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 03/02/2023

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	INITIAL COMMENTS An unannounced complaint investigation was conducted 03/01/23 through 03/02/23. One of the three complaint allegations resulted in a deficiency. Event ID# YBP211.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide incontinence care to 2 of 2 dependent residents (Resident #1 and #2) reviewed for assistance with activities of daily living (ADLs). Findings included. 1.) Resident #1 was admitted to the facility on 11/14/22 with diagnoses including leukemia, anemia, cognitive communication deficit, and chronic kidney disease. A care plan dated 11/22/22 revealed Resident #1 was incontinent of bladder. The goal of care was to receive assistance with toileting, to remain comfortable, clean, and dry, and free from skin breakdown. Interventions included to monitor the perineal area for redness and irritation and provide incontinence care as needed. The Minimum Data Set (MDS) quarterly assessment dated 01/17/23 revealed Resident #1 had moderately impaired cognition. She was	F 677	Resident #1 was discharged from the facility on 3/7/2023. Resident #2 was assessed on 3/11/2023 by the Director of Nursing. No redness or skin breakdown noted. All incontinent residents in the facility will be assessed by the Director of Nursing or designee by 3/19/2023. All residents with new redness or impaired skin integrity will be reported to the provider once identified. Education will be provided by the Director of Nurses or Designee to all clinical care staff on ensuring care is provided based on the needs of each individual resident. Care is to be provided to prevent redness and moisture associated skin issues and is based on the needs of each resident. If staff are unable to meet the needs of the residents they should request help from a member of nursing management. Education will be provided by the Director of Nursing or designee by 3/19/2023	3/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2023

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.

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	345507	A. BUILDING ______ B. WING ______	C 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 1 incontinent of bowel and bladder and required extensive one person assistance with transfers and activities of daily living (ADLs). An interview was conducted on 03/01/23 at 11:20 AM with Nurse Aide #1. She stated she was the assigned nurse aide for Resident #1 and arrived for her shift at 7:00 AM and was scheduled to work until 3:00 PM today. She stated she provided one round of incontinence care to all residents on her assignment since she started her shift at 7:00 AM. She stated Resident #1 was oriented to person only and had difficulty voicing her needs. She stated she provided incontinence care once to Resident #1 earlier around 9:00 AM. Continuous observations conducted on 03/01/23 from 11:20 AM until 2:00 PM of the 600 hallway which included Resident #1's room revealed there was no incontinence care provided to Resident #1 during that time. A strong urine smell was noted in the hallway. A follow up interview was conducted with Nurse Aide #1 on 03/01/23 at 2:00 PM. She stated she had 12 residents on her assignment which was a typical assignment, and stated the workload was manageable and she was able to provide care to the residents and get her work done by the end of her shift. She stated she had 2 residents to provide incontinence care to, Resident #1 and Resident #2, before her shift ended at 3:00 PM. She stated she last provided incontinence care to Resident #1 around 9:00 AM. An observation of incontinence care was conducted on 03/01/23 at 2:45 PM with Nurse Aide #1 along with Nurse Aide #3. Resident #1 was resting in bed and was alert to person only.	F 677	Director of Nursing or designee will conduct rounds 5x week for 4 weeks, 3x week for 4 weeks and 1x week for 4 weeks auditing 5 incontinent residents ensuring that care is being provided timely and there are no new areas of skin irritation related to the frequency of incontinent care. Audits will be reviewed weekly in resident review and monthly in QA meeting. The Quality Assurance Performance Improvement committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 677	Continued From page 2	F 677		

The brief was saturated with urine and a large amount of soft brown stool, and dried stool was noted on Resident #1's buttocks and posterior leg. The skin on her buttocks and perineum was intact with bilateral redness noted on the perineal area and on and between the buttocks. Barrier cream was applied.

