	-	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	IB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE SURVEY COMPLETED
		345507	B. WING				C 04/05/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE			WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 578 SS=D	CFR(s): 483.10(c)(6) §483.10(c)(6) The rig discontinue treatment to participate in experi formulate an advance	ht to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive.	F	578	8		5/1/18
	construed as the right the provision of medie	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	requirements specifie subpart I (Advance D (i) These requirement inform and provide we residents concerning medical or surgical tra- resident's option, form (ii) This includes a wr facility's policies to im and applicable State (iii) Facilities are perm entities to furnish this legally responsible for requirements of this s (iv) If an adult individue time of admission and information or articula has executed an adva may give advance dir individual's resident re- with State Law. (v) The facility is not r provide this information or she is able to receivant	is include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the plement advance directives law. nitted to contract with other information but are still r ensuring that the section are met. Ual is incapacitated at the d is unable to receive the whether or not he or she ance directive, the facility ective information to the epresentative in accordance relieved of its obligation to on to the individual once he ve such information.					
		must be in place to provide					
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/26/2018

PRINTED: 05/09/2018

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.

Electronically Signed

	MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	B. WING		C 04/05/2018
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
ARE OF MYRTLE GRO	VE			
SUMMARY ST	ATEMENT OF DEFICIENCIES			N (X5)
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
Continued From page	e 1	E 578		
the information to the individual directly at the				
This REQUIREMENT	is not met as evidenced			
-	iew and record review the		Process that led to deficiency cited:	
			Facility failed to update the electronic	:
÷				
status changed after admission to the nursing home. Findings included:	status.			
			Procedure for implementing plan of	
			correction:	
•	•			1
				n the
÷			electronic medical record to Advance	
	s of the vertebra, and		Directives Binder.	
hypertension.				
A 03/27/18 7:05 DM r	progress note documented		· · · ·	
resuscitate)Resider	nt signed consent for		updating Advance Directive/Code Sta	
	•		Monitoring procedure:	
documented, "Reside Resident is DNR."	ent has advanced directives.		Advance Directive/Code Status	
A 04/03/18 11:36 AM	social service progress note		medical record and Advance Directive	
			Binder to be completed for four week	
			starting 4-18-18 by the Medical Reco	rds
been reviewed and a	re located on the chart."			atue
On 04/03/18 at 3:18 F	PM review of Resident			
			medical record and Advance Directive	
			Binder to be completed for three mon	
			starting 5-9-19 by the Medical Record	ls
accumented her code	e status was "tull code".			will
	OVIDER OR SUPPLIER SARE OF MYRTLE GRO SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page the information to the appropriate time. This REQUIREMENT by: Based on staff interv facility failed to updat records with a change sampled residents (R status changed after home. Findings inclu Record review reveal admitted to the facility 03/27/18 with a full co documented diagnos- fibrosis, fracture of th compression fracture hypertension. A 03/27/18 7:05 PM p "Code Status: DNR (resuscitate)Resider treatment form and D On 03/28/18 Residen documented, "Resider Resident is DNR." A 04/03/18 11:36 AM documented, "ADVAN STATUS: Full Code. been reviewed and a On 04/03/18 at 3:18 F #138's electronic med resident's profile page medical administratio	OVIDER OR SUPPLIER CARE OF MYRTLE GROVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update its electronic medical records with a change in code status for 1 of 1 sampled residents (Resident #138) whose code status changed after admission to the nursing home. Findings included: Record review revealed Resident #138 was admitted to the facility from the hospital on 03/27/18 with a full code status. The resident's documented diagnoses included pulmonary fibrosis, fracture of the sacrum, multiple compression fractures of the vertebra, and hypertension. A 03/27/18 7:05 PM progress note documented, "Code Status: DNR (do not resuscitate)Resident signed consent for treatment form and DNR form." On 03/28/18 Resident #138's care plan documented, "Resident #138's care plan documented, "Resident #138's care plan	A BUILDING. 3445507 B. WING	345507 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STARE OF MYRTLE GROVE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID RECOMPTIONEY MUST DEPRECIENCIES PROEMER CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPROPH DEFICIENCY MUST DEPRECIENCIES Continued From page 1 F578 the information to the individual directly at the appropriate time. Process that led to deficiency cited: Tag This REQUIREMENT is not met as evidenced by: Process that led to deficiency cited: Tag Based on staff interview and record review the facility failed to update its electronic medical records with a change in code status for 1 of 1 sampled residents (Resident #138) whose code status change after admission to the nursing home. Findings included: Process that led to deficiency cited: Tag Record review revealed Resident #138 was admitted to the facility from the hospital on 032/718 with full code status. The resident's documented diagnoses included pulmonary fibrosis, fractures of the vertebra, and hypertension. Process that led to deficiency cited: treatment form and DNR form." On 03/2/18 11:36 AM social service progress note documented, "RoyANCED DIRECTIVE/CODE STATUS: Full Code. Advanced directives. Resident is DNR." Monitoring procedure for Urective/Code Status comparing current orders in electronic medical record and Advance Directive/Code Status comparing current orders in electronic medical record and Advan

Facility ID: 960602

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CENTER	S FOR MEDICARE &				OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345507	B. WING		04/05/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 578	On 04/03/18 at 3:37 F notebooks kept at the the presence of a req Resident #138 on 03/ status from full code to physician's order doc code status was DNF DNR sheet document on the resident's DNF On 04/04/18 at 4:12 F Development Coordin three places staff cou code status. She rep status notebook at ea e-MAR, and the elect commented nurses w needed to know a coo up the e-MAR or elect computers, but if were station they might loo notebook. On 04/04/18 at 4:32 F was a problem becau notebook documenta #138's code status w medical record it was	PM review of the code status e nursing stations revealed uest form signed by (27/18 to change her code to DNR, a 03/28/18 umenting the resident's R, and a 03/28/18 golden rod ting there was no expiration R status. PM Nurse #1 (the Staff hator) stated there were and quickly check a resident's orted there was a code ach nursing station, the ronic profile page. She vorking on the hall who de status would probably pull thronic profile page on their e sitting at the nurse's ik in the code status PM Nurse #2 stated there use in the code status tion showed Resident as DNR, but in the electronic	F 57	 be reviewed weekly/month Committee. Title of person responsible implementing plan of corrective Staff Development Nurse Medical Records Director Date when corrective action completed: 5-1-19 	e for ection:
	when staff reported R have stopped breathi in her computer quick the resident was full of resuscitation (CPR) n resident who did not initiated. Nurse #2 re Resident #138's orde	g medications on the hall Resident #138 appeared to ng, and the nurse checked kly where it was documented code, cardiopulmonary night be begun on the wish to have such measures sported the nurse who wrote r for a change in her code d the information in the			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/09/2018 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 05/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH R	OAD		
				WILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page electronic record.	93	F 57	8			
	(DON) stated residen hospital to the nursing admitted to the nursing status. She reported family members want after the residents have home for awhile. She was changed by obta the nurse who wrote to responsible for change electronic medical red she also reviewed the make sure the same of documented in writing the electronic record. why Resident #138's did not match the cod	ing the code status in the cord. According to the DON, code status notebooks to					
F 658 SS=D	resident's code status determine that would or look on the e-MAR reported it was import choices by making su up-to-date and accura status was document system and on paper	a nurse was passing all and needed to know a the fastest way to be to go to the profile page in her computer. She tant to honor resident re the code status was ate, and the same code ed in both the electronic	F 65	8			5/1/18
33-0	§483.21(b)(3) Compre						

