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

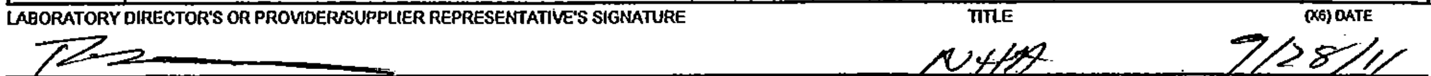
PRINTED: 09/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING ______ B. WING ______	C 09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC 28619

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #RMJC11.	F 000	This written plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews the facility failed to administer medications as ordered by the physician for two (2) of eleven (11) sampled residents. Residents #61 and #114. The findings are: 1. Resident #114 was admitted to the facility 8/8/11 with diagnoses which included atrial fibrillation. Admission orders included Coumadin, 7 milligrams every day. Labwork to monitor and adjust the Coumadin levels was done and communicated to the resident's physician. A Fax was communicated to the resident's physician on 8/15/11 which read, "PT (prothrombin time) 48.7 INR (international normalized ratio) 4.1. Currently taking 7 milligrams (ordered at hospital). On antibiotics for pneumonia and urinary tract infection." The physician responded on 8/15/11 with an order to "Hold Xs 2 days. Restart on Wednesday at 6 milligrams Coumadin every day. Recheck PT/INR two weeks." The Fax indicated the order had been received by Licensed Nurse #2.	F 281	Resident # 14 experienced no negative outcome. Both medication aides involved in this incident in-serviced to closely read the medication order record prior to the administration of any medication. The Licensed nurses responsible for transcription of medication orders were additionally trained for the following, when a Coumadin order is discontinued: 1. Highlight the entire Coumadin order across the page. 2. Document (d/c) discontinue in the right hand margin, initial and date. 100% audit of all residents on Coumadin completed and all other orders transcribed as ordered.	9/15/11 9/16/11 9/15/11 10/18/11

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



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
OCT 03 2011
BY: MH

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F 281	Continued From page 1 Review of the August 2011 Medication Administration Record for Resident #114 revealed the order for Coumadin 7 milligrams orally every day with initialed signatures noting the Coumadin had been administered at 4:00 PM on 8/9, 8/10, 8/11, 8/12, 8/13, 8/14, 8/15 and 8/16. The entry for Coumadin had been highlighted yellow and another entry had been written for Coumadin 6 milligrams orally every day. Review of the MAR revealed there was no indication on the entry what day the 7 milligrams of Coumadin had been discontinued. On 9/15/11 at 10:00 AM LN #2 stated he spoke with the physician of Resident #114 on 8/15/11around noon and received the order to "Hold Xs 2 days. Restart on Wednesday at 6 milligrams Coumadin every day". LN#2 stated after receiving the order he highlighted the entry for Coumadin 7 milligrams on the resident's MAR and wrote "D/C (discontinued)" under the entry. LN#2 stated he wrote a new entry for Coumadin 6 milligrams noting it should be started on 8/17. LN#2 could not explain why the 7 milligrams of Coumadin would have been administered to Resident #114 on 8/15/11 and 8/16/11 when it had been discontinued. On 9/15/11 at 2:30 PM Medication Aide #1 (that initialed on the MAR administration of the Coumadin to Resident #114 on 8/15/11) reported she could not explain why Coumadin would have been given to Resident #114 on 8/15/11. Medication Aide #1 stated she knew if an order was highlighted it meant it was discontinued. On 9/15/11 at 3:30 PM Medication Aide #2 (that initialed on the MAR administration of the Coumadin to Resident #114 on 8/16/11) stated	F 281	100% Coumadin audits are completed 5 days per week for 4 weeks, by the Director of Nurses, Assistant Director of Nurses,or the Quality Assurance Nurse. After 4 weeks Coumadin audits are done weekly to include each Coumadin/INR order/ change documented during the week. The Director of Nurses and Assistant Director of Nurses are responsible for monitoring of compliance and report findings to the quality assurance committee quarterly. Resident #61 experienced no negative outcomes. The nurse involved was re-educated for observing administration of medications at the assigned time as ordered. This nurse also watched the pharmacy medication pass video. All Licensed nurses and medication aides are audited 1 medication pass annually and prn, by the Staff Development Coordinator, Pharmacy Consultant, Assistant Director of Nursing or Regional Nurse Consultant. Results of the audits are reviewed quarterly in the quality assurance meeting. The Director of Nurses is responsible to monitor compliance.	10/18/11 9/30/11

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F 281	Continued From page 2 he could not explain why Coumadin would have been given on Resident #114 on 8/16/11. Medication Aide #2 stated he knew if an order was highlighted it meant it was discontinued. On 9/15/11 at 3:15PM the facility Director of Nursing (DON) stated she could not explain why Coumadin would have been given to Resident #114 on 8/15/11 and 8/16/11. The DON reviewed the August MAR for Resident #114 and stated LN#2 should have dated when the Coumadin was discontinued and either highlighted through the entire entry (which would have included the calendar days to the right of the order) or drawn a line after the 8/14/11 date to ensure staff administering medications were aware of the change in the order. 2. Record review revealed Resident #61 was admitted to the facility 8/10/06 with diagnoses which included osteoporosis. Medication administration was observed for Resident #61 on 9/14/11 from 3:21 p.m. until 3:30 p.m. Calcium 600mg (milligrams) with vitamin D 400 IU (international units) was poured at 3:26 p.m. and administered to the resident immediately afterwards, along with seven (7) other medications. Review of Physician Order sheet dated 9/11/11 revealed orders for Calcium 600mg and Vitamin D 400 IU twice a day at 8 a.m. and 5 p.m. Review of the September 2011 Medication Administration Record (MAR) had times for administration at 8 a.m. and 5 p.m.	F 281		

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F 281	Continued From page 3 During an interview on 9/14/11 at 3:55 p.m., LN #1 stated the calcium was given "a little early" and that she usually gave it a little closer to the time specified on the MAR at 5 p.m. During an interview on 9/14/11 at 4:20 p.m., the facility corporate nurse stated her expectations were for staff to give all medications within the one hour time frame as specified in the facility policy.	F 281		