STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		1/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/28/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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
E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to have subsistence food available to meet the needs for residents and staff as identified in the emergency preparedness plan. This had the potential to affect all residents in the facility. Findings included: The facility's emergency preparedness plan revealed a document titled, "Disaster supply inventory- emergency food supply, minimum of a three-day supply", will be maintained on the premises at all times. An Emergency Supply List completed on 12/09/2021 at 12:45 PM by the Dietary Manager revealed the following dry storage room items on hand: 8 cases of pudding 8 cases of applesauce 4 cases of soup 2 cases of chicken dumplings 2 cases of corned beef hash	E 015	E015 Did not have the required 3 day emergency food supply on hand No specific resident was identified in this issue. Current residents are at risk of this issue if there is an emergency. The Administrator will ensure that the order has been placed and the food supplies are in the facility by 1/28/2022. To prevent this from recurring, the Administrator has reeducated the Dietary manager concerning the expectation that the supplies for the 3 day emergency food must be maintained in the building at all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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
E 015	Continued From page 2 2 cases of spaghetti sauce 2 cases of 24 pack water bottles 4 cases of Gatorade 2 cases of dry cereal 2 cases of green beans 2 cases of corn 2 cases of beef stew 3 cases of gelatin 3 cases of fruit 2 cases of ravioli An interview was completed with the Dietary Manager (DM) on 12/09/21 at 4:20 PM. The DM expressed the facility did not have complete 3-day emergency food supply on hand for the residents. She was aware the facility should have a 3-day supply of emergency food on hand at all times. An interview was conducted with the Administrator on 12/15/21 at 12:45 PM. He explained that the facility's Dietary Manager should always have an inventoried 3-day emergency food supply on hand.	E 015	times. This will be completed by 1/28/2022. To monitor and maintain ongoing compliance, the Administrator will inspect the supplies. This inspection will be completed weekly for 12 weeks. This plan has been reviewed and recommendations have been made by an Ad hoc Quality Assessment committee meeting on 1/27/2022 The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted onsite from 12/06/21 through 12/10/21 and remotely through 01/04/22. Event ID #TQDX11. 6 of the 47 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at scope and severity of (J) CFR 483.12 at tag F600 at scope and severity of	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C **01/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD** **WILMINGTON, NC 28412**

(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	Continued From page 3 (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy for F580 began on 11/12/21 and was removed on 12/30/21. Immediate Jeopardy for F600 began on 11/11/21 and was removed on 12/15/21. Substantard Quality of Care was identified at: CFR 483.45 at tag F760 at scope and severity of (H). An extended survey was conducted.	F 000		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 561	Continued From page 4 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews the facility failed to provide a resident (Resident #63) with soft drinks from his personal supply when requested resulting in him crying and stating staff had "made him feel like a child". This was for 1 of 36 residents reviewed for choices. Findings included: Resident #63 was admitted to the facility on 12/31/15 with diagnoses that included peripheral vascular disease and chronic pain. The annual Minimum Data Set (MDS) indicated Resident #63's cognition was intact. The Care Plan for Resident #63 revealed a plan of care for Risk for Dehydration with information that included: Resident states he does not like water; requests not to have a water pitcher and requests soda only to drink. A nursing note dated 11/30/21 at 1:36 PM by Nurse #5 indicated Resident #63 was upset because he "didn't have any soft drinks". It further revealed the Activities Assistant (AA) was notified Resident #63 was "requesting more soda".	F 561	F 561 Self Determination Resident # 63 was provided soft drinks and snacks of his choice by the facility on 12/8/2021. Current residents have the potential to be affected. A 30 day look back of the concern log was done by the facility social worker to validate that no residents had any concerns related to self-determination. The look back was from 12-21-2021 through 1-20-2022. Follow up was based on findings. To prevent this from recurring, the Administrator/designee reeducated all staff on residents' rights with a focus on dignity and respect. This education was completed on 12-8-2021. Any staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 561

Continued From page 5

A nursing note by Nurse #5 dated 12/4/21 at 10:38 AM reported Resident #63 "couldn't stand water and wouldn't drink water".

An observation and interview was conducted on 12/7/21 at 12:26 PM with Resident #63. He was observed to be talkative, dressed, and up in wheelchair. The Activities Assistant (AA) knocked on the door and entered the room. AA stated she had just given him a 12-pack of soft drinks on Sunday and it was only Tuesday. She further stated she was not going to give him his other 12-pack of soft drinks because he was drinking them too fast. Nurse #4 entered the room and told Resident #63 he needed to drink more water. She further stated he shouldn't be drinking so many soft drinks. Resident #63 stated he didn't like water and was not going to drink water. He revealed he had paid for the soft drinks and wanted them. Resident #63's face had turned red and he began to raise his voice. After AA and Nurse #4 left Resident #63's room he began to cry and stated they had made him feel like a child.

AA was interviewed on 12/7/21 at 3:49 PM. AA stated she was the person in charge of shopping for personal items for the residents in the facility. She reported she bought Resident #63 two 12-packs of soft drinks per week with his money. AA acknowledged she could buy three 12-packs of soft drinks per week but didn't think he should drink that many. She stated she thought she had treated Resident #63 with dignity and respect. She further stated she had been unaware Resident #63 had cried after she left the room.

An interview was conducted on 12/7/21 at 4:09

F 561

received this reeducation by the Director of Nursing/ designee.

Agency staff and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee.

To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor a random sample of 5 interviewable residents to validate they have not experienced any issues with dignity and respect.

Monitoring will be documented for 5 residents weekly for 12 weeks with a completion date of 3-25-2022. An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22.

The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 561	Continued From page 6 PM with Nurse #4. She admitted she had entered Resident #63's room to join the conversation AA was having with him about the soft drinks. She reported she was only trying to help Resident #63. She stated she had asked him to take a drink of water and then follow it with a drink of soda. She further stated she was just trying to get Resident #63 to drink more water. She indicated she was aware Resident #63 didn't like water and was not going to drink water. She stated she was unaware Resident #63 had cried when she had left the room. An interview was conducted with Activities Director (AD) on 12/8/21 at 10:51 AM. She reported that she had informed AA that the residents had the right to make their own choices. She stated she had told AA to give Resident #63 his soft drinks. She further stated that the Activities department would bring Resident #63 his soft drinks when he requested them. The Director of Nursing (DON) was interviewed on 12/9/21 at 12:55 PM. The DON stated the residents had a right make their own choices. He further stated it was Resident #63's right to drink what he wanted. He indicated the staff should have treated Resident #63 with dignity and respected his choices. An interview was conducted with the Regional Consultant Nurse on 12/8/21 at 02:54 PM. He stated the facility staff had been reeducated on Residents Rights and the right to make their own choices on 12/8/21. The Administrator was interviewed on 12/9/21 at 9:00 AM. He stated he had heard about what happened to Resident #63. He stated the staff	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 561	Continued From page 7 had already been reeducated on Resident Rights and the right to make their own choices on 12/8/21. He further stated that the staff involved had been informed that they needed to respect the residents' rights to make their own choices.	F 561		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced	F 563		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 563	Continued From page 8 by: Based on record review and staff interviews, the facility failed to allow access to a resident by immediate family and other relatives of the resident for 1 of 2 resident (Resident #332) reviewed for visitation. Findings Included: Resident #332 was admitted to the facility on 12/8/2021. Resident #332 was unavailable for an interview on 12/9/2021. An interview conducted with Nurse #7 on 12/9/2021 at 4:53 P.M. revealed when two of Resident #332's family members arrived on the evening of 12/8/2021, only one family member was allowed to go to Resident #332's room. During the interview Nurse #7 stated Resident #332's out of town family member was unvaccinated, and she was unsure what the CDC guidelines were for visitation. Nurse #7 asked the family member to wait at the front entrance while the vaccinated family member visited with Resident #332. An interview conducted with the Administrator on 12/9/2021 at 5:08 P.M. revealed he was unaware a visitor was not allowed access to a resident in the facility the night of 12/8/2021. The Administrator stated, "I would expect staff to follow the process and let them in or reach out to me if there was anything of significance". During the interview the Administrator revealed there were no restrictions on visitation and staff should reach out to him if there are any questions about allowing access of a visitor into the facility.	F 563	F563 Visitation Resident #332 suffered no harm as a result of family not being able to visit. Current residents have the risk of being affected by this issue. A look back from 12/1/2020-1/7/2022 was performed by the Director of Social Services and there were no issues noted on the concern log related to visitation. To prevent this from recurring, the Administrator or designee reeducated all staff on the current visitation guidelines per CMS guidance. This was completed by 1/2/22. Any staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation by the Administrator or designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Administrator or designee. Residents have been notified that visitation is open for all visitors with no limitations to time of day/night or length of visitation by Social Services. This was completed on 1/12/22 A message was sent through Regroup to all Responsible party’s telephone numbers on file on 1/11/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 563	Continued From page 9 An interview conducted with the Director of Nursing (DON) on 12/9/2021 at 5:12 P.M. revealed he was unaware of a newly admitted resident's visitor not being allowed access into the building to see their family member. The DON further stated there were no restrictions on visitations and the visitor should have been granted access to visit Resident #332.	F 563	Signs are posted at the front door with this change in visitation. This was completed by the Administrator To monitor and maintain ongoing compliance, the administrator or designee will question visitors randomly when they are in the building to ensure that they are aware of the updated visitation guidelines. The Administrator or designee will question residents randomly to ensure that they understand the updated visitation guidelines. This will be documented with 5 visitors a week and 2 alert and oriented residents a week for 12 weeks with a completion date of 3-18-2022. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 10 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practioner interviews, the facility failed to 1) notify	F 580	F 580 Notify of Changes The resident was sent to the hospital for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580 Continued From page 11

the resident's provider until 11/13/21 when a resident presented with signs and symptoms of a change of condition that started on 11/12/21 to include signs and symptoms of pain, decreased oral intake, not ambulating, or getting out of bed, refusing care, and requiring two staff assistance with transfers after an unwitnessed fall on 11/11/21 for 1 of 2 residents (Resident #11) reviewed for notification. The delay in notification to the provider resulted in delayed identification and treatment of a left femoral sub capital neck displaced fracture (fracture in the neck of the thigh bone) which required surgical intervention, and 2) failed to notify the provider of a delay in receiving an ordered medication for Ampyra 10 milligrams (prescribed for the treatment of symptoms related to Multiple Sclerosis) until the 13th day of the resident not receiving the medication (Resident #66) for 1 of 2 residents reviewed for notification.

Immediate Jeopardy began on 11/12/21 when Resident #11 presented with signs and symptoms of pain, decreased oral intake, inability to ambulate or transfer out of bed, refusing care, and requiring assistance of two staff to transfer and the physician was not notified.

Immediate Jeopardy was removed on 12/30/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy Removal. The facility will remain out of compliance at a lower scope and severity level D isolated with potential for more than minimal harm to correct the deficient practice and to ensure that the education and monitoring systems put in place to remove the Immediate Jeopardy are effective. Example #2 was cited at a scope and severity level D.

F 580

evaluation and treatment on 11/13/2021.

To identify other residents that have the potential to be affected, an audit of all falls that occurred from 11/11/2021 to 12/20/2021 was performed by the Regional Director of Clinical Services to validate that the medical provider was notified of any significant change in condition. There were no negative findings.

An audit of missing/ out of scheduled medications has been completed for a 7 day look back period of 1/13/22 to 1/20/22 and notification that the physician has been be validated. Any lack of notification was completed at the time of identification.

To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on of the change of condition policy and stop and watch (a form utilized to assist the staff to identify when there is a change in condition). The certified nursing assistants, personal care aides, and therapists were reeducated on stop and watch. This education was completed on 12/20/2021. This education included any agency staff currently working in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 12 Findings included: 1. Resident #11 was admitted to the facility on 07/19/21 with diagnoses that included dementia. A review of the incident report documented as completed by Nurse Supervisor (NS) #2 on 11/11/21 at 3:00 AM revealed "Nursing Aide (NA) [#1] and Patient Care Assistant (PCA) [#1] informed nurse [#1] at 3:10 AM resident was observed on the floor in her room with her head under the sink in a fetal position with walker over lower legs and wheelchair facing her. The NA discovered resident on the floor at 3:00 AM and got help from the PCA. Due to uncomfortable position, the NA and PCA lifted Resident #11 back to wheelchair and then informed nurse." An interview was conducted with Nurse Aide (NA) #1 via phone on 12/10/21 at 5:30 AM who provided care for Resident #11 the night of 11/11/21 after her fall. NA #1 stated when she came back to work on Friday 11/12/21 from 7:00 AM -3:00 PM and brought Resident #11 her breakfast tray, the resident was sitting in her wheelchair, slumped over. NA #1 stated she told Nurse #2 and Nurse #2 told NA #1 to get her into bed. NA #1 stated when she and NA #2 were moving Resident #11, they tried to get the resident to stand up with her walker because that was how the resident usually transferred and the resident refused to get up and became combative. NA #1 stated she and NA #2 tried to move the resident from the chair to the bed and she was crying out like she was in pain. NA #1 stated she and NA #2 tried to transfer the resident with a gait belt and Resident #11 started complaining "No! Stop!" NA #1 stated she and	F 580	The expectation that the physician be notified if a medication is unavailable, being given late/out of scheduled time, or if there is a change of condition of a resident. This was completed 1/27/2022 Any licensed nurse that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency staff and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor the 24 hour report to validate if any change in resident condition that has occurred and the MD/RP were notified. Director of Nursing/designee will also review the documentation to identify any missed/out of scheduled medication and validate that the physician has been notified. Monitoring will be documented occur 5 x weekly for 4 weeks, and then weekly for 8 weeks. This plan has been reviewed, recommendations have been made, and the plan was accepted by an Ad hoc Quality Assessment committee meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 580	Continued From page 13 NA #2 got the sit to stand mechanical lift to transfer the resident. NA #2 stated the Resident #11 did not tolerate the transfer and showed signs of pain, but she and NA #2 were able to get the resident to bed. NA #1 stated Resident #11 was showing signs that she was in pain such as moaning and crying. NA #1 stated she went to Nurse #2 and told her the resident was having pain when she and NA #2 transferred her and Nurse #2 stated it was probably because she had been sitting in the wheelchair for so long and to let her know when NA #1 went back to the room. NA #1 stated she went back in the resident ' s room around 10:00 AM by herself to check and change the resident and Resident #11 was refusing care. NA #1 stated Resident #11 said, "Stop, quit!" when NA #1 attempted to roll her. NA #1 stated she reported this to Nurse #2 and Nurse #2 said "I'm busy right now, I ' m trying to finish my med pass." NA #1 stated when she went to bring the resident her lunch tray, the Physical Therapist (PT #1) had asked if NA #1 noticed a change in Resident #11 and NA #1 said yes, Resident #11 was not eating and refusing to let NA #1 change her and she was crying out. NA #1 stated while she was talking with PT #1, Nurse #2 was right there at the medication cart. NA #1 stated when she went to change Resident #11 to do her care at around 2:30 PM, she was wincing and moaning and said to "Stop" and was pushing NA #1's hands away. An interview was conducted with NA #2 on 12/10/21 at 10:00 AM who worked 7:00 AM to 3:00 PM on 11/12/21. NA #2 reported when she came in on 11/12/21 she did rounds with NA #1. NA #2 stated the resident was noted to be slumped over in her wheelchair. NA #2 stated she and NA #1 went to put Resident #11 in the	F 580	on 1/27/2022 The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 580	Continued From page 14	F 580		

bed and when she and NA #1 stood the resident up from the wheelchair and tried transfer her, she made a noise of discomfort and was acting out of the ordinary. NA #2 stated Resident #11 was very wet and very soiled and she grimaced and moaned when she and NA #1 moved her. NA #2 stated Resident #11 wasn't responding to NA #1 and NA #2 and wasn't eating anything. NA #2 stated she believed both she and NA #1 reported to Nurse #2 that Resident #11 was not her normal self because she was not eating and had pain. NA #2 reported the resident slept for a majority of the day which was out of the norm.

