STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. BUILDING _____ B. WING _____	04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF WAYNESVILLE	360 OLD BALSAM ROAD WAYNESVILLE, NC 28786

(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 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 and staff interviews, the facility failed to follow physician orders to discontinue a medication for one (1) of ten (10) residents (Resident #63), and failed to obtain an order from the physician for a recommended nutritional supplement for one (1) of two (2) residents (Resident #12). The findings are: 1. Resident #63 was admitted to the facility on 11/09/11. Resident #63's diagnoses included Alzheimer's Disease and vascular dementia with delirium. A review of the physician orders dated 01/17/12 included an order to administer: "Haloperidol (Haldol) 0.5 mg (milligram) tablet; Take ½ (half) tablet by mouth twice a day." Further review of the Medication Administration Record (MAR) revealed the medication was scheduled at 8:00 AM and at 8:00 PM every day. Continued review of the medical record revealed that on 03/19/12 the pharmacist recommended to the physician a gradual dose reduction of the haloperidol for Resident #63. The physician responded and discontinued the haloperidol order on 03/23/12. Further review of the MAR for the month of March 2012 revealed that Resident #63	F 281	F 281 Resident #63 received no further doses of discontinued medication haloperidol 0.25mg after 3/30/12. A 100% audit of all residents' medication records and the current physician's orders was completed on 4/30/2012. No other residents received medications after orders were received to discontinue. Beginning on May 14, 2012 all physician's orders will be transcribed by one nurse and signed off by two licensed nurses. Administrative nurses will audit all physicians orders for complete and accurate transcription three times per week until June 26, 2012. After 6/26/12 daily audits will be completed with the induction of phase IV of the electronic health records that include physician order entry. Results of the audits will be reported at the QA quarterly meetings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara J Dias — TITLE: administrator — (X6) DATE: 5/22/12

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.

Original Signature date: 5/16/12

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

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F 281	Continued From page 1 continued receiving a half tablet of haloperidol 0.5 mg twice a day until 03/30/12. Resident #63 received thirteen (13) doses of haloperidol 0.25 mg from 03/23/12 to 3/30/12 without a physician order. An interview with Licensed Nurse (LN) #2 on 04/27/12 at 8:34 AM revealed that all new and discontinued physician orders were signed off by the nurse receiving the orders. She stated that it was the responsibility of the nurse receiving the orders to transcribe the changes immediately to the MAR. The nurse was not sure why the medication was administered after it was discontinued. An interview with the Director of Nursing (DON) on 04/27/12 at 9:39 AM confirmed all medication changes were documented by the nurse who received the orders. She stated that monthly physician orders were checked for accuracy at the beginning of the month by two licensed nurses. The DON was not aware why the haloperidol was not discontinued for Resident #63 on 03/23/12. 2. Resident #12 was admitted to the facility with diagnoses including pneumonia, anemia and muscle weakness. A quarterly Minimum Data Set (MDS) dated 03/14/12 indicated Resident #12 was cognitively intact and able to feed herself. A review of the medical record revealed Resident #12 weighed 130 pounds on 01/03/12 and 121 pounds on 02/13/12. Further review revealed the resident weighed 125 pounds on 02/23/12. A review of nursing notes revealed that on 02/14/12 the facility Weight Committee, consisting of the Dietary Manager (DM) and Licensed Nurse (LN)	F 281	Resident #12 received orders for nutritional supplement on 4/27/12. 100% audits were completed on 5/15/12 on all residents identified with weight losses with recommendations for nutritional supplements by the weight committee. No other residents were in need of nutritional supplements for weight loss without orders for supplements. Physicians will receive change in weight form during rounds at the facility and will no longer be faxed this information. Change in Weight form that the physician reviews will convey recommendations for nutritional supplements. Dietary manager and LN#1 will audit weekly for weight loss/gain, reviewing physician's weight loss/gain form weekly and consult with Registered dietician for appropriate interventions. LN#1 will report to QA meeting quarterly the results of their weekly reviews.	5/15/12 5/15/12