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) D/	NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		OMPLETED
		345507	B. WING _			C 04/05/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, C	TTY, STATE, ZIP CODE	04/00/2010
				5725 CAROLINA BE		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page	o. 4	F6	50		
1 000			FC	58		
		d or arranged by the facility,				
	as outlined by the col must-	mprehensive care plan,				
	(i) Meet professional	standards of quality				
		Γ is not met as evidenced				
	by:					
	-	ons, physician interview,		F-658		
	resident interview, sta	aff interview, and record				
		ed to enter physician orders		Process that	led to deficiency cited:	
		dical system resulting in 1 of			to enter complete physician	
		(Resident #79) not receiving			ectronic medical record due	
	-	to promote eye health) and			ng the facilities triple audit	
		o promote healthy urine		-	ntering physician orders for	
		e continued from the hospital. d to apply compression		new admissio	to apply compression	
		ampled residents (Resident		-	per physician order due to	
	#64 and Resident #3				lidation by assigned nurse.	
		g application. Findings			induction by assigned hurse.	
	included:			Procedure for	r implementing plan of	
				correction:	Sector Se	
	1. A 03/12/18 hospita	al discharge summary		100% educati	ion for license nurses on	
		ity was to continue providing			be completed by facility Staff	
	Resident #79 with Flo	omax 0.8 milligrams (mg)			nurse starting 4-20-18 that	
	daily (QD) and Ocuvi	te one capsule QD.			nitial audit of signed	
					ers and hospital discharge	
		led Resident #79 was			nen a second audit that	
		y on 03/12/18 with diagnoses			udit of the electronic	
		prostatic hyperplasia (BPH)			ers and signed physician	
	and glaucoma.				astly a third audit that t of the electronic physician	
	Review of the facility'	s 03/12/18 handwritten			gned physician orders. 100%	
		vealed on the second page			admissions and return	
		ident #79 had physician			eginning on 4-5-18 for the	
		8 mg QD and Ocuvite 1			by Director of Nursing or	
	capsule QD.	-			ensure that the physician	
					ared to the hospital discharge	
		admission progress note		orders were t	ranscribed properly.	
		nt #79 was alert and oriented				
	v 3 was able to make	e his needs known, was		Physician ord	lers were reviewed and	

Facility ID: 960602

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DEPARTMENT OF HEA CENTERS FOR MEDIC						FOF	ED: 05/09/2018 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345507	B. WING			04	C 4/05/2018
NAME OF PROVIDER OR SUPP	LIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		F		57	725 CAROLINA BEACH ROAD		
AUTUMN CARE OF MYRT		E		W	/ILMINGTON, NC 28412		
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
fractures, and level on a sca "All orders app earlierPhan A 03/12/18 10 documented F glaucoma, wa daily, and was management. Review of Res record reveale physician orde review of his N electronic med (e-MARs) reve Flomax or Oct admission on On 04/04/18 a physician state negatively affe Flomax and O continued from resident was r control the oct glaucoma, and vitamin to pron the risk of not diagnosis was he reported th Resident #79 urination prob	d after a was hav le of 1 - proved by macy not :16 PM p Resident s suppos a receiving dication a ealed he did dication a ealed he uvite sind 03/12/18 tt 2:45 Pl ed the re ected due cuvite w n his hos ecciving ular pres d the Oci mote eye receiving the resid lems. tt 3:09 Pl	fall at home with multiple ing constant pain at a 5 10. y provider in house ified of admission." whysician progress note #79 had a diagnosis of sed to receive Ocuvite g Flomax for BPH 9's electronic medical not have electronic omax or Ocuvite, and 18 and April 2018 administration records had not received any ce his nursing home	F	658	clarified for 100% of residents with compression stockings. 100% of nursi department educated on validating us of compression socks as per physician orders starting on 4-3-18 by the Staff Development Nurse. Monitoring procedure: Audit of new admissions and return admissions beginning on 4-5-18 for th next 30 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital disch orders were transcribed properly. 100% audit of existing residents with physicians orders for compression soct to ensure compression socks were on ordered completed by the Staff Development Nurse on 4-5-18. Daily a of compliance with usage of compress socks as per physician orders starting 4-5-18 by Staff Development Nurse or designee for next 30 days. Results of audits will be reviewed wee beginning on 4-6-18 by the QAPI Committee. Weekly audit results will b reviewed in the May 2018 QAPI Committee Meeting. Title of person responsible for implementing plan of correction: Staff Development Nurse Director of Nursing Date when corrective action will be completed: 5-1-18	e arge ks audit ion on kly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 05/2018
NAME OF P	ROVIDER OR SUPPLIER		ł	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	it appeared to her tha handwritten physiciar medical record forgot the written orders. SH a three-point check sy accuracy of orders wi orders from the hospi second nurse entering electronic medical sys (usually herself or a u orders in the electron handwritten Admissio the nurse practitioner on-call physician revie Admission Orders and additions, or deletions into the electronic sys DON, if the reviewing want an order continu hospital they would w She reported she was check system for order Resident #79 not to re Ocuvite which had be On 04/04/18 at 3:45 F Resident #79 from 7:0 nurse hand transcribe discharge summary, s list to the physician of changes, entered or fo orders into the electron nurse from the next s third time for accurace On 04/05/18 at 10:25 was being dischargeo	t the nurse who entered the orders into the electronic to enter the second page of he explained the facility had ystem to ensure the th one nurse hand writing tal discharge summary, a g the orders into the stem, and a third nurse init manager) comparing the ic system against the n Orders. She commented (NP), primary physician, or ewed the handwritten d made any changes, s before they were entered stem. According to the physician or NP did not led or carried over from the rite a discontinue order. s unsure how the three-point er accuracy failed, causing eccive the Flomax and ten ordered. PM Nurse #2, who cared for 00 AM to 7:00 PM, stated a ed orders from the hospital submitted the handwritten r NP for review and had another nurse enter the onic system, and then a hift reviewed the orders a y. AM Resident #79 stated he	F	658			

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345507	B. WING				/05/2018	
NAME OF P	ROVIDER OR SUPPLIER		ł	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 658	while he was in the fareceived his Flomax a commented his prefer receive the Flomax at he would continue to home because they w However, he commer any eye problems or urination while residin 2. a. Resident #64 w 02/02/18. The reside included cerebrovasc hemiplegia/aphasia/d chronic atrial fibrillatio The resident's 02/09/ set (MDS) documente was moderately impa- behaviors including re required extensive as activities of daily living A 03/23/18 physician documented, "Apply" stockings to both legs Remove TED stockin Review of the resider administration record AM on 04/03/18 Nurs "appl(ied) TED stocki morning for edema Al OOB (out of bed)". (M made to interview Nu returned the message On 04/03/18 at 3:48 F	acility and that he had not and Ocuvite. The resident rence would have been to and Ocuvite in the facility, and take these medications at vere important to him. Inted he had not experienced increased problems with ag in the nursing home. Was admitted to the facility on nt's documented diagnoses ular accident (CVA) with ysphagia/gastrostomy, on, and hypertension. 18 admission minimum data ed the resident's cognition ired, he exhibited no esistance to care, and he esistance from staff with his g (ADLs). order for Resident #64 TED (compression) s every morning and gs to both legs at bedtime." It's April 2018 medication (MAR) documented at 6:00 e #5 initialed that he had ngs to both legs every PPLY BEFORE GETTING Multiple phone calls were	F	658				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/09/2018 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 05/2018
NAME OF PI	ROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD		
					/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	8	F 6	58			
	socks, and tennis sho have compression sto	bes on. The resident did not ockings on.					
	sitting up in his wheel	PM Resident #64 was still chair with shorts, athletic nis shoes on. The resident sion stockings on.					
		PM nursing assistant (NA) #64's room, and closed the					
	not assigned to care f asked to re-apply the stockings because the	PM NA #1 stated she was for Resident #64, but was resident's compression ey had been soiled earlier in had gotten around to putting the resident yet.					
	Resident #64 had his earlier in the day, but when they put the res They reported they ha	PM NA #2 and NA #3 stated compression stockings on they had removed them ident back to bed for a nap. ad forgotten to reapply them, is room were the same on earlier in the day.					
	could not remember w compression stocking shift earlier in the mor resident wore them for supposed to be put of mornings before he g before the resident wa	PM Nurse #4 stated she whether Resident #64 had us on when she began her rning. She reported the or edema, and they were in the resident in the ot out of bed and removed as put to bed at night. PM the Director of Nursing					
	(DON) stated it was h	er expectation that if a ian order for compression					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C 105/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	stockings that they be residents did not have when they were in be were put to bed at nig re-applied when the s from shorter stays in On 04/04/18 at 3:45 F a nurse, usually appl compression stocking also apply and remov before she signed off were applied on the N	e applied daily. She reported e to wear the stockings d, but unless the residents ght, the stockings should be staff got the residents up bed such as naps. PM Nurse #1 stated she, as	F	658			
	5/10/16 with diagnose The Minimum Data S quarterly assessment severely cognitively in extensive assist with members with bed me toileting and one staff activities of daily living no impairments and u wheelchair. Resident including resistance to A review of Resident plan of care updated self-care deficit relate	et (MDS) dated 1/2/18 revealed Resident #3 was mpaired and required an the assistance of two staff obility, transfers, and assistance with all other g (ADLs). Resident #3 had used a walker and a t #3 exhibited no behaviors o care. #3 ' s care plans included a					