An interview with the PT #1 on 12/10/21 at 10:30 AM revealed PT #1 had gone to see Resident #11 on 11/12/21 due to the resident having a fall which was reported to her through risk management (a meeting with nursing and department heads to discuss falls). PT #1 stated Resident #11 was noted to have had a significant change because she was not out of bed or ambulating. PT #1 stated when she went into the resident's room to see her, she was lying in bed and PT #1 tried to touch her to wake her, but the resident did not respond. PT #1 stated NA #1 and Nurse #2 were outside of Resident #11's door and she reported to Nurse #2 that she needed to be checked out due to change of status because she was not moving or walking and she was usually up and ambulating and NA #1 told PT #1 that it took 2 aides to transfer Resident #11 back to bed that morning.

An interview with Nurse #2 on 12/10/21 at 10:15 AM revealed Nurse #2 stated on 11/12/21 she went to the resident's room after PT #1 had told her Resident #11 did not seem right and the resident was in her bed. Nurse #2 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 15	F 580		

resident was lethargic but she thought it was because she had been told by NA #1 that Resident #11 had been sitting up in her wheelchair. Nurse #2 stated no one told her she had fallen and if she had known she would have done a thorough assessment. Nurse #2 stated she did not assess her and added that the resident did not verbalize much but did not show signs and symptoms of pain and no one had ever told her Resident #11 was in pain. Nurse #2 stated the resident never ate that day and never got out of bed, which was not her norm, but she thought the resident was just tired from sitting up in the wheelchair.

During the interview with NA #1 via phone on 12/10/21 at 5:30 AM, NA #1 stated when she came back to work on 11/13/21 from 7:00 AM to 3:00 PM and went to bring Resident #11 her breakfast tray about 7:30 AM or so, Resident #11 was lying in bed on her right side and she would not eat breakfast. NA #1 stated she told Nurse #3 the resident was in pain because was refusing to let her change her and reposition her to set her up to eat. NA #1 stated Resident #11 was moaning and wincing and showing signs like she was in pain when she was trying to move her. NA #1 stated she reported this to Nurse #3 and asked Nurse #3 to please look at her. NA #1 stated Nurse #3 assessed Resident #11 and Nurse #3 stated the resident was having pain and needed an x-ray on her left leg.

An interview with Nurse #3 via phone on 12/11/21 at 11:02 AM revealed when she came on duty the morning of 11/13/21, Nurse #6 told her in report Resident #11 had a fall with an abrasion to her shoulder but that she seemed okay. Nurse #3 stated NA #1 came to her about 7:45 AM and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 16	F 580		

asked her to please assess Resident #11. Nurse #3 stated NA #1 was concerned that the previous nurse (Nurse #2) had not followed up and checked on the resident. Nurse #3 stated NA #1 stated "Why was no one following up as to why she is still in bed and not eating?" Nurse #3 stated she went in to assess Resident #11 and because she could not verbally express if she had pain, she started to do passive range of motion and when she moved the resident's left leg, she cried out with a loud sound and was reaching down toward her left leg and moaning. Nurse #3 stated she gave Resident #11 some pain medicine and notified the physician and obtained an order for an x-ray which resulted in a fracture and she was sent to the hospital and required surgery.

An interview was conducted with Nurse Practioner (NP) #1 via phone on 12/16/21 at 12:15 PM. NP #1 stated he was not made aware Resident #11 was not eating or getting out bed and would have expected the nursing staff to notify him of this change of condition. Review of the hospital record dated 11/13/21 at 7:01 PM revealed Resident #11 presented to the Emergency Department (ED) with new left hip fracture. Resident had a fall two days ago and staff noted her to not be using her left leg. An x-ray was obtained {on 11/13/21} and read moderately displaced sub capital left hip fracture with no dislocation. Resident is hemodynamically stable and without a fever and she is lying on her right side and states she does not need any medication for pain at this time. Per Emergency Medical Services (EMS) she had pain with any movement.

Hospital records revealed another x-ray was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 17	F 580		

taken at 8:50 PM and the impression read "left sub capital neck displaced fracture."

The emergency department course and medical decision making revealed the x-ray was positive for left sub capital neck displaced fracture, on call orthopedic surgeon notified and will plan for surgery on {11/15/21} and to admit the resident.

The hospital discharge summary dated 11/17/21 revealed Resident #11 was status post Open Reduction Internal Fixation (ORIF) with hemi-arthroplasty (replacing half of a hip joint after traumatic injury in which the femoral head is fractured) on 11/15/21.

Administrator was notified of the Immediate Jeopardy on 12/30/21 at 8:25 AM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

a. The facility failed to notify the residents provider until 11/13/21 when the resident presented with signs and symptoms of a change in condition that started on 11/12/21 which included signs and symptoms of pain, decreased oral intake, not ambulating or getting out of bed, refusing care, and requiring 2 staff to assist with transfers after an unwitnessed fall on 11/11/21. On 11/13/21 the provider was notified of the resident's change in condition and orders were obtained and followed. The resident was medicated for pain per Physician's orders and x-rays were obtained which showed a left hip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580 Continued From page 18 F 580

fracture. The resident was sent to the hospital for further evaluation per Physician orders.

b. All residents have the potential to be affected. On 12/30/21 medical records were reviewed for all residents that sustained a fall since 11/11/2021 by the Regional Director of Clinical Services to ensure that the provider was made aware of any resident with any significant change. There were no negative findings.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

a. The Regional Director of Clinical Services reeducated all licensed nurses on 12/30/2021 on the Resident Change in Condition Policy to include that the Medical Provider must be notified of any change in the resident's condition and request further orders. If the provider does not respond in a timely manner, the Medical Director will be contacted for guidance, consultation, and orders. This education will also be provided to any agency staff working in the facility. On 12/30/2021, the Regional Director of Clinical Services educated all certified nursing assistants, personal care aides and therapists on stop and watch, (a form the facility utilizes which assists the staff to identify when there is a change in the resident ' s condition) when they identify any changes in the resident condition to inform the licensed nurse so further assessment and treatment can be initiated. Any staff that were unable to be educated will be removed from the schedule on 12/30/2021 and will be required to have the education prior to working in the facility.

Person responsible for the removal plan: LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 19	F 580		

The facility alleges the removal date of the Immediate Jeopardy was 12/30/21.

The Immediate Jeopardy removal date was 12/30/21.

The Removal Plan of the Immediate Jeopardy was validated on 01/04/22.

The facility provided in service sheets showing staff received the in service on Resident Change in Condition Policy and the Stop and Watch form. The facility provided audits of all resident with falls since 11/11/21 that showed a physician was notified. The Administrator stated all staff have been in serviced including three agency staff used by the facility. A sample of staff including nurses, nurse aides, and the Therapy Director were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the Resident Change in Condition Policy. Staff confirmed they received the education on the Resident Change of Condition Policy and the Stop and Watch form and the nurses were knowledgeable of both and the nursing aides were knowledgeable on the Stop and Watch Form. All facility policy and procedures that were provided to address the deficient practice were reviewed. The Immediate Jeopardy was removed on 12/30/21.

2. Resident #66 was admitted to the facility on 11/10/21. Her diagnoses included in part; Multiple Sclerosis.

A physician's order dated 11/10/21 revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 20	F 580		

Continued From page 20

order for Ampyra 10 milligram (mg) tablets extended release give one table by mouth two times a day for Multiple Sclerosis.

A review of the Medication Administration Record (MAR) dated November 2021 for Resident #66 revealed Ampyra 10 milligrams was not documented as being administered twice a day from 11/10/21 - 11/23/21 per the physician's order resulting in 26 missed doses.

A progress note dated 12/03/21 by Nurse Practitioner #1 revealed in part; Resident #66 was seen today, stated she felt okay, denied pain, no acute distress noted. Continue Ampyra. Was notified by nursing on 11/23/21 that the resident had not been receiving Ampyra since the resident's initial admission on 11/10/21. Ampyra was able to be obtained and was restarted on 11/24/21.

A phone interview was conducted on 12/13/21 at 2:45 PM with Nurse Practitioner #1. He indicated per his progress note dated 12/03/21, he was notified by nursing on 11/23/21 that Resident #66 had not received Ampyra since her admission on 11/10/21. He stated Ampyra was prescribed for walking issues, and the medication did not stop the progression of Multiple Sclerosis. He stated he was not certain as to why she did not receive Ampyra for that length of time and indicated staff should have notified one of the providers sooner that there was an issue with obtaining the medication.

An interview was conducted on 12/09/21 at 02:40 PM with Nursing Supervisor #1. She stated Nurse #10 had notified her that the medication (Ampyra) wasn't there, and pharmacy needed approval for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 21 it. She instructed Nurse #10 to call (the Senior Care Program that Resident #66 was affiliated with) to see if they could supply the medication and then call pharmacy. She stated the (Senior Care Program) informed the facility that they did not supply resident medications and the medication would need to come from the facility's pharmacy. Nursing Supervisor #1 reported another nurse checked on the medication again after the issue had not been resolved but she could not recall which nurse it was and could not recall an exact date. She indicated she thought the issue had been resolved after that time by the Director of Nursing (DON) or one of the nurses because she was not made aware of any issue after that. She stated if a medication was missing the nurse would call the pharmacy regarding the medication and if the medication could not be obtained the physician should have been notified. An interview was conducted on 12/10/21 at 10:32 AM with Nurse #10. She stated Ampyra needed to have prior approval from the Administrator due to the cost before the pharmacy could fill the medication order. She indicated she spoke with Nursing Supervisor #1 regarding trying to get the Ampyra but could not recall an exact date. She indicated she wasn't certain when the provider was notified. An interview was conducted on 12/10/21 at 02:14 PM with the Director of Nursing. He stated the pharmacy called and made the facility aware that preauthorization was needed to fill the order for Ampyra 10 milligrams, but he could not recall a date or the time frame when he was made aware of the medication issue. He indicated the resident went from 11/10/21 through 11/23/21 without receiving Ampyra so any correspondence with	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 580	Continued From page 22 pharmacy occurred during that time. He stated he wasn't sure why the authorization form was not followed through with. He stated he had only worked at the facility for six months and indicated he was not certain of whose responsibility it was to fill out the authorization forms. He stated the provider should have been made aware of Resident #66 not receiving Ampyra sooner and staff should not have waited until the 13th day of not receiving the medication so that the issue could have been addressed. A phone interview was conducted on 12/13/21 at 4:30 PM with the Corporate Nurse Consultant. He stated the DON should have followed through with completing the medication authorization form and sending the form back to the pharmacy so that the order could have been filled. He indicated Resident #66 should not have gone 13 days without receiving Ampyra, and the provider should have been notified sooner of the delay in getting the medication. A phone interview was conducted on 12/13/21 at 4:45 PM with the facility Physician. He stated he was not made aware that Resident #66 didn't have the Ampyra until (the Senior Care Program) reached out to him and he could not recall exactly when that was. He indicated it was around the time the issue was resolved. He stated Resident #66 didn't receive Ampyra until the 12th or 13th day after her admission but stated he was not aware of why the medication was delayed. He indicated he should have been notified sooner so the issue could have been addressed.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 23 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practioner and Physician interviews, the facility neglected the resident by not conducting a full body assessment and a neurological assessment to include range of motion of all extremities prior to moving the resident after a fall on 11/11/21. The facility also neglected to perform continued neurological assessments including range of motion and vital signs to assess for any change of condition; and failed to identify a change of condition when the resident presented with signs and symptoms of pain, decreased oral intake, inability to ambulate or transfer out of bed, refusing care, and requiring assistance of two staff to transfer on 11/12/21 for 1 of 5 residents (Resident #11) reviewed for accidents. The failures resulted in delayed identification and treatment of a left femoral sub capital neck displaced fracture (fracture in the neck of the thigh bone) which was identified on an x-ray on 11/13/21 and required hospitalization and surgical intervention.	F 600	F 600 Resident # 11 was sent to the hospital on 11/13/2021 for further evaluation and treatment per Physicians orders. To identify other residents that have the potential to be affected. On 12/14/2021 medical records were reviewed for all residents that sustained a fall since 11/11/2021 by the Director of Nursing to ensure they were properly assessed post fall and that none had sustained any unidentified injuries or had a significant change in condition. There were no negative outcomes as evidenced by head to toe assessments and pain assessments completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600 Continued From page 24 F 600

Immediate Jeopardy began on 11/11/21 at 3:10 AM when Resident #11 had an unwitnessed fall and was transferred to her wheelchair without being assessed by a nurse. The facility neglected the resident by not conducting a full body assessment and a neurological assessment to include range of motion of all extremities prior to moving the resident after the fall. The facility neglected to perform continued neurological assessments including range of motion and vital signs to assess for any change of condition and failed to identify a change of condition when the resident presented with signs and symptoms of pain, decreased oral intake, inability to ambulate or transfer out of bed, refusing care, and requiring assistance of two staff to transfer. The failures resulted in delayed identification and treatment of a left femoral Sub Capital neck displaced fracture which required surgical intervention. Immediate Jeopardy was removed on 12/15/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy Removal. The facility will remain out of compliance at a lower scope and severity level D isolated with potential for more than minimal harm to correct the deficient practice and to ensure that the education and monitoring systems put in place to remove the Immediate Jeopardy are effective.

Findings included:

Resident #11 was admitted to the facility on 07/19/21 with a diagnosis that included dementia. Resident was admitted to the hospital on 11/13/21 with diagnosis of left femoral Sub Capital neck displaced fracture.

To prevent this from recurring, the Director of Nursing/designee reeducated all staff on 12/14/2021 concerning a full physical assessment by nurses after a fall including range of motion, complete neurological assessments when assigned, and pain assessment expectations as part of identification of a change of condition.

