STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	03/05/2020

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, the facility failed to treat a resident (Resident #10) with dignity by; 1) not having a call bell within reach to alert staff she was wet and uncomfortable, 2) ignoring a resident ' s request to clean her more thoroughly and; 3) leaving a resident in a wet bed for 1 of 3 residents observed for dignity. Findings included: Resident #10 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] quarterly assessment revealed the resident was mildly cognitively impaired and required extensive assistance with two staff physical assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and was always incontinent of bowel and bladder. A review of Resident #10 ' s care plan revealed a plan of care for incontinence of bowel and bladder with interventions to include monitor peri area for redness, irritation, skin excoriation and breakdown and provide incontinence care as needed. 1a. An observation of Resident #10 on 03/02/20 at 11:30 AM revealed Resident #10 was calling out for help. Resident #10 was noted to be lying in her bed. The call bell was noted to be on the floor. An interview was conducted with Resident #10 on 03/02/20 at 11:30 AM. Resident #10 stated she needed to be changed and she could not reach her call bell to call for help. Resident #10 stated she was wet and was uncomfortable. An interview was conducted with NA #10 on 03/02/20 at 11:45 AM. NA #10 noted the call bell on the floor and stated it was not within the resident ' s reach. NA #10 stated she was not the resident ' s nursing assistant today but she would find her aide and let her know she needed to be changed. NA #10 stated Resident #10 was alert and used her call bell to call for assistance. NA #10 stated the call bells should be within reach for each resident so they could use it to call for assistance. 2a An observation of Resident #10 on 03/03/20 at 2:50 PM revealed Resident #10 was banging on her bedside table. The resident ' s call bell was lying by her side tucked under her leg but within reach. An interview was conducted with Resident #10 on 03/03/20 at 2:50 PM. Resident #10 stated she needed some water and needed to be changed. Resident #10 pressed her call bell to request for help at 2:50 PM. The resident could not recall the last time she had incontinent care done, but stated she was wet and needed to be changed. A continuous observation from 2:50 PM until 3:30 PM was conducted on 03/03/20. At 3:30 PM, NA #9 entered the room. NA #9 was observed asking the resident what she needed and the resident stated she needed some water. NA #9 left the room to get water and returned. She asked the resident if she needed to be changed and the resident stated yes. NA #9 began to do incontinent care on Resident #10. She unfastened the brief. The brief was noted to be saturated with urine. The urine had soaked through the brief, through the pad on the bed, and through the bed sheets. NA #9 began to clean the resident ' s peri area and was noted to take two disposable wipes and wiped the sides of her groin and on top of her labia. NA #9 did not open the labia to thoroughly clean the resident. The resident said You need to clean it! Get in there and clean it! NA #9 reached for two more wipes and proceeded cleaning her peri area the same way by wiping the sides of the groin and the top of her labia. The resident yelled Why can ' t you clean it better? You need to get in the cracks! The NA was holding up the resident ' s leg and reached for two more wipes and cleaned the vaginal area again in the same manner she had done the previous two times. The resident was yelling and upset that the resident was not cleaning her thoroughly. NA #9 removed two more wipes and on the fourth attempt she opened the labia and cleansed the area with the wipes. She began to clean her buttocks and removed two wipes and wiped over her buttocks and slightly opened her buttocks to cleanse. The resident yelled You ' ve got to get into the cracks and clean me! NA #9 repeated the process of cleaning her buttocks again and performed the peri care properly after being told by the resident. 3a When NA #9 completed the incontinent care, she applied the brief and covered the resident up. NA #9 removed the wet pad and stated she needed to go and get a new pad and sheets. The bottom of the bed sheet was still wet and the resident was lying on the wet sheet. After 15 minutes, the NA arrived back to the room. NA #9 grabbed the clean linens off the cart and began to change the resident ' s wet bed. Resident #10 stated she did not understand why she had to wait so long to get her bed changed. An interview was conducted with NA #9 on 03/03/20 at 3:45 PM. NA #9 stated it took her a while to answer the call bell because she was gathering her information about her assignment. NA #9 reported she thought she was cleaning the resident in the proper way. NA #9 stated she received training on how to perform incontinent care and she thought she was cleaning inside the resident ' s peri area. NA #9 reported the brief was very wet and looked as though it had not been changed for a good bit. NA #9 stated she should not have let Resident #10 lay on a wet sheet and she should have removed the wet bed sheets. An interview was conducted with the Administrator and Regional Consultant on 03/05/20 at 4:00 PM. The Administrator stated his expectation of his nursing assistants was to ensure the call bells were within reach at all times so the residents would be able to make their needs known. The Administrator reported he expected his nursing staff to treat the residents with dignity and respect and to listen and respond to their requests so they do not get upset and to not leave a resident sitting in a wet bed.
