PRINTED: 08/24/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345507	B. WING _			C 07/29/2	022
	ROVIDER OR SUPPLIER	VE		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		01/20/2	V
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		-	(X5) MPLETION DATE
F 000	from 07/26/22 through The following intakes NC00189244, NC001 NC00190173, NC001 4 of the 15 complaint substantiated resulting Immediate jeopardy v	ation survey was conducted n 07/29/22. were investigated: 89493, NC00189712, 90196, and NC00191295. allegations were g in deficiencies.	FO	00			
F 580 SS=D	removed on 07/07/22 A partial extended su Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tre a need to discontinue	rvey was conducted. jury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is,	F 5	TITLE		(X6) D	

Electronically Signed 08/15/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/24/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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 07/29/2022	
	ROVIDER OR SUPPLIER	VE		57	REET ADDRESS, CITY, STATE, ZIP CODE 25 CAROLINA BEACH ROAD ILMINGTON, NC 28412	0111	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	commence a new form (D) A decision to transpected that the facility when making noting (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must a resident and the resident and resident	erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or as as specified in paragraph ecord and periodically mailing and email) and resident posite distinct part. A facility stinct part (as defined in ein its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced ew and interviews with staff er the facility failed to notify medication was unable to of 1 resident (Resident #6)	F	580	Resident #6 is no longer in the facility cannot be corrected. On 8/11/2022, to identify like residents	and	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING _				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				57	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		V	VILMINGTON, NC 28412		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE		
F 580	Continued From page	2	F t	580			
	Findings included:				that have the potential to be affected, t Director of Nursing scheduled Omnical pharmacy to audit current resident		
	Resident #6 was adm	itted to the facility on			medication orders to ensure that curren	nt	
		diagnoses which included in			medications ordered were available. Ti		
		onic obstructive pulmonary			MD was made aware of all missing		
		on, and hypertension.			medications and the medications were ordered from the pharmacy.		
		physician order for Resident					
#6 entered on 5/13/22 by the supervisor reveale					To prevent this from happening again t	ne	
		give 0.5 tablet twice per day, I pressure if less than 110 or			Director of Nursing or designee will re-educate the medication aides and the	20	
	heart rate less than 6	-			licensed staff by 8/15/2022 on the prod		
	Ticali fate less than o	0.			for ordering medications to include	.033	
	Review of Resident #	6's Medication			medications from pharmacy and house)	
	Administration Record	d (MAR) for May 2022			stock medications and notifying the ME		
	revealed the medicati	, ,			a medication cannot be obtained.		
	documented as given	on 5/13/22 at 9 PM,					
	5/14/22 at 9 AM and 9	9 PM, and 5/15/22 at 9AM.			To monitor and maintain ongoing		
		ulse readings were not			compliance the Director of Nursing or		
	recorded on the MAR	•			designee will audit 10 random resident		
	5/14/22 at 9 AM and 9	9 PM, and 5/15/22 at 9 AM.			physician orders for medications week	y	
					x4 weeks then monthly x2 months to		
		6's medical record revealed			ensure current residents have		
		1 5/14/22 at 1:16 PM which			medications ordered and available. If	:11	
	_	alol was not available.			medications are unavailable the MD wi		
		entation in the medical			be notified. Audits will begin on 8/15/20 The results of the audits will be forward		
		physician was notified that I was not available or that			to the facility QAPI committee for further		
		were not on administered			review and recommendations.	31	
	on 5/13/22 through 5/				review and recommendations.		
