STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff, resident and nurse practitioner interviews and record review the facility failed to have physician ordered medications available for 1 of 3 sampled residents (Resident #2). The findings included: Resident #2 was admitted to the facility on 12/01/17 diagnosed with a fracture from fall at home, major depression, heart disease and others. Medications ordered by the physician included: 12/01/17 Effexor (antidepressant) 75 milligrams, 3 capsules at bedtime 12/02/17 Coreg (beta blocker) 25 milligrams twice daily for heart disease The most recent Minimum Data Set (MDS) dated 12/08/17 specified the resident's cognition was intact and she took antidepressant medication daily. The Care Area Assessment (CAA) for psychotropic medication specified the resident was stable using daily psychotropic medications.	F 658	Plan of correction: Failure to provide professional standards of care. Corrective action for resident affected. The resident currently resides at this facility. It is policy of the facility to provide all medications ordered by providers when and how directed by providers. This deficiency is related to failure to follow facility policy in ordering medications to be available upon time of administration. Also Nurse 1 and Nurse 2 did not utilize back up medications available. A supply of frequently used medications are available in the medication room and is refilled by pharmacy on a regular basis. A complete audit was completed of the medication administration record starting on January 4th, 2018 to ensure all medications were administered, and the not administered medications were not related to awaiting from pharmacy. The Director of Nursing and Assistant Director of Nursing provided education to nurses and medication aides on procedure related to obtaining medications from pharmacy and was completed on January 5th, 2018. Systemic Changes: Beginning January 5th, 2018 the Director of Nursing or	1/15/18

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

Electronically Signed | 02/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 658	Continued From page 1 A care plan was developed for the use of psychotropic medications and specified the medications were to be given as ordered. On 01/03/18 at 1:05 PM Resident #2 was interviewed in her room and expressed that while in the facility she had to go without her depression medication sometime in December. Review of the Medication Administration Record (MAR) for December 2017 revealed on 12/17/17 and 12/18/17 Effexor was not administered by Nurse #1 and Nurse #2. Electronic documentation specified "other" for the reason the medication was not administered. Further review of the MAR revealed on 12/18/17 Coreg was not administered by Nurse #2. Electronic documentation specified "other" for the reason the medication was not administered. On 01/03/18 at 2:15 PM the Director of Nursing (DON) was interviewed and explained the process for reordering medications. She reported that it was the responsibility of the nurse to reorder medications when a resident was running low by faxing a refill request to pharmacy. She reviewed Resident #2's MAR and reviewed pharmacy refill requests and reported the medications had not been refilled in advance. The DON stated she would expect a nurse to contact the physician if a prescribed medication was unable or utilize a 24-hour back-up	F 658	designee will perform audits daily of the medication administration records. The audit will include the review of not administered medications to ensure none are related to awaiting from pharmacy. The Director of Nursing or designee will bring this information to morning risk rounds to be presented to the team daily Monday thru Friday for four weeks, and then weekly for another four weeks. After the completion of these audits The Director of Nursing will review the need of any further audits. Any identified areas of concern will be addressed promptly. Quality Assurance: The Director of Nursing will submit circumstances of event and related audits to the QAPI committee February 12,2018 and monthly until determined substantial compliance sustained. Effective date of compliance: January 15th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE STATESVILLE, NC 28625**

(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 658	Continued From page 2	F 658		

pharmacy to obtain out-of-stock medications. Additionally, the DON reported the facility had access to medications kept on hand for emergency.

On 01/03/18 at 2:27 PM the Nurse Practitioner (NP) was interviewed on the telephone and stated there were no side effects or outcome to Resident #2 for missing 1 to 2 doses of Effexor or Coreg.

On 01/03/18 at 2:30 PM Nurse #2 was interviewed on the telephone and explained she was an agency nurse and when administering medications to Resident #2 on 12/18/17 Effexor and Coreg were unavailable. The nurse stated she notified the resident that the medications were unavailable. Nurse #2 added that she reviewed the electronic medication record and noted that a refill request for the medications had been faxed to pharmacy. The nurse stated she assumed the medications were going to be delivered and intended to administer the medications once they arrived at the facility. Nurse #2 stated she did not ask for help in the situation nor did she contact the physician regarding the medications.

On 01/03/18 at 4:00 PM Nurse #1 was interviewed and stated that on 12/17/17 Resident #2 was out of her Effexor and she faxed a refill request to pharmacy. The nurse added that she assumed the medication would be delivered and did not take additional steps to ensure Resident #2 had her depression medication.