STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Nash	1210 Eastern Avenue Nashville, NC 27856

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, and staff and Medical Doctor interviews, the facility failed to enter a physician's order into the electronic medical record and document the administration of a medication for 1 of 4 residents reviewed for medication administration documentation (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] for surgical aftercare following surgery on the digestive system. Documentation in a nursing progress note dated 5/8/2025 at 12:59 PM written by Nurse #1 revealed Resident #1 was observed vomiting, the physician was notified, and an order was obtained for ondansetron (a medication used to prevent nausea and vomiting) 4 milligrams (mg) every 6 hours as needed. There was no documentation in the electronic medical record of a physician's order for ondansetron or documentation on the medication administration record (MAR) of its administration ondansetron for Resident #1 during the resident's stay at the facility. Nurse #1 was interviewed on 5/21/2025 at 11:36 AM. Nurse #1 explained she was notified on the morning medication pass on 5/8/2025 by a family member of Resident #1 that Resident #1 was vomiting and feeling very nauseous. Nurse #1 further explained she called Medical Doctor (MD) #1 and received the order for ondansetron to be administered to Resident #1. Nurse #1 indicated that the medication ondansetron was available for the residents in medication storage. Nurse #1 did not recall if she gave the medication ondansetron to Resident #1 and could not explain why the medication ondansetron did not appear on the physician orders or the MAR for Resident #1. Nurse #3 was interviewed on 5/21/2025 at 12:01 PM. She explained that she took over the medication cart from Nurse #1 on 5/8/2025 at approximately 12:00 PM. In the nursing report given to her from Nurse #1 on that day, it was explained that Resident #1 was vomiting, an order for ondansetron was obtained, and ondansetron was administered. Nurse #3 confirmed her awareness that Resident #1 would require monitoring after receiving the ondansetron on that day. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. Building B. Wing	05/22/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MD #1 was interviewed on 5/21/2025 at 4:09 PM. He stated he was not the physician for Resident #1, but because he was the facility medical director, he was sometimes called for medical orders for other residents. MD #1 did not recall giving the order for ondansetron for Resident #1 on 5/8/2025 due to the frequency with which he received calls regarding residents. MD #1 confirmed that if he gave a verbal order, he would expect the order to be documented and implemented. The Director of Nursing (DON) was interviewed on 5/22/2025 at 8:21 AM. The DON stated she did not find any documentation or evidence in the electronic medical record of Resident #1 indicating an order for the medication ondansetron was entered into the record or the administration of ondansetron. The DON thought ondansetron was likely given to Resident #1 on 5/8/2025 but she could not confirm that. The DON stated she expected that the nurses would enter the physician orders into the electronic medical record once received and then document the administration of the medication on the MAR. The DON felt the documentation was important for the continuity of care and the monitoring of Resident #1 if she received the medication ondansetron.