Facility ID: 960602

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	MENT OF HEALTH AN				FC	TED: 05/09/2018 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
		345507	B. WING			C 04/05/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	boots (off-loading soft bed, proper foot wear to floor in front of resis socks when out of bed A record review of the on 11/2/17 revealed a stockings to be applie removed in the evenin An observation of Res AM and at 2:25 PM re- noted to be lying in be place. Resident #3 w bilateral ankle edema stockings in place as An interview was cond 4/3/18 at 2:35 PM. N #3 did not wear anyth "she just wore nonskin reviewed the Medicat (MAR) at this time and order for TED stocking shift of 7:00 AM till 7:0 reviewed the Treatme (TAR). Nurse #4 stat the TAR for the 7:00 A #4 stated she had not resident, but she had bunny boots. Nurse # legs and feet at this ti Resident #3 had sligh there were no TED sto #4 stated she did not TED stockings in her not seen them on her the MAR for the 7:00	 a boots) to both feet while in , no powder, non-slip strips dent ' s recliner, nonskid d and TED stockings. a physician ' s order written in order for knee high TED d in the morning and ng. sident #3 on 4/3/18 at 9:01 avealed Resident #3 was ed with nonskid socks in as noted to have slight and there were no TED ordered. ducted with Nurse #4 on urse #4 revealed Resident ing on her feet and stated d socks." Nurse #4 ion Administration Record d she noted there was no gs on the MAR during the 20 PM. Nurse #4 also and there was no order on AM till 7:00 PM shift. Nurse is seen TED stockings on the seen the resident wear the f4 observed the resident's 	F 658			

Facility ID: 960602

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION) DATE SURVEY COMPLETED	
		345507	B. WING				C 04/05/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 658	MAR for the second s night shift nurse was and remove them in t that was why the order TAR for the first shift. the TED stockings sh #3 at the start of her s A review of the MAR of Nurse #5 signed the f stockings were applie mark and Nurse #5 's An interview was atter at 3:00 PM with Nurse schedule, worked 7:00 into 4/3/18 and whose indicating the TED sto voicemail message w Attempted to interview on 4/4/18 at 11:57 AM message for a returner return the phone calls An interview with Nur revealed that nursing could apply the TED sto them on a resident, th check to be sure they MAR or TAR. Nurse supposed to sign off to or administered a me actually done it. An interview with the on 4/4/18 at 4:00 PM expectation of the nur the task as ordered th	shift. Nurse #4 stated the to apply them in the morning he evening before bed and er was not on her MAR or Nurse #4 confirmed that ould have been on Resident shift on 4/3/18. on 4/3/18 revealed that MAR indicating that TED to as evidenced by a check is initials. mpted via phone on 4/3/18 e #5 who, according to the 0 PM till 7:00 AM on 4/2/18 e initials were on the MAR ockings were applied A as left for a returned call. w Nurse #5 a second time A and left a voicemail ed call. Nurse #5 did not is and was not interviewed. se #2 on 4/4/18 at 3:49 PM assistants (NAs) or nurses stockings, and if a NA put he nurse would need to were on before signing the #2 stated nurses are not hat they have done a task dication until they have Director of Nursing (DON)	F	658				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED //B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345507	B. WING			C 04/05/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE	(X5) COMPLETION DATE
F 658	the order was to apply morning and remove DON confirmed there when to apply them. stated to apply TED s expectation would be followed the physiciar	y the TED stockings in the them in the evening. The were no parameters as to The DON stated if the order tockings, then her that the nurses ensure they n's order as written.		658		
F 755 SS=D	CFR(s): 483.45(a)(b)(§483.45 Pharmacy Se The facility must prov drugs and biologicals them under an agreen §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accuration dispensing, and administ biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisit the facility. §483.45(b)(2) Establist	ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed er drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident. onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of in of all controlled drugs in	F7	755		5/1/18

Event ID: OFWS11

Facility ID: 960602

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED
		345507	B. WING			C 4/05/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		4/03/2010
				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 755	§483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on record rev Pharmacy Technician to provide medication	nines that drug records are in count of all controlled drugs riodically reconciled. is not met as evidenced iew and staff and Certified interviews the facility failed is to meet the needs of	F	F-755 F-755 Process that led to defic		
	(Resident #188) who Findings included:	amily request at		Facility failed to follow problem obtaining medications from pharmacy for a new adm Procedure for implement correction: Affected resident was dis	om backup nission. ting plan of scharged.	
	Review of the Hospitalist Discharge Summary dated 06/19/17 revealed Resident #188 had diagnoses of paroxysmal atrial fibrillation (a condition where the upper heart chambers lose their normal rhythm and beat chaotically occasionally and stop spontaneously), sepsis and insulin dependent diabetes mellitus. Resident #188 was to start taking Eliquis (a blood thinner) twice each day and Levaquin (an antibiotic) every night. Resident #188 was to continue taking Sotalol (a drug to help regulate the beating of the heart), Lantus insulin, Humalog insulin, Trulicity, and Hyzaar (a medication to reduce blood			100% of license nurses obtaining medications as backup pharmacy by cal to request medications a be completed by the Sta Nurse and Director of Nu 4-20-18. 100% audit of new admi admissions for the past on 4-27-18 to be comple Director of Nursing or de that residents received t timely.	s ordered from lling the pharmacy are sent STAT to off Development ursing beginning ssions and return 60 days starting eted by the esignee to ensure	
	(MAR) for 06/19/17 re received 25 units of L Levaquin 750mg (mil Eliquis 5mg at 9:00 P	ation Administration Record evealed Resident #188 antus insulin at bedtime, ligrams) at 8:00 PM and M. The Sotalol was not dent #188 on 06/19/17 at		Monitoring procedure: 100% audit of new admi admissions beginning or days by Director of Nurs ensure medications are pharmacy, to include ba ordering procedure when received timely for medic administration.	n 4-5-18 for 30 ing or designee to ordered from the ckup pharmacy n needed, and	