During a follow up interview conducted with Nurse Aide #1 on 03/01/23 at 3:00 PM she stated she did not notice the redness on Resident #1's buttocks and perineal area when she did her incontinence care at 9:00 AM this morning, and stated she received barrier cream with each incontinence episode. She stated she typically provided a round of incontinence care to residents that required assistance with care shortly after arriving for her shift. She stated after one round of incontinence care was done breakfast usually arrived on the hall, then after breakfast she would provide baths or showers and assist residents with getting up and dressed. She stated by that time lunch would arrive on the hall, and she would assist with lunch then after lunch she would provide another round of incontinence care. She stated some residents required more frequent incontinence care and those residents would receive incontinence care as needed otherwise she typically provided incontinence care twice per shift. She stated she had not checked Resident #1 for incontinence since she last provided her care at 9:00 AM this morning. She stated there was not enough time to provide incontinence care every 2 hours to all of the incontinent residents.

2.) Resident #2 was admitted to the facility on 08/30/19 with diagnoses including

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 03/02/2023

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

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F 677	Continued From page 3	F 677		

Non-Alzheimer's dementia, and heart disease.

A care plan dated 09/19/22 revealed Resident #2 was incontinent of bladder. The goal of care was to receive assistance with toileting, to remain comfortable, clean, and dry, and free from skin breakdown. Interventions included to monitor for redness and irritation and provide incontinence care as needed.

The Minimum Data Set (MDS) quarterly assessment dated 12/31/22 revealed Resident #2 was severely cognitively impaired. He was incontinent of bowel and bladder and required one-to-two-person assistance with activities of daily living (ADLs).

During an interview with Nurse Aide #1 on 03/01/23 at 2:00 PM she stated she needed to provided incontinence care to Resident #2 and stated she had provided incontinence care once to Resident #2 this shift which was at 10:00 AM this morning.

An incontinence care observation was conducted on 03/01/23 at 2:15 PM with Nurse Aide #1 along with Nurse Aide #2. Resident #2 was disoriented and could not adequately voice his needs. A strong urine odor was noted in the resident's room. Incontinence care was provided to Resident #2, his skin was intact, with no redness observed, and the brief was heavily saturated with urine. Nurse Aide #2 stated the residents brief was usually saturated with urine when they did his care.

An interview was conducted on 03/02/23 at 4:15 PM with the unit manager. She stated there was

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	345507	A. BUILDING ______ B. WING ______	C 03/02/2023

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

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F 677	Continued From page 4 no set time to provide incontinence care but all incontinent residents should be checked on at least every 2 hours and provided care if needed at that time. The unit manager stated nurse aides were educated on providing incontinence care every two hours. During an interview on 03/02/23 at 5:00 PM with the unit manager, along with the Regional Nurse Consultant and the Administrator they each acknowledged that Resident #1 should not have gone from 9:00 AM until 2:45 PM without being provided incontinence care. The unit manager indicated Resident #1 and #2 required every two hour incontinence care. The Regional Nurse Consultant and the Administrator stated education would be provided to the nurse aide.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner interviews the facility failed to	F 686	Resident #1 no longer resides in the facility.	3/21/23

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	345507	A. BUILDING ______ B. WING ______	C 03/02/2023

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F 686 Continued From page 5

perform daily wound care treatments on an unstageable right heel pressure wound according to the physician's order for 1 of 1 resident (Resident #1) reviewed for wound care.

Findings included.

Resident #1 was admitted to the facility on 11/14/22 with diagnoses including leukemia, anemia, cognitive communication deficit, and chronic kidney disease.

The Minimum Data Set (MDS) admission assessment dated 11/21/22 revealed Resident #1 had moderately impaired cognition. She required extensive one person assistance with transfers and activities of daily living (ADLs). There were no pressure wounds on admission.

A care plan dated 01/16/23 revealed Resident #1 was at risk of skin breakdown related to impaired mobility. The goal of care was the pressure ulcer, skin breakdown, or injury would show signs of healing as evidenced by decreased size and depth by the next review. Interventions included in part; to administer medications and treatments as ordered.

A weekly skin assessment dated 02/24/23 documented by the unit manager revealed an unstageable right heel wound measuring 3.5 cm (centimeters) x 6.8 cm, the area was in house acquired. The physician and the Responsible Party (RP) were notified.

