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 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 An unannounced complaint investigation survey was conducted from 09/20/22 to 09/21/22. One of the eight complaint allegations was substantiated and cited. Intakes NC00192409, NC00190801, NC00190371 and NC00189501, Event IID# QFY011.	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 record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of wrong dosage for 3 medications and omission of 2 medications. These errors constituted 5 out of 28 opportunities, resulting in a medication error rate of 17.86% for 2 of 5 residents (Residents #1 and Resident #2) observed during medication administration. The findings included: 1. Resident #1 was admitted to the facility on 2/24/22 with diagnoses that included gastroesophageal reflux disease (GERD). A physician's order in Resident #1's medical record dated 6/18/22 indicated an active order for Pantoprazole 40 mg (milligrams) give 1 tablet by mouth two times a day for GERD.	F 759	Resident # 1 and Resident # 2 both remain in the facility and neither resident experienced any negative outcome as a result of the medication errors identified during the survey. Each residents medical provider and responsible party were made aware of the medication errors on 9/22/2022 All residents have the potential to be affected by this deficient practice, therefore on 9/21/2022, the DON and clinical management team interviewed all current working nurses to determine if there were any medications that were not available to administer. Any concerns were addressed and follow up completed. The DON and clinical management team completed medication pass competencies on all current nurses who are working on 9/21/2022 to verify that the rights of the	10/11/22

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

Electronically Signed | 10/11/2022

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 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 759	Continued From page 1 An observation was made on 9/21/22 at 7:49 AM of Nurse #1 while she administered medications to Resident #1. She pulled a medication card labeled as Pantoprazole 20 mg (milligram) tablets and popped one tablet into a medication cup. She entered Resident #1's room and proceeded to administer this medication to her. An interview with Nurse #1 on 9/21/22 at 2:58 PM revealed she didn't notice that the card of Pantoprazole tablets was marked as 20 milligrams and she should have administered two tablets instead of one. Nurse #1 stated it was her first time being assigned to work on the hall in 3 months and was not very familiar with the residents and their medications. An interview with the Director of Nursing (DON) on 9/21/22 at 3:45 PM revealed Nurse #1 should have looked at the card of Pantoprazole tablets and checked the dosage before administering this medication to Resident #1. The DON stated Nurse #1 should have administered two Pantoprazole 20 mg tablets instead of one. 2. Resident #2 was admitted to the facility on 5/16/22 with diagnoses that included hypertension, major depressive disorder, and asthma. The physician's orders in Resident #2's electronic medical record indicated the following active orders: a. 5/16/22 - Guaifenesin Extended Release (ER) 12-hour 600 mg (milligrams) give 1 tablet by mouth two times a day for congestion. b. 5/16/22 - Duloxetine 30 mg - give 1 capsule	F 759	medication pass were followed, including reading the order and comparing the order to the medication card. Any areas of concerns identified were corrected at the time of the observation. To prevent this from recurring, on 09/22/2022 the Director of nursing or designee completed education to the nurses and medication aides, on the process of medication administration, including giving medications as ordered, utilization of the Omnicell as a backup for medications not available, on 10/07/2022. This education is ongoing for all new hires and agency staff after 10/07/2022. During routine rounds, clinical managers will randomly observe and interview nurses on the process of medication administration. The clinical managers will validate that medication are available and will observe for administration of medications following physician orders. Follow up will be completed on areas of concern. The Omnicell inventory will be run at a minimum two times monthly by a member of the clinical team beginning the week of 10/10/2022 and refills will be ordered as necessary. Beginning October 2022 the central supply clerk or designee will audit monthly, at a minimum, house stock inventory to ensure the community has the appropriate levels of house stock medications to administer as ordered, and will re-order as necessary based on the direction of the director of nursing or designee. To monitor and maintain ongoing	

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 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 759	Continued From page 2 by mouth in the morning and 2 capsules by mouth at bedtime for depression. c. 5/17/22 - Amlodipine 10 mg - give 1 tablet by mouth in the morning for hypertension. d. 6/14/22 - Cranberry tablet 250 mg - give 2 tablets by mouth in the morning for UTI (urinary tract infection) prevention. On 9/21/22 at 8:05 AM, Nurse #1 was observed as she prepared and administered Resident #2's medications. Nurse #1 searched for Resident #2's Duloxetine and Amlodipine medication cards in the 200 hall medication cart but could not find them. Nurse #1 re-ordered Resident #2's Duloxetine online and called the pharmacy to order a refill of Resident #2's Amlodipine. Nurse #1 proceeded to pull the rest of Resident #2's medications which included one capsule of Cranberry 250 mg and one tablet of Guaifenesin 400 mg. An interview with Nurse #1 on 9/21/22 at 2:58 PM revealed she didn't notice that the order for the Cranberry capsules indicated to give 2 capsules and that she had always given the Guaifenesin to Resident #2 because she had never seen a stock bottle of Guaifenesin ER being available at the facility. An observation of the upstairs medication room on 9/21/22 at 3:10 PM with Nurse #1 and the Director of Nursing (DON) revealed an automated dispensing cabinet which contained stock medications. The DON stated that Amlodipine was available in the stock cabinet. However, Duloxetine was not available. Nurse #1 stated that she didn't know she had access to the stock cabinet but that she had been trained on how to get medications out of it. The DON showed	F 759	compliance, beginning the week of 10/3/2022 the Director of Nursing or clinical manager, will conduct an audit and document results of 10 resident medication administration per week for 12 weeks, to validate compliance with the medication administration process. Any negative findings will be followed up promptly. The results of the audits will be forwarded to the facility QAPI committee, including the facility pharmacy consultant, for further review and recommendations beginning the week of 10/10/2022. The QA committee reserves the right to modify the plan of correction in the event that there are concerns identified through the auditing process. The facility Director of Nursing is responsible for compliance. Date of compliance is 10/11/2022	

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 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 759	Continued From page 3	F 759		

Nurse #1 a list of access codes posted on the side of the cabinet, and it included Nurse #1's username that she could have used to access the cabinet and retrieve medications that were not available in her medication cart.

An interview with the Director of Nursing (DON) on 9/21/22 at 3:45 PM revealed Nurse #1 should have pulled the Amlodipine off the stock cabinet and since Duloxetine was not available, she should have called the pharmacy and requested to have it sent to the facility as soon as possible. The DON stated that Nurse #1 should have looked at the order for Cranberry capsules and she should have given Resident #2 two capsules instead of one capsule as indicated in the order. The DON also stated that Resident #2's family used to supply her Guaifenesin ER, but they wanted them to obtain it from the pharmacy once their supply was depleted. The DON confirmed that they didn't have Guaifenesin ER available on stock and only had the regular Guaifenesin which came in a lower dosage. Nurse #1 should have called the pharmacy or the Nurse Practitioner to clarify the order about the Guaifenesin ER. Further interview with the DON revealed the nurses were supposed to verify the right resident and they should be checking the medication cards to see if they were the same as the order indicated in the computer before giving medications to the residents.