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 _____	C 11/26/2024

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 11/25/24 through 11/26/24. Event ID# FSEQ11. The following intakes were investigated: NC00223317 and NC00223833. 6 of the 6 complaint allegations did not result 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 and interviews with resident and staff, the facility failed to remove used lidocaine and clonidine patches as specified by the physician for 2 of 3 residents reviewed for unnecessary medications (Resident #1 and	F 757	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	11/29/24

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

Electronically Signed | 12/05/2024

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F 757	Continued From page 1 Resident #2). The findings included: 1. Resident #1 was admitted to the facility on 11/11/20 with diagnoses including heart failure and high blood pressure. The physician's orders dated 05/22/24 revealed Resident #1 had an order to receive 1 patch of clonidine 0.3 milligrams (mg)/24 hours once every 7 days for high blood pressure. A review of the care plan for heart failure initiated on 07/08/24 revealed Resident #1 was at risk for cardiopulmonary symptoms related to high blood pressure. The goal was to remain free from cardiac crisis through the review date. Interventions included providing medication as ordered. The Medication Administration Records (MARs) indicated Resident #1 had received clonidine patch once every 7 days since it was initiated on 05/22/24. The last 3 patches of clonidine were administered on 08/07/24, 08/14/24, and 08/21/24 before Resident #1 was admitted to the hospital on 08/25/24. Further review of MARs revealed the last 2 patches of clonidine were administered by Medication Aide #1 (MA). A review of the nurse's progress notes revealed Resident #1 was noted with acute changes in the level of consciousness on 08/25/24 in the evening. Nurse #2 checked his vital signs including blood pressure and it was within the normal ranges of 112/72. Then she called the on-call provider to obtain an order to send Resident #1 to the emergency department (ED)	F 757	Resident #1 was discharged to hospital on 11/1/2024 and has not returned. The lidocaine patch was immediately removed from Resident # 2 on 11/26/2024. The Assistant Director of Nursing audited all residents who have medicated patches ordered to ensure patches were removed as ordered on 11/26/2024. No areas of concerns were identified. All Licensed Nurses, Paramedics and Medication Aides were educated by the Assistant Director of Nursing on ensuring patches are removed per Providers orders. This education was completed on 11/27/2024. This education will be added to orientation for newly hired Licensed Nurses, Paramedics and Mediation Aides. To monitor and maintain compliance the Director of Nursing and or Designee will audit 4 residents with orders for medicated patches weekly for 12 weeks to ensure patches are removed per Providers orders. The audits will be brought to the Quality Assurance Performance Improvement committee for review and recommendations monthly for 3 months. Date of Compliance 11-29-2024	

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F 757	Continued From page 2	F 757		

for evaluation and treatment.

The medical records indicated Resident #1's blood pressure was within the normal range of 112/72 on 08/25/24 at 9:15 PM before he was transferred to the ED. Further review of Resident #1's blood pressure records from 08/15/24 through 08/25/24 indicated they were within the normal ranges.

A review of the hospital discharge summary dated 08/29/24 revealed Resident #1 was sent to ED on 08/25/24 in the evening due to altered mental status. His blood pressure upon arriving at the ED at 10:10 PM remained normal at 148/74. Nursing staff in ED reported Resident #1 was found to have 2 clonidine patches with different application dates on his body. Resident #1 was later diagnosed with pneumonia and urinary tract infections in the hospital.

An attempt to conduct a phone interview with Nurse #2 on 11/26/24 at 8:48 AM was unsuccessful. She did not return the call.