	revealed she did not r administer sotalol as and on 5/14/22 at 9PI Resident #6 for the 7	ordered on 5/13/22 at 9PM M when she was assigned to PM to 7 AM shift. Nurse # 3					
	further stated when a available or not admir	medication was not nistered the physician was to					

			(X3) DATE SURVEY COMPLETED			
		345507	B. WING _			C 07/29/2022
	ROVIDER OR SUPPLIER CARE OF MYRTLE GRO	VE		STREET ADDRESS, CITY, STATE, ZIF 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	, CODE	
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F 580	be notified to obtain firstated she did not not Resident #6 did not reas ordered on 5/13/22 Multiple unsuccessful interview Nurse #9, the to Resident #6 on 5/1 PM shift. Multiple attempts were Nursing Supervisor were 5/14/22 and 5/15/22 for An interview on 7/27/2 revealed the medical was not available in the AM-7 PM. Nurse #2 arrived on duty on 5/1 #6 complained of flutther heart was racing. Resident #6 and notes	urther orders. Nurse # 3 tify the physician that eceive the medication sotalol 2 and 5/14/22 at 9 PM. I attempts were made to ne nurse that was assigned 3/22 and 5/14/22 for 7 AM-7 The made to interview the worked on 5/13/22, from 7 AM-7 PM. 22 at 11:25 AM with Nurse # ation sotalol for Resident #6 the facility on 5/15/22 from 7 stated that when she 15/22 at 7:00 AM Resident tering in her chest and that Nurse #2 assessed at that her blood pressure elevated. Nurse #2 stated	F	580	NCY)	
	condition and that soft physician instructed Namedication sotalol as disregard the allergy know how long it wou received an order to shospital. Resident #6 emergency medical sadmitted with a diagnorardiac complications. An interview with Nur 7/28/22 at 12:15 PM was that the nurse wo	alol was not available. The Nurse #2 to obtain the soon as possible and to Toprol. Nurse #2 did not ald take to arrive, so she send Resident #6 to the was sent to the hospital via ervices where she was osis of sepsis with no further				

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(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 COMPLETION
F 684 SS=E	orders given. NP state that Resident #6 had sotalol on 5/13/22 and An interview on 7/28/2 Regional Director of Control that her expectation wordered by the physica available and if it was notified as soon as possible to a could be made, or fur Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident residents received accordance with profession practice, the compreheare plan, and the resident resident resident practice, the compreheare plan, and the resident REQUIREMENT by: Based on record revistaff interviews, the fathospital discharge sur resident (Resident #1 transcribe and adminimedications to include and an antidepressar discharge medication	and be made, or further ed she was not made aware not received prescribed d 5/14/22. 22 at 4:25 PM with the Clinical Services revealed was that all medications ian would be readily not, the physician would be essible so a substitution ther orders given. are indamental principle that interest and care provided to ed on the comprehensive dent, the facility must ensure iteratment and care in essional standards of itensive person-centered sidents' choices. The is not met as evidenced ew, Nurse Practitioner, and itellity failed to review the immary for a newly admitted iteration of the ordered ea a stool softener (Colace) at (Mirtazapine) listed on the	F 68	30	view I
	medication administra	1 of 3 residents reviewed for ation.		summary are reconciled and ordered upon admission. Any changes made the physician or physician extender w	•

		` '	(3) DATE SURVEY COMPLETED				
		345507	B. WING _			C 07/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2022
				57	25 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE			ILMINGTON, NC 28412		
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F 684	Continued From page The findings included		F 6	84	noted on the discharge summary and a		
	which includes the ph level of care as well a needs and medication Colace 100 milligrams Mirtazapine 15 mg da signed by the Physici hospital on 05/23/22. provider 's initials or noted on the FL2 form A review of the hospit received from the disc 05/27/22 revealed, in Colace 100 mg twice mg daily. There were initials or signatures f discharge summary. A diagnoses documents summary form.	cal discharge summary, also charging hospital, dated part, the following orders: per day, and Mirtazapine 15 e no handwritten provider 's from the facility noted on the Also, there were no ed on the discharge			missing orders will be reported to the Mand corrected. To prevent this from happening again to Director of Nursing or designee will reeducate licensed nursing staff on the admission order entry process and the follow up validations involved in the completion of the admission process by 8/15/2022. To monitor and maintain ongoing compliance the Director of Nursing or designee will audit new admissions and readmissions 5 days a week x4 weeks monthly x2 months to ensure that all medications on the hospital discharge summary are reconciled and ordered upon admission. Audits will begin on 8/15/2022. Any changes made by the physician or physician extender will be noted on the discharge summary. The admitting nurse will review the orders with MD or NP upon admission. The	he y d the	