Any staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation by the Director of Nursing/ designee.

Agency licensed staff and newly hired staff will have this education during their orientation period by the Director of Nursing/designee.

To monitor and maintain ongoing compliance, the Director of Nursing or designee will conduct post fall audits to validate that a full physical assessment by the nurse after a fall including range of motion, complete neurological assessments when assigned, and pain assessment expectations as part of identification of a change of condition.

Monitoring will be documented for each fall 5days a week for 4 weeks, then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 25 The Minimum Data Set quarterly assessment dated 09/17/21 revealed Resident #11 was severely cognitively impaired and did not demonstrate any refusal of care or behaviors. Resident #11 required limited assistance with one staff physical assistance with bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, toileting, and personal hygiene. Resident #11 had one fall with no injury, required a walker or wheel chair for mobility device and was not steady but able to stabilize self without human assistance. A plan of care dated 09/17/21 revealed Resident #11 was at risk for falls related to dementia. Interventions included to keep bed in lowest position and apply non skid socks while in bed. A review of an incident report documented as completed by Nurse Supervisor (NS) #2 on 11/11/21 at 3:10 AM revealed "Nursing Aide (NA) [#1] and Patient Care Assistant (PCA) [#1] informed Nurse [#1] at 3:10 AM resident was observed on the floor in her room with her head under the sink in a fetal position with walker lying over her lower legs and her wheelchair facing her. The NA discovered resident on the floor at 3:10 AM and got help from the PCA. Due to uncomfortable position, the NA and PCA lifted Resident #11 back to wheelchair and then informed nurse." Review of the neurological check (an assessment to check neurological function) assessments beginning on 11/11/21 at 3:10 AM revealed hand grasps were equal, vital signs (VS) were recorded as blood pressure (BP) 114/72, respiration rate (RR) 18 breaths per minute (bpm), heartrate (pulse) was recorded as 72 beats per minutes	F 600	weekly review for 8 weeks. An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 26	F 600		

(bpm) at 3:10 AM. The neuro checks were documented every 15 minutes X 4 for 1 hour, every 30 minutes for 2 hours, every 1-hour X 2 by Nurse #1 and each assessment indicated the hand grasps were equal, no range of motion was assessed, and each VS recording for these assessments were recorded as BP 114/72, RR 18, Pulse 72 with the time recorded for each assessment as 3:10 AM and the date stamp of 11/11/21. There were no continued neurological check assessments documented for 11/11/21.

Review of the hospital record dated 11/13/21 at 7:01 PM revealed Resident #11 presented to the Emergency Department (ED) with new left hip fracture. Resident had a fall two days ago and staff noted her to not be using her left leg. An x-ray was obtained {on 11/13/21} and read moderately displaced sub capital left hip fracture with no dislocation. Resident is hemodynamically stable and without a fever and she is lying on her right side and states she does not need any medication for pain at this time. Per Emergency Medical Services (EMS) she had pain with any movement.

Hospital records revealed another x-ray was taken at 8:50 PM and the impression read "left sub capital neck displaced fracture."
The ED course and medical decision making revealed the x-ray positive for left sub capital neck displaced fracture, on call orthopedic surgeon notified and will plan for surgery on {11/15/21} and to admit the resident.

The hospital discharge summary dated 11/17/21 revealed Resident #11 was status post Open Reduction Internal Fixation (ORIF) with hemi-arthroplasty (replacing half of a hip joint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 27	F 600		

after traumatic injury in which the femoral head is fractured) on 11/15/21.

An interview with NA #1 via phone on 12/10/21 at 5:30 AM who worked the nightshift on 11/11/21 revealed at about 3:00 AM she and PCA #1 noted Resident #11 laying on her left side with her head under the sink. Resident #11's walker was straddled on top of the resident and her wheelchair was facing the resident at the end of bed and Resident #11 was asleep on the floor, she was dressed and had socks and shoes on her feet. NA #1 stated she went to get Nurse #1 to come and check on her, and when she told Nurse #1, Nurse #1 replied "I ' m coming, I'm coming." NA #1 stated PCA #2 was in the next room assisting another resident and she went through the adjoining bathroom to ask PCA #2 to come and help NA #1 and PCA #1. NA #1 stated she sat with Resident #11 for no less than 20 minutes waiting because she knew the nurse needed to assess her. NA #1 stated after about 20 minutes, she decided to go ahead and transfer Resident #11 to get her off the cold floor because Nurse #1 was taking too long. NA #1 stated she, PCA #1 and PCA #2 got the mechanical lift and transferred the resident to the wheel chair. NA #1 stated Resident #11 had no complaints of pain at the time of the transfer. NA #1 stated about an hour and half later (about 5:00 AM) Nurse #1 went in to see the resident and NA #1 went with her. NA #1 stated Nurse #1 asked NA #1 if she saw any signs of injury during the transfer and NA #1 stated she noted a bruise on her elbow and shoulder. NA #1 stated Nurse #1 observed that as well and asked NA #1 if the resident had any complaints of pain during the transfer and NA #1 reported she did not. NA #1 stated Nurse #1 checked Resident #11's head and there were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 28	F 600		

bumps and Nurse #1 said the resident was fine and left the room. NA #1 stated at 6:00 AM she and PCA #2 went to the resident ' s room to do the last round and transfer Resident #11 to bed, but she was combative and would not let them transfer her. NA #1 stated she told Nurse #1 that the resident refused to let them transfer her to bed. NA #1 stated Resident #11 was in her wheel chair when she last saw her at 7:00 AM on 11/11/21.

An interview with PCA #1 via phone on 12/10/21 at 11:15 AM revealed on the night of 11/11/21, he and NA #1 were in the room because the resident had a fall. PCA #1 stated NA #1 told PCA #2 they needed help and PCA #2 went to get Nurse #1 to notify her of the fall. PCA #1 stated Resident #11 was lying on her left side with her head under the sink. PCA #1 stated he and PCA #2 and NA #1 lifted the resident without a mechanical lift after about 20 minutes of waiting for Nurse #1 because they wanted to get the resident off the floor. PCA #1 stated she tolerated the transfer fine and had no signs or symptoms of pain or complaints of pain. He stated they transferred her to the wheelchair because it was closer than the bed. PCA #1 stated he left the 300 hall and went back to his hall and in the morning when he checked on Resident #11 before he left about 7:00 AM and Resident #11 was sleeping.

An interview with PCA #2 via phone on 12/11/21 at 9:41 AM revealed she had last checked Resident #11 at 12:00 AM on 11/11/21 and she was in her reclining chair and did not need to be changed at that time. PCA #2 stated around 3:00 AM she was in the room next door to Resident #11 when NA #1 opened the adjoining bathroom door and told her she needed help with Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 29	F 600		

#11 because she had fallen. PCA #2 stated NA #1 and PCA #1 were with Resident #11 and she was lying on the floor on her left side with her head under the sink. PCA #2 stated, at this time, she went to the 200 hall to get Nurse #1 and Nurse #1 stated she was coming but it had taken her a long while to come down to the room. PCA #2 was unable to say how long it took. PCA #2 stated she went back to the room and they (NA #1, PCA #1, and PCA #2) waited a while for Nurse #1 but she had not come after about 20 minutes, so they decided to move her to the wheelchair. PCA #2 stated PCA #1 held the wheelchair and her and NA #1 lifted the resident off the floor under her arms and transferred her to the wheelchair. PCA #2 stated she did not use the mechanical lift. PCA #2 was not aware she was supposed to use a mechanical lift. PCA #2 stated they kept asking Resident #11 if she was okay and she would say "yes" or if she had any pain and the resident said, "no." PCA #2 stated she did not recall going back in the resident ' s room after they transferred her. PCA #2 stated she left the facility at 6:30 AM.

An interview with Nurse #1 on 12/09/21 at 8:30 AM who worked 7:00 PM to 7:00 AM on 11/11/21 stated she was told by NA #1 that the resident had fallen and NA #1 and PCA #1 had already transferred the resident to the wheelchair before she could assess Resident #11. Nurse #1 stated NA #1 and PCA #1 moved her because they said she looked uncomfortable. Nurse #1 stated NA #1 and PCA #1 should not have moved Resident #11 until she assessed her. Nurse #1 stated whenever a resident had an unwitnessed fall, the staff needed to determine if the resident hit their head and if the resident could not say, nursing would start doing neurological (neuro) checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 30 Nurse #1 explained that the neuro checks included checking the resident's level of consciousness to see if the resident could respond verbally to the nurse, check the residents' pupils to see if they react to light as they should, check the residents' hand grasps on both sides to see if the strength was equal and check the resident's range of motion to see if they have any pain upon movement. Nurse #1 stated an initial set of vital signs needed to be obtained as well. She stated the assessments should be done every 15 minutes for one hour, every 30 minutes for 2 hours, every hour for 4 hours, every 4 hours for 16 hours, and every 8 hours for 48 hours. Nurse #1 stated staff were not supposed to move a resident after a fall until the resident was assessed by a nurse. Nurse #1 added if a resident was unable to stand by themselves and were dependent on staff to reposition them, a mechanical lift with 2 staff members should be used to transfer the resident to the bed or a wheelchair. Nurse #1 stated she did not know how long it took before she assessed the resident because she was busy on another hall, but when she got to the room she saw Resident #11 sitting in the wheelchair and the resident said her shoulder hurt. Nurse #1 stated she noted she had a small abrasion on Resident #11's shoulder which she cleansed with normal saline, applied an antibiotic ointment and covered with a dressing. Nurse #1 stated the resident also had a red area on her left inner elbow. Nurse #1 stated she did not check the range of motion (ROM) to the upper and lower extremities because the resident could not follow commands to raise her arms or extend her legs. Nurse #1 stated she did not do neuro checks because Resident #11 could not follow the command to squeeze her hands to check for equal strength on each side or the	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 31	F 600		

command to push down on her legs to check for equal strength on each side. Nurse #1 stated the resident had no signs or symptoms of pain and she left her in the wheelchair. Nurse #1 stated she should have checked passive range of motion (conducting the range of motion without the residents ' assistance) to see if Resident #11 could move her extremities without pain and she should have obtained new vital signs with every neurological check assessment.

An interview was conducted with Nurse Supervisor (NS) #1 via phone on 12/13/21 at 8:33 AM who worked 7:00 AM - 7:00 PM on 11/11/21. NS #1 stated she received in report from Nurse #1 Resident #11 had a fall around 3:00 AM but that Resident #11 was okay. NS #1 stated when she went in to see Resident #11 that morning to give her medications, she assessed Resident #11 while she was sitting in her wheelchair by conducting passive range of motion to her upper and lower extremities and she had no signs or symptoms of pain. NS #1 stated the resident appeared to be at baseline and was answering NS #1's questions appropriately. NS #1 stated since the Nurse Practioner (NP) #1 was in the building on 11/11/21 she had let him know the resident had a fall and he had gone in to assess Resident #11. NS #1 stated neither PCA #3 nor NA #8 came to her and reported Resident #11 was in pain or not eating. NS #1 stated Nurse #1 did not inform her that Resident #11 was transferred after her fall before Nurse #1 could assess her. NS #1 stated she had no knowledge that had occurred. NS #1 stated the resident would ambulate and she did not see her ambulate on 11/11/21. NS #1 stated she had done the neurological assessments; she just did not record the results in the computer system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 32	F 600		

NS #1 stated she should have documented her findings to include current vital signs, hand grasps, pupil assessment and range of motion in the computer system to ensure the nursing staff were aware of all the assessments conducted to monitor for any change in condition.

There was no documentation for the continued neuro check assessments from NS #1 which would have been for every 1-hour X 2 (9:00 AM and 10:00 AM) and every 4 hours X 2 (2:00 PM and 6:00 PM) during her shift on 11/11/21.

A progress note written by Nurse Practioner #1 on 11/11/21 at 12:12 PM revealed "resident was in her wheelchair, sitting up eating lunch. She was noted to have a fall over night. Nursing states she was laying on the floor on her left shoulder. Small abrasion noted to left posterior shoulder, open to air. Resident denied any pain and had full range of motion. Resident stated she was "doing ok."

An interview with Nurse Practioner (NP) #1 via phone on 12/13/21 at 11:50 AM reported when he was made aware by NS #1 Resident #11 had a fall, he assessed the resident on 11/11/21. NP #1 reported when he entered the resident's room she was sitting in her wheelchair eating lunch. NP #1 stated he was told by staff the resident had an abrasion to her left shoulder but no complaints of pain or any other obvious injury. NP #1 stated the resident had no acute distress and he had moved her arms and palpated her lower back, hips, and knees to see if there was any pain. The NP #1 stated he did not do any range of motion with the lower extremities and added, typically, the nurses would assess range of motion if a resident had a fall. NP #1 stated he would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 600	Continued From page 33	F 600		

expected the nurses to do a full assessment to include vital signs, neuro assessments, and range of motion to see if the resident had any pain or decreased range of motion in any extremities. He stated he would expect the nursing staff to complete a comprehensive assessment to determine how and when to move a resident after a fall, but that a nurse should do a complete assessment before a resident was transferred.

An interview was conducted with NA #8 on 12/10/21 at 11:30 AM who worked the 7:00 AM - 3:00 PM shift on 11/11/21. NA #8 stated she could not remember taking care of Resident #11 on 11/11/21 and could not recall getting a report from NA #1 regarding Resident #11 having a fall.

An interview with PCA #3 via phone on 12/13/21 at 10:35 AM who worked the 7:00 AM - 3:00 PM shift on 11/11/21 revealed she could not recall getting in report from NA #1 that Resident #11 had a fall. PCA #3 stated she had no knowledge of the resident having a fall and could not recall caring for Resident #11 on 11/11/21. PCA #3 stated what she remembered about Resident #11 was that she would be up and walking the halls with her walker and sometimes she would sit in her room in her recliner. PCA #3 stated it was rare for the resident to sit in her wheelchair or to be in her bed.

An interview with NA #7 via phone on 12/11/21 at 10:47 AM who worked the 3:00 PM - 11:00 PM shift on 11/11/21 revealed she could not recall anything about the evening of 11/11/21 related to Resident #11.

An interview with NA #9 via phone on 12/11/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 34	F 600		

11:15 AM who worked from 7:00 PM - 7:00 AM shift on 11/11/21 going into 11/12/21 revealed she could not recall anything about the evening or the early morning hours of 11/11/21 or 11/12/21 related to Resident #11.

An interview with NA #5 via phone on 12/14/21 at 8:41 AM who worked the 3:00 PM - 11:00 PM shift on 11/11/21 revealed she could not recall anything about the evening of 11/11/21 related to Resident #11.

An interview with NA #14 via phone on 12/13/21 at 12:11 PM who worked on 11/11/21 from 11:00 PM - 7:00 AM reported she had worked the 100/200 hall that night and did not provide any care to Resident #11. NA #14 stated she was not aware Resident #11 had a fall. NA #14 stated the resident was usually up and ambulating and was confused and would need redirection when she wandered. She stated the resident very rarely slept in her bed and would usually sleep in her recliner.