A progress note documented by the Nurse Practitioner dated 02/24/23 at 2:19 PM revealed in part; Resident #1 was seen today at the request of nursing staff for evaluation of a right

F 686

All orders were reviewed by the Director of Nursing on 3/17/2023 to ensure all wound care orders were on the Treatment Administration Record. All residents with current treatment orders will be assessed by 3/19/2023.

Education will be provided by the Director of Nursing or designee to all nurses on ensuring wound care orders are entered into the TAR and not the MAR by the Director of Nursing or designee by 3/19/2023.

All orders will be reviewed in the Clinical Morning Meeting for 12 weeks to ensure any newly entered wound care orders are appropriately placed into the Treatment Administration Record. Any orders placed on the MAR will be updated and moved to TAR. Re-education will be completed with the nurse that confirmed or entered the order. Additionally, the DON or designee will spot check 5 wounds 3x a week for 12 weeks to ensure treatments are being completed according to the physician□s order. All audits will be reviewed weekly in resident review and monthly in Quality Assurance Performance Improvement meeting. The QA team may change the plan of correction or extend the audits to ensure ongoing compliance.

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 03/02/2023

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F 686	Continued From page 6	F 686		

heel wound. Resident #1 endorsed pain with movement of right leg and pain to right heel. Visually inspected a large unstageable wound to the right heel that was open and malodorous with moderate serosanguinous drainage. Orders placed for soft heel lift boots and to cover wound in a dry 4x4 gauze and kerlex gauze. Maintain the site clean and dry. Optimize comfort measures, resident is receiving Hospice services.

A physician's order dated 02/24/23 for Resident #1 revealed to cover the right heel wound with one 4x4 gauze, then wrap with Kerlix dry gauze (provides fast wicking action, aeration and absorbency, and reduces the risk of maceration). Keep the wound clean and dry. Once daily to the right heel wound.

Review of Resident #1's Medication Administration Record (MAR) dated February 2023 revealed the right heel wound dressing change was administered by Nurse #1 on 02/25/23 and 02/26/23, and administered by Nurse #2 on 02/27/23, and 02/28/23. Nurse #1 also signed off on the MAR on 03/01/23 at 9:00 AM that the daily dressing change was administered.

During an interview on 03/01/23 at 3:15 PM with Nurse #1 she stated Resident #1 received daily dressing changes to her right heel. She stated she had changed the dressing to Resident #1's right heel wound earlier today, and applied a new dressing. She stated the wound had some drainage with edema that she observed this morning during the dressing change.

A wound care observation was conducted on 03/01/23 at 3:25 PM with Nurse #1. Resident #1

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F 686		F 686		

Continued From page 7

was resting in bed with no signs of distress. Upon observation a soiled dressing was in place to the right heel. The dressing was dated 2/26. The nurse observed that the dressing was dated 2/26 then stated she had not done the dressing change earlier today as she reported to the surveyor and documented on the MAR and stated her description was from her assessment of the wound on 2/26/23. The wound was observed with a moderate amount of serosanguinous (yellow with small amounts of blood) drainage from the wound and on the dressing, and on the residents bed linens. Nurse #1 cleaned the wound and applied the new dressing.

During an interview on 03/02/23 at 12:00 PM with the Nurse Practitioner she stated Resident #1 was ordered to receive daily dressing changes to the right heel wound. She stated Resident #1 was recently placed on Hospice services and daily dressing changes were ordered to optimize comfort and indicated the wound most likely would not resolve.

A phone interview was conducted on 03/02/23 at 1:00 PM with Nurse #2 who signed the MAR on 02/27/23 and 02/28/23 that the dressing change was administered to Resident #1. She stated she did not administer the heel wound treatments to Resident #1 on 02/27 or 02/28/23. She stated she was told that a designated nurse (Nurse #3) would be administering the wound treatments on those dates to all residents including Resident #1. She stated she inadvertently signed off on the MAR thinking the wound care would be done by Nurse #3. She indicated she did not verify that the wound care was done prior to the end of her shift on those dates.