	with surgical repair, h depression. A review of the physic medical record (EMR Nurse #1 on 05/27/22 orders for Colace 100 Mirtazapine 15 mg da orders indicated anoth Sertraline, was ordered. The Minimum Data S dated 06/02/22 revea.	her antidepressant, ed at 100 mg daily. et (MDS) 5-day assessment			admitting nurse will enter the orders an have a second nurse will sign off on the discharge summary that all admission orders were reviewed and entered into PCC correctly. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	е	

			(X3) DATE S				
		345507	B. WING _			07/2) 29/2022
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F 684	from 05/27/22 through #1 was discharged rereceive Colace or Mir An interview was con 07/27/22 at 11:10 AM transcribed the orders #1 from the Medicaid and she should have the hospital discharge confirmed the FL2 for Mirtazapine. Nurse # the orders on the FL2 Nurse Practitioner (NI signature on FL2 forn were already reviewe physician who signed physician from the dis #1 stated she did not discharge summary was Resident #1 and adde the packet." Nurse # unusual Resident #1 a FL2 form, but she distated the protocol was summary forms ' ord NP or the Physician be should have look summary orders inste Nurse #1 stated once with the NP or the Physiciane with the NP or	esident received an of 7 days. Ition Administration Records of 06/28/22 when Resident vealed Resident #1 did not tazapine during his stay. Iducted with Nurse #1 on Nurse #1 stated she on 05/27/22 for Resident Long Term Care FL2 form, transcribed the orders from	F	584			
	admission orders to v	_					

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F 684	phone on 07/27/22 a Resident #1 came fr discharge summary. know what an FL2 fo seeing this form. NF was admitted to the admissions coordina discharge summary, work, etc. in one pac she received the pac orders and revise the discontinue orders if going to require the diagnoses next to ea ordered. NP #3 stat and give a copy to th resident. NP #3 stat that Resident #1 had medications she trie which would have be record, but she could sure she had review discharge summary, Colace and Mirtazap ordered for Resident expectation of the no discharge summary NP by checking to so by the Physician or I in the electronic medi	inducted with (NP) #3 via at 2:35 PM. NP #3 stated om a hospital with a NP #3 stated she did not form was and did not recall P #3 stated when a resident facility from the hospital the stor would give her the the history and physical, laborated the resident was not medication and put a fach medication and put a fach medication that was feed she would sign the orders fine nurse taking care of the freed when she had learned that not received his ordered do looking back on her orders freen scanned in his medical do not find them. The NP was feed the orders and signed the but she was not aware the folione were not transcribed or at #1. NP #3 stated her cursing staff was to confirm the orders with a Physician, or fine if the orders were signed NP prior to putting the orders dical record.	F 68	4	
	Director of Clinical S at 4:10 PM. The RD were reviewed with t	nducted with the Regional ervices (RDCS) on 07/27/22 PCS stated once the orders the NP or the Physician, they lmission orders to verify they			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER CARE OF MYRTLE GRO	VE	STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
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F 760 SS=K	care of the resident a orders into the EMR. Colace and Mirtazapi as not being transcrib. Resident #1 's stay p An interview was con Administrator on 07/2 the facility missed ide Mirtazapine were not per the hospital disch 07/27/22. Residents are Free or CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resident medication errors. This REQUIREMENT by: Based on record revistaff interviews, the fahospital discharge menewly admitted reside the failure to transcrib anticoagulant (blood the discharge medicat (anticoagulant) was no5/27/22 through 06/developed swelling to the hospital, and was The facility also failed administer a blood primedication that was a summary (Resident #medication used to the	them on to the nurse taking and the nurse would enter the The RDCS confirmed the ne orders were not identified and or administered during rior to 07/27/22. Iducted with the 7/22 at 3:25 PM. He stated, ntifying that the Colace and transcribed or administered arge summary until If Significant Med Errors If Eliament its-ness are free of any significant If is not met as evidenced If we, Nurse Practitioner, and acility failed to review the edication summary for a cent (Resident #1) resulting in the end administer an thinner) medication listed on tion summary. Eliquis ot administered from 14/22 (18 days). Resident #1 of the left arm, was sent to diagnosed with a blood clot.	F 76		s that eview d e by vill be I any MD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345507	B. WING		C 07/29/2022