An interview with Medication Aide #1 (MA) via phone on 12/13/21 at 12:11 PM who worked 7:00 PM - 7:00 AM on 11/11/21 going into 11/12/21 revealed she could not recall the night of 11/11/21 and could not recall being told by NS #1 Resident #11 had a fall. MA #1 stated if the resident did have a fall and neuro checks were needed, the nurse would get the neuro checks and she would obtain the vital signs. MA #1 could not recall obtaining any vital signs for Resident #11 during this shift. MA #1 stated she believed Nurse #9 from the Rehab Hall would have been the nurse overseeing her as the MA and she would have done the neuro assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 35	F 600		

An interview was conducted with Nurse #9 via phone on 12/14/21 at 2:10 PM. Nurse #9 who worked the Rehab Hall the night of 11/11/21 going into 11/12/21 reported she was not overseeing the Medication Aide on the night of 11/11/21. Nurse #9 stated she was not informed that neurological assessments needed to be done for Resident #11 and therefore did not complete any neuro assessments for this resident. There were no neuro check assessments documented during the shift 7:00 PM - 7:00 AM on 11/11/21 going into 11/12/21 which would have included every 4 hours X 2 more times (10:00 PM and 2:00 AM) for Resident #11.

During the interview with NA #1 via phone on 12/10/21 at 5:30 AM she stated she came back to work on Friday 11/12/21 from 7:00 AM -3:00 PM and when she arrived she brought Resident #11 her breakfast tray and Resident #11 was sitting in the wheelchair, slumped over. She stated she told Nurse #2 (day shift nurse) and Nurse #2 told NA #1 to get her into bed. NA #1 stated when she and NA #2 were moving Resident #11, they tried to get her to stand up with her walker because that was how the resident usually transferred and the resident refused to get up and became combative. NA #1 stated she and NA #2 tried to move the resident from the chair to the bed and she was crying out like she was in pain. NA #1 stated they tried to transfer her with a gait belt and Resident #11 started complaining "No! Stop!" NA #1 stated they got the sit to stand mechanical lift which she did not tolerate but she and NA #2 were able to get the resident to bed. NA #1 stated Resident #11 was showing signs that she was in pain like moaning and crying. NA #1 stated she and NA #2 got her to the bed and laid her down and then the resident rolled on to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 36	F 600		

her right side. NA #1 stated she went to Nurse #2 and told her the resident was having pain when she and NA #2 transferred her and Nurse #2 stated it was probably because she had been sitting in the wheelchair and to let her know when NA #1 went back to the room. NA #1 stated she went back in the resident ' s room around 10:00 AM by herself to check and change Resident #11 and the resident was refusing care. NA #1 stated Resident #11 said, "stop, quit" when NA #1 attempted to roll her. NA #1 stated she reported this to Nurse #2 and Nurse #2 said "I ' m busy right now, I ' m trying to finish my med pass." NA #1 stated when she went to bring the resident her lunch tray, the Physical Therapist (PT #1) was in Resident #11 ' s room and had asked if NA #1 noticed a change in Resident #11 and NA #1 said yes, and that Resident #11 was not eating and refusing to let NA #1 change her and she was crying out. NA #1 stated while she was talking with PT #1, Nurse #2 was with them while she was at the medication cart. NA #1 stated when she went to change Resident #11 to do her care at around 2:30 PM, she was wincing and moaning and said to "stop" and was pushing NA #1's hands away. NA #1 stated she told Nurse #2 again, but NA #1 did not observe Nurse #2 go into her room to assess the resident at that time.

An interview was conducted with NA #2 on 12/10/21 at 10:00 AM who worked 7:00 AM - 3:00 PM on 11/12/21. NA #2 reported when she came in on 11/12/21 she did rounds with NA #1. NA #2 stated the resident was noted to be slumped over in her wheelchair. NA #2 stated she and NA #1 went to put Resident #11 in the bed and when she and NA #1 stood the resident up from the wheelchair and tried to transfer her, Resident #11 made a noise of discomfort and was acting out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 37	F 600		

the ordinary because she grimaced and moaned when she and NA #1 moved her. NA #2 could not recall using the sit to stand mechanical lift to transfer her. NA #2 stated Resident #11 was very wet and very soiled and NA #2 stated both she and NA #1 reported to Nurse #2 that Resident #11 was not her normal self because she had not eaten and was showing signs and symptoms of pain. NA #2 reported the resident slept for a majority of the day which was out of the norm. NA #2 stated she did not follow up with the Nurse #2 to see if she had gone to see the resident and when she left at 3:00 PM and Resident #11 was still sleeping in bed.

An interview with PT #1 on 12/10/21 at 10:30 AM revealed she had gone to see Resident #11 on 11/12/21 due to the resident having a fall which was reported to her through risk management (a meeting with nursing and department heads to discuss falls). PT #1 stated Resident #11 had a significant change because she was not out of bed or ambulating. PT #1 stated when she went into the resident's room to see her, she was lying in bed and PT #1 tried to touch her to wake her, but the resident did not respond. PT #1 stated NA #1 and Nurse #2 were outside of Resident #11's door and she reported to Nurse #2 that she needed to be checked out due to change of status because she was not moving or walking and she was usually up and ambulating and NA #1 told PT #1 that it took 2 aides to transfer Resident #11 back to bed that morning.

An Interview with Nurse #2 on 12/10/21 at 10:15 AM revealed on 11/12/21 when she arrived, she was never made aware by Medication Aide #1 Resident #11 had a fall. Nurse #2 stated she went to the resident's room after PT #1 had told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 38	F 600		

her Resident #11 did not seem right and the resident was in her bed. Nurse #2 stated the resident was lethargic but she thought it was because Resident #11 had been sitting up in her wheelchair for a while. Nurse #2 stated no one told her she had fallen and if she had known she would have done a thorough assessment. Nurse #2 stated she did not assess her and added that the resident did not verbalize much and did not show signs and symptoms of pain and no one had ever told her Resident #11 was in pain. Nurse #2 stated the resident never ate that day and never got out of bed, which was not her norm, but again she thought the resident was just tired from sitting up in her wheelchair.

A follow up interview was conducted with Nurse #2 via phone on 12/15/21 at 12:56 PM. Nurse #2 revealed neuro checks were initiated whenever a resident had an unwitnessed fall and they would continue for 3 days (72 hours). Nurse #2 confirmed she documented the neuro checks in the computer system but did not make the connection as to why she was doing neuro checks when she was documenting them. Nurse #2 stated she did do the neuro checks but added she did not always check the range of motion or obtain current vital signs when she was doing her neuro checks and the previous vital signs that were recorded auto populated in the computer system. Nurse #2 stated part of doing neuro check assessment was to obtain current vital signs with each assessment and it was important to check them to make sure there was no significant change in condition in the resident, and to check range of motion. Nurse #2 stated she should have questioned why she was having to document and perform the neuro checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 39	F 600		

Review of the neuro check assessments by Nurse #2 beginning on 11/12/21 at 9:00 AM hourly until 12:00 PM revealed hand grasps were equal and moved extremities equally, vital signs (VS) were recorded by Nurse #2 as blood pressure (BP) 114/72, respiration rate (RR) 18 breaths per minute (bpm), heartrate (pulse) was recorded as 72 beats per minutes (bpm) at 3:10 AM with a time stamp of 11/11/21. On 11/12/21 the neuro checks would have been due to be completed at 10:00 AM and 6:00 PM by Nurse #2.

Interview with Nurse #6 on 12/11/21 at 6:37 AM who worked 7:00 PM - 7:00 AM on 11/12/21 revealed he received report from Nurse #2 Resident #11 had a fall with no injury. Nurse #6 stated he was told Resident #11 was transferred from the floor without being assessed by Nurse #1. Nurse #6 stated Nurse #2 did not mention anything about the resident having pain, not eating, or staying in bed all day. Nurse #6 stated during the night on 11/12/21, Resident #11 had no signs or symptoms of pain. Nurse #6 stated he had administered eye drops to her, and at this point Resident #11 was in bed and responding to him while applying the eye drops and following the command to open her eyes. Nurse #6 stated at one point during the night NA #3 came to him to assist with giving Resident #11 a boost in the bed and while they repositioned her, she had no signs or symptoms of pain. Nurse #6 stated NA #3 had not reported the resident was having any pain during the shift. Nurse #6 stated the resident stayed in bed all shift. Nurse #6 added, the resident would sometimes sleep in bed all night especially if she had been up all day, but most times the resident was in bed maybe 5 - 10% of the time. Nurse #6 stated if he were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 40	F 600		

assessing a cognitively impaired resident after a fall he would perform passive range of motion as part of his assessment to determine if the resident had any pain or rotation of the extremities. Nurse #6 stated he did not perform passive range of motion on Resident #11 because he was told she was fine after her fall. Nurse #6 stated he did not recall recording neuro check assessments in the computer system for Resident #11.

Review of the continued neuro check assessments for Resident #11 on 11/12/21 revealed Nurse #6 recorded the vital signs (VS) as blood pressure (BP) 114/72, respiration rate (RR) 18 breaths per minute (bpm), heartrate (pulse) was recorded as 72 beats per minutes (bpm) at 3:10 AM with a time stamp of 11/11/21, and indicated the resident was able to verbalize needs and obeyed commands, moved all extremities equally and hand grasps were equal.

During the interview with NA #1 via phone on 12/10/21 at 5:30 AM, NA #1 stated when she came back to work on 11/13/21 from 7:00 AM to 3:00 PM and went to bring Resident #11 her breakfast tray about 7:30 AM or so, Resident #11 was lying in bed on her right side and refused to be set up to eat breakfast. NA #1 stated Resident #11 was moaning and wincing and showing signs like she was in pain when she was trying to move her. NA #1 stated she told Nurse #3 the resident seemed like she was in pain and was refusing to let her change her and reposition her to set her up to eat. NA #1 stated she asked Nurse #3 to please look at her. NA #1 stated Nurse #3 assessed Resident #11 and after Nurse #3 assessed her, Nurse #3 said the resident was having pain and needed an x-ray on her left leg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600 Continued From page 41 F 600

An interview was conducted with Nurse #3 via phone on 12/11/21 at 11:02 AM. Nurse #3 revealed when she came on duty the morning of 11/13/21, Nurse #6 told her in report Resident #11 had a fall with an abrasion to her shoulder but that she seemed okay. Nurse #3 stated NA #1 came to her about 7:45 AM and asked her to please assess Resident #11. Nurse #3 stated NA #1 was concerned that the previous nurse (Nurse #2) had not followed up and checked on the resident. Nurse #3 stated NA #1 stated "Why was no one following up as to why she was still in bed and not eating?" Nurse #3 stated she went in to assess Resident #11 and because she could not verbally express if she had pain, she started to do passive range of motion and when she moved the resident ' s left leg, she cried out with a loud sound and was reaching down toward her left leg and moaning. Nurse #3 stated she gave Resident #11 some pain medicine and notified the physician and obtained an order for an x-ray which resulted in a fracture and she was sent to the hospital.

On 11/13/21 the incident report (related to Resident #11 ' s fall on 11/11/21 at 3:00 AM) was updated by NS #2 and stated, "resident complained of pain on 11/13/21 and NA {#1} called Nurse {#3} to room around 8AM and said, "Can you please check on her?" Nurse assessed for signs of pain and upon range of motion to left leg resident winced and cried out. MD notified, x-ray ordered for left hip and femur. X-ray arrived around 12 noon and the report came back around 5:30 PM that resident had an acute left hip fracture."

An interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 42	F 600		

Rehabilitation Manager on 12/10/21 at 5:45 PM. The Rehab Manager stated it would take a lot more force than a transfer with 3 staff to worsen the fracture to the resident's leg. The Rehab Manager added that sometimes nursing staff may not be able to tell if there was any injury upon assessment and the injury could be more evident later.

An interview was conducted with Director of Nursing (DON) on 12/10/21 at 6:08 PM. The DON stated he had no knowledge the nurse aide and patient care assistants moved Resident #11 before being assessed by the nurse. The DON reported whenever a resident had a fall, the nurse was to complete a head-to-toe assessment with vital signs for a witnessed or unwitnessed fall. The DON stated if the fall was unwitnessed, and the resident was not cognitively aware to report if they had hit their head or not, the nurses would be expected to initiate neurological checks which would include current vital signs with each assessment, assessing hand grasps, range of motion of all extremities, mental status and an assessment of the pupil size and reaction to light. The DON stated the neuro checks should be completed for the full 72 hours in order to effectively monitor for any change of condition.

An interview with Nurse Practioner (NP) #1 on 12/16/21 at 12:15 PM revealed NP #1 stated he was not made aware Resident #11 was not eating or getting out bed and would have expected the nursing staff to notify him of this change of condition. NP #1 stated we would have expected the nurses to follow the facility ' s protocol for assessing neuro checks especially for a cognitively impaired resident who had an unwitnessed fall to monitor for any acute physical

F 600

Continued From page 43

changes or mental status changes.

An interview was conducted with the facility Physician via phone on 12/15/21 at 3:10 PM. The physician reported he would have expected the nursing staff to assess Resident #11 before she was transferred from the floor to the wheelchair and he would have expected the nursing staff to do a full neurological assessment including updating vital signs and checking range of motion with each assessment to monitor for any acute physical or mental status changes. The physician stated he could not say for certain if moving the resident without being assessed caused or worsened the fracture to the resident ' s left leg, but if a full assessment had been done, the nursing staff would have possibly identified there was lack of movement or pain prior to moving her. The physician also stated that a resident may not always demonstrate pain after an initial fall and could present pain after a day or so which was why the neuro assessments were important to obtain.

Administrator was notified of the Immediate Jeopardy on 12/14/21 at 9:15 AM .