F 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, the facility failed to keep a call bell within reach for 3 out of 3 residents observed who required nursing assistance. Resident #10, Resident #50 and Resident #180. Findings included: 1. Resident #10 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] quarterly assessment revealed the resident was mildly cognitively impaired and required extensive assistance with two staff physical assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and was always incontinent of bowel and bladder. An observation of Resident #10 on 03/02/20 at 11:30 AM revealed Resident #10 was calling out for help. Resident #10 was noted to be lying in her bed. The call bell was noted to be on the floor. An interview was conducted with Resident #10 on 03/02/20 at 11:30 AM. Resident #10 stated she needed to be changed and she could not reach her call bell to call for help. Resident #10 stated she was wet and was uncomfortable. An interview was conducted with NA #10 on 03/02/20 at 11:45 AM. NA #10 noted the call bell on the floor and stated it was not within the resident ' s reach. NA #10 stated she was not the resident ' s nursing assistant today but she would find her aide and let her know she needed to be changed. NA #10 stated Resident #10 was alert and used her call bell to call for assistance. NA #10 stated the call bells should be within reach for each resident so they could use it to call for assistance. 2. Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS quarterly assessment dated [DATE] revealed the resident was mildly cognitively impaired and required extensive assistance with one staff physical assistance with bed mobility, dressing and toileting and total dependence with one staff physical assistance with personal hygiene. Resident #50 had an impairment to one side to upper and lower extremities and was always incontinent of bowel and bladder. An observation of Resident #50 on 03/02/20 at 11:55 AM revealed an alert and oriented resident lying in his bed. The resident ' s call bell was noted to be on the floor. An interview was conducted with Resident #50 on 03/02/20 at 11:55 AM. Resident #50 reported he had pain.

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

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

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Resident #50 was asked if he let the nurse know and reported he could not ask for help because he could not reach his call bell. An interview was conducted with Nurse #4 on 03/02/20 at 12:05 PM. Nurse #4 stated Resident #50 was alert and oriented and used his call bell to request for assistance. Nurse #4 stated she did not know Resident #50 was in pain and she would medicate him. Nurse #4 stated call bells should be within reach at all times for residents because that was how they communicated to the staff if they needed anything. 3. Resident #180 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS admission assessment dated [DATE] revealed Resident #180 was mildly cognitively impaired. She required limited assistance with one staff physical assistance with bed mobility, transfers, dressing and personal hygiene and extensive assistance with one staff physical assistance with toileting. Resident #180 had no impairments and used a walker and wheelchair. She was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #180 was receiving scheduled pain medications for complaints of frequent pain which affected her sleeping and rated her pain 10 out of 10 on the pain scale. Resident #180 received 7 days of opioids (narcotic pain medication) during this assessment period. An observation of Resident #180 on 03/05/20 at 9:30 AM revealed an alert and oriented resident crying out and stating I ' m in pain! I can ' t reach my call bell! Why won ' t the nurse get me the help I need, I asked her over an hour ago! Resident #180 was visibly crying and in distress. The call bell was noted to be lying on the floor beside the bed out of reach of Resident #180. Resident #180 was lying on her back and was unable to reposition herself. An interview with Resident #180 on 03/05/20 at 9:30 AM revealed she had a fall on 03/04/20 and hurt her hip. Resident #180 stated she asked the nurse to please help her reposition her pillows and lower her legs and she stated the nurse reported she would get someone to help. Resident #180 stated That was over an hour ago! Resident #180 was crying and stated she was in pain. An interview with Nurse #3 on 03/05/20 at 9:34 AM revealed the resident told her she was in pain and needed help repositioning when she went in to the room to give the resident her medications. Nurse #3 stated she told the resident she would get someone to help her. Nurse #3 stated she believed it was about 8:15 AM when she told the NA. Nurse #3 could not remember which NA she told. Nurse #3 stated Resident #180 was alert and used the call bell to call for help if she needed it. Nurse #3 stated the call bells should be within reach at all times so the residents could notify staff if they needed assistance. An interview was conducted with NA #11 and NA #12 at 9:40 AM when they appeared in Resident #180 ' s room. NA #11 and NA #12 reported they were just informed by Nurse #3 to come in and help Resident #180. NA #11 and #12 stated this was the first time they were hearing about the resident needing assistance. NA #11 and NA #12 assisted Resident #180 with repositioning her bed, pillows and legs. Resident #180 reported she was much more comfortable and she had been in that position for too long and was not able to reposition herself. NA #11 placed the call bell within reach for Resident #180. An interview was conducted with the Administrator and the Regional Consultant on 03/05/20 at 4:00 PM. The Administrator reported his expectation of the nursing staff was to make sure call bells were kept within reach at all times so that staff could meet the requests and needs of the residents.