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	0112312022
				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 OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 760		9 ident #6). This deficient	F 76	Director of Nursing or designee will	
	practice occurred for significant medication	2 of 3 residents reviewed for errors.		reeducate licensed nursing staff on admission order entry process and follow up validations involved in the	the
	facility failed to transc (anticoagulant medica	regan on 05/27/22 when the ribe and administer Eliquis ation) for Resident #1. The vas removed on 07/07/22		completion of the admission proces 8/15/2022.	s by
	when the facility provi acceptable credible a jeopardy removal. Th	ded and implemented an llegation of immediate le facility remains out of		To monitor and maintain ongoing compliance the Director of Nursing designee will audit new admissions readmissions 5 days a week x4 we monthly x2 months to ensure that a	and eks the
	E (no actual harm wit minimal harm that is r ensure education is c	r scope and severity of level th potential for more than not immediate jeopardy) to ompleted and monitoring e are effective. The facility		medications on the hospital dischar summary are reconciled and orders upon admission. Audits will begin o 8/15/2022. Any changes made by the	ge ed n
	examples #1b and #2			physician or physician extender will noted on the discharge summary. T admitting nurse will review the orde	he rs with
	The findings included			the MD or NP upon admission. The admitting nurse will enter the orders	s and
	form which includes the recommended level of diagnoses, care need include orders for Elic signed by the Physicia hospital on 05/23/22.	f care as well as medical s and medications) did not juis. The FL2 form was an from the discharging There were no handwritten signatures from the facility		have a second nurse will sign off or discharge summary that all admissi orders were reviewed and entered PCC correctly. The results of the au will be forwarded to the facility QAF committee for further review and recommendations.	on nto udits
	also received from the 05/27/22 revealed, in Eliquis 5 milligrams (r There were no handw	arge medication summary, e discharging hospital, dated part, the following order: ng) one tablet 2 times daily. rritten provider 's initials or acility noted on the discharge			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	1	07/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 760	Resident #1 was ad 05/27/22. Diagnose with surgical repair a A review of the physical record (EMI Nurse #1 on 05/27/2 orders for Eliquis 5 in times daily for Resident dated 06/02/22 reversident surgery. The did not receive any assessment. Review of Nurse Prace on 06/02/22 assession part, intertrochanter anticoagulation with A nursing note writte 8:38 AM regarding Fextreme swelling to pain/discomfort. No Resident states, 'I like this.' Physician resident. New order Ultrasound [U/S] and Eliquis [blood thinned U/S called in. Inquired arrival and was infort today but could not by Updated Nurse Prace radiology was uncertainty and was uncertainty of the prace of the prace of the prace of the pracent with the prace of the prace o	mitted to the facility on as included left hip fracture and coronary artery disease. Sician orders in the electronic R) which were transcribed by 22 revealed there were no mg to be administered two lent #1. Set (MDS) 5-day assessment aled Resident #1 was d was assessed as having MDS indicated Resident #1 anticoagulants during this actitioner #3 's progress note ment and plan revealed, in ic fracture of right femur,	F 76	60		

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		345507	B. WING				29/ 2022
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F 760	on 06/15/22 with an of thinning medication) days. The ER record regarding diagnoses extremity, venous do taking Xarelto." A nursing note writter "resident returned to Emergency Medical Signature Resident was diagnot extremity [LUE] deep LUE continued to be pain. New order for Xignature New order for Xignature 15 mg twice pwritten on 06/15/22. An interview was con 07/27/22 at 11:10 AM transcribed the order from the Medicaid Loshe should have tran hospital discharge suthe FL2 form did not stated she did not reversible form with the Physicial because there was a she assumed they we realized later the phyform was the physicial hospital. Nurse #1 st	ecord dated 06/14/22 was sent back to the facility order to start Xarelto (blood 15 mg twice per day for 21 I provided instructions of "acute DVT to upper ppler of upper arm, start n on 06/15/22 revealed facility at 12:25 AM via Services from the hospital. sed with positive left upper vein thrombosis [blood clot]. swollen, and resident denied	F	