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AUTUMN CARE OF MYRTLE GROVE	**5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412**

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F 686	Continued From page 8 An interview was conducted on 03/02/23 at 3:15 PM with Nurse #3. She stated she just started the role of wound care nurse this week on 02/27/23. She stated she did not administer Resident #1's heel wound treatment on 02/27 or 02/28/23. She stated she only reviewed the Treatment Administration Record (TAR) to identify who needed wound care and stated the wound order for Resident #1 was entered wrong and the order flowed to the MAR and not the TAR. She stated when she did treatments on 2/27/23 and 2/28/23 she did not see an order for dressing changes for Resident #1 on the TAR and did not administer any dressing changes. She stated she was informed yesterday by the unit manager and the error was corrected so that the wound treatment showed on the TAR. During an interview on 03/02/23 at 5:00 PM with the unit manager, along with the Regional Nurse Consultant and the Administrator, the unit manager stated the order was entered wrong in Resident #1's electronic medical record but it was corrected yesterday. They each indicated Resident #1 should have received daily dressing changes according to the physician orders.	F 686		
F 842 SS=D	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 except to the extent the facility itself is permitted to do so.	F 842		3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 9	F 842		

§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-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 10	F 842		

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 observations, record review, and staff interviews the facility failed to accurately document in the medical record the administration of wound treatments and a weekly skin assessment for 1 of 1 resident (Resident #1) reviewed for wound care.

Findings included.

Resident #1 was admitted to the facility on 11/14/22 with diagnoses including leukemia, anemia, cognitive communication deficit, and chronic kidney disease.

The Minimum Data Set (MDS) admission assessment dated 11/21/22 revealed Resident #1 had moderately impaired cognition. She required extensive one person assistance with transfers and activities of daily living (ADLs). There were no pressure wounds on admission.

Provider's Plan of Correction:

On 3/13/2023 nurse #2 corrected the Treatment Administration Record for 2/27/2023 and 2/28/2023 for resident #1. The weekly wound assessment that was completed by resident #4 on 2/28/2023 was struck out on 3/13/2023 by the Regional Director of Clinical Services. Resident #1 no longer resides in the facility.

All residents with wounds have the potential to be affected. All nurses that signed off on a treatment or completed a weekly wound assessment since 3/2/2023 were interviewed by 3/17/2023 to ensure their documentation was accurate and that the treatments and assessments were completed by them. No additional issues were identified.

Education was provided to all clinical staff

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 03/02/2023

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 11

A physician's order dated 02/24/23 for Resident #1 revealed to cover right heel wound with one 4x4 gauze, then wrap with Kerlix dry gauze (provides fast wicking action, aeration, and absorbency, and reduces the risk of maceration). Keep the wound clean and dry. Once daily to right heel wound.

Review of Resident #1's Medication Administration Record (MAR) dated February 2023 revealed the right heel wound dressing change was initialed as administered by Nurse #2 on 02/27/23, and 02/28/23 and administered by Nurse #1 on 03/01/23 at 9:00 AM.

A weekly skin assessment dated 02/28/23 for Resident #1 documented by Nurse #4 revealed an unstageable wound to right heel, measuring 3.5 cm (centimeters) x 6.8 cm. The area was in house acquired. The wound bed is red, no odor, peri-wound appearance is pink. The wound is improving. Pain level is zero. The family and Physician were notified.

During an interview on 03/01/23 at 3:15 PM with Nurse #1 she stated Resident #1 received daily dressing changes to her right heel. She stated she had no further treatments to provide to Resident #1 today because she had already changed the dressing to Resident #1's right heel wound earlier today and applied a new dressing. She stated the wound had some drainage with edema that she observed that morning when she did the dressing change.

A wound care observation was conducted on 03/01/23 at 3:25 PM with Nurse #1. Resident #1 was resting in bed with no signs of distress. Upon observation a soiled dressing was in place to the

F 842

on documentation accuracy by the Director of Nursing or designee by 3/19/2023. Staff should only document what they witnessed or completed themselves.