Facility ID: 960602

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	-	D HUMAN SERVICES MEDICAID SERVICES	_		FORM	0: 05/09/2018 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		345507	B. WING			C 05/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD		
Actomity				WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From page	2 14	F 755	Results of audits will be reviewed wee	kly	
	insulin, Eliquis, Sotald ordered for that day. In an interview on 04/ stated when the hosp received, the orders w admission order shee pharmacy along with orders. The orders w another nurse into the that last June the faci medicine kit (E-kit) wh common medications residents until the me from the pharmacy. S were not received in a pharmacy, a telephon the pharmacy to let th were needed that day still not received the of told so that the nurse pharmacy. She indica pharmacy that the con call so the medication quickly if needed.	t receive the Humalog of or Trulicity which were 04/18 at 3:26 PM Nurse #2 ital discharge orders were vere transcribed onto the t and then were faxed to the the hospital discharge ere then transcribed by e computer. She indicated lity had an emergency		Results of audits will be reviewed wee by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Director of Nursing Staff Development Nurse Date when corrective action will be completed: 5-1-18	кіў	
	called to the pharmac of the residents nurse pharmacy made deliv midnight and 4:00 AM not received by that ti	y and was the responsibility . She indicated the eries sometime between I. If the medications were me the nurse needed to call ocal back-up pharmacy				

Facility ID: 960602

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DEPART CENTER		FORM	APPROVED				
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING	B. WING		COMPLETED C 04/05/2018 C C 04/05/2018 C C 04/05/2018 C C MORE CONSECTION COMPLETION COMPLETION COMPLETION	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD NILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
F 755	5 Continued From page 15		F	755			
	stated the process for transcribe them from orders and have them or Nurse Practitioner. faxed to the pharmace and any ordered med in the E-kit would be a the orders were trans record and the pharm the electronic record. were delivered by the PM and 10:30 PM or special delivery if nee someone should have inform them that the of been received and re either from the consu back-up pharmacy. S expect the medication 9:00 AM medication a In a follow-up intervie called the pharmacy to when she saw Reside not available but that the call. In a telephone intervie Nurse #6 verified she on the 7:00 PM shift of when hospital dischar the orders were trans computer. The orders pharmacy and if past the Director of Nursin and the pharmacy sho	aded. Nurse #3 stated e called the pharmacy to ordered medications had not quested a special delivery ltant pharmacy or the local he indicated she would ns to be provided prior to the administration time. w Nurse #1 stated she he morning of 06/20/17 ent #188's medications were she had not documented ew on 04/04/18 at 7:45 PM was Resident #188's nurse on 06/19/17. She stated rge records were received cribed and put in the s were then faxed to the the cut-off time of 3:00 PM g (DON) would be notified					

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DEPART CENTER		FORM APPROVED OMB NO. 0938-0391					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
		345507	B. WING		OMB NO. 0938-0391 LE CONSTRUCTION (X3) DATE SURVEY COMPLETED C 04/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
NAME OF P	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: AUTUMN CARE OF MYRTLE GROVE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 755 Continued From page 16 medications were needed that evening. She indicated medications were received from the pharmacy between 6:00 AM and 7:00 AM and should have been available for the 9:00 AM medication administration. Nurse #6 stated she followed up with the pharmacy because the medications were not received and passed the information on to Nurse #2 in report and also informed the Nursing Supervisor although she could not recall which supervisor she told. She indicated she did not document that she had contacted the pharmacy for Resident #188's medications. In an interview on 04/05/18 at 9:40 AM the DON indicated medications for new admissions were usually delivered the evening of the admission. She stated that when she did rounds the morning of 06/20/17 she discovered Resident #188's medications had not been delivered and that she placed a call to the pharmacy. She indicated the medications were delivered later that day in the afternoon. She indicated the pharmacy delivered medications twice each night to the facility and that Resident #188's medications were just missed. She indicated it was her expectation that the facility be able to provide medications to eacl resident when they were admitted. She stated			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN CARE OF MYRTLE GROVE							
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 755	medications were new indicated medications pharmacy between 6: should have been ava medication administra followed up with the p medications were not information on to Nurs informed the Nursing could not recall which indicated she did not contacted the pharma medications. In an interview on 04/ indicated medications usually delivered the She stated that when of 06/20/17 she disco medications had not b placed a call to the ph medications twice eac that Resident #188's missed. She indicate the facility be able to resident when they w she expected timely of the pharmacy and the pharmacy receive admission orders at 6 indicated the pharmace	aded that evening. She is were received from the 00 AM and 7:00 AM and allable for the 9:00 AM ation. Nurse #6 stated she oharmacy because the received and passed the se #2 in report and also Supervisor although she is upervisor she told. She document that she had acy for Resident #188's 05/18 at 9:40 AM the DON is for new admissions were evening of the admission. she did rounds the morning vered Resident #188's been delivered and that she harmacy. She indicated the ivered later that day in the ated the pharmacy delivered ch night to the facility and medications were just d it was her expectation that provide medications to each ere admitted. She stated telivery of medications from a use of the local back-up red. ew on 04/05/18 at 10:20 AM cy Technician (CPT) stated d Resident #188's :12 PM on 06/19/17. She cy did not receive a e facility to let them know	F	755			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOR	D: 05/09/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345507	B. WING			C /05/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1	00/2010
			57	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE	w	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755 F 760 SS=D	that if the facility need they needed to call and the on-call Pharmacis order. She indicated medications were reco pharmacy at 1:00 PM stated if the facility had called the pharmacy to medications were need have received the me unable to provide a lis would have been avail Residents are Free of CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Residen medication errors. This REQUIREMENT by: Based on physician in staff interview, and re to administer three do (anticoagulant) as ord of 2 sampled residen anticoagulant medication	hdicated it was understood led medications that night ad inform the pharmacy so t could come in and fill the that Resident #188's eived by the facility from the on 06/20/17. The CPT d faxed the orders and o let them know the eded then the facility would dications. The CPT was st of the medications that ilable in the facility E-kit. 'Significant Med Errors are that its- tts are free of any significant is not met as evidenced interview, resident interview, cord review the facility failed uses of Coumadin lered by the physician for 1 ts who were receiving tions. Findings included:	F 755	F-760 Process that led to deficiency cited: Facility failed to enter complete physic orders into electronic medical record of to not following the facilities triple aud process for entering physician orders	due it	5/1/18
	Resident #79 with Co every Tuesday and Sa every Monday, Wedna and Sunday. The forr resident's PT/INR (pro	ty was to continue providing umadin 7.5 milligrams (mg) aturday and Coumadin 5 mg esday, Thursday, Friday, m also documented the othrombin time/international 22.1/2.04 on the morning of		new admissions. Procedure for implementing plan of correction: 100% education for license nurses on procedure to be completed by facility Development nurse starting 4-20-18 t includes an initial audit of signed physician orders and hospital dischare	Staff hat	