The facility provided the following credible allegation for Immediate Jeopardy removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

a. On 11/11/2021 at approximately 3:10 AM Nurse Aide (NA) #1 for Resident #11 reported to the charge nurse (Nurse #1) that the resident had an unwitnessed fall and was on the floor beside the bed. NA #1, Patient Care Assistant (PCA) #1,

F 600

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 44 and PCA #2 transferred the resident back in to the wheelchair prior to the nurse completing the head-to-toe assessment. The facility failed to monitor the resident post fall for signs and symptoms of injury or pain per policy. When Nurse #1 completed her initial post fall assessment of Resident #11 she did not check the range of motion (ROM) to the upper and lower extremities and she did not do neurological checks. Resident #11 should have had a head-to-toe assessment completed, to include a pain assessment, every 12 hours for 72 hours post fall. On 11/12/21, NA #1, NA #2, and Physical Therapist #1 reported to Nurse #2 signs of pain, decreased oral intake, and a change in Resident #11's baseline status as she was not out of bed or ambulating. When Nurse #2 checked on Resident #11 on 11/12/21 she noted the resident was lethargic, but she had not completed a thorough assessment as she had not been notified of Resident #11 ' s fall on 11/11/21. This resulted in the facility failing to identify a significant change in condition for Resident #11 until 11/13/21 when NA #1 reported to Nurse #3 that Resident #11 had not eaten breakfast and had signs of pain. Nurse #3 assessed Resident #11 for pain and while doing ROM to the left lower extremity, the resident showed signs and symptoms of pain when she winced and cried out. Nurse #3 obtained an order for an x-ray due to complaints of pain on 11/13/21. The x-ray revealed a left femoral sub capital (fracture in the neck of the thigh bone) neck displaced fracture. Resident #11 was sent to hospital on 11/13/21 and had surgery. A 24 -hour report was completed for an allegation of neglect for Resident #11 on 12/14/2021. All residents have the potential to be affected by this deficient practice.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600		F 600		

Continued From page 45

b. On 12/14/2021 medical records were reviewed for all residents that sustained a fall since 11/11/2021 by the Director of Nursing (DON) to ensure they were properly assessed post fall and that none had sustained any unidentified injuries or had a significant change in condition. Review included initial head- to- toe assessments, initial pain assessment, fall assessment, fall risk evaluation, therapy referral, neuro checks, and head to toe assessments scheduled and completed every 12 hours post fall for 72 hours. A 30 day look back of falls revealed 29 falls. 28 residents had incomplete or missing assessments. There were no negative outcomes as evidenced by head-to-toe assessments and pain assessments completed on 12/14/2021 by the Director of Nursing.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

a. The Director of Nursing re-educated all staff on 12/14/2021 on the Falls Program the facility utilized which consist of Fall Prevention and Management Program One Page Guide (summarizes the entire falls program to be utilized by the staff as a quick reference), Fall Prevention and Management Policy, Pre-admission Review; Fall Risk Referral/Assessment Process, Post Fall Huddle Process, Fall Committee meeting; initial head to toe assessments; expectations that all residents will be assessed by a nurse prior to moving a resident post fall so that further harm or injury does not occur; pain assessments; identifying and reporting changes in condition, shift report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 600	Continued From page 46	F 600		

and neglect/abuse. Any staff members that were unable to be educated were removed from the schedule on 12/14/2021 and will be required to meet with the Director of Nursing or designee to have the education prior to working in the facility.

b. The Director of Nursing or designee will ensure all new employees will be educated on the Falls Program the facility utilized; which consist of Fall Prevention and Management Program One Page Guide, Fall Prevention and Management Policy, Pre-admission Review; Fall Risk Referral/Assessment Process, Post Fall Huddle Process, Fall Committee meeting; initial head to toe assessments; expectations that all residents will be assessed by a nurse prior to moving a resident post fall so that further harm or injury does not occur; pain assessments; identifying and reporting changes in condition, shift report and neglect/abuse on orientation prior to providing direct resident care.

Person responsible for the removal plan: LNHA

The facility alleges the removal date of the Immediate Jeopardy was 12/15/21.

The Removal Plan of the Immediate Jeopardy was validated on 12/16/21.

A sample of staff including nurses, nurse aides, and nursing supervisors were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the fall prevention and management policy and procedures related to any resident who had a fall. Staff stated they were in serviced verbally and in person and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 600	Continued From page 47 provided written materials regarding neglect, fall prevention, fall management, assessments by the nurse post fall, reporting change in condition, and ensuring a resident who had a fall was assessed prior to transferring. Nurses interviewed revealed education was provided to conduct a comprehensive assessment on any resident post fall to monitor for signs and symptoms of injury or pain and that a nurse must assess the resident prior to moving them post fall. The nurses were educated to communicate with the oncoming shift in shift report any pertinent information about the resident who had a fall. A review of all the documents provided to correct the deficient practice was completed. All facility policy and procedures that were provided to address the deficient practice were reviewed. The Immediate Jeopardy was removed on 12/15/21.	F 600		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 727	F 727 RN 8 Hrs/7 days/Wk, Full time	1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 727	Continued From page 48 facility failed to prevent the Director of Nursing (DON) from having a resident care assignment including working on the medication cart with a facility census of greater than 60 residents for 1 of 30 days reviewed (12/1/2021). The findings included: A review of the staffing schedule for 12/1/2021 showed the facility census was 80. The average facility census for the previous month of November was 83. An interview was conducted on 12/7/2021 at 4:07 P. M. with the Scheduler. The Scheduler revealed when a nurse called out for their shift, nurses in the management positions were used to fill the assignment. The Scheduler stated the DON worked a full twelve-hour assignment on 12/1/2021 with a facility census over 60 residents. During the interview the Scheduler stated she was unaware the DON was unable to have a clinical assignment when the buildings census was higher than 60 residents. An interview was conducted on 12/7/2021 at 4:34 P. M. with the DON revealed upper management was used on a rotating schedule to fill call out positions as needed. The DON stated since he was hired in July 2021, he worked both part of a twelve hours shifts and the full twelve-hour shift as needed. During the interview the DON stated he was unaware he was unable to have a clinical assignment and had he known this he would not have worked as a floor nurse. An interview was conducted on 12/8/2021 at 3:33 P. M. with the Administrator revealed the DON worked as a clinical nurse as needed. During the	F 727	DON No residents were affected as a result of the Director of Nursing having a resident care assignment including working on the medication cart on 12/1/2021. To identify other residents that have the potential to be affected, an audit of the 24 hour report was done by the Regional Director of Clinical Services. No residents were noted to have ill effects on 12/1/2021 while the Director of Nursing was assigned to a medication cart. To prevent this from recurring, the Regional Director of Clinical Services reeducated the Administrator and the scheduler that the Director of Nursing may only be assigned to a medication cart if the average daily occupancy is less than 60 or if there is a waiver in place.This education was complete on 1/24/2022. To monitor and maintain ongoing compliance, Administrator/designee will monitor the daily staffing sheets to ensure the Director of Nursing is not assigned to a medication cart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 727	Continued From page 49 interview the DON stated he was unaware the DON was not allowed to have a clinical assignment when the facility census was over 60 residents and had he been aware of this the DON would not have worked a clinical assignment.	F 727	Monitoring will be done weekly for 12 weeks. An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 50 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, and Physician interviews the facility failed to act upon the recommendations contained in the monthly Consultant Pharmacist's Medication Regimen Review (MRR) for 5 of 5 residents (Resident #35, #20, #61, #19, #63) whose medications were reviewed. Findings included. 1.) Resident #35 was admitted to the facility on 08/01/18 with diagnoses to include in part; Bipolar Disorder. A physician's order dated 01/28/20 for Resident #35 revealed an order for Lithium Carbonate Capsule (a mood stabilizer used in the treatment of Bipolar Disorder) 150 milligrams. Give orally two times a day for BPD (Bipolar Disorder). A review of the monthly Consultant Pharmacist MRR reports dated 07/01/21 - 10/15/21 which were provided to the facility revealed Resident #35 received Lithium and a Lithium level was not	F 756	F 756 Drug Regimen Review Residents # 35, 20, 61, 19, and 63 suffered no harm as a result of the pharmacy recommendations not being completed. To identify other residents that have the potential to be affected, an audit of the current month December 2021 was completed on 12/7/2021 by the Regional Director of Clinical Services to validate that the recommendations were completed by the Medical Provider and any changes in orders were noted in the medical record. To prevent this from recurring, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 51 filed in the chart. The recommendation read in part; serum lithium concentrations were recommended following dosing changes and at least every two months in those 65 years of age and older. The rationale included; Lithium had a boxed warning (used to communicate potential or dangerous side effects, or to communicate important instructions for safe use of the drug) describing the close relationship between lithium levels and toxicity. The recommendation was repeatedly sent to the facility monthly on 07/15/21, 08/13/21, 09/17/21, and 10/14/21. A review of the lab reports for Resident #35 from 07/01/21 - 10/15/21 revealed no lab results were on file for Lithium levels. The last documented Lithium level was obtained 05/25/20 with a result of 0.46 mmol/L (millimoles per liter) (normal values 0.50 - 1.20 mmol/L). The Minimum Data Set (MDS) quarterly assessment dated 10/23/21 revealed Resident #35 was cognitively intact. She exhibited no behaviors, and no rejection of care during the assessment period. An interview was conducted on 12/07/21 at 2:00 PM with the Administrator along with the Corporate Nurse Consultant. They each stated the monthly pharmacy MRR reports had not been acted on and not scanned into the medical records since the Director of Nursing (DON) started in July 2021. The Corporate Nurse Consultant stated the DON was trained upon hire on the process regarding the MRR reports, which was to notify the providers of the MRR recommendations provided by the Consultant Pharmacist immediately once the reports were received in the facility so they could be	F 756	Regional Director of Clinical Services provided reeducation to the Director of Nursing and the Administrator on the procedure of addressing pharmacy recommendations within 7 days after receipt from the licensed pharmacist each month. The education was completed on 1/27/2022. To monitor and maintain ongoing compliance, the Administrator or designee will monitor monthly pharmacy recommendations each month to validate the recommendations have been addressed within 7 days of the receipt of the recommendations. This will be documented monthly for 3 months. An ad hoc meeting for review, recommendations, and acceptance was held on 12-7-22. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 52	F 756		

addressed. The Administrator stated he had spoken to the DON regarding acting on MRR recommendations, but he did not provide a specific date as to when that was.

An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR reports.

A phone interview was conducted on 12/13/21 at 11:56 AM with Consultant Pharmacist #1. He stated he was new to the facility and to working as a Consultant Pharmacist. He stated he spoke with the DON in October 2021 regarding the MRR reports and some of the recommendations had been addressed. He also addressed the facility's lack of response to the MRR reports to the previous Consultant Pharmacist (#2). He stated when he conducted the monthly MRR's he would check to see if the previous months recommendations were addressed and if it was scanned into the electronic medical record (EMR). He stated if there was no documentation in the EMR he would check to see if the physician orders were altered. He stated he thought the issue was being addressed by the facility and stated the previous Consultant Pharmacist (#2) had spoken with Corporate to address the issue. He stated Resident #35's Lithium 150 mg order was considered a low dose and there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 53	F 756		

significant concern regarding not having Lithium levels checked per his recommendations in July through October 2021.

A phone interview was conducted on 12/13/21 at 4:00 PM with Consultant Pharmacist #2 along with the Corporate Nurse Consultant. The Consultant Pharmacist stated she spoke with the Administrator at the facility verbally in July, August, and September 2021, and Consultant Pharmacist #1 had also made the facility aware of no follow up with the MRR recommendations. She stated the pharmacy consulting process included; the Consultant Pharmacist notified the DON when they were starting the MRR, then the pharmacist would let the facility know when the MRR reports were completed, then the reports were emailed to the DON. She stated a QI (Quality Improvement) summary was provided to the facility which also showed the facility response rate to the pharmacy reports. She stated the Administrator was made aware in July, August, and September, and stated Consultant Pharmacist #1 last spoke with the DON in October regarding the issue. She stated if a recommendation was extremely important the Consultant Pharmacist would call the provider. During the phone interview the Corporate Nurse Consultant stated he expected the pharmacy reports to be completed and forwarded to the providers by the DON when they were received in the facility.

A phone interview was conducted on 12/13/21 at 4:45 PM with the Physician. He stated he was not aware the facility had not followed up on the monthly pharmacy recommendations in over six months. He stated labs were routinely ordered anyway every 6 months unless they were needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 54	F 756		

more frequently. He indicated he was not aware Resident #35's Lithium levels were not checked within the recommended time frames. He stated Resident #35 had a history of refusing care at times and reported he had spoken with Resident #35 on several occasions regarding her medications including Lithium. He voiced no significant concern regarding her medications.

A phone interview was conducted on 12/16/21 at 11:38 AM with the DON. He stated he was not aware that he had to do anything with pharmacy recommendations. He stated the Consultant Pharmacist never came to him regarding the monthly MRR recommendations not being completed. He stated a new process regarding acting on MRR recommendations would begin this week.

2.) Resident #20 was admitted to the facility with diagnoses to include; psychosis, agitation, and combativeness.

A review of the Medication Administration Record (MAR) from June - December 2021 revealed Resident #20 received the following antipsychotic medication: Risperidone 0.5 milligrams (mgs) at bedtime from 06/26/21 through 08/23/21 and Risperidone 0.25 mgs at bedtime from 09/01/21 to present.

A review of the monthly pharmacy recommendation reports revealed a recommendation had been provided to the facility in 07/15/21, 08/13/21, and 09/17/21 by the pharmacist for an AIMS (abnormal involuntary movements) assessment to be completed for Resident #20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 55 Record review revealed Resident #20 had never received an AIMS assessment. The MDS assessment dated 11/26/21 revealed Resident #20 had severely impaired cognition and received antipsychotic medications on 7 of 7 days during the assessment period. An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR reports. In an interview with Consultant Pharmacist #1 on 12/16/21 at 11:20 AM, he stated it was important for the facility to complete an AIMS assessment for residents who were receiving an antipsychotic medication to help identify the presence of side effects such as tardive dyskinesia (abnormal involuntary movements) on admission to the facility then every six months thereafter. 3.) Resident #61 was admitted to the facility on 12/13/19 with diagnoses to include in part; Gastrointestinal (GI) bleed, E. coli (Escherichia coli - a bacteria commonly found in the intestines). A review of the Consultant Pharmacist MRR report dated 06/13/21 read in part: repeated recommendation, please respond promptly.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 56	F 756		

Resident #61 has received Omeprazole 20 mgs (milligrams) orally since 12/20/19. The recommendation was to reevaluate the continued need for the PPI (proton pump inhibitor) medication and discontinue Omeprazole 20 orally every day and initiate Famotidine (acid reducing medication) 20 mgs orally at bedtime with the end goal of discontinuation. The rationale included; long term PPI use was associated with increased risk of C. Difficile, infections, bone loss, and fractures. If PPI therapy was to continue at the current dose, it was recommended that the prescriber document an assessment of risk versus benefit, indicating that it continued to be a therapeutic intervention, and the facility IDT (interdisciplinary team) ensured ongoing monitoring for effectiveness and potential adverse consequences.

A review of Resident # 61's physician orders revealed Omeprazole 20 mgs orally every day was an active order. There were no adverse consequences documented.

The MDS assessment dated 11/09/21 revealed Resident #61 had moderately impaired cognition.

An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR reports.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 57	F 756		

4.) Resident #19 was admitted to the facility on 11/17/20 with diagnoses to include in part; overactive bladder.

A review of the Consultant Pharmacist MRR report dated 06/15/21 read in part: Resident #19 receives Oxybutynin (prescribed for treatment of overactive bladder) 10 mgs once a day for overactive bladder which may increase the risk of adverse events. The recommendation was if continued therapy for incontinence was required to consider decreasing the dose to 5 mgs at bedtime. The rationale included; Oxybutynin was highly anticholinergic and may increase dry mouth and impair cognition.