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CARE OF MYRTLE GRO	VE	•	STREET ADDRESS, CITY, STATE, Z 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 760	there was "a lot of stustated she thought it came from the hospit did not question it. Nowas to review the dislisted medications wit before the orders were she should have done looked further for disc instead of using the Fonce the orders were Physician, they would initials or signature or verify they have been could then enter the could then enter the ordered Eliquis fron 06/14/22 after the hospital. He stated or investigated why the stated the facility four from the hospital and use this summary to but instead had used Administrator stated investigation into the on 07/06/22. The Administrator stated investigation into the on 07/06/22. The Administrator into the on 07/06/22. The Administrator was not signed or inition to indicate they had reactioner (NP) #3 varieties.	off in the packet." Nurse #1 was unusual Resident #1 al with a FL2 form, but she urse #1 stated the protocol charge summary forms ' the NP or the Physician re put into the EMR, which re, and she should have charge summary orders reviewed with the NP or the reviewed with the NP or the reviewed with the NP or the reviewed and the nurse orders into the EMR. ducted with the reviewed and the nurse orders into the EMR. ducted with the reviewed and the nurse orders into the EMR. ducted with the reviewed and the nurse orders into the EMR. ducted with the reviewed and the nurse orders into the EMR. ducted with the resident #1 not receiving om Resident #1 's spouse resident was sent to the n 06/14/22 the facility Eliquis was not ordered. He nd a discharge summary realized the nurse did not transcribe the medications the FL2 form. The t was noticed at this time the spital discharge summary to ninistrator added, the Eliquis error was completed ministrator confirmed that e summary that was found ialed by the facility provider eviewed the orders.	F	760		

A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MYRTLE GROVE A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	C 07/29/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD	
AUTUMN CARE OF MYRTLE GROVE 5725 CAROLINA BEACH ROAD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 760 Continued From page 13 hospital with a discharge summary. NP #3 stated she did not know what an FL2 form was and did not recall seeing this form. NP #3 stated when a resident was admitted to the facility from the hospital the admissions coordinator would give her the discharge summary, the history and physical, lab work, etc. in one packet. The NP stated once she received the packet she would go through the orders and revise the orders if needed or discontinue orders if she felt the resident was not going to require the medication and put a diagnosis next to each medication that was ordered. NP #3 said she would sign the orders and give a copy to the nurse taking care of the resident. NP #3 stated when she had learned of Resident #1 having a deep vein thrombosis (DVT) and he had not received his ordered Eliquis she tried looking back on her orders which would have been scanned in his medical record, but she could not find them. The NP was sure she had reviewed the orders and signed the discharge summary, and she knew Resident #1 was on Eliquis because she had that information in her history and physical. NP #3 stated the DVT likely occurred because Resident #1 did not get his blood thining medication for 18 days. NP #3 stated the expectation of the nursing staff was to confirm discharge summary orders with a Physician, or Nurse Practitioner by checking to see if the orders were signed by the Physician or NP prior to putting the orders in the electronic medical record. An interview was conducted with the Regional Director of Clinical Services (RDCS) on 07/27/22 at 4:10 PM. The RDCS stated the protocol was the Physician or Nurse Practitioner reviewed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	COMPLETED	
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	OVIDER OR SUPPLIER	OVE	5	TREET ADDRESS, CITY, STATE, ZIP CODE 725 CAROLINA BEACH ROAD VILMINGTON, NC 28412	1 3772072022
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	would then enter the medical record. The Physician was a during the survey. The Administrator a Clinical Services we jeopardy on 07/27/2 · Identify those recipare likely to suffer, a a result of the noncon Resident #1 was with the error in transcripsignificant medication hospitalization related to the property of the physician of the incomplete in the physician external document. The sign not transcribed was medication. The physician external significant external the first visit on 5/27 was unaware that the Discharge Summary incomplete.	the RDSC stated the nurse and available for interview and Regional Director of the immediate 2 at 6:15 PM. Significant medications related to be provided to a venous clot. 27/22 when the admitting left the physician, nurse physician assistant (PA) to refer the admitting resident. The document that was used by the Discharge Summary inficant medication that was Eliquis-a blood thinning and ard did include Eliquis in her nat were being given during 1/22 with the resident. She are transcription of the	F 760		