Facility ID: 960602

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	IDENTIFICATION NUMBER:	. ,		COMPLETED
				С
	345507			04/05/2018
ROVIDER OR SUPPLIER				
CARE OF MYRTLE GRO	VE			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE COMPLETI
	<u>, 18</u>	E 76	n	
Record review reveal admitted to the facility that included atrial fib irregularities), conges pulmonary embolism the left wrist, hand, ar Review of the facility's Admission Orders rev of the document Resi order for Coumadin 7 Saturday and for Cou days. A 03/12/18 2:45 PM at documented Residen x 3, was able to make being admitted after at fractures, and was hat level on a scale of 1 - "All orders approved I earlierPharmacy no A 03/12/18 10:16 PM documented Residen Coumadin 7.5 mg on al documented the resid Coumadin 5 mg on al documented the resid Coumadin therapy for "INR goal 2 - 3. Check Review of the facility administration record #79 did not receive C PM administration, or	ed Resident #79 was y on 03/12/18 with diagnoses rillation (heart rhythm tive heart failure, history of (blood clot), and fracture of nd pubis (pelvis). s 03/12/18 handwritten yealed on the second page dent #79 had a physician .5 mg on Tuesday and madin 5 mg on all other admission progress note t #79 was alert and oriented this needs known, was a fall at home with multiple tying constant pain at a 5 10. by provider in house otified of admission." physician progress note t #79 was to receive Tuesday and Saturday and I other days. The physician lent was receiving r atrial fibrillation. ck INR and adjust meds." electronic medication (e-MAR) revealed Resident oumadin, scheduled for 5:00 n 03/12/18 (Monday),	F 76	orders, and then a second aud includes an audit of the electro physician orders and signed pl orders, and lastly a third audit includes audit of the electronic orders and signed physician or audit of new admissions and re admissions beginning on 4-5-1 past 60 days by Director of Nu designee to ensure that the ph orders compared to the hospita orders were transcribed proper Monitoring procedure: Audit of new admissions and re admissions beginning on 4-5-1 next 30 days by Director of Nu designee to ensure that the ph orders compared to the hospita orders were transcribed proper Results of audits will be review by the QAPI Committee for 4 v Title of person responsible for implementing plan of correction Staff Development Nurse Director of Nursing	nic hysician that physician rders. 100% eturn 8 for the rsing or ysician al discharge rly. eturn 8 for the rsing or ysician al discharge rly. eturn eturn eturn eturn sig or ysician al discharge rly. red weekly veeks.
	Continued From page Record review reveal admitted to the facility that included atrial fib irregularities), conges pulmonary embolism the left wrist, hand, ar Review of the facility Admission Orders rev of the document Resi order for Coumadin 7 Saturday and for Cou days. A 03/12/18 2:45 PM a documented Residen x 3, was able to make being admitted after a fractures, and was ha level on a scale of 1 - "All orders approved I earlierPharmacy no A 03/12/18 10:16 PM documented Residen Coumadin 7.5 mg on al documented the resic Coumadin 5 mg on al documented the resic	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER: 345507 345507 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included atrial fibrillation (heart rhythm irregularities), congestive heart failure, history of pulmonary embolism (blood clot), and fracture of the left wrist, hand, and pubis (pelvis). Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had a physician order for Coumadin 7.5 mg on Tuesday and Saturday and for Coumadin 5 mg on all other	IDENTIFICATION NUMBER: A. BUILDING 345507 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 18 F 76I Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included atrial fibrillation (heart rhythm irregularities), congestive heart failure, history of pulmonary embolism (blood clot), and fracture of the left wrist, hand, and pubis (pelvis). F 76I Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had a physician order for Coumadin 7.5 mg on Tuesday and Saturday and for Coumadin 5 mg on all other days. A 03/12/18 2:45 PM admission progress note documented Resident #79 was alert and oriented x 3, was able to make his needs known, was being admitted after a fall at home with multiple fractures, and was having constant pain at a 5 level on a scale of 1 - 10. "All orders approved by provider in house earlierPharmacy notified of admission." A 03/12/18 10:16 PM physician progress note documented Resident #79 was to receive Coumadin 7.5 mg on Tuesday and Saturday and Coumadin 5 mg on all other days. The physician documented the resident was receiving Coumadin 5 mg on all other days. The physician documented the resident was receive Coumadin 5 mg on all other days. The physician documented the resident was receive Coumadin 5 mg on all other days. The physician documented the receive Coumadin, scheduled for 5:00 PM administration record (e-MAR) revealed Resident #79 did not receive Coumadin, scheduled for 5:00 PM administration, o	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLAN (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING 345507 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE IEACH FOR MYRTLE GROVE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES PRETX REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX Continued From page 18 F 760 Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included atrial fibrillation (heart thythm irregulantites), congestive heart failure, history of pulmonary embolism (blood clob), and fracture of the left wrist, hand, and pubis (pelvis). F 760 Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had a physician orders and signed physician orders orders and signed physician orders compared to the hosplit orders compared to the hosplit orders or

Facility ID: 960602

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391					
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED				
		345507	B. WING			C 04/05/2018					
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE						
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE				
F 760	mg every Monday, W and Saturday for Res e-MAR revealed the r Coumadin as ordered Review of the electron documented the orde discontinued on 03/16 order started the resid every Monday, Wedn and Sunday. Review resident received the 03/16/18 and thereaft The facility's electron 03/17/18 a physician Coumadin 7.5 mg eve for Resident #79. Re the resident received on 03/17/18 and thereaft A 03/19/18 STAT (at of PT/INR, the first draw resident's 03/12/18 ho on 03/19/18 the resid with the INR out of the Resident #79's 03/19, data set (MDS) docur intact, he exhibited no delirium/mood issues problems, he required staff with most of his a (ADLs), and he had o medication on 5 of the assessment period.	ednesday, Thursday, Friday, ident #79. Review of the esident received the I on 03/15/18. nic physician orders r for Coumadin 1 mg was 5/18, and a new physician dent on Coumadin 5 mg esday, Thursday, Friday, of the e-MAR revealed the Coumadin as ordered on order also initiated ery Tuesday and Saturday view of the e-MAR revealed the Coumadin as ordered eafter. once emergency lab) m by the facility since the ospital PT/INR, documented ent's PT/INR was 13.6/1.26, e goal range of 2 - 3.	F	760							

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	MPLETED
						С
		345507	B. WING		0	4/05/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL		
				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	JVE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From page	e 20	F 76	0		
		is a problem. The goal for	170	0		
		he resident will be free from				
	discomfort or adverse					
		ough the review date."				
	Interventions for the					
	"Assess/document/re	eport to nurse/MD (physician)				
		toms) of anticoagulant				
		as ordered. Report abnormal				
		, Review medication list for				
		Skin inspection with care				
		ort abnormalities to the				
	nurse."					
	On 04/04/18 at 2:45	PM Resident #79's primary				
	physician stated he r					
		to be held. He reported				
	recalling his nurse pr	actitioner (NP) catching that				
	Coumadin was not be	eing administered to				
	Resident #79 althoug					
		to be continued from the				
		ented the resident was				
	-	for control of his atrial				
	-	ined the goal was to keep the				
		en 2 - 3. He explained that nen labs were drawn in the				
		ing of 03/12/18 with the				
		cumented INR of 2.04. The				
		d obviously by the time the				
		R was drawn on 03/19/18				
		as out of range at 1.26, and				
	missed doses of Cou	madin contributed to this.				
		s, the physician reported				
		imadin given for heart				
	-	ased the chance of a heart				
	-	physician stated in the				
	-	ent #79 was very mobile in				
		chances of a heart attack ased somewhat below the				
	were propably decrea	ased somewhat below the	1			1

Facility ID: 960602

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M		-			FORM): 05/09/2018 1 APPROVED 9. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	LETED
	345507	B. WING		_		, 05/2018
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
AUTUMN CARE OF MYRTLE GROV	/F		5725 CAROLINA BEACH R	ROAD		
AUTOMIN CARE OF MITRILE GROV	'E	· · · ·	WILMINGTON, NC 2841	12		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
exhibited or complained indicative of heart prob notes also revealed the concerns or complaints were of a cardiac natu physician, the NP who doses of Coumadin wa available for interview. On 04/04/18 at 3:09 P (DON) reported she w #79 had missed doses comparing the facility's Orders against the e-N to her that the nurse w physician orders into the record forgot to enter the written orders. She ex- three-point check systen of orders with one nurse the hospital discharge entering the orders into system, and a third nu unit manager) compar electronic system agai Admission Orders. Sh primary physician, or of the handwritten Admiss changes, additions, or entered into the electron the DON, if the review want an order continued hospital they would wr The DON commented Coumadin increased the deep venous thrombos increased the chance	sident the resident never ed of signs and symptoms blems. (Review of progress ere were no documented is from the resident that tre). According to the o discovered the missing as on vacation and not	F 760				