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to provide proper perineal care and failed to shave a resident ' s face for 2 of 3 residents observed for activity of daily living (ADL) care. (Resident #10 and Resident #50) Findings included: 1. Resident #10 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] quarterly assessment revealed the resident was mildly cognitively impaired and required extensive assistance with two staff physical assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and was always incontinent of bowel and bladder. A review of Resident #10 ' s care plan revealed a plan of care for incontinence of bowel and bladder with interventions to include monitor peri area for redness, irritation, skin excoriation and breakdown and provide incontinence care as needed. An observation of Resident #10 on 03/03/20 at 2:50 PM revealed Resident #10 was banging on her bedside table. The resident ' s call bell was lying by her side tucked under her leg but within reach. An interview was conducted with Resident #10 on 03/03/20 at 2:50 PM. Resident #10 stated she needed some water and needed to be changed. Resident #10 pressed her call bell to request for help at 2:50 PM. The resident could not recall the last time she had incontinent care done. A continuous observation from 2:50 PM until 3:30 PM was conducted on 03/03/20. At 3:30 PM, NA #9 entered the room. NA #9 was observed asking the resident what she needed and the resident stated she needed some water. NA #9 left the room to get water and returned. She asked the resident if she needed to be changed and the resident stated yes. NA #9 began to do incontinent care on Resident #10. She unfastened the brief. The brief was noted to be saturated with urine. The urine had soaked through the brief, through the pad on the bed, and through the bed sheets. NA #9 began to clean the resident ' s peri area and was noted to take two disposable wipes and wiped the sides of her groin and on top of her labia. NA #9 did not open the labia to thoroughly clean the resident. The resident said You need to clean it! Get in there and clean it! NA #9 reached for two more wipes and proceeded cleaning her peri area the same way by wiping the sides of the groin and the top of her labia. The resident stated Why can ' t you clean it better? You need to get in the cracks! The NA was holding up the resident ' s leg and reached for two more wipes and cleaned the vaginal area again in the same manner she had done the previous two times. The resident was yelling and upset that the resident was not cleaning her thoroughly. NA #9 removed two more wipes and on the fourth attempt she opened the labia and cleansed the area with the wipes. She began to clean her buttocks and removed two wipes and wiped over her buttocks and slightly opened her buttocks to cleanse. The resident yelled You ' ve got to get into the cracks and clean me! NA #9 repeated the process of cleaning her buttocks again and performed the peri care properly after being told by the resident. When she completed the incontinent care, she applied the brief and covered the resident up. NA #9 removed the wet pad and stated she needed to go and get a new pad and sheets. The bottom of the bed sheet was still wet and the resident was lying on the wet sheet. After 15 minutes, the NA arrived back to the room. NA #9 grabbed clean linens off the cart and began to change the resident ' s wet bed. An interview was conducted with NA #9 on 03/03/20 at 3:45 PM. NA #9 stated it took her a while to answer the call bell because she was gathering her information about her assignment. NA #9 reported she thought she was cleaning the resident in the proper way. NA #9 stated she received training on how to perform incontinent care and she thought she was cleaning inside the resident ' s peri area. NA #9 reported the brief was very wet and looked as though it had not been changed for a good bit. NA #9 stated she should not have let Resident #10 lay on a wet sheet and she should have removed the wet bed sheets. An interview was conducted with the Administrator and Regional Consultant on 03/05/20 at 4:00 PM. The Administrator stated his expectation of his nursing assistants was to perform peri care properly to avoid urinary infections and skin breakdown and to perform incontinent care every two hours or as needed. 