The DON or designee will spot check 5 wounds 3x a week for 12 weeks to ensure treatments are being completed according to the physician□s order and documented accurately in the electronic medical record. All weekly wound assessments will be completed by a nurse designated by the DON for 12 weeks. Any nurse, other than the designated individual, will be interviewed by the DON to ensure the documentation is accurate and the nurse assessed the wound prior to completed the wound assessment. All audits will be reviewed weekly in resident review and monthly in Quality Assurance Performance Improvement meeting. The QA team may change the plan of correction or extend the audits to ensure ongoing compliance.

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 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 12	F 842		

right heel. The dressing was dated 2/26. Nurse #1 observed that the dressing was dated 2/26 then stated she had not done the dressing change yet today and her description she reported was from her assessment of the wound on 2/26/23. She stated she should not have reported to the surveyor that she had completed Resident #1's wound care earlier today and should not have documented on the MAR at 9:00 AM that Resident #1's wound care had been done when it wasn't.

A phone interview was conducted on 03/02/23 at 1:00 PM with Nurse #2 who signed the MAR on 02/27/23 and 02/28/23 that the dressing change was administered to Resident #1. She stated she did not administer the heel wound treatments to Resident #1 on 02/27 or 02/28/23. She stated she was told that a designated nurse (Nurse #3) would be administering the wound treatments on those dates to all residents including Resident #1. She stated she inadvertently signed off on the MAR thinking the wound care would be done by Nurse #3. She indicated she did not verify that the wound care was done prior to the end of her shift on those dates. She stated she should not have signed the MAR without verifying that the wound care was done.

Several attempts were made to contact Nurse #4 who documented that she completed a skin assessment of the heel wound on 02/28/23 with no response.

During an interview conducted on 03/02/23 at 4:00 PM with the unit manager she stated Nurse #1 should not have reported or documented inaccurately on the MAR that she completed wound care for Resident #1 at 9:00 AM on

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F 842	Continued From page 13 03/01/23 when she had not done the dressing change. She stated Nurse #2 should not have signed the MAR indicating the wound treatment was done without verifying that it was done. She stated when conducting weekly wound assessments, the nurse should visibly assess the wound and accurately document the wound description. She indicated Nurse #4 should not have documented that a skin assessment was done on 02/28/23 without visibly assessing the wound. She indicated the 02/28/23 skin assessment was inaccurate as evidenced by the 02/26/23 date on the dressing that was observed on Resident #1 on 03/01/23. During an interview on 03/02/23 at 5:00 PM with the unit manager, along with the Regional Nurse Consultant and the Administrator, they each indicated that nursing staff should accurately document the care and treatments provided in the residents electronic medical record.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		3/21/23

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F 867	Continued From page 14	F 867		

are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

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F 867	Continued From page 15 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

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F 867	Continued From page 16 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification survey on 02/09/23, a recertification survey on 01/04/22, and a recertification survey on 03/05/20. This was for four deficiencies that were originally cited in the areas of providing treatment and services to prevent and heal pressure ulcers, Quality Assurance and Performance Improvement, resident records, and the provision of care for dependent residents. These areas were subsequently recited on the current complaint investigation survey on 03/02/23. The continued failure during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	F-667 ADL Care Provided for Dependent Residents - Resident #1 was discharged from the facility on 3/7/2023. Resident #2 was assessed on 3/11/2023 by the Unit Manager. No redness or skin breakdown noted. All incontinent residents in the facility will be assessed by the Director of Nursing or designee by 3/19/2023. All residents with new redness or impaired skin integrity will be reported to the provider immediately. F-686 Treatment/Svcs to Prevent/Heal Pressure Ulcer - Treatment order for Resident #1 was moved from the Medication Administration Record to the Treatment Administration Record on 3/1/2023 by the Regional Director of Clinical Services. All orders were reviewed by the Regional Director of Clinical Services on 3/13/2023 to ensure	

F 867

Continued From page 17

Findings included.