A review of the physician orders for Resident #19 from June 2021 - December 2021 revealed Oxybutynin 10 mgs remained an active order.

The MDS assessment dated 09/30/21 revealed Resident #19 had no cognitive impairments.

An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR reports.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 58	F 756		

5.) Resident #63 was admitted to the facility on 12/31/15 with diagnoses to include; coronary artery disease, history of myocardial infarction (heart attack) with stent placement, and chronic pain.

Review of the Pharmacy Consultant MRR report dated 10/15/21 indicated Resident #63 had an order to crush medications and received medications that were not recommended to be crushed per manufacturers guidance. The medications that were not to be crushed for Resident #63 included Imdur (an extended -release heart medication) and MS Contin (an extended-release pain medication).

A review of the MDS assessment dated 11/10/21 revealed Resident #63 was cognitively intact.

An interview and observation was conducted on 12/09/21 at 11:10 AM with Nurse #5. She stated the only medication she did not crush for Resident #63 was the MS Contin because it was extended release. She stated she was unaware Imdur was also extended release. She reported she had already crushed and administered the Imdur to Resident #63.

An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 756	Continued From page 59 reports. He indicated this recommendation was not addressed and stated he expected nurses not to crush medications that should not be crushed.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 758

Continued From page 60

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete assessments for abnormal involuntary movements (AIMS) for 2 of 5 residents who were reviewed for unnecessary medications and had received antipsychotic medication (Residents #43 and #20).

Findings included:

1. Resident #43 was admitted to the facility on 08/21/21 with diagnoses that included mood disorder and agitation.

Review of the August, September, October, November, and December 2021 Medication Administration Records revealed Resident #43 received the following antipsychotic medication: Seroquel 50 MG at bedtime (started on 08/27/21).

Review of a pharmacy recommendation dated November 1, 2021 requested a gradual dose reduction to Seroquel 25 MG which was declined by the physician on 12/07/21. The

F 758

F 758 Free from Unnecessary Psychotropic Meds Abnormal involuntary movements (AIMS) assessments were completed on 12/9/2021 for residents # 43 and 20 with no negative findings.
To identify other residents that have the potential to be affected, an audit of residents receiving anti-psychotic medications using the pharmacy review report done each month was performed by the Regional Director of Clinical Services on 12/10/21 to validate that the AIMS assessments were completed as scheduled. The audit identified one resident that was missing an assessment and it was completed immediately by the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 758	Continued From page 61 recommendation did not include a recommendation to complete an AIMS assessment. Record review revealed Resident #43 had never received an AIMS assessment. 2. Resident #20 was admitted to the facility on 06/25/21 with diagnoses that included psychosis, agitation, and combativeness. Review of the June, July, August, September, October, November, and December 2021 Medication Administration Records revealed Resident #20 received the following antipsychotic medication: Risperidone 0.5 MG at bedtime from 06/26/21 through 08/23/21 and Risperidone 0.25 MG at bedtime from 09/01/21 to present. Review of the monthly pharmacy recommendations revealed a recommendation had been provided to the facility in July 2021, August 2021 and September 2021 by the pharmacist for an AIMS assessment to be completed for Resident #20. Record review revealed Resident #20 had never received an AIMS assessment. In an interview conducted with Nurse #7 on 12/9/21 at 9:20 AM she stated she had retired from the position of Director of Nursing and was working part time at the facility to help out doing various jobs. She explained an AIMS assessment was due every time a Minimum Data Set Assessment (MDS) was completed for any resident who had received a psychotropic, antipsychotic, or hypnotic medication. She stated when a resident was admitted the staff member	F 758	To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on the expectation that any resident who is ordered an anti-psychotic medication must have an AIMS completed at least quarterly or with a significant change. This education was completed on 1/14/2022. Any licensed nurse that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. To monitor and maintain ongoing compliance, the Director of Nursing or designee will use the pharmacy review report done each month to monitor the AIMS assessments to validate they have been completed as scheduled. Monitoring will be done for 3 months. An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22. The Director of Nursing will report the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 758	Continued From page 62 who entered the physician orders would also select all the associated recurring assessments to be completed - like the AIMS assessment. She concluded if the person entering the physician orders did not select an associated assessment it would not be triggered by the computer. She noted once an assessment was triggered for a resident, every time the assessment was due the computer would show the name of the assessment in bold on the due date. She further stated if the assessment was past due it would show on the computer screen in red. She was not sure if there was a system in place to ensure the AIMS assessments were being triggered on admission and completed when required. In an interview conducted with the Director of Nursing on 12/09/21 at 12:30 PM he stated he was not familiar with the AIMS assessment or how often it was to be completed by nursing. In an interview with the facility pharmacist on 12/16/21 at 11:20 AM he stated it was important for the facility to complete an AIMS assessment for residents who were receiving an antipsychotic medication to help identify the presence of side effects such as tardive dyskinesia (abnormal involuntary movements) on admission to the facility and every six months thereafter. The presence of side effects would indicate a dose reduction or discontinuation of the medication was needed. He noted if the pharmacist recognized during monthly review that a required AIMS assessment had not been completed, a recommendation would be made to the facility to complete the assessment. He stated if the facility did not follow up on the pharmacy recommendation within thirty days, the pharmacy	F 758	results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 758	Continued From page 63 supervisor would be notified, and another recommendation would be issued to the facility.	F 758		
F 760 SS=H	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, Pharmacy Supervisor, Nurse Practitioner, and Physician interviews the facility failed to 1) complete and return a medication authorization form to the pharmacy regarding a medication order for Ampyra (prescribed for the treatment of symptoms related to Multiple Sclerosis) which resulted in the resident not receiving 26 doses of the medication and caused a decline in function. 2) the facility administered a muscle relaxing medication with a narcotic pain medication and did not wait the ordered one hour in between medication administration of the relaxing medication after giving a narcotic medication 30 out of 30 days during the month of November and 7 out of 7 days reviewed during the month of December, administered a scheduled morning muscle relaxing medication late and administered the medication along with the afternoon muscle relaxing medication 3 out of 30 days during the month of November, and; administered a sleep aide medication late 4 out of 30 days during the month of November and 2 out of 7 days reviewed in the month of December for 1 of 5 residents reviewed for unnecessary medications. (Resident # 42); and 3) the facility failed to follow manufacturer's instructions to not crush an extended release medication (Imdur) for	F 760	F 760 Significant Medication Errors Resident #42 had no somnolence documented related to this issue. This was documented by the surveyor on 12/7/21. The order was clarified with the physician. Resident # 66 is no longer living in the community. Resident #63 did not have any documented change in vital signs related to this issue. Current residents have the potential to be affected by these issues. Current pharmacy prior authorization information in the Omnicare website has been reviewed to ensure there is no outstanding form that has not been processed timely. This was completed on 1/25/22. Medication Administration Records have been reviewed to validate that there has been no missed dose of medication for any outstanding prior authorization form that has not been processed completely. This was completed on 1/25/22 An audit of missing mediations related to	1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 64	F 760		

2 of 5 residents (Resident #66 and #63) reviewed for medication administration.

Findings included.

Example #1

Resident #66 was admitted to the facility on 11/10/21. Her diagnoses included in part; Multiple Sclerosis, and muscle weakness.

A physician's order dated 11/10/21 revealed an order for Ampyra 10 milligram (mg) tablets extended release. Give one tablet by mouth two times a day for Multiple Sclerosis.

The Minimum Data Set (MDS) admission assessment dated 11/16/21 revealed Resident #66 had adequate vision and hearing with clear speech. She had mildly impaired cognition, and exhibited no behaviors and no rejection of care. She required extensive two-person assistance with bed mobility, transfers, and activities of daily living.

A care plan dated 11/18/21 revealed Resident #66 had a diagnosis of Multiple Sclerosis. The goal of care included in part; to administer medications as ordered, and monitor and document side effects and effectiveness.

A review of the Medication Administration Record (MAR) dated November 2021 for Resident #66 revealed Ampyra 10 milligrams was not documented as being administered twice a day from 11/10/21 - 11/23/21 per the physician's order resulting in 26 missed doses.

A progress note dated 12/03/21 by Nurse

---

the prior authorization forms has been completed for a 7 day look back period of 1/13/22 to 1/20/22. No medications were missed related to the outstanding prior authorizations.
An audit of sleeping aids given out of schedule has been completed for a 7 day look back period of 1/13/22 to 1/20/22 to review that notification was made to the physician and has been be validated. Any lack of notification was completed at that time.

Audits have been completed by the Director of Nursing or designee by 1/27/22

To prevent this from recurring, licensed nursing staff have been reeducated concerning:
-Medication Administration Documentation must be completed at the time of the administration of the medication
-The process for prior authorization forms from pharmacy for medications that have not yet been sent.
-Who to notify if there is a missing medication
-The expectation that physician orders will be followed as they are written
-How to identify if a medication that should not be crushed prior to administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 65 Practitioner #1 revealed in part; Resident #66 was seen today, stated she felt okay, denied pain, with no acute distress noted. Continue Ampyra. Was notified by nursing on 11/23/21 that the resident had not been receiving Ampyra since the resident's initial admission on 11/10/21. Ampyra was able to be obtained and was restarted on 11/24/21. A phone interview was conducted on 12/13/21 at 2:45 PM with Nurse Practitioner #1. He stated he could not say how much it affected Resident #66 by not receiving Ampyra. He stated the medication was prescribed for walking issues, and the medication did not stop the progression of Multiple Sclerosis. He stated he was not fully aware if Resident #66 had a decline in function, and stated he was not certain as to why she did not receive the Ampyra for that length of time. He stated he last evaluated Resident #66 on 12/06/21 and she seemed okay. An interview was conducted on 12/09/21 at 02:40 PM with Nursing Supervisor #1. She stated Nurse #10 had notified her that the medication (Ampyra) wasn't there, and pharmacy needed approval for it. She instructed Nurse #10 to call (the Senior Care Program that Resident #66 was affiliated with) to see if they could supply the medication and then call pharmacy. She stated the (Senior Care Program) informed the facility that they did not supply resident medications and the medication would need to come from the facility's pharmacy. Nursing Supervisor #1 reported another nurse checked on the medication again after the issue had not been resolved but the nursing supervisor could not recall which nurse it was and could not recall an exact date. She indicated she thought the issue had been	F 760	-The expectation that the physician be notified if a medication is unavailable, being given late/out of scheduled time, or if there is a change of condition of a resident. This education will be completed by on 1/27/22 by the Director of Nursing or designee. Any licensed staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. The Director of Nursing has been reeducated by the Regional Director of Clinical Services concerning the process for completing prior authorization for medications that had not been sent. This education was completed on 1/27/22 To monitor and maintain ongoing compliance, the Director of Nursing or designee will : Review the pharmacy prior authorization information in the Omnicare website to ensure that there is no outstanding prior authorization that has not been addressed. Review the administration record for the residents with sleep aids to ensure that they received within the scheduled time. These reviews will be documented 5 days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760 Continued From page 66

resolved after that time by the Director of Nursing (DON) or one of the nurses because she was not made aware of any issue after that. She stated she thought the DON handled authorization forms and indicated if a medication was missing the nurse would call the pharmacy regarding the medication and if the medication could not be obtained the physician should have been notified.

The admission nurse for Resident #66 on 11/10/21 was unavailable for interview.

An interview was conducted on 12/10/21 at 10:32 AM with Nurse #10. She stated Resident #66 was admitted to the facility due to diverticulitis and issues with mobility. She stated the resident was alert and oriented to person, place, and time, was wheelchair bound, and could communicate her needs. She stated the medication Ampyra had to have prior approval from the Administrator, and Pharmacy told her they sent the authorization form to the facility. She stated the medication authorization forms were sent to the DON or the ADON (Assistant Director of Nursing) for approval. Nurse #10 stated she called the (Senior Care Program) and asked them about supplying the medication and they said the facility needed to provide the medication. She stated she didn't recall Resident #66 having a decline in function during her time at the facility.

An interview was conducted on 12/10/21 at 11:17 AM with Nurse Aide #18. She stated Resident #66 was oriented to person, place, and time and could voice her needs. She stated at one point Resident #66 declined, but then she seemed better, then declined again with transfers. She stated the resident went from requiring two-person assistance with the mechanical lift for

F 760

a week for 4 weeks and then weekly for 8 weeks

Medication administration will be observed to validate that medications are being given according to physician orders.

This will be documented for 1 nurse a day for 5 days, then 4 nurses a week for 8 weeks.

.

An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22.

The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 67 transfers on admission and progressed to only needing two-person assistance to stand and pivot with transfers, then started needing the mechanical lift again. She stated therapy staff informed her that Resident #66 was back to needing the mechanical lift for transfers, but she could not recall the date. An interview was conducted on 12/10/21 at 11:25 AM with Nurse Aide #19. She stated on admission Resident #66 needed the mechanical lift with two-person assistance, then improved to needing one person assistance to stand and pivot for transferring, then suddenly declined to needing two-person assistance with transfers. She stated she could see a decline in Resident #66 while she was at the facility. She stated initially Resident #66 could stand with assistance long enough for the nurse aide to get some of her clothing on, then the nurse aide was off a few days and when she came back to work, she noticed Resident #66 had declined in function. She stated her orientation declined too, and her appetite decreased but the resident continued to be able to feed herself. An interview was conducted on 12/09/21 at 12:00 PM with the Pharmacy Supervisor. She stated the pharmacy tried to fill the medication Ampyra for Resident #66 a couple of times but Ampyra was not covered by the insurance they had on file. The pharmacy sent out a non-covered medication authorization form to the facility on 11/10/21, 11/18/21, and again on 11/23/21. She stated someone from the facility must have called about the medication on 11/18/21 and the non-covered form was faxed again but the form was not filled out by the facility with the needed insurance information. She stated someone from the facility	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 68	F 760		

called the pharmacy on 11/23/21 and the form was faxed again and was received back to the pharmacy on that day and the medication was sent to the facility the same day on 11/23/21. She stated sometimes the facility would have the pharmacy send a small supply while waiting on authorization forms therefore a small supply of Ampyra could have been sent for Resident #66. She stated Ampyra was indicated for patients with Multiple Sclerosis to improve walking and muscle strengthening. She stated without the medication Resident #66 could have had a decline in ADL (activities of daily living) function or quality of life but stated the medication didn't stop the disease from progressing. She indicated abruptly stopping the medication wouldn't cause an acute relapse.

A follow up phone interview was conducted on 12/13/21 at 11:30 AM with the Pharmacy Supervisor. She stated the medication went from 11/10/21 until 11/23/21 before pharmacy received the approval to dispense. She stated the facility could have had the medication within 24 hours after the pharmacy received the initial order if they had received the non-covered medication authorization.