2. Resident #50 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS quarterly assessment dated [DATE] revealed the resident was mildly cognitively impaired and required extensive assistance with one staff physical assistance with bed mobility, dressing and toileting and total dependence with one staff physical assistance with personal hygiene. Resident #50 had an impairment to one side to upper and lower extremities and was always incontinent of bowel and bladder. A review of Resident #50 ' s care plan revealed a plan of care for self-care deficit related to left sided weakness. Interventions included, in part, to assist with activities of daily living such as dressing, grooming, toileting and oral care. An observation of Resident #50 on 03/02/20 revealed an alert resident lying in bed at 11:30 AM. Resident #50 was noted to have a significant amount of whiskers on his face and was not shaven. An interview was conducted with Resident #50 on 03/02/20 at 11:30 AM. Resident #50 reported he would like to have a shave and he would ask his NA to shave him today. Resident #50 stated it had been a while since he had his face shaven. An observation of Resident #50 at 4:00 PM on 03/02/20 revealed Resident #50 was lying in bed, unshaven. Resident #50 appeared to be sleeping at this time. An observation of Resident #50 at 10:00 AM on 03/03/20 revealed the resident was lying in bed and his face was noted to be unshaven. An interview with Resident #50 at 10:00 AM on 03/03/20 revealed he would like to be shaven and the staff did not always ask if he would like to get a shave. An observation of Resident #50 at 3:45 PM on 03/03/20 revealed the resident was lying in bed and his face was unshaven. A record review of a shower report for Resident #50 dated 03/03/20 revealed the resident received a bed bath. There were check boxes to the left of the shower report with yes, no, or refused. The boxes were noted to be checked off yes to indicate the resident was shaven, nails were cleansed and clipped, there was need for podiatry, and a bed bath was given. An interview with Resident #50 at 3:45 PM on 03/03/20 revealed he was cleaned up by NA #1 but she did not offer to shave him. Resident #50 stated, he would like to be shaved. An interview was conducted with NA #1 at 2:45 PM on 03/04/20. NA #1 reported she gave Resident #50 a bath on 03/03/20 and did incontinent care. She stated she did not shave the resident

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) and added, he did not need it. She stated she did not ask the resident if he would like to be shaved. NA #1 confirmed that she checked the boxes on the shower sheet to indicate Resident #50 had been shaven and his nails were cut. NA #1 stated it was a habit and she usually checked the boxes off out of habit. NA #1 stated a resident should not have to ask to be shaved. NA #1 reported shaving a beard on a man or facial hair on a woman should be completed with ADL care. An interview was conducted with the Administrator and the Regional Consultant on 03/05/20 at 4:00 PM. The Administrator stated his expectation for his nursing assistants (NAs) was to complete ADL care on their assignments which included personal hygiene. The Administrator stated, a resident should not have to wait to be asked to get a shave and it was not up to the NAs to decide if a resident needed a shave or not.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to supervise a resident who was at risk for falls by leaving him unattended in the bathroom for 1 of 4 residents (Resident #46) reviewed for falls. Findings included: Resident #46 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Admission/Readmission Evaluation dated 10/17/19 revealed that Resident #46 was at risk for falls and had three or more falls in the 90 days prior to admission to the facility. Resident #46's Care Plan initiated on 10/17/19 revealed he was at risk for falls and had interventions of maintaining the call light in reach and educating him on the use of the call light. Resident #46 also had a self-care deficit Care Plan initiated on 10/17/19. The interventions included assisting with toileting and transferring with the assistance of one person. The admission Minimum Data Set ((MDS) dated [DATE] revealed that Resident #46 was severely cognitively impaired and needed the extensive assistance of one person for transfers, hygiene, and toilet use. Resident #46 was occasionally incontinent of bladder and had a history of [REDACTED]. A nursing note dated 11/24/19, written by Nurse #2, revealed that Resident #46 was found sitting upright on the bathroom floor of his room. No apparent injury was noted but Resident #46 was sent to the Emergency Department (ED) for evaluation. The ED Encounter dated 11/24/19 revealed that Resident #46 complained of pain in the back of the head and his neck but denied any other injury. A CT scan of the head and cervical spine were completed and showed no bleeding or fracture. Resident #46 was sent back to the facility. In an interview on 03/04/20 at 11:20 AM the Rehabilitation Director stated that Resident #46 would get up on his own even though he was not supposed to. She indicated that Resident #46 was considered a fall risk and that he should not be left alone in the bathroom. In an interview on 03/04/20 at 2:32 PM Nursing Assistant (NA) #1 indicated that on 11/24/19 she was working with Resident #46 and had taken him into the bathroom to use the toilet. She stated she left him alone in the bathroom while she went to take a break and had forgotten to inform the other NA on the hallway or the nurse that Resident #46 was alone in the bathroom. NA #1 stated that she knew that Resident #46 was at risk for falls. In a telephone interview on 03/04/20 at 4:17 PM Nurse #2 verified that Resident #46 had been found on the bathroom floor on 11/24/19. Nurse #2 stated that Resident #46 did get up on his own and walk around even though he had been educated that he should not do that. She indicated that Resident #46 needed the assistance of one person for transfers and should not have been left alone in the bathroom. In an interview on 03/05/20 at 9:30 AM the Director of Nursing (DON) stated that Resident #46 had a history of [REDACTED].