regarding the blood pressure until post fall. The physician reported she could not be certain the resident fell due to a hypotensive episode, but he had had a history of hypotension and recently had hypotensive episodes that he had to be sent to the ER so she had decided to start him on the Midodrine. The physician reported the blood pressures were below 100 mm/hg for several hours on 01/07/20 and she would have expected the nurses to administer the medication as ordered.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		2/11/20

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F 761	Continued From page 8 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instructions, and staff interviews the facility failed to remove an expired insulin pen from the medication cart, failed to record an opened date on an insulin pen, failed to remove an expired container of UTI Stat liquid (an oral supplement that protects against recurrent urinary tract infections), and failed to accurately label and record an opened date for an oral inhaler for 1 of 5 medication carts observed. Findings included: In an observation with Nurse #1 on 1/26/20 at 12:15 PM an opened Lantus insulin injectable pen was in a drawer on the 100-hall medication cart. The manufacturer's label directed to discard 28 days after opening. The insulin pen had a sticker attached with a handwritten opened date of 12/27/19. Nurse #1 verified that the insulin pen should have been discarded after the 28th day. A Basaglar insulin injectable pen to be discarded 28 days after opening was observed with six doses remaining and no opened date. Further observation revealed a container of UTI Stat liquid with an opened date of 10/16/19 and an expiration date of 1/13/20. A Breo Ellipta oral inhaler indicated for chronic obstructive pulmonary disease and asthma was observed opened with no pharmacy label that included the resident's name and dosing instructions, and no opened date. The manufacturer's instructions for the Breo inhaler directed to discard it 6 weeks after opening. In an interview with Nurse #1 on 1/26/20 at 12:15	F 761	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a. The insulin pen on 100 hall cart was discarded and re-ordered on 1/26/2020. Uti Stat Liquid was discarded and replaced on 1/26/2020. The Breo inhaler was discarded and a new one was available on 1/26/2020. 2. Address how corrective action will be accomplished to those residents having the potential to be affected by the same deficient practice: 2a. 100% of medication carts were audited by DON/designee to ensure there are no expired medications on cart and none stored without opened date by 1/31/2020. 2b. 100% of Medication rooms will be checked by DON/designee for any expired medications, improper storage, expired supplies for example: dressings, blood tubes on 1/31/2020. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. 100% of all Licensed Nurses will be educated on proper medication storage, expired medications, inappropriate storage for example: dressings, blood tubes. 3b. Any newly hired, License Nurses, will be educated on appropriate medication storage, improper storage, expired medications and supplies: dressings, blood tubes.	

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F 761	Continued From page 9 PM she reported that she was unaware that the insulin and the UTI Stat was expired, and the insulin pen and inhaler was not properly labeled. She indicated that it was the responsibility of the nurses who administered the insulin to make sure the insulin was not used past the expiration date, and that all medications had a pharmacy label with the resident's name and dosing instructions, and the date the medication was opened. In an interview with the Administrator on 01/29/20 at 10:02 AM she acknowledged that the medication cart was observed with expired and improperly labeled medications. She indicated that the nurses were responsible for assuring medications were discarded by the expiration date, had the appropriate pharmacy label, and labeled with an opened date.	F 761	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4a. Medication carts will be audited 5 times per week times 4 weeks, then 3 times per week for 4 weeks then weekly times 4 weeks. 4b. Medication rooms, supply rooms will be audited 3 times per week times 4 weeks, then weekly times 8 weeks; to include but not limited to for expired medications, inappropriate storage of medication, expired supplies, by Unit Managers/designees. 4b. Results of audits will be taken to QAPI monthly times 3 months for review and revision as warranted. 5. Date of compliance: 02/12/2020	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance (QA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification and complaint investigation survey of 02/09/19. This was for one recited deficiency that was originally cited in February 2019 and subsequently recited on the	F 867	1. Address how corrective action will be accomplished for those residents found to have been affected: 1a.Resident # 64 was administered aldactone 12.5 mg and bumex 1 mg at the same time. Medication Administration times were changed by MD on 2/6/2020. Systane was administered to both eyes when order read left eye. Medication	2/11/20

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F 867	Continued From page 10 current recertification and complaint investigation of 01/30/20. The recited deficiency was for the facility's failure to ensure it was free of medication error rates of 5 percent or greater. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. This tag is cross-referenced to: F759: Free of Medication Error Rates of 5% or more: Based on observation, record review, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 1 of 5 residents (Resident #64) observed during medication administration. Review of the facility's survey history revealed F759 was cited during the facility's 02/09/19 annual recertification and complaint investigation surveys because the facility failed to ensure it was free of medication error rates of 5 percent or greater as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 6 residents (Resident #12) observed during medication administration. In an interview on 01/29/20 at 4:57 PM with the Administrator and the Interim Director of Nursing (IDON), it was stated that they felt the previous plan of correction for F759 was not effective due to the nurses not following medication orders as written, order transcription errors, and a lack of attention to detail when it came to medications.	F 867	Administrattion education was provided to nurse #5. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 2a. A 100 percent audit of orders was conducted by DON/RDCS to ensure medication administration directions were clear and followed correctly on1/30/2020. 3. Address what measures will be put into place or systemic changes to ensure that the deficient practice will not occur: 3a. All new admits, readmit(s) physician orders will be reviewed during clinical morning meeting for administration accuracy of medication orders per DON/designees. 3b. 100% of all Licensed Nurses will be educated on appropriate medication administration. 3c. New Hires, Licensed Nurses, will be educated on orientation regarding proper administration of medications. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 4a. DON/designee will observe medication administration by nurses for compliance with policy. There will be documentation for 3 nurses per week for 12 weeks. Director of Nursing/or licensed designee will review the documentation by the nurses of any medications to ensure that appropriate follow up occurred and to identify any trends. 5. Date of completion will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 11	F 867	by 02/12/2020	