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	
		345507	B. WING				05/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MYRTLE GRO	VE			25 CAROLINA BEACH ROAD ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 760	Resident #79 was exit of either of these con- was unsure how the to order accuracy failed, miss three doses of C On 04/04/18 at 3:45 F Resident #79 from 7:0 nurse hand transcribed discharge summary, s list to the physician or changes, entered or horders into the electron nurse from the next si third time for accuracy Resident #79 had not any signs of cardiact thome stay. On 04/05/18 at 10:25 was being discharged reported his primary p that he had missed so while he was in the fa commented he had missed symptoms of heart rhy discomfort during his	hibiting signs and symptoms ditions. She reported she hree-point check system for causing Resident #79 to coumadin. PM Nurse #2, who cared for DO AM to 7:00 PM, stated a ed orders from the hospital submitted the handwritten r NP for review and had another nurse enter the onic system, and then a hift reviewed the orders a y. According to Nurse #2, complained to her about rouble during his nursing AM Resident #79 stated he d home tomorrow. He obysician made him aware ome doses of Coumadin icility. However, he ot experienced any signs or ythm problems or cardiac		760			5/1/18
SS=D	§483.50(a)(2) The fact (i) Provide or obtain la ordered by a physicial practitioner or clinical accordance with State practice laws. (ii) Promptly notify the	sility must- aboratory services only when n; physician assistant; nurse nurse specialist in e law, including scope of					

Facility ID: 960602

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/09/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		PLETED
		345507	B. WING				C 1 05/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MYRTLE GRO	VE		57	725 CAROLINA BEACH ROAD		
ACTOMIN		v E		N	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	outside of clinical refe with facility policies a notification of a practi physician's orders. This REQUIREMENT by: Based on physician is staff interview, and re- to obtain PT/INR (pro- normalized ratio) resu- physician for 1 of 2 s receiving anticoagula included: A 03/12/18 hospital d documented the facilit Resident #79 with Co- every Tuesday and S every Monday, Wedn and Sunday. Dischar "Continue Coumadin help prevent blood cle from your injuries." T the resident's PT/INR morning of 03/12/18 p hospital. Record review reveal admitted to the facility that included atrial fib irregularities), conges pulmonary embolism the left wrist, hand, at	boratory results that fall erence ranges in accordance ind procedures for itioner or per the ordering is not met as evidenced interview, resident interview, ecord review the facility failed thrombin time/international ults as ordered by the ampled residents who were nt medications. Findings ischarge summary ity was to continue providing pumadin 7.5 milligarms (mg) aturday and Coumadin 5 mg resday, Thursday, Friday, rge instructions included, with INR goal 2 - 3 daily to obs while you are recovering the form also documented a was 22.1/2.04 on the prior to discharge from the ed Resident #79 was y on 03/12/18 with diagnoses rillation (heart rhythm stive heart failure, history of (blood clot), and fracture of	F	773	F-773 Process that led to deficiency cited: Facility failed to enter complete physici orders into electronic medical record du to not following the facilities triple audit process for entering physician orders for new admissions. Procedure for implementing plan of correction: 100% education for license nurses on procedure to be completed by facility S Development nurse starting 4-20-18 the includes an initial audit of signed physician orders and hospital discharge orders, and then a second audit that includes an audit of the electronic physician orders and signed physician orders, and lastly a third audit that includes audit of the electronic physicia orders and signed physician orders. 10 audit of new admissions and return admissions beginning on 4-5-18 for the past 60 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharged orders were transcribed properly.	ue or taff at e an 0%	
	Admission Orders rev of the document Resi	vealed on the second page ident #79 had a physician 5 mg on Tuesday and			Monitoring procedure: 100% audit of new admissions and retu admissions beginning on 4-5-18 for the		

Facility ID: 960602

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345507	B. WING	С		
	ROVIDER OR SUPPLIER	545507		STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2018	
				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	
F 773	Continued From page	e 24 Imadin 5 mg on all other	F 77:	past 60 days by Director of Nursing	1 or	
	-	order for "Labs: PT/INR Q		designee to ensure that the physici orders compared to the hospital dis orders were transcribed properly. A	an scharge	
	documented Residen x 3, was able to make	admission progress note t #79 was alert and oriented e his needs known, was a fall at home with multiple		new admissions and return admiss beginning on 4-5-18 for the next 30 by Director of Nursing or designee ensure that the physician orders) days	
	fractures, and was ha level on a scale of 1 - "All orders approved	aving constant pain at a 5 10. by provider in house		compared to the hospital discharge were transcribed properly.		
	earlierPharmacy no A 03/12/18 10:16 PM	otified of admission." physician progress note		Results of audits will be reviewed v by the QAPI Committee for 4 week	-	
	documented, "(Atria therapy-INR goal 2-3 meds."	al fibrillation) on coumadin Check INR and adjust		Title of person responsible for implementing plan of correction: Staff Development Nurse Director of Nursing		
	#79 did not receive C PM administration, or	(e-MAR) revealed Resident oumadin, scheduled for 5:00		Date when corrective action will be completed: 5-1-18		
	Resident #79 was scl drawn on 03/15/18 (T did not get drawn, an	s lab notebook revealed heduled to have a PT/INR 'hursday). However, the lab d there were no PT/INR on the resident's lab results				
	Review of the facility's Resident #79 was scl emergency) PT/INR of the 03/19/18 lab draw	n a 03/15/18 lab draw. s lab notebook revealed heduled for a STAT (at once, on 03/19/18. Results from v documented the resident's 6, with the INR out of the				

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 05/09/2018 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING				(X3) DATE COMP	SURVEY LETED
		345507	B. WING			_	04/	。 05/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET	DDRESS, CITY, ST	ATE, ZIP CODE	-	
AUTUMN	CARE OF MYRTLE GRO	/E			ROLINA BEACH R GTON, NC 2841			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 773	data set (MDS) docur intact, he exhibited no delirium/mood issues, problems, he required staff with most of his a (ADLs), and he had o medication on 5 of the assessment period. On 03/27/18 Residen "The resident is on ar to) atrial fibrillation" as the problem was, "The discomfort or adverse anticoagulant use thro Interventions for the p ordered. Report abno (physician)." On 04/04/18 at 2:45 F physician reported red (NP) catching that Co administered to Resid resident had a physic continued from the ho resident was receiving his atrial fibrillation, an keep the resident's IN explained that goal wa drawn in the hospital with the resident havin 2.04. The physician the resident's next PT 03/19/18 the resident 1.26, and missed dos to this. He reported o results was important adjusted to a new nur	nented his cognition was o signs and symptoms of psychosis/behavior l extensive assistance from activities of daily living nly received anticoagulant e 7 days of the look back at #79's care plan identified ticoagulant therapy r/t (due a problem. The goal for e resident will be free from reactions related to ough the review date." roblem included, "Labs as rmal lab results to the MD PM Resident #79's primary calling his nurse practitioner umadin was not being ent #79 although the an order for it to be spital. He commented the g Coumadin for control of nd explained the goal was to R between 2 - 3. He as reached when labs were on the morning of 03/12/18 ng a documented INR of stated obviously by the time	F 73	/3				