#1 had left Resident #46 alone in the bathroom while she went to take a break. The DON stated that it was unacceptable to leave residents with fall risks alone on the toilet because they could fall and injure themselves.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, the facility failed to provide pain management for 1 of 1 residents observed by not responding timely to a request to be repositioned which caused increased pain and distress for Resident #180. Findings included: Resident #180 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The MDS admission assessment dated [DATE] revealed Resident #180 was mildly cognitively impaired. She required limited assistance with one staff physical assistance with bed mobility, transfers, dressing and personal hygiene and extensive assistance with one staff physical assistance with toileting. Resident #180 had no impairments and used a walker and wheelchair. She was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #180 was receiving scheduled pain medications for complaints of frequent pain which affected her sleeping and rated her pain 10 out of 10 on the pain scale. Resident #180 received 7 days of opioids (narcotic pain medication) during this assessment period. A review of the care plan revealed Resident #180 had a plan of care in place for pain related to fractures. Interventions included, in part, to monitor for signs or symptoms of pain. An observation of Resident #180 on 03/05/20 at 9:30 AM revealed an alert and oriented resident crying out and stating I ' m in pain! I can ' t reach my call bell! Why won ' t the nurse get me the help I need, I asked her over an hour ago! Resident #180 was visibly crying and in distress. The call bell was noted to be lying on the floor beside the bed out of reach of Resident #180. Resident #180 was lying on her back and was unable to reposition herself. An interview with Resident #180 on 03/05/20 at 9:30 AM revealed she had a fall on 03/04/20 and hurt her hip. Resident #180 stated she asked the nurse to please help her reposition her pillows and lower her legs and she stated the nurse reported she would get someone to help. Resident #180 stated That was over an hour ago! Resident #180 was crying and stated she was in pain. An interview with Nurse #3 on 03/05/20 at 9:34 AM revealed the resident told her she was in pain and needed help repositioning when she went in to the room. Nurse #3 stated she told the resident she would get someone to help her. Nurse #3 stated she believed it was about 8:15 AM when she told the NA. Nurse #3 could not remember which NA she told. An interview was conducted with NA #11 and NA #12 at 9:40 AM when they appeared in Resident #180 ' s room. NA #11 and NA #12 reported they were just informed by Nurse #3 to come in and help Resident #180. NA #11 and #12 stated this was the first time they were hearing about the resident needing assistance. NA #11 and NA #12 assisted Resident #180 with repositioning her bed, pillows and legs. Resident #180 reported she was much more comfortable and she had been in that position for too long and was not able to reposition herself. An interview was conducted with Director of Nursing (DON) on 03/05/20 at 1:45 PM. The DON reported Nurse #3 should have ensured the resident ' s pain was addressed at that time and not left her in pain. An interview was conducted with the Administrator on 03/05/20 at 4:00 PM. The Administrator reported his expectation of the nursing staff was to deliver care at the time a resident needed care and to help provide relief from her pain. The Administrator added, if nursing staff needed additional help to assist a resident, they should get it timely.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by 9 medications that were administered late out of 25 observations resulting in a medication error rate of 36% for 6 of 7 sampled residents observed during a medication pass. (Resident #7, Resident #57, Resident #49, Resident #34, Resident #39, and Resident #31). Findings Included: 1)During a medication pass observation with Nurse #3 on 3/4/20 at 10:25 AM, Nurse #3 was observed administering the following medications to Resident #49: One tablet of [MEDICATION NAME] 37.5 milligrams (mg) crushed, and one tablet of [MEDICATION NAME] 0.5 mg crushed and administered via Resident #49 's gastrostomy tube. A medication reconciliation was conducted on 3/4/20 at 1:00 PM. The reconciliation revealed, [MEDICATION NAME] 37.5 mg and [MEDICATION NAME] 0.5 mgs were due to be administered at 9:00 AM. The [MEDICATION NAME] was scheduled to be administered twice a day and the [MEDICATION NAME] 0.5 mg was scheduled to be administered twice a day at 9:00 AM and 9:00 PM. An interview was conducted with Nurse #3 on 3/4/20 at 11:30 AM. Nurse #3 reported that she began the medication pass on the 700 hallway then proceeded to the 600 hall and she got behind schedule. She reported that she kept getting called away from her medication cart and it caused her to be late. 2) During a medication pass observation with Nurse #3 on 3/4/20 at 10:30 AM, Nurse #3 was observed administering the following medications to Resident #34: One tablet of [MEDICATION NAME] 25-100 mgs, and one tablet of Entacapone 200 mgs by mouth. A medication reconciliation was conducted on 3/4/20 at 1:15 PM. The reconciliation revealed [MEDICATION NAME] 25-100 mgs and Entacapone 200 mgs were both scheduled to be administered at 8:00 AM. The [MEDICATION NAME] was scheduled to be administered four times a day at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The Entacapone was scheduled to be administered three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. 