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION G	COMI	(X3) DATE SURVEY COMPLETED	
		345507	B. WING			C / 29/2022
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F 760	missed in the initial adiagnosed with a blowould have been probeen given according. Residents who are a risk for this deficient. On 6/16/2022, the R Services completed review on all resident using the Discharge the transcribed order been corrected. Specify the action to process or system for adverse outcome frow when the action will. Current nursing staff the day on 7/06/22 or order entry process involved in the comprocess. This education was process. This education was process will be adjucted included for staff who are current. The process will be review the review will be done orders will be review. The nurse orders from the Discorders from the Discorders from the Discorders from the Discorders.	identified as having been admission process. He was not clot in his left arm that evented if the Eliquis had g to the Discharge Summary. Idmitting to the facility are at practice. Idmitting to the	F 7			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	OMPLETED
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F 760	be given to the nurse the facility. The ord Electronic Medical relation in A second review will nurse who is working the admission. This on the same Discharapproved by the physical three initial transcription. This education will be the process of transe the next resident where the facility. The facility alleges of the facility alleges of the facility alleges of the facility on 7/07/22. On 7/29/22 the Creeby onsite verification the 6/16/22 medical by the RDCS. Reviverified education worder entry process involved in the comparison of the facility of the comparison of the facility of the facility alleges of the facility all	igned Discharge summary will be admitting the resident into ers will be transcribed into the secord. I be completed by a second g in the facility at the time of a review will be documented arge Summary that was evician or extender to ensure on was complete and correct. De completed on 7/06/22 and corription will be in place with the is admitted/readmitted to the removal of immediate	F 7	,		
	received education admission order entremoval date of 7/0 1b. The Medicaid Leform which includes recommended level	and were aware of the rry process. The facility 's 7/22 was validated. ong Term Care FL2 form (a the physicians ' of care as well as medical				
		eds and medications) did not letoprolol Succinate. The FL2				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CARE OF MYRTLE GRO	VE		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	1 01/25/2022
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F 760	handwritten provider the facility noted on the facility noted on the A review of the dischalso received from the 05/27/22 revealed, in Metoprolol Succinate daily. There were no initials or signatures f discharge summary. Resident #1 was adm 05/27/22. Diagnoses	ne Physician from the on 05/23/22. There were no is initials or signatures from the FL2 form. arge medication summary, the discharging hospital, dated part, the following order: 25 mg, give 1/2 tablet twice handwritten provider is something the facility noted on the	F 76	60	
	medical record (EMR Nurse #1 on 05/27/22 orders for Metoprolol to be administered tw #1. The Minimum Data S dated 06/02/22 revea cognitively intact and recent surgery. Review of a nursing r revealed Resident #1 06/28/22. The physician 's orde (discharge date) revealed.	was assessed as having note written on 06/28/22 was discharged home on ers through 06/28/22 aled Resident #1 had no uccinate at any time during			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 760	Continued From page	e 18	F7	760			
F 760	The Medication Admin from 05/27/22 through metoprolol succinate Resident #1 at any tir facility. An interview was cond 07/27/22 at 11:10 AM transcribed the orders from the Medicaid Lor she should have transchospital discharge sufthe FL2 form did not i Succinate. Nurse #1 the orders on the FL2 Nurse Practitioner before FL2 form, and she reviewed and realized signed the FL2 form via discharging hospital. see the other hospital see the other hospital 5/27/22) when she was and added there was Nurse #1 stated she to Resident #1 came froform, but she did not the protocol was to resummary forms ' listed or the Physician befort the EMR, which she seemed the sident #1 came froform the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the sident #1 came froform the Physician befort the EMR, which she seemed the protocol was to result the protocol was to result the Physician befort the Physician before	nistration Records (MARs) in 06/28/22 revealed was not administered to me during his stay at the ducted with Nurse #1 on . Nurse #1 stated she is on 5/27/22 for Resident #1 ing Term Care FL2 form, and scribed the orders from the immary. Nurse #1 confirmed include Metoprolol stated she did not review if form with the Physician or cause there was a signature assumed they were already if later the physician from the Nurse #1 stated she did not indischarge summary (dated as admitting Resident #1 in a lot of stuff in the packet. If hought it was unusual if the hospital with a FL2 in question it. Nurse #1 stated wiew the discharge in the NP in the orders were put into should have done, and she	F	760			