During an interview conducted on 11/26/24 at 8:54 AM, MA #1 confirmed she had applied the clonidine patch for Resident #1 on 08/14/24 and 08/21/24. Typically, she and other nursing staff would apply the patch to a clean, dry, and intact skin area on Resident #1's shoulder and rotated sites each time. She recalled before she applied the patch on 08/21/24, she could not find the used clonidine patch that had applied on 08/14/24 despite checking both shoulders and other part of Resident #1's body. She even asked a nurse aide to assist her searching for the used clonidine patch without any success. She thought the clonidine patch could have fallen off during

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F 757	Continued From page 3	F 757		

shower. It was not unusual as had happened to other residents before. After trying to look for the used clonidine patch and unsuccessful, she written the date of application on the new clonidine patch and applied it to Resident #1's right shoulder.

An interview was conducted with the Assistant Director of Nursing (ADON) on 11/26/24 at 10:02 AM. She confirmed receiving reports from the hospital that Resident #1 was found with 2 clonidine patches with different application dates on his body upon arriving ED. She interviewed MA #1 and found that she could not find the used clonidine patch before applying the new one on 08/21/24. MA #1 explained to her that she had looked all over Resident #1's body, even with the help from a nurse aide for long periods of time, but still could not find the used clonidine patch. The ADON stated the used clonidine patch could have been stuck to the clothing. She added despite having 2 clonidine patches on 08/25/24, Resident #1 did not suffer any adverse reactions as his blood pressures were stable after the last clonidine patches were applied on 08/21/24, and even upon arriving ED on 8/25/24. She stated Resident #1 could have developed tolerance to clonidine patch after being treated with it for years.

2. Resident #2 was admitted to the facility on 11/19/24 with diagnoses including lower back pain.

A review of the baseline care plan for pain initiated on 11/19/24 revealed Resident #2 was admitted to the facility after having surgery. She reported having lower back and surgical pains. The goal was to keep her pain under control until

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F 757	Continued From page 4	F 757		

the next review date. Interventions included providing pain medications as ordered.

The physician's orders dated 11/20/24 revealed Resident #2 had an order to receive 1 patch of lidocaine 4% adhesive patch once daily. The order specified to apply the lidocaine patch to the mid-back in the morning and removed it at bedtime.

A review of the MARs indicated Resident #2 had received 1 lidocaine patch once daily since it started on 11/22/24. Further review of the MARs indicated the lidocaine patch that applied on 11/25/24 morning was removed on 11/25/24 in the evening.

During a medication pass observation conducted on 11/26/24 at 9:19 AM, Nurse #3 was observed applying a lidocaine patch to Resident #2 in her room. Nurse #3 started by dating the new lidocaine patch. When she lifted Resident 2's clothing at the back, the used lidocaine patch dated 11/25/24 was still attached to Resident #2's mid-back region. Nurse #3 removed the used lidocaine patch before applying the new patch to the mid-back of Resident #2.

An interview was conducted with Resident #2 on 11/26/24 at 9:21 AM. She stated the lidocaine patch was applied yesterday morning and the evening nurse did not remove it last night. She denied having any adverse reactions from the lidocaine patch that was attached overnight.

During an interview conducted on 11/26/24 at 9:23 AM, Nurse #3 confirmed she was the nurse who applied the lidocaine patch for Resident #2 yesterday morning. She expected the second

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F 757	Continued From page 5	F 757		

shift nurse to remove it as specified by the order.

A phone interview was conducted with Nurse #4 on 11/26/24 at 9:39 AM. She confirmed she was providing care for Resident #2 on 11/25/24 in the second shift. She explained she was not aware of the order of removing the lidocaine patch at bedtime for Resident #2 as she did not recall seeing the order in her computer when she was doing medication pass on 11/25/24 in the evening. She could not recall removing any lidocaine patch for Resident #2 on 11/25/24.

During an interview conducted on 11/26/24 at 10:38 AM, the Director of Nursing (DON) stated the order of lidocaine removal at bedtime was unclear and it might have caused confusion among nurses. It was her expectation for all the nurses to remove the lidocaine and clonidine patches in a timely manner as specified by the physician's order.

An attempt to conduct a phone interview with the Medical Director on 11/26/24 at 11:48 AM was unsuccessful. He did not return the call.