Facility ID: 960602

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/09/2018 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY LETED
		345507	B. WING_				C 05/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A				57	725 CAROLINA BEACH ROAD		
AUTUWIN	CARE OF MYRTLE GRO	VE		W	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 773	values enabled the C adjusted quickly to ke goal range which mad resident might develop heart attack. The phy assessments of the re exhibited or complain indicative of heart pro notes also revealed th concerns or complain were of a cardiac natu physician, the NP why doses of Coumadin w available for interview On 04/04/18 at 3:09 F (DON) reported she w #79 had missed dose comparing the facility Orders against the e- to her that the nurse w physician orders into record forgot to enter written orders which i PT/INR lab orders. S a three-point check sy accuracy of orders wi orders from the hospi second nurse entering electronic medical sys (usually herself or a u orders in the electron handwritten Admissio the NP, primary phys reviewed the handwri made any changes, a they were entered into	oumadin dose to be sep the resident's INR in the de it less likely that the p a blood clot or have a visician commented during esident the resident never ed of signs and symptoms oblems. (Review of progress here were no documented ts from the resident that ure). According to the o discovered the missing vas on vacation and not t. PM the Director of Nursing vas not aware that Resident s of Coumadin. After 's handwritten Admission MAR, she stated it appeared who entered the handwritten the electronical medical the second page of the ncluded the Coumadin and he explained the facility had ystem to ensure the th one nurse hand writing tal discharge summary, a g the orders into the stem, and a third nurse unit manager) comparing the	F 7	773			

Facility ID: 960602

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C C	38-0391
	VEY
345507 B. WING 04/05/2018	2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN CARE OF MYRTLE GROVE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	(X5) MPLETION DATE
 F 773 Continued From page 27 over from the hospital they would write a discontinue order. The DON commented missing doses of Cournadin increased the chance of developing at deep venous thrombosis (blood clot) and/or increased the chance of having a heart attack. She stated she had not been made aware that Resident #79 was exhibiting signs and symptoms of either of these conditions. She reported she was unsure how the three-point check system for order accuracy failed, contributing to Resident #79's 03/15/18 P7/INR not getting drawn. On 04/04/18 at 3:45 PM Nurse #2, who cared for Resident #79 from 7:00 AM to 7:00 PM, stated a nurse hand transcribed orders from the hospital discharge summary, submitted the handwritten list to the physician or NP for review and changes, entered or had another nurse enter the orders into the electronic system, and then a nurse from the next shift reviewed the orders a third time for accuracy. According to Nurse #2, Resident #79 had not complained to her about any signs of cardiac trouble during his nursing home stay. On 04/05/18 at 10:25 AM Resident #79 stated he was being discharged home tomorrow. He reported his primary physician made him aware that he had missed some doses of Coumadin and a T71NR lab draw while he was in the facility. However, he commented he had not experienced any signs or symptoms of heart rhythm problems or cardiac discomfort during his nursing home stay. On 04/05/18 at 1:13 PM the DON stated the philebotomist usually drew labs around 6:00 AM, but if there were problems and a facility nurse 	

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		ID HUMAN SERVICES			PRINTED: 05/09/2 FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/05/2018	
		345507	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE		25 CAROLINA BEACH ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 773	Continued From page	e 28	F 773			
	had to gather the bloc be drawn a little later reported part of the re #79 did not get his 03 because the nurse in was out of the facility	odwork, then the labs would	1773			
F 812 SS=F		tore/Prepare/Serve-Sanitary 2)	F 812		5/1/18	
	§483.60(i) Food safe The facility must -	ty requirements.				
	state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision doe	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable				
	serve food in accorda standards for food se This REQUIREMENT by: Based on observation facility failed to maint mayonnaise at 41 de failed to air dry kitche	is not met as evidenced n and staff interview the ain cold salads made with grees Fahrenheit or below, mware before stacking it in		Process that led to deficiency cited: Facility failed to maintain cold salads made with mayonnaise at 41 degrees Fahrenheit or below due to not handlir	-	
	storage, and failed to	de-stain kitchenware and itchenware. Findings		cold salad as to maintain temperature 41 degrees Fahrenheit or below. Facility failed to air dry kitchenware be	of	

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Facility ID: 960602

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED
				С	
		345507	B. WING		04/05/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
		NE.		5725 CAROLINA BEACH ROAD	
AUTUWIN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
F 812	Continued From page	29	F 812	2	
	and sitting on a food p calibrated thermomet temperature of the eg the tray pan after the assembled. The the degrees Fahrenheit. who prepared the sar an alternate item for t reported he obtained walk-in refrigerator, b eggs to make sure he of egg salad to prepa time the cook stated to operation at 11:30 AM At 10:40 AM on 04/05 manager (ADM) state mayonnaise should b degrees Fahrenheit. adding extra ingrediel had caused temperat commented it was im containing mayonnais temperature to avoid an extended period o residents sick. At 10:46 AM on 04/05 facility made its own e eggs, pickle relish, m	e covered with plastic wrap preparation counter. A er was used to check the g salad which remained in sandwiches had been rmometer registered 55 At this time the dietary aide ndwiches stated they were he lunch meal He left over egg salad from the ut added three to four more a had an adequate amount re five sandwiches. At this the trayline would begin <i>A</i> . 5/18 the assistant dietary ed chilled salads made with e kept at or below 41 She reported she thought ints to the left over egg salad ure problems. She portant to keep products se at the appropriate the chance of spoilage over f time which could make 5/16 the cook stated the egg salad, and it contained ustard, mayonnaise, and		 stacking it in storage due to not air dry and storage procedure. Facility failed to de-stain kitchen dispose of abraded kitchenware not consistently auditing kitchen stains and replacement. Procedure for implementing plan correction: 100% education for dietary staff handling of cold salads to mainta temperature of 41 degrees Fahr below beginning on 4-12-18 by th Manager. 100% education for dietary staff procedure for air drying kitchenv before it is stacked in storage be on 4-12-18 by the Dietary Mana 100% education for dietary staff de-staining of kitchenware schee procedure beginning on 4-12-18 Dietary Manager. 100% education for dietary staff reviewing kitchenware for abrass disposal and replacement during dishwashing process beginning 4-12-18 by the Dietary Manager. and replacement during dishwashing process beginning 4-12-18 by the Dietary Manager. Monitoring procedure: 	ware and due to ware for n of on proper ain enheit or the Dietary on proper vare eginning ger. on dule and by the f pleted on on ions for g the daily on . 100% ns tary
	were supposed to be	could get sick from		Audit of proper handling of cold observation and temperature as 5 days a week, when cold foods present on menu, by the Dietary beginning on 4-12-18 for 4 week Audit of proper procedure for air	sessment are Manager (s.

Event ID: OFWS11

Facility ID: 960602

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				FORM	D: 05/09/2018 MAPPROVED D. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	
	345507	B. WING			C 105/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.0	00/2010
	_	5	725 CAROLINA BEACH ROAD		
AUTUMN CARE OF MYRTLE GROV	E	\ \	WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 11:42 AM on 04/02/18, on top of one another of inside. During a follow-up tour at 7:55 AM on 04/04/18 stacked on top of one a were wet inside. At 10:40 AM on 04/05/manager (ADM) stated the survey the dietary so on making sure all kitcl before stacking it in storage pror bacteria which could mean to have air cickitchenware so stackin was not a good practic could grow. He reported make residents sick. During an inspection beginning at 10:20 AM coffee mugs (33%) were stain interior surfaces of 7 of bowls (29%) were abra touch. 	 the kitchen, beginning at 14 of 18 tray pans stacked on a storage rack were wet r of the kitchen, beginning 8, 8 of 15 tray pans another on a storage rack 18 the assistant dietary 4 that several times prior to staff had been in-serviced henware was air dried orage. She reported that kitchenware of top of one moted the growth of nake residents sick. 18 the cook stated it was irculating around drying 19 it wet on a storage rack we since germs and mold ed these could potentially n of kitchenware, 10 out/04/18, 8 of 24 d dark brown stains inside eight-ounce clear drinking ed brown. In addition, the f 24 plastic soup/cereal aded and rough to the 18 the assistant dietary 	F 812	kitchenware before it's stacked in sto beginning on 4-12-18, 5 days a week weeks by the Dietary Manager. Audit of de-staining schedule (every week) beginning on 4-5-18 for 4 wee the Dietary Manager. Audit of kitchenware for abrasions beginning on 4-5-18, 5 days a week f weeks by the Dietary Manager. Results of audits will be reviewed we by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Dietary Manager Date when corrective action will be completed: 5-1-18	for 4 other ks by or 4	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/09/2018 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345507	B. WING		_		C 05/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF MYRTLE GRO			5725 CAROLINA BEACH R	OAD		
AUTOWIN	SARE OF MITRILE GRO	VE		WILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 842 SS=D	shortage of help it had since the procedure w reported abraded kitch be disposed of becau materials could slough the abraded surfaces bacteria. At 10:46 AM on 04/05 dietary staff de-staine discolored weekly, but that had occurred due reported kitchenware with abrasions, cracks to be taken to the diet they could document requiring disposal. He manager know how m order so he/she could away. He commenter contact with food coul germs, bacteria, and n kitchenware was mad Resident Records - Id CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (i) A facility may not re resident-identifiable to accordance with a coul agrees not to use or o	monthly, but because of a d been longer than a month vas last completed. She henware was supposed to se pieces of plastic or other h off into resident food and were more apt to harbor 6/18 the cook stated the d kitchenware that was t it had been awhile since to a shortage of staff. He which was compromised s, and chips was supposed tary manager or ADM so the number of pieces e explained this helped the nuch new kitchenware to a replenish what was thrown ed abraded surfaces making ld contaminate the food with materials from which the le. Bentifiable Information $483.70(i)(1)-(5)$ and the public. Lease information that is the public. Lease information that is the public. Lease information that is the food with materials from which the agent only in that under which the agent disclose the information that is the public.	F 8	12	JEFICIENCY)		5/1/18