This tag is cross referenced to:

F686: Based on observations, record review, staff, and Nurse Practitioner interviews the facility failed to perform daily wound care treatments on an unstageable right heel pressure wound according to the physician's order for 1 of 1 resident (Resident #1) reviewed for wound care.

During the recertification survey completed on 02/09/23 the facility failed to implement new wound treatment orders prescribed by the wound care physician for 1 of 3 residents (Resident #62) reviewed for wound care.

F867: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification survey on 02/09/23, a recertification survey on 01/04/22, and a recertification survey on 03/05/20. This was for four deficiencies that were originally cited in the areas of providing treatment and services to prevent and heal pressure ulcers, Quality Assurance and Performance Improvement, resident records, and the provision of care for dependent residents. These areas were subsequently recited on the current complaint investigation survey on 03/02/23. The continued failure during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.

During the recertification survey completed on 02/09/23 the facility's Quality Assurance and

F 867

all wound care orders were on the Treatment Administration Record.
F-842 Resident Records-Identifiable Information - On 3/13/2023 nurse #2 corrected the Treatment Administration Record for 2/27/2023 and 2/28/2023 for resident #1. The weekly wound assessment that was completed by resident #4 on 2/28/2023 was struck out on 3/13/2023 by the Regional Director of Clinical Services. Resident #1 no longer resides in the facility. All residents with wounds have the potential to be affected. All nurses that signed off on a treatment or completed a weekly wound assessment since 3/2/2023 were interviewed by 3/17/2023 to ensure their documentation was accurate and that the treatments and assessments were completed by them. No additional issues were identified.
The facility administrator was educated by the Regional Director of Clinical Services on 3/15/2023 on Quality Assurance Performance Improvement program, Quality Assurance Fundamentals and the corrective actions for citations F667, F686 and F842.
To monitor ongoing Quality Assurance Performance Improvement, the Regional following Director of Clinical Services or the Regional Director of Operations will attend the monthly Quality Assurance Performance Improvement meeting to assure pertinent items are included and worked on monthly for 3 months.

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F 867	Continued From page 18	F 867		

Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey on 01/04/22, a complaint investigation on 07/29/22, a focused infection control survey on 02/17/21 and a recertification survey on 03/05/20. This was for 4 deficiencies that were originally cited in the areas of notification of changes, quality of care, labeling and storage of drugs and biologicals, and food storage, these areas were subsequently recited on the current recertification complaint investigation survey on 02/09/23. The continued failure during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.

F842:Based on observations, record review, and staff interviews the facility failed to accurately document in the medical record the administration of wound treatments and a weekly skin assessment for 1 of 1 resident (Resident #1) reviewed for wound care.

During the recertification survey on 01/04/22 the facility failed to 1) accurately document neurological assessment data to include current vital signs with each neurological assessment recorded, failed to document neurological assessments that had reportedly been done, and inaccurately documented neurological 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.

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F 867	Continued From page 19 F677: Based on observations, record review, and staff interviews the facility failed to provide incontinence care to 2 of 2 dependent residents (Resident #1 and #2) reviewed for assistance with activities of daily living (ADLs). During the recertification survey on 03/05/20 the facility failed to provide proper perineal care and failed to shave a resident's face for 2 of 3 residents observed for activities of daily living (ADL) care. (Resident #10 and Resident #50). An interview conducted on 03/02/23 at 5:00 PM with the Administrator, the Regional Nurse Consultant and unit manager revealed the previous wound care nurse recently retired and they recently designated a nurse to provide wound care, and also a new Nurse Practitioner entered an order wrong and stated more training was needed. The Regional Nurse Consultant stated the QAPI program was ineffective because they had not had time to implement their plan of correction before the new complaint investigation occurred. They each indicated more staff education was needed in the areas of wound care, documenting accurately in resident records and providing ADL care to residents. The Administrator stated the facility needed to improve systems currently in place including providing continued education.	F 867		