3) During a medication pass observation with Nurse #3 on 3/4/20 at 10:48 AM, Nurse #3 was observed administering the following medications to Resident #39: One tablet of [MEDICATION NAME] 25 mgs by mouth. A medication reconciliation was conducted on 3/4/20 at 1:25 PM. The reconciliation revealed [MEDICATION NAME] 25 mgs was

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) scheduled to be administered twice a day at 9:00 AM and 9:00 PM. 4) During a medication pass observation with Nurse #3 on 3/4/20 at 11:00 AM, Nurse #3 was observed administering the following medications to Resident #31: One tablet of [MEDICATION NAME] 75 mg by mouth and one tablet of Potassium Chloride 20 milliequivalents by mouth. A medication reconciliation was conducted on 3/4/20 at 1:30 PM. The reconciliation revealed [MEDICATION NAME] 75 mg was scheduled to be administered twice a day at 9:00 AM and 9:00 PM, Potassium Chloride was scheduled to be administered twice a day at 9:00 AM and 9:00 PM. 5) During a medication pass observation with Nurse #3 on 3/4/20 at 11:15 AM, Nurse #3 was observed administering the following medications to Resident # 57: One tablet of [MEDICATION NAME] 5 mg by mouth. A medication reconciliation was conducted on 3/4/20 at 1:45 PM. The reconciliation revealed [MEDICATION NAME] 5 mg was scheduled to be administered twice a day at 9:00 AM and 9:00 PM. 6) During a medication pass observation with Nurse #3 on 3/4/20 at 11:20 AM, Nurse #3 was observed administering the following medications to Resident #7: One tablet of [MEDICATION NAME] 20 mgs by mouth. A medication reconciliation was conducted on 3/4/20 at 1:55 PM. The reconciliation revealed [MEDICATION NAME] 20 mgs was scheduled to be administered at 9:00 AM and 9:00 PM. A follow up interview was conducted with Nurse #3 on 3/5/20 at 9:50 AM. She reported that her assignment was manageable although it did cause her to get behind schedule with her medication pass at times. She reported that she was aware that medications were to be administered one hour before and one hour after the scheduled time that was listed on the electronic medical record. An interview with the Director of Nursing (DON) was conducted on 3/5/20 at 10:00 AM. The DON reported the protocol for medication administration times was one hour before the medication was due and one hour after the medication was due to be administered. The DON stated it was her expectation that the nursing staff administered medications as ordered by the physician and according to the times listed on the Medication Administration Record [REDACTED]
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, manufacturer's instructions, and staff interviews the facility failed to remove an expired [MEDICATION NAME] Emergency Kit (medication to treat very low blood sugar) from the medication cart, failed to accurately record an opened date for an oral inhaler, failed to refrigerate two bottles of [MEDICATION NAME] liquid (an anticonvulsant medication used to treat nerve pain and [MEDICAL CONDITION]) for 1 of 4 medication carts observed and failed to remove an expired container of [MEDICATION NAME] Topical Ointment from 1 of 1 treatment carts. Findings Included: In an observation with the Corporate Nurse Consultant on 3/2/20 at 12:46 PM an expired [MEDICATION NAME] emergency kit was in a drawer on the 200/300 hall medication cart. The manufacturer's label had an expiration date of February 2020. The Corporate Nurse Consultant verified that the [MEDICATION NAME] kit should have been discarded after the 29th day of February 2020. An [MEDICATION NAME] disk oral inhaler indicated for the treatment of [REDACTED]. The manufacturer's instructions for the [MEDICATION NAME] inhaler directed to discard it 4 weeks after opening. Further observation of the medication cart revealed two opened bottles of [MEDICATION NAME] liquid with a pharmacy label instructing to refrigerate the medication. In an observation of the wound treatment cart on 3/2/20 at 1:00 PM a container of [MEDICATION NAME] Topical Ointment (used for the treatment of [REDACTED]. In an interview with the Corporate Nurse Consultant on 3/2/20 at 1:00 PM she reported that it was the responsibility of the nurses to check the carts daily for expired medications. In an interview with the Director of Nursing on 3/5/20 at 10:00 AM she acknowledged that the medication cart was observed with expired and improperly stored medications. She indicated that the nurses were responsible for assuring medications were discarded by the expiration date, labeled with an opened date, and stored according to the instructions on the pharmacy label.