Facility ID: 960602

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345507	B. WING				05/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 842	§483.70(i)(1) In accor professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme	dance with accepted is and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, <i>v</i> iolence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when	F	842	2		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 05/09/20 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/05/2018	
		345507	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF MYRTLE GRO)VF	5	5725 CAROLINA BEACH ROAD		
Acronit			V	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 & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	Continued From pag	e 33	F 842			
	legal age under State		1 042			
	§483.70(i)(5) The medical record must contain-					
	(i) Sufficient information to identify the resident;(ii) A record of the resident's assessments;					
		ive plan of care and services				
	provided;					
		y preadmission screening				
	and resident review e determinations condu					
		e's, and other licensed				
	professional's progress notes; and					
		logy and other diagnostic				
	· ·	equired under §483.50.				
		T is not met as evidenced				
	by: Based on observation	ons, record review and staff		Process that led to deficiency cited:		
		/ inaccurately documented a		Facility inaccurately documented a tas	sk as	
	task as completed or			completed on the Medication		
		d for 1 of 2 residents		Administration Record due to the nurs		
		red for the application of TED		not validating that the task was completed and the task was completed by the task was completed by the task of		
		ngs to be applied to both ind removed at bedtime.		prior to recording completion of task o Medication Administration Record.	11	
	Findings Included:			Procedure for implementing plan of correction:		
	Resident #3 was add	nitted to the facility on		100% license nurse education on		
		oses of heart disease.		validating that tasks are completed pri	or	
	_			documenting its completion on the		
		Set (MDS) dated 1/2/18		Medication Administration Record		
		t revealed Resident #3 was		beginning on 4-3-18 by the Staff		
		mpaired and required an the assistance of two staff		Development Nurse.		
		obility, transfers, and		Monitoring procedure:		
		f assistance with all other		Audit of resident's Medication		
	activities of daily livin	g (ADLs). Resident #3 had		Administration Record with compressi	on	
	no impairments and			socks to ensure compliance with		
	wheelchair. Residen including resisting ca	t #3 exhibited no behaviors ire.		accurately documenting completed tag beginning on 4-5-18 for 30 days by the		
					-	

Facility ID: 960602

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/09/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345507	B. WING				C 05/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				57	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		w	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	A review of Resident i plan of care updated i self-care deficit relate dementia with interve boots (off-loading soft bed, proper foot wear to floor in front of resi- nonskid socks when of TED stockings. A record review of the on 11/2/17 revealed a stockings to be put or removed at night. An observation of Re- am and at 2:25 pm re noted to be lying in be place. Resident #3 h- edema and there wer as ordered. An interview was con- 4/3/18 at 2:15 pm. Ni #3 did not wear anyth "she just wore nonski reviewed the Medicat (MAR) at this time and order for TED stockin shift of 7:00 am till 7:0 reviewed the Treatment (TAR). Nurse #4 state the TAR for the 7:00 af #4 stated she had not resident, but she had boots. Nurse #4 obse feet at this time and it	 #3 ' s care plans included a on 1/4/18 to include a d to history of falls and ntions to include bunny boots) to both feet while in , no powder, non-slip strips dent ' s reclining chair, out of bed, and an order for e physician ' s order written in order for knee high TED in the morning and sident #3 on 4/3/18 at 9:01 vealed Resident #3 was ed with nonskid socks in ad slight bilateral ankle e no TED stockings in place ducted with Nurse #4 on urse #4 revealed Resident ing on her feet and stated d socks." Nurse #4 ion Administration Record d she noted there was no gs on the MAR during the 	F	842	Assistant Director of Nursing. Results of audits will be reviewed weel by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Staff Development Nurse Assistant Director of Nursing Date when corrective action will be completed: 5-1-18	kly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) [DATE SURVEY COMPLETED
		345507	B. WING				C 04/05/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE		
F 842	not have the TED sto she did not know if th stockings in her room seen them on her. Ni MAR for the 7:00 pm to apply the TED stoc the second shift. Nur nurse was to apply th remove them in the e was why the order wa for the first shift. Nurse check mark and initia TAR, it would mean th by the nurse with the Nurse #4 confirmed th should have been on her shift on 4/3/18. A review of the MAR of Nurse #5 signed off th applied on Resident # mark and Nurse #5 's An interview was atte at 3:00 pm with Nurse schedule, worked 7:0 into 4/3/18 and whose indicating the TED sto voicemail message w Nurse #5 did not return not interview with Nur revealed that Nurse #	ckings on. Nurse #4 stated e resident had TED and stated she had not urse #4 then reviewed the till 7:00 am shift. The order ckings was on the MAR for se #4 stated the night shift em in the morning and vening before bed and that as not on her MAR or TAR se #4 stated if there was a ls in the box on the MAR or nat the task was completed initials that were indicated. hat the TED stockings Resident #3 at the start of on 4/3/18 revealed that nat TED stockings were #3 as evidenced by a check	F	842	2		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								PRINTED: 05/09/2018 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		345507	B. WING				C 04/05/2018		8	
NAME OF PROVIDER OR SUPPLIER			•	5	STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN CARE OF MYRTLE GROVE				5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ID PROVIDER'S PLAN (F CORRECTION (X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ΞIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		COMPL DA	ETION	
F 842	Continued From page	e 36	F	842	2					
	and if a NA put them on a resident, the nurse									
would need to check to before signing the MAR		to be sure they were on AR. Nurse #2 stated if a								
check mark was on th		ne MAR and there were								
		, it would mean the nurse Nurse #2 stated nurses are								
not supposed to sign off that t		off that they have done a								
task or administered a medicat actually done it.		a medication until they have								
	An interview with the Director of Nursing (DON) on 4/4/18 at 4:00 pm revealed that her									
expectation of the nurses would be										
the task as ordered then sign off TAR that the task was done. The										
the order was to apply the TED stoc										
morning and remove th		them at night. The DON								
to apply them. The D		no parameters as to when DON stated if the order								
stated to apply TED st		stockings, then her								
expectation would be th they were applied before		that the nurses ensured fore signing the task off as								
	completed.									
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OFWS1				Fa	acility ID: 960602	continua	ation sheet	Page 3	37 of 37	