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F 281	Continued From page 2 #1, noted the resident had experienced a recent acute illness and weight loss. The committee recommended the addition of a protein nutritional supplement, Med Pass 2.0, 60 cc by mouth three times a day. The committee also placed the resident on weekly weights until stable, monitored intake, and offered alternative foods based on likes and dislikes. The note further revealed that LN #1 would contact the physician by fax memorandum to request the order for the supplement. A review of the physician orders and Medication Administration Record from 02/14/12 to 04/26/12 revealed no physician order for Med Pass supplement for Resident #12. An interview with the DM on 04/27/12 at 9:34 AM revealed that the Weight Committee met on 02/14/12 and reviewed Resident #12's weight loss. The DM stated that he and LN #1 decided to request an order from the physician for Resident #12 to receive 60cc of Med Pass 2.0 by mouth three times a day. The DM stated he thought the resident was receiving the supplement. An interview with LN #1 on 04/27/12 at 10:44 AM revealed that he usually notified the physician by fax about nutritional supplement recommendations made by the Weight Committee. He stated he then placed a copy of the fax in the nursing report book to notify nurses about the requested order, and he kept a copy. He stated that if the physician did not respond to the fax timely with an order, he expected the nursing staff to notify him so he could follow up by calling the physician. LN #1 stated that on 02/14/12 he faxed the physician the recommendation and request for the Med Pass order for Resident #12. He stated that from what	F 281		

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F 281	Continued From page 3 he could tell, the physician did not respond to the faxed request. LN #1 stated he was not informed by nursing staff that they had not received an order for the supplement. On 04/27/12 at 11:40 AM the Director of Nursing was interviewed. She stated she expected nursing staff to notify LN #1 when a faxed request for an order was not received, and she expected LN #1 to follow up with the physician.	F 281	F371 Dietary staff will be inserviced on 5/17/12 on monitoring of the nourishment refrigerators. Ice cream cups inside freezers will not be stored in the doors of the freezer. Freezers temperatures will be checked twice daily by dietary staff and third shift nursing to ensue the freezers are operating at zero degrees Fahrenheit or below and the ice cream is firm to the touch. The dietary staff and third shift nursing staff will document refrig/freezer's temperatures and if ice cream stored in freezers are firm to touch on QA will document temperatures and firmness of ice cream on QA nourishment rm refrig/freezer temperature form. If ice cream is soft it will be disposed of immediately.	5/17/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure ice cream was kept frozen in two (2) of two (2) nourishment room freezers. The findings are: On 04/27/12 at 3:05 PM an observation was made of the West Wing Nourishment Room refrigerator freezer with the Dietary Manager (DM). Twenty-six 4 ounce containers of ice cream and eight 3.5 ounce ice cream sandwiches were found to be soft to the touch and unfrozen.	F 371		5/17/12 BJ/Dir

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F 371	Continued From page 4 Eleven of the ice cream containers had ice cream residue around the edge of the lid which appeared to have oozed out of the container. The thermometer in the freezer read 14 degrees Fahrenheit. Review of the Refrigerator/Freezer Temperature Log revealed documented freezer temperatures of below 0 degrees Fahrenheit for the last five days. The DM discarded all twenty-six containers of ice cream and all eight ice cream sandwiches. On 04/27/12 at 3:12 PM an observation was made of the East Wing Nourishment Room refrigerator freezer with the Dietary Manager. Six 4 ounce containers of ice cream were found to be soft to the touch and unfrozen. Four of the ice cream containers had ice cream residue around the edge of the lid which appeared to have oozed out of the container. The thermometer in the freezer read 0 degrees Fahrenheit. Review of the Refrigerator/Freezer Temperature Log revealed documented freezer temperatures of below 0 degrees Fahrenheit for the last five days. The DM discarded all six containers of ice cream. The Dietary Manager (DM) was interviewed at that time. He stated that ice cream in the freezers should be hard to the touch and frozen. He stated the ice cream residue on the lids may have been from partial thawing. He noted that most of the soft ice cream had been stored in the door compartment of the freezer which may be warmer than the main compartment of the freezer. On 04/27/12 at 5:09 PM the Maintenance Director was interviewed. He stated he had examined the refrigerator in the West Wing Nourishment Room at 4 PM and noted the thermometer read 10	F 371		

