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 10/26/2023

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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/25/23 through 10/26/23. Event ID# 5VD711. The following intake was investigated NC00208324. 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, and Nurse Practitioner interviews the	F 757	Duplicate order of Zyrtec for resident #1 was removed by the nurse practitioner	11/9/23

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

Electronically Signed | 11/10/2023

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F 757	Continued From page 1 facility failed to prevent the duplication of drug therapy by administering a duplicate order of the antihistamine Zyrtec (Cetirizine) prescribed for allergies. This resulted in 13 additional doses of the medication being administered to the resident which exceeded the recommended daily dose. This occurred for 1 of 1 resident (Resident #1) reviewed for unnecessary medications. Findings included. Resident #1 was admitted to the facility on 01/19/21 with diagnoses including in part; vascular dementia with mood disturbance, chronic kidney disease, and allergic rhinitis. The Minimum Data Set (MDS) quarterly assessment dated 08/17/23 revealed Resident #1 had severely impaired cognition. She required extensive assistance with activities of daily living. She received antipsychotics, antidepressants, hypnotics, diuretics, and opioids during the assessment period. A physicians order dated 05/19/21 revealed Resident #1 was prescribed Zyrtec (Cetirizine HCl) tablets 10 milligram (mg). Give 10 mgs by mouth at bedtime for allergies. This order was entered into the electronic Medication Administration Record (MAR) to be administer nightly at 9:30 PM. A new physicians order dated 10/10/23 revealed Resident #1 was prescribed Cetirizine HCl oral tablets 10 milligram (mg). Give 10 mgs by mouth one time a day for allergies. This order was entered into the MAR by Nurse #1 to be administer daily at 9:30 AM. Review of the Medication Administration Record	F 757	and the dose was reduced on 10/26/2023. The NP reviewed all other medications for the resident on 10/27/2023. The DON or designee will review every resident□s medication list in the facility by 11/7/2023 to ensure there are no other residents with duplicate medication orders. All duplicate orders will be reported to the MD and corrected if necessary. The DON or designee will educate all nurses on order entry and duplicate order alerts by 11/3/2023. Any nurse unable to be educated by 11/3/2023 will be removed from the schedule until education can be provided. The DON or designee will review all orders for new admissions, readmissions and residents that were sent to the ER 5x week and ensure each medication ordered is not a duplicate order. Any duplicate orders identified will be reported to the MD, corrected if necessary and re-education will be provided to the nurse who entered the duplicate medication. The audits will start on 11/7/2023 and be completed for 12 weeks. AOC 11/9/2023	

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F 757	Continued From page 2	F 757		

(MAR) dated October 2023 revealed Resident #1 received Zyrtec (Cetirizine) 10 mgs daily at 9:30 AM and nightly at 9:30 PM on 10/12, 10/13, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, and 10/25, resulting in 13 duplicate doses.

During a phone interview on 10/25/23 at 5:00 PM Nurse #1 stated she entered the orders for Resident #1 on 10/09/23 upon her return from the hospital. She stated if she entered a duplicate order for Zyrtec (Cetirizine) then it was done in error. She stated the facility protocol included that a second nurse reviewed medication orders once the order was entered into the medical record. She stated the unit manager reviewed the orders that were entered on 10/09/23.

During an interview on 10/26/23 at 3:37 PM Unit Manger #1 stated when she reviewed orders each morning the system only showed what orders were entered the day before. She stated the previous order which showed on the MAR was written for Zyrtec and the new order was written for the generic form (Cetirizine) which could be why it was missed. She stated the duplicate order was entered in error.

A phone interview was conducted on 10/26/23 at 11:45 AM with the Consultant Pharmacist. He stated Zyrtec (Cetirizine) 10 mgs administered twice a day would be considered duplicate therapy. He stated the maximum recommended dose was up to 10 mgs daily. He stated he had not completed the Medication Regimen Review for October yet and therefore was not aware of the duplicate order for Resident #1. He stated side effects of a higher dose would include drowsiness and it could also affect renal function.

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F 757	Continued From page 3 He stated upon review of Resident #1's recent laboratory report her renal function was within normal limits. A phone interview was conducted on 10/26/23 at 1:30 PM with Nurse Practitioner #1. She stated typical dosing for Zyrtec (Cetirizine) was 5 -10 mgs. She stated she last fully evaluated Resident #1 on 08/24/23 but had seen her since that time. She stated she was not aware of the duplicate order. She stated she did not feel that the duplicate therapy for that period of time caused any significant outcome for Resident #1. During an interview on 10/26/23 at 4:00 PM the Director of Nursing stated there was a process in place to review medication orders but unfortunately the duplicate order was missed. He indicated additional education would be provided.	F 757		