	Nurse #1 stated once with the NP or the Ph and hand write their in admission orders to v	ead of using the FL2 form. the orders were reviewed ysician, they would date, nitials or signature on the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	•	7/29/2022	
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F 760	the facility found a dishospital and realized summary to transcribinstead had used the Administrator explain identified a medication related to an anticoach had not realized until the surveyor that the also not been transcribing Administrator confirm discharge summary the signed or initialed by indicate they had revision and put a diagnosis resident was admitted hospital with a discharge summary the signed or initialed by indicate they had revision and put a diagnosis resident was admitted hospital with a discharge summary the sident was admitted hospital the admission her the discharge sumphysical, lab work, et stated once she rece go through the orders needed or discontinual resident was not goin and put a diagnosis resident was not	ducted with the 27/22 at 3:25 PM. He stated scharge summary from the the nurse did not use this e the medications but FL2 form. The ed that on 6/14/22 the facility on error for this resident gulant medication, but they 7/27/22 when identified by Metoprolol Succinate had ibed and administered. The ned that the hospital hat was found was not the facility provider to iewed the orders.	F 7	, , , , , , , , , , , , , , , , , , ,			
	the resident. The NF had reviewed the ord discharge summary, aware of the Metopro	by to the nurse taking care of P stated she was sure she ers and signed the but she added she was not solol Succinate being ordered. Int #1 's blood pressure and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 760	not getting the order added it was a neces have been ordered. expectation of the n discharge summary Nurse Practitioner be orders were signed to putting the orders record. An interview was concompleted a plan of separate medication that was not transcribed to the election of the elect	stable during his stay despite red Metoprolol Succinate, but assary medication and should NP #3 stated her sursing staff was to confirm orders with a Physician, or y checking to see if the by the Physician or NP prior in the electronic medical and the electronic medical services (RDCS) on 07/27/22 and (anticoagulant medication) and the electronic medical record for the discharge and #1, but they had not and Metoprolol Succinate on the form was also not electronic medical record for an approximate that in their RDCS stated she would have to capture that in their RDCS stated the protocol was arse Practitioner reviewed the reders, and then passed the and they who was responsible the RDSC stated the nurse are orders in the electronic mot available for interview	F 7	60		
	5/13/22 and dischar #6's medical diagno pneumonia, chronic	admitted to the facility on ged on 5/15/22. Resident ses included in part: obstructive pulmonary ation, and hypertension.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 760	Continued From pag	ne 21	F 7	60		
	Profile Report dated indicated she was to milligrams twice per pressure if less than 60. An allergy was I used to treat hyperter Review of the facility Resident #6 reveale sotalol 80 milligrams hold for systolic blocheart rate less than Nursing Supervisor. Review of Resident Administration Recorevealed the medica 5/13/22 at 9 PM, 5/1 5/15/22 at 9AM. Review of Resident a progress note date indicated the drug so Review of Resident the hospital Emerge dated 5/15/22 indicated the drug so Resident #6 heart rate and sepsilife-threatening infections.	physician orders for d an order dated 5/13/22 for give 0.5 tablet twice per day, d pressure if less than 110 or 60 was entered by the #6's Medication rd (MAR) for May 2022 tion sotalol was not given on 4/22 at 9 AM and 9 PM, and #6's medical record revealed at 5/14/22 at 1:16 PM which otalol was not available. #6's medical record revealed ncy Department Encounter ted resident presented with g in her chest and her heart was noted to have elevated				
	revealed she did not	/22 at 5:33 PM with Nurse #3 recall why she did not ordered on 5/13/22 at 9PM				