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline, failed to clean kitchen baseboards, failed to clean stove/oven filters, and failed to monitor food storage areas. Findings included: 1. During a 03/03/20 12:35 PM observation of the kitchen trayline operation sixteen bowls of Cole slaw were left in a large baking pan. Dietary staff was pulling the Cole slaw to place on resident trays which were being loaded into the last meal cart going out on resident hallways. A calibrated thermometer registered 43.6 degrees Fahrenheit when the temperature of the Cole slaw was checked. The cook stated the slaw had been stored in the walk-in refrigerator until the trayline began operation at approximately 12:00 noon, and the Cole slaw was being pulled from refrigeration as needed. During an interview with the facility's Dietary Manager (DM) on 03/04/20 at 9:55 AM she stated cold salads made with protein such as mayonnaise were supposed to be kept at or below 41 degrees Fahrenheit during the entire operation of the trayline. She reported this procedure was important because it helped ensure that resident health was protected since bacteria could grow in cold foods which remained above 41 degrees Fahrenheit for long periods of time. She commented she thought the problem was that the dietary staff was bringing the Cole slaw out of refrigeration in batches which were too large, and the temperature rose above 41 degrees Fahrenheit before it could all be placed on resident trays. During an interview with Dietary Employee #1 on 03/04/20 at 2:40 PM she stated residents could get sick if cold foods were above 41 degrees Fahrenheit for very long. She reported foodborne illness could make elderly residents very sick. She commented that if dietary staff pulled large batches of cold salad from refrigeration then it should be placed on ice to keep the temperature below 41 degrees Fahrenheit. 2. During initial tour of the kitchen, beginning at 11:40 AM on 03/02/20, baseboards around the perimeter of the kitchen had dried food debris caked on them, especially behind the stove/ovens and storage racks and under the sink systems. During an interview with the facility's Dietary Manager (DM) on 03/04/20 at 9:55 AM she stated the kitchen was deep cleaned by the dietary staff once a month which included cleaning behind and under equipment, but if staff saw problems before then they were supposed to clean as needed. She reported the presence of food debris could cause pest problems in the kitchen. During an interview with Dietary Employee #1 on 03/04/20 at 2:40 PM she stated every evening dietary staff were supposed to sweep and mop the kitchen floor. However, she reported it appeared food debris was getting pushed up against the baseboards and drying on them. She commented not removing dried food debris could cause roach problems. 3. During initial tour of the kitchen, beginning at 11:40 AM on 03/02/20, the seven filters above the stove/oven system were coated with grease and oil, and dust had collected on them. During an interview with the facility's Dietary Manager (DM) on 03/04/20 at 9:55 AM she stated the stove filters were supposed to be cleaned by dietary once every two weeks, but she reported that because of shortage of dietary staff it had probably been much longer since the filters were last cleaned. She commented dirty filters could be a fire hazard. During an interview with Dietary Employee #1 on 03/04/20 at 2:40 PM she stated the stove filters were supposed to be cleaned once every two weeks, and if they needed cleaning before then, the AM cook took care of them. She reported it had probably been two months since the filters were last cleaned because dietary was working short of staff. She commented the combination of greasy, oily filters and the heat from the stove system could cause a fire to start. 4. During initial tour of the kitchen, beginning at 11:40 AM on 03/02/20, a 4-pound container of cheesecake mix, a 24-ounce packet of strawberry gelatin mix, 2 bags of elbow macaroni, and a 35-ounce bag of bran flakes all opened and found in the dry storage room were without labels and dates. In the dry storage room there were gelatin crystals that had spilled and not been cleaned up, and a gallon jug of barbecue sauce which warned refrigerate after opening on the label had not been placed in refrigeration. In the walk-in refrigerator two 7-pound containers of Cole slaw had a use-by date of 02/27/20, an opened bag of lettuce and a quarter of a fresh tomato covered in plastic wrap had no labels or dates on them, and a bag of sliced turkey had a use-by date of 02/20/20 on it. In the walk-in freezer an opened bag of French toast was not labeled and dated. During a follow-up tour of the kitchen on 03/04/20 at 9:28 AM a 32-ounce packet of lemonade drink mix and a 32-ounce bag of light brown sugar found in the dry storage room were opened but without labels and dates. Gelatin and lemonade crystals had spilled out on shelving and onto the lids of canned goods without being cleaned up. During an interview with the facility's Dietary Manager (DM) on 03/04/20 at 9:55 AM she stated Dietary Employee #1 was responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	03/05/2020