An interview was conducted on 12/10/21 at 02:14 PM with the Director of Nursing. He stated the pharmacy called and made the facility aware that preauthorization was needed to fill the medication order, but he could not recall a date or the time frame when he was made aware of the medication issue. He indicated the resident went from 11/10/21 through 11/23/21 without receiving the Ampyra so any correspondence with pharmacy occurred during that time. He stated he wasn't sure why the authorization form was not followed through with, and stated no staff brought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 69 the non-covered medication authorization forms to him. He stated he had only worked at the facility for six months and indicated he was not certain of whose responsibility it was to fill out the authorization forms. He indicated he wasn't sure which fax the pharmacy used for correspondence with the facility but stated on 11/23/21 the pharmacy was given another fax number to use, and the authorization form was completed and returned to pharmacy and Resident #66 was administered Ampyra beginning 11/24/21. An interview was conducted on 12/10/21 at 3:22 PM with the Rehab Director. She stated Resident #66 received therapy services from 11/10/21 - 12/06/21. She stated Resident #66 required moderate assistance with transfers which meant 74% assistance was needed by staff with transfers. She stated initially Resident #66 was progressing, then she began a slow steady decline. She stated by 12/06/21 the resident required 75% with two-person assistance with transfers and was only able to walk 8 feet and required walking with the parallel bars with 75% assistance which was a decline. She stated Resident #66 was asked by therapy staff that day if she felt bad and stated the resident was not complaining of pain. She stated Resident #66 still tried to do as much as she could. She stated her last therapy session was on 12/06/21 and a stop/watch form was completed by therapy, which was a communication tool used to alert nursing that a concern was identified. A phone interview was conducted on 12/13/21 at 4:30 PM with the Corporate Nurse Consultant. He stated Resident #66 initially required the use of the parallel bars for walking then progressed to a rollator, then went back to needing the parallel	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 760	Continued From page 70	F 760		

bars but stated she never stopped ambulating. He stated she continued to be able to participate in therapy at some level. He stated the DON should have followed through with completing the medication authorization form and sending the form back to the pharmacy so that the order could have been filled. He indicated Resident #66 should not have gone 12 days without receiving the Ampyra.

A phone interview was conducted on 12/13/21 at 4:45 PM with the facility Physician. He stated he was not made aware that Resident #66 didn't have the medication Ampyra until (the Senior Care Program) reached out to him and he could not recall when exactly that was. He stated Resident #66 didn't receive the medication until the 12th or 13th day after her admission but stated he was not aware of why the medication was delayed. He stated she should have received the medication after her admission, she didn't, and it did cause a decline in function.

A phone interview was conducted on 12/16/21 at 12:07 PM with the Occupational Therapist from the (Senior Care Program). He stated their Nurse Practitioner was informed that Resident #66 had not received Ampyra for two weeks. He stated he was very familiar with Resident #66 and had provided rehab care to the resident for a long time. He stated prior to her hospitalization she was living home alone and was independent with ADL's (activities of daily living) and was admitted to the nursing facility for short term rehab with the expectation of going back to her apartment. He reported that when she was seen at (the Senior Care Program) during her time at the nursing facility he realized she was not making progress with therapy which was concerning to him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760		F 760		

Continued From page 71

Example #2

Resident #42 was admitted to the facility on 06/21/21. Diagnoses included, in part, chronic pain, osteoarthritis, gout, insomnia, and colon cancer.

The Minimum Data Set quarterly assessment dated 10/30/21 revealed Resident #42 was moderately cognitively aware and received 7 days of hypnotics and opioid medication.

Resident #42's care plan dated 10/30/21 revealed the resident had pain affecting his left shoulder with diagnosis of osteoarthritis, potential for flare up of gout. Interventions included, in part, to administer pharmacological interventions as indicated per physician and monitor the effectiveness.

Review of the physician ' s orders revealed to administer Tizanidine (a muscle relaxing medication) 4 milligrams (mg) give one tablet by mouth twice daily for pain; do not give within 1 hour of Percocet (a narcotic pain medication), and an order for Percocet 10/325 mg one tablet by mouth every 8 hours for chronic pain.

A review of the Medication Administration Record (MAR) for November 2021 and December 2021 revealed the muscle relaxing medication was to be given one hour after the narcotic pain medication was given and was scheduled at 8:00 AM and 1:00 PM. The narcotic pain medication was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM.

The Medication Administration Audit Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 72	F 760		

(MAAR) for the month of November and the first week of December (December 1 - 7) was reviewed. The report listed the name of the medication that was ordered by the physician, the time the medication was to be administered, the time the nurse removed the medication from the medication cart, the actual time the medication was administered, and the name of the nurse who administered the medication.

The MAAR for the month of November revealed the muscle relaxing medication was administered the same time as the narcotic pain medication 30 out of 30 days reviewed without waiting the prescribed hour in between medications by Nursing Supervisor (NS) #1, Nurse #2 and Nurse #3.

The MAAR for the first week in December revealed the muscle relaxing medication was given the same time as the narcotic pain medication 7 out of 7 days reviewed without waiting the prescribed hour in between medications by Nurse #2, and Nurse #3.
An observation of Resident #42 was conducted on 12/07/21 at 12:50 PM. Resident #42 was alert and oriented and was lying in bed and had no signs or symptoms of sedation.

An interview with Resident #42 was conducted on 12/07/21 at 12:50 PM. Resident #42 reported he was having pain in his shoulder and his foot and stated the nurse had medicated him for his pain a few hours ago. The resident stated he was not sleepy and he did not feel sedated. Resident #42 was conversing and eating his lunch.

a. An interview was conducted with Nursing Supervisor (NS) #1 on 12/08/21 at 11:10 AM. NS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 73	F 760		

#1 explained the columns on the Medication Administration Audit Reports and stated the 1st column was the name of the medication to be given, the 2nd column on the report was the time the medication was ordered to be given, the 3rd column was when the nurse clicked on the medication to be given in the computer system and took the medication out of the medication cart, and the 4th column was the time stamped after the administration of the medication to the resident. NS #1 confirmed that she had given the muscle relaxing medication and the narcotic pain medication to Resident #42 at the same time and added, "I must have missed the part of the order that said do not give within one hour of Percocet." NS #1 stated the medications should not have been entered in the computer system to be given at the same time since the order stated to wait one hour after giving the pain medication.

An interview was conducted with Nurse #2 on 12/09/21 at 10:15 AM. Nurse #2 confirmed she had been administering the muscle relaxing medication and the narcotic pain medication together during the month of November and December and stated she should have followed the physician order to wait one hour before administering the muscle relaxer after Resident #42 received the narcotic pain medication. Nurse #2 stated although they were written to give at the same time, nurses have a one-hour window before and after a medication was due and she should have waited the hour and administered the muscle relaxing medication at 9:00 AM.

An interview was conducted with Nurse #3 on 12/11/21 at 11:02 AM via phone. Nurse #3 stated she should have looked at the order more closely and did not realize the muscle relaxing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 74	F 760		

medication needed to be administered an hour after the narcotic pain medication.

b. A review of the MAR for November 2021 revealed the muscle relaxing medication was scheduled to be given at 8:00 AM and 1:00 PM.

The Medication Administration Audit Report (MAAR) for November revealed on 11/06/21 the muscle relaxing medication was ordered to be given at 8:00 AM and was administered late at 12:02 PM along with 1:00 PM dose by Nurse #2. On 11/12/21 the muscle relaxing medication was ordered to be given at 8:00 AM and was administered late along with the 1:00 PM dose at 1:21 PM by Nurse #2. On 11/14/21 the muscle relaxing medication was ordered to be given at 8:00 AM and was administered late along with the 1:00 PM dose at 12:18 PM by Nurse #3.

An interview with Nurse #2 on 12/09/21 at 10:15 AM stated when the muscle relaxing medication due at 8:00 AM was given 4-5 hours late on 11/6 and 11/12 (given at 12:02 PM and 1:21 PM), she should not have administered the 1:00 PM dose of the muscle relaxer to Resident #42 with it. Nurse #2 stated she should have called the physician to let him know the medications were being administered late and see what orders he would give.

An interview was conducted with Nurse #3 on 12/11/21 at 11:02 AM via phone. Nurse #3 confirmed she should not have administered the 1:00 PM dose of the muscle relaxer with the muscle relaxer that was due to be given at 8:00 AM on 11/14/21. Nurse #3 stated she "double dosed" the resident by giving both the 8:00 AM and 1:00 PM medication together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 75	F 760		

c. Review of the physician ' s orders revealed to administer Ambien (sleep aide) 5 milligrams (mg) one tablet by mouth at bedtime for insomnia.

Review of manufacturer ' s instructions for the administration of Ambien include, in part, "take medication before bed, and do not take the medication when your schedule does not permit you to get a full nights ' sleep (7-8 hours). Side effects include feeling drowsy and experiencing memory problems because the effects of the medication have not worn off."

A review of the Medication Administration Record (MAR) for November 2021 and December 2021 revealed the sleep aide medication was to be given at 11:00 PM each night.

The Medication Administration Audit Report (MAAR) for the month of November and the first week of December (December 1 - 7) was reviewed. The report listed the name of the medication that was ordered by the physician, the time the medication was to be administered, the time the nurse removed the medication from the medication cart, the actual time the medication was administered, and the name of the nurse who administered the medication.

The MAAR for the month of November revealed on 11/01/21 the sleep aide medication was ordered to be given at 11:00 PM and was administered at 2:57 AM on 11/02/21 by Nurse #1. On 11/02/21 the sleep aide medication was ordered to be given at 11:00 PM and was given at 4:11 AM on 11/03/21 by Nurse #1. On 11/13/21 the sleep aide medications was ordered to be given at 11:00 PM and was administered at 2:04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760		F 760		

Continued From page 76
AM on 11/13/21 by Nurse #6. On 11/27/21 the sleep aide medication was ordered to be given at 11:00 PM and was administered at 4:06 AM on 11/28/21 by Nurse #6.

The MAAR for the first week in December revealed on 12/02/21 the sleep aide medication was ordered to be given at 11:00 PM and was administered at 3:11 AM on 12/03/21 by Nurse #6. On 12/05/21 the sleep aide medication was ordered to be given at 11:00 PM and was administered at 4:00 AM on 12/06/21 by Nurse #1.

An observation of Resident #42 on 12/06/21 at 10:50 AM revealed an alert and oriented resident lying in bed. Resident #42 was awake and participated in conversation.

An interview with Resident #42 on 12/06/21 at 10:50 AM revealed the resident was sharing his likes and dislikes regarding his breakfast choices and stated that he was having pain to his shoulder and the nurse had medicated him.

An interview with Nurse #1 on 12/09/21 at 8:30 AM was conducted. Nurse #1 reviewed the MAAR report and explained what each column meant. She stated the 1st column was the name of the medication to be given, the 2nd column on the report was the time the medication was ordered to be given, the 3rd column was when the nurse took the medication out of the medication cart, and the 4th column was when the nurse returned from the resident's room after administering the medication. Nurse #1 confirmed the medications were given late on each of the dates in November and December, and added, she thought there may have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 760	Continued From page 77 some problems with the computer system shutting off in the middle of a medication pass so she would have had to sign them off as administered later on. An interview was conducted with Nurse #6 on 12/11/21 at 6:37 AM via phone. Nurse #6 stated if the time stamp stated that he gave the medication at 2:04 on 11/13/21 and 4:06 AM on 11/28/21 and at 3:11 AM on 12/02/21 then that was the time he administered the medication. Nurse #6 confirmed that each of those days the medication was late and he should have notified the physician before administering the medication. Nurse #6 could not recall any of the days or could not say why the medications were late. Nurse #6 stated he has never had the computer shut off in the middle of a medication pass. An interview was conducted with the Nurse Practioner (NP) on 12/13/21 at 11:51 AM. The NP stated he would have expected the nurses to follow the orders as written by the provider and would expect the nurses to notify him before administering medications that were late. The NP stated giving the ordered 8:00 AM dose with the 1:00 PM dose was double dosing and he would expect nurses not to administer the 8:00 AM late medication, but to call him for new orders. The NP stated he would have also expected the nurses to follow the physicians order with the sleep aide and administer it at 11:00 PM as ordered and not 3 or more hours later. The NP stated giving a sleep aide that late into the morning could cause the resident somnolence during the day.	F 760		

F 760 Continued From page 78 F 760

Example #3

Resident #63 was admitted to the facility 12/31/15 with diagnoses that included coronary artery disease, history of myocardial infarction (heart attack) with stent placement, and chronic pain.

Review of the Pharmacy Consultation Report for 10/15/21 indicated Resident #63 had an order to crush mediations and received medications that were not recommended to be crushed per manufacturer's guidance. The medications that were not be crushed included MS Contin (an extended-release pain medication) and Imdur (an extended-release heart medication).

Review of the annual Minimum Data Set assessment dated 11/10/21 indicated Resident #63 was cognitively intact.

The care plan for Resident #63 dated 11/10/21 revealed he had a plan of care to remain free from complications related to altered cardiac status through next review. Interventions included, in part, to administer medications as directed by the physician and to monitor for chest pain.

Review of Resident #63's Medication Administration Record for 12/2021 revealed he had orders to include:
*Crush medications
* Imdur tablet extended-release 24-hour 60 mg one tablet by mouth daily (heart medication)
* MS Contin tablet extended release 15 mg (Morphine Sulphate ER-pain medication) tablet by mouth twice a day.

An interview and observation was conducted on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 79	F 760		

12/09/21 at 11:10 AM with Nurse #5. She stated the only medication she did not crush for Resident #63 was the MS Contin because it was extended release. Nurse #5 further stated she was unaware Imdur was also extended release. She removed the Imdur medication package from the medication cart and on the right side at the top of the blister pack was written DO NOT CRUSH. Nurse #5 stated Resident #63 could swallow his medications whole but he didn't like how they tasted. She stated the resident preferred the medications crushed with applesauce.

A telephone interview was conducted on 12/09/21 at 12:00 PM with the Pharmacy Supervisor. She stated that Imdur should definitely not be crushed because it was an extended-release medication. She further stated that crushing Imdur would cause all the nitrates to be released in a short period of time and this could cause the heart rate to not be controlled correctly and the blood pressure could drop.

An interview was conducted on 12/09/21 at 1:48 PM with the Nurse Practitioner (NP) #1. He stated Imdur was an extended release heart medication and should not be crushed. He further stated that crushing Imdur was concerning because it could slow the heart rate and cause hypotension (low blood pressure). NP#1 indicated that crushing Imdur had the potential to cause serious harm to the resident.