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F 371	Continued From page 5 degrees Fahrenheit. He stated the refrigerator had an auto-defrost feature but that it should not thaw food in the freezer or make ice cream soft to the touch. He stated he would monitor the refrigerators closely for any pattern of temperature fluctuation.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews, and staff interviews, the facility's pharmacy failed to accurately label medication and include correct administration instructions in the Medication Administration Record (MAR) for a steroid based	F 425	F425 Resident #45 had instructions placed on medication administration record to rinse mouth after each use of flovent inhaler on 4/26/12 at 11 am. Legacy Pharmacy was notified to send instruction stickers for resident's flovent inhaler. 100% audit of the medication administration records for those residents ordered corticosteroid inhalers was completed. All residents had the correct instructions on the medication administration record as well as on the inhaler.	4/26/12 5/14/12 BBDuo 5/14/12 BBDuo

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F 425	Continued From page 6 inhaler for one (1) of twelve (12) residents observed during medication pass (Resident #45). The findings are: Resident #45 was admitted with diagnoses including asthma, chronic airway obstruction, acute respiratory failure and pneumonia. A review of the current physician orders included an order dated 02/07/12 to administer Flovent 220 mg (milligrams) inhaler, one puff in the morning, scheduled at 8:00 AM. Resident #45 was observed during medication administration on 04/26/12 at 7:46 AM. On 04/26/12 at 7:46 AM, Licensed Nurse (LN) #3 was observed administering medication to Resident #45. The nurse prepared the Flovent 220 mg Inhaler by cleaning and shaking it and instructed Resident #45 to exhale, then inhale while LN #3 activated the inhaler appropriately. After the administration of the steroid based inahler, LN #3 failed to offer water to Resident #45 to rinse/gargle. A review of the product label and the MAR did not have any instructions by the pharmacy to rinse/gargle the mouth after the inhaler use. No auxiliary instruction labels were present on the pharmacy dispensed product. An interview with LN #3 on 04/26/12 at 7:53 AM confirmed that she had never offered a rinse/gargle after the Flovent Inhaler administration and LN #3 was not aware that it was a steroid based inhaler. The interview revealed that the pharmacy had not provided any information related to rinsing/gargling of the	F 425	All residents admitted with steroidal inhalers will have a clarification order written and sent to the pharmacy that instructs resident to rinse mouth after use. These instructions will be printed on the medication administration record every month. Pharmacy will be responsible for the proper labeling of the inhaler prior to dispensing to facility. All new residents with steroidal inhalers will have the product label checked for the instruction sticker prior to accepting it into the medicine cart by 11-7 nurse. QA nurse will audit weekly and report to DON for 4 weeks. Then audits will be completed monthly by QA nurse. QA nurse will report to QA meeting quarterly.	

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F 425	Continued From page 7 mouth after the inhaler use. The nurse was aware that some inhaler products needed rinsing of the mouth after use. An interview with the pharmacist at the provider pharmacy on 04/27/12 at 8:55 AM revealed that all steroid based inhalers should include specific instructions to rinse/gargle the mouth after use of the inhaler and an auxiliary label should be affixed to the dispensed product also. The interview revealed that for this inhaler, Flovent 220 mg, for Resident #45 the instructions were not included on the MAR by oversight and no additional label was affixed on the product.	F 425	This 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 the requirements established by state and federal law.	