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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) for monitoring the food storage areas. She reported labeling and dating and use-by and best-by dates were supposed to be checked daily. She commented all opened food items were to have labels and dates on them, no food items were used past their use-by dates, and food items with labels documenting refrigerate after opening were not to be kept in the dry storage room after being opened. According to the DM, dating and labeling helped ensure residents received the freshest food possible. She stated foods could spoil if they were not refrigerated after opening as directed on the label. She also reported using food items past their use-by dates was dangerous because the foods might contain mold and/or bacteria. She commented sugary crystals that had not been cleaned up in the dry storage room could attract ants and roaches. During an interview with Dietary Employee #1 on 03/04/20 at 2:40 PM she stated she was supposed to check food storage areas daily, but she had been so busy that that was not always happening. She reported all food items which were opened or removed from their original packaging and repackaged should have labels and dates on them. She commented the facility did not use foods past their use-by dates because they could make residents sick, and the facility was supposed to place opened foods in the refrigerator if the label advised so. She remarked it was important to keep storage areas clean so there would not be pest and rodent problems. According to Dietary Employee #1, the goal of the facility was to monitor food storage areas thoroughly, and make sure all policies were followed which would allow residents to get the freshest, best quality, and safest foods possible to promote good health.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations and staff interviews the facility failed to clean and disinfect personal glucometers (a device used to check blood sugars) which were stored in the residents room for 2 of 2 sampled residents observed for blood sugar checks. (Resident #7, and Resident #57). Findings included: A review of the facility policy for glucometer cleaning and disinfecting dated May 2016 read (in part); the nurse will clean the residents glucometer after each use. The glucometer should be cleaned and disinfected by wiping the surface with a germicidal towelette for a three-minute contact time per label instructions. A review of the manufacturer's package instructions indicated the glucometer should be cleaned and disinfected using two towelettes, one for cleaning and a second wipe for disinfecting for one minute and allowing the exteriors to remain wet for the corresponding contact time (1-2 minutes) according to what type of disinfectant was used. An observation of a medication pass was conducted on 3/4/20 at 10:00 AM for Resident #57. Nurse #3 sanitized both hands, applied gloves and removed the personal glucometer from the device storage container located in the residents room. Nurse #3 did not clean the glucometer prior to use. Nurse #3 proceeded to obtain the blood sugar from Resident #57 after disinfecting the tip of the finger with an alcohol wipe. Nurse #3 used a lancet (a small needle) to obtain the blood sample. Once the result displayed on the device, Nurse #3 removed the contaminated glucometer strip from the glucometer and placed the device back into the storage container. Nurse #3 did not clean the glucometer prior to placing it back into the storage container. She removed her gloves, washed her hands, then left the residents room and returned to the medication cart. An observation of a medication pass was conducted on 3/4/20 at 4:00 PM for Resident #7. Nurse #3 sanitized both hands applied gloves and removed the personal glucometer from the storage container located in Resident #7 's room. Nurse #3 did not clean the device prior to use. Nurse #3 proceeded to obtain the blood sample on Resident #7 after wiping the tip of the finger with an alcohol wipe. Nurse #3 used a lancet to obtain the blood sample to apply to the glucometer strip. Once the result displayed on the device Nurse #3 removed the contaminated strip from the glucometer and placed the device back into the storage container. Nurse #3 did not clean the glucometer prior to placing the device back into the storage container. Nurse #3 removed her gloves, washed her hands, left the residents room and returned to the medication cart. In an interview with Nurse #3 on 3/4/20 at 4:30 PM she stated that the residents had their own personal glucometers and the meters didn't require cleaning after every use. When Nurse #3 was asked what the facility policy for cleaning glucometers was, she stated to clean the glucometer for one minute. She reported that she thought the glucometer was cleaned once a day. During an interview with the Director of Nursing (DON) on 3/5/20 at 10:00 AM she stated that the facility used germicidal wipes/towelettes which required a two-minute contact time with the glucometer for cleaning and disinfecting glucometers. She stated the nurses had been in serviced on the facility policy regarding cleaning and disinfecting glucometers and were expected to clean and disinfect glucometers after every use. The facility Administrator stated on 3/5/20 at 3:07 PM that it was his expectation that the nurses cleaned the glucometers according to the policy and the manufacturer's instructions.