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F 760	Resident #6. Nurse #checked the emerger the medication. She is an E kit in May which medications that coul the medications were pharmacy. Nurse #3 is made deliveries betword the medications were delivery the nurse was determine why they we stated she did not do information on to Nurse 5/14/22 7 AM-7 PM so Nurse #3 further state not available or not as was to be notified to conformation on the state of the	M when she was assigned to a could not recall if she could not recall if she could make the facility had contained some common do be used for residents until received from the indicated that the pharmacy een midnight and 3:00 AM. The not received on that is to call the pharmacy to were not received. Nurse #3 this and did not pass the se #9 who worked on thift assigned to Resident #6. The physician solution further orders. Nurse notify the physician that exceive medication sotalol as and 5/14/22 at 9 PM. Inducted on 7/27/22 at 11:25 to was assigned to Resident PM shift. Nurse #2 revealed of for Resident #6 was not with the could be shift. Nurse #2 revealed of for Resident #6 was not with the could be shift. Nurse #2 stated that the duty on 5/15/22 at 7:00 AM and of fluttering in her chest is racing. Nurse #2 and noted that her blood attes were elevated. Nurse the physician of Resident at sotalol was not available, and the of the physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available. The physician of Resident at sotalol was not available.	F7	760			
		Id take to arrive, so she send Resident #6 to the					

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F 760	hospital. Resident #6 emergency medical s admitted with a diagn. An interview with Nur AM indicated that who admitted the orders we computer. Nurse #1 call should be made to them that the medical Nurse #1 indicated the checked to see which available. Nurse #1 a local pharmacy that quickly if needed. She physician was to be not that were not available. An interview was con Manager on 7/27/22 and Manager stated that to inform the facility wallergy or discrepancy clarification from the pharmacy noted Resi and sent a fax regard sotalol. On 5/13/22 at PM the pharmacy cal clarification of the ord allergy. The facility do calls from the pharmacy attempts via fax and the with the facility the set.	was sent to the hospital via ervices where she was osis of sepsis. se #1 on 7/27/22 at 11:40 en a new resident was vere transcribed into the indicated that a telephone of the pharmacy to informations were needed that day, at the E kit was to be medications were also indicated that there was could provide medications e revealed that the otified of any medications e or not given. ducted with the Pharmacy at 3:48 PM. The Pharmacy he pharmacy's protocol was in a phone call or fax of an or in an order which required on 5/13/22 at 3:48 PM the dent #6's allergy to Toprol ing potential sensitivity to a 3:52 PM and again at 6:17 led the facility to request er for sotalol due to Toprol ind not answer the phone are sotalol was placed on a due to unsuccessful wo phone calls to clarify insitivity.	F	760			
	· ·	he nurse that was assigned 3/22 and 5/14/22 for 7 AM-7					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MYRTLE GROVE				STREET ADDRESS, CITY, STATE, ZIP COE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412)E	OTTESTEDEE	
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F 760	PM shift. Nurse #9 n facility. Phone and to Nurse #9 did not return. Multiple attempts were Nursing Supervisor, volume 5/14/22 from 7 AM-71 no longer worked at the messages were left with did not return. An interview with Nur 7/28/22 at 12:15 PM that Resident #6 wou allergic to Toprol and pharmacy would not #2 further indicated the received sotalol while adverse effect. NP # expectation was that provider when a med not given so that a sufurther orders given. receiving sotalol coulfibrillation, however a also be indicative of a An interview on 7/28/Regional Director of that her expectation would be staff are to be notified pharmacy. She also expectation was that the physician would be sufficient	o longer worked at the ext messages were left which rn. The made to interview the who worked on 5/13/22 and PM. The Nursing Supervisor the facility Phone and text which the Nursing Supervisor the facility Phone and text which the Nursing Supervisor the sensitive to sotalol if was surprised that the deliver the medication. Note that Resident #6 had a in the hospital without 2 revealed that the the nurse would notify the ication was not available or obstitution could be made, or NP #2 stated that not do cause a worsening of atrial in elevated heart rate could a sepsis reaction. 22 at 4:25 PM with the Clinical Services revealed was that there would be een the pharmacy and the I Director of Clinical Services e expected that the nursing dof all calls from the	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345507	B. WING			C 07/29/2022		
NAME OF PR	ROVIDER OR SUPPLIER	2.000		STREET ADDRESS, CITY, STATE, ZIP CODE				
AUTUMN (CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD				
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(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		