Interview with the Director of Nursing (DON) was conducted on 12/09/21 at 12:55 PM. He stated crushing Imdur could cause serious adverse reactions. He further stated the nurses should look at the medication package prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 760	Continued From page 80 administering a medication. He indicated he expected the nurses not to crush medications that should not be crushed.	F 760		
F 835 SS=H	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide effective oversight to ensure a system was in place to 1) complete and return non covered medication authorization forms to the pharmacy to prevent a delay in receiving medications (Resident #66). 2) act upon pharmacy recommendations contained in the monthly Consultant Pharmacist's Medication Regimen Reviews for 5 of 5 residents (Residents #35, #20, #61, #19, #63) whose medications were reviewed. The findings included: 1)This tag is cross-referenced to: F760 H: Based on record review, staff interviews, Pharmacy Supervisor, Nurse Practitioner, and Physician interviews the facility failed to complete and return a medication authorization form to the pharmacy regarding a medication order for Ampyra (prescribed for the treatment of symptoms related to Multiple Sclerosis) which resulted in the resident not receiving 26 doses of	F 835	F 835 Administration Resident # 66 was assessed by the provider on 11/19//2021 and there were no negative findings due to the medication not being administered. Residents # 35, 20, 61, 19, and 63 suffered no harm as a result of the pharmacy recommendations not being completed. To identify other residents that have the potential to be affected, an audit was performed on any current medications needing authorization to validate there were not outstanding authorizations needing approval. This was completed by the Regional Director of Clinical Services on 1/25/2022 with no negative findings. An audit of Pharmacy Recommendations for December 2021 was performed by the Regional Director of Clinical Services on 12/7/2021 to validate they were addressed by the Medical Provider and	1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 835	Continued From page 81 the medication and caused a decline in function for 1 of 5 residents (Resident #66) reviewed for medication administration. An interview was conducted on 12/10/21 at 02:14 PM with the Director of Nursing (DON). He stated he wasn't sure why the authorization form was not followed through with, and stated no staff brought the non-covered medication authorization forms to him. He stated he had only worked at the facility for six months and indicated he was not certain of whose responsibility it was to fill out the authorization forms. He indicated he wasn't sure which fax the pharmacy used for correspondence with the facility but stated on 11/23/21 the pharmacy was given another fax number to use, and the authorization form was completed and returned to the pharmacy. A phone interview was conducted on 12/13/21 at 4:30 PM with the Corporate Nurse Consultant. He stated the DON should have followed through with completing the medication authorization form and sending the form back to the pharmacy so that the order could have been filled. 2)This tag is cross-referenced to: F756 E: Based on record review, staff, Consultant Pharmacist, and Physician interviews the facility failed to act upon the recommendations contained in the monthly Consultant Pharmacist's Medication Regimen Review (MRR) for 5 of 5 residents (Resident #35, #20, #61, #19, #63) whose medications were reviewed. An interview was conducted on 12/07/21 at 2:00 PM with the Administrator along with the	F 835	noted in the residents medical record. There were no negative findings. To prevent this from recurring, the Regional Director of Clinical Services/designee educated the Director of Nursing and the Administrator on the procedure for addressing monthly pharmacy recommendations on 1/25/2022. The Regional Director of Clinical Services educated the Director of Nursing on the process for prior authorization on medications not covered by insurance. This education was completed on 1/25/2022. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor monthly pharmacy recommendations to validate the recommendations have been addressed on a timely manner. This audit will be done monthly for 3 months The Director of Nursing or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 835	Continued From page 82 Corporate Nurse Consultant. They each stated the monthly pharmacy MRR reports had not been acted on and not scanned into the medical records since the Director of Nursing (DON) started working in the facility in July 2021. The Corporate Nurse Consultant stated the DON was trained upon hire on the process regarding the MRR reports, which was to notify the providers of the MRR recommendations provided by the Consultant Pharmacist immediately once the reports were received in the facility so they could be addressed. The Administrator stated he had spoken to the DON regarding acting on MRR recommendations, but he did not provide a specific date as to when that was. An interview was conducted on 12/09/21 at 1:00 PM with the DON. He stated he was not aware that he was supposed to do anything with the monthly pharmacy MRR reports. He stated he started working at the facility in July 2021 and thought the unit manager was supposed to follow up with the pharmacy recommendations and forward them to the providers. He stated he wasn't aware until now that it was his responsibility. He reported no one had spoken to him regarding his responsibility to act on MRR reports.	F 835	audit medications needing prior authorization from the pharmacy weekly to validate no there were no missed doses related to time of processing the prior authorization of medications. This audit will be done weekly for 12 weeks. An ad hoc meeting for review, recommendations, and acceptance was held on 1-27-22. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842	Continued From page 83 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842	Continued From page 84 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practioner and Physician interviews, the facility failed to; 1) accurately document neurological assessment data to include current vital signs with each neurological check assessment recorded, failed to document neurological check assessments that had reportedly been done, and inaccurately documented neurological check assessments as completed including strength of hand grasps and range of motion of all extremities for 1 of 2 residents (Resident #11) observed; and 2) failed to accurately document the administration of a medication that was ordered but was not available in the facility for 1 of 2 Residents (Resident #66) observed. Findings included: A review of an incident report documented as	F 842	F 842 Resident #11 has shown no neurological changes since her fall. Resident #66 is no longer living in this community. To identify other residents that have the potential to be affected, an audit of medications ordered compared to medications available has been completed by the pharmacist. This audit showed no missing medications in the medication carts. The audit was completed by the pharmacist on 1/12/22. Residents who have been assigned neurological assessments are at risk for this issue. Those residents will have the documentation reviewed to ensure it is complete. The identified residents did not have missing information in their neurological	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842	Continued From page 85 completed by Nurse Supervisor (NS) #2 on 11/11/21 at 3:10 AM revealed "Nursing Aide (NA) [#1] and Patient Care Assistant (PCA) [#1] informed Nurse [#1] at 3:10 AM resident was observed on the floor in her room with her head under the sink in a fetal position with walker lying over her lower legs and her wheelchair facing her. The NA discovered resident on the floor at 3:10 AM and got help from the PCA. Due to uncomfortable position, the NA and PCA lifted Resident #11 back to wheelchair and then informed nurse." 1a. Review of the neurological (neuro) check assessments for Resident #11 beginning on 11/11/21 at 3:10 AM which were recorded in the facilities ' computer system revealed at 3:10 AM vital signs (VS) were recorded as blood pressure (BP) 114/72, respiration rate (RR) 18 breaths per minute (bpm), and heartrate (HR) was recorded as 72 beats per minutes (bpm) at 3:10 AM. The neuro checks were documented by Nurse #1 in the computer system every 15 minutes X 4 for 1 hour (3:00 AM, 3:15 AM, 3:30 AM, and 4:00 AM), every 30 minutes for 2 hours (4:30 AM, 5:00 AM, 5:30 AM, 6:00 AM), and every 1-hour X 2 (7:00 AM and 8:00 AM). Each VS recording for these assessments were recorded as BP 114/72, RR 18 bpm, and HR 72 bpm with the time recorded for each assessment as 3:10 AM and the date stamp of 11/11/21. An interview with Nurse #1 who worked 7:00 PM to 7:00 AM on 11/11/21 was conducted on 12/09/21 at 8:30 AM. Nurse #1 stated whenever a resident had an unwitnessed fall, the staff needed to determine if the resident hit their head and if the resident could not say, nursing would start doing neurological (neuro) checks including	F 842	assessments. Completed by the Director of Nursing or designee by 1/25/22 To prevent this from recurring, the licensed nursing staff have been reeducated to only document medications as given if they were given. They have also been reeducated to complete each neurological assessment completely with new vital signs and new physical checks with each assessment. This education was completed by 1/27/22 by the Director of Nursing or designee. Any licensed staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review the documentation in the charts to identify any medication that is not available. The medication administration record will be reviewed to validate that there is no documentation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842 Continued From page 86

an initial set of vital signs. Nurse #1 stated the neuro check assessments including VS should be done every 15 minutes for one hour, every 30 minutes for 2 hours, every hour for 4 hours, every 4 hours for 16 hours, and every 8 hours for 48 hours. Nurse #1 stated she should have obtained new VS with every neuro check assessment.

b. Review of the neuro check assessments for Resident #11 by Nurse #2 beginning on 11/12/21 at 9:00 AM hourly until 12:00 PM revealed the VS were recorded as BP 114/72, RR 18 (bpm), and HR 72 (bpm) at 3:10 AM with a time stamp of 11/11/21.

An interview with Nurse #2 who worked 7:00 AM to 7:00 PM was conducted on 11/12/21 via phone on 12/15/21 at 12:56 PM. Nurse #2 stated she did not always obtain current VS when she was doing her neuro checks for Resident #11 and the previous VS that were recorded auto populated in the computer system. Nurse #2 stated part of doing neuro check assessments was to obtain current VS with each assessment and it was important to recheck them with each assessment to make sure there was no significant change in condition in the resident.

c. Review of the neuro check assessments for Resident #11 by Nurse #6 on 11/12/21 at 10:00 PM and 2:00 AM revealed the VS were recorded as BP 114/72, RR 18 (bpm), and HR 72 (bpm) at 3:10 AM with a time stamp of 11/11/21.

An interview with Nurse #6 who worked 7:00 PM - 7:00 AM on 11/12/21 was conducted on 12/11/21 at 6:37 AM revealed he did not recall recording neuro check assessments including VS in the

F 842

the medication being given when it was not in the building. This will be identified by any medications waiting delivery related to prior authorizations.
The assigned residents with neurological assessments will be reviewed for completion. If there are any that are incomplete, a full assessment will be completed for that resident.

Monitoring will occur 5x weekly for 4 weeks, then weekly x 8 weeks.
This plan has been reviewed and recommendations have been made by an Ad hoc Quality Assessment committee meeting on 1/27/22.

The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842	Continued From page 87	F 842		

computer system for Resident #11.

d. Review of the neuro checks assessments for Resident #11 revealed there was no documentation in the computer system from NS #1 that the continued neuro check assessments which would have been for every 1-hour X 2 (9:00 AM and 10:00 AM) and every 4 hours X 2 (2:00 PM and 6:00 PM) during her shift on 11/11/21.

An interview with Nurse Supervisor (NS) #1 who worked 11/11/21 from 7:00 AM to 7:00 PM was conducted via phone on 12/13/21 at 8:33 AM. NS #1 stated she received in report from Nurse #1 Resident #11 had a fall around 3:00 AM but that Resident #11 was okay. NS #1 stated when she went in to see Resident #11 the morning of 11/11/21 to give the resident her medications, she assessed Resident #11 while she was sitting in her wheelchair by conducting passive range of motion to her upper and lower extremities and the resident had no signs or symptoms of pain. NS #1 stated she had done the neurological assessments; she just did not record the results in the computer system. NS #1 she should have documented her findings in the computer system to include current vital signs, hand grasps, pupil assessment and range of motion in the computer system to ensure the nursing staff were aware of all the assessments conducted to monitor for any change in condition.

e. Review of the neurological check assessments documented by Nurse #1 for Resident #11 beginning on 11/11/21 at 3:10 AM recorded in the facilities ' computer system revealed each assessment that was done from 3:10 AM through 8:00 AM indicated the hand grasps were equal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD** **WILMINGTON, NC 28412**

(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 842	Continued From page 88	F 842		

An interview with Nurse #1 was conducted on 12/09/21 at 8:30 AM. Nurse #1 stated she did not do neuro checks because Resident #11 could not follow the command to squeeze her hands to check for equal strength on each side or the command to push down on her legs to check for equal strength on each side.

f. Review of the neuro check assessments for Resident #11 by Nurse #2 beginning on 11/12/21 at 9:00 AM hourly until 12:00 PM revealed hand grasps were equal and resident moved extremities (range of motion) equally.

An Interview with Nurse #2 on 12/10/21 at 10:15 AM revealed on 11/12/21 when she arrived for her shift, she was not made aware Resident #11 had a fall and stated that she did not assess Resident #11. Nurse #2 stated part of doing neuro check assessments was to check the resident ' s hand grasps and range of motion of all extremities. Nurse #2 stated she did do some of the neuro checks but added she did not always check hand grasps and the range of motion of the extremities and she should not have documented that she assessed hand grasps and range of motion of the extremities.

g. Review of the neuro check assessments for Resident #11 by Nurse #6 on 11/12/21 at 10:00 PM and 2:00 AM revealed Resident #11 was able to verbalize needs and obeyed commands, moved all extremities equally and hand grasps were equal.

An interview with Nurse #6 on 12/11/21 at 6:37 AM revealed he received in report from Nurse #2 Resident #11 had a fall with no injury. Nurse #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 842	Continued From page 89	F 842		

Continued From page 89

stated he did not perform range of motion or check hand grasps on Resident #11 because he was told Resident #11 was fine after her fall. Nurse #6 stated he did not recall recording neuro check assessments in the computer system for Resident #11.

2.) Resident #66 was admitted to the facility on 11/10/21. Her diagnoses included in part; Multiple Sclerosis.

A physician's order dated 11/10/21 revealed an order for Ampyra 10 milligram (mg) tablets extended release give one table by mouth two times a day for Multiple Sclerosis.

A review of the Medication Administration Record (MAR) dated November 2021 revealed Ampyra 10 milligrams was scheduled for administration at 9:00 AM and 9:00 PM with a start date of 11/10/21. Ampyra was signed off by Nurse #10 as administered to Resident #66 at 9:00 AM on 11/13/21 and at 9:00 AM on 11/16/21. Ampyra was signed off by Nurse #5 as administered at 9:00 AM on 11/21/21. Ampyra was signed off by Nurse #12 as administered at 9:00 PM on 11/22/21.

A progress note dated 12/03/21 by Nurse Practitioner #1 revealed in part; Resident #66 was seen today. Was notified by nursing on 11/23/21 that the resident had not been receiving Ampyra since the resident's initial admission on 11/10/21. Ampyra was able to be obtained and was restarted on 11/24/21.

An interview was conducted on 12/10/21 at 10:32 AM with Nurse #10. She stated Ampyra had to have prior approval from the Administrator due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING ______ B. WING ______	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

(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 842	Continued From page 90	F 842		

Continued From page 90

the cost. She stated when she signed off that the medication was administered to Resident #66 on 11/13/21 and 11/16/21 it was done in error because they didn't have Ampyra in the facility on those dates.

A phone interview was conducted on 12/13/21 at 5:52 PM with Nurse #5. She stated she recalled taking care of Resident #66 and remembered an issue with Ampyra. She stated she thought she gave the Ampyra but wasn't sure. She indicated if she signed off on the MAR that Ampyra was administered, and the medication wasn't in the facility then it was signed in error.

A phone interview was conducted on 12/13/21 06:41 PM with Nurse #12. She stated she recalled signing off on the MAR several times that Ampyra was not administered, but she must have checked off that it was administered on 11/22/21. She stated she didn't give Ampyra on that date because it was not in the facility.

A phone interview was conducted on 12/16/21 at 11:09 AM with the Director of Nursing. He stated Ampyra should not have been signed off on the MAR as administered by the nurse because the medication was not in the facility on those dates. He stated he expected staff to document accurately on the MAR.