JUN 14 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a hospice plan of care for one (1) of two (2) sampled residents reviewed for hospice (Resident # 118). In addition, the facility failed to develop a plan of care with measurable nutrition goals for three (3) of five (5) sampled residents reviewed for nutrition (Resident #'s 91 and 82). The findings include: 1. Cross Refer F309, example #1. Resident	F 279	Preparation and submission of this plan of correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under state and federal law. I am signing the document below to signify I have received this document and that the plan of correction being submitted on this document is accurate. My signature does not indicate the facility has accepted the allegations contained in this 2567 or the deficiencies in which the alleged deficiencies were cited. Corrective action for residents found to be affected & for the residents having the potential to be affected by the deficient practices: 1-There was no evidence that any resident was adversely affected by the deficient practice. 2- The facility will work with the Hospice staff to develop a Hospice Plan of Care. 3- The facility will develop a plan of care with measurable objectives & timetables to meet resident's medical, nursing, mental & physical needs that are identified in the comprehensive assessment.	05/26/11 06/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faye M. Kenney	Administrator	6/10/11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 1 #118 was admitted to the facility on 4/5/11 with diagnoses of Hypertension, Diarrhea, Anemia, and Dysphagia. Review of the Minimum Data Set (MDS), dated 4/12/11, revealed she had moderately impaired cognitive skills, and required extensive assistance for all activities of daily living. Resident #118 was observed on 5/16/11, at 2:58 p.m. She was lying in bed and non-responsive to verbal stimuli. The resident's family was at bedside. The family member communicated the resident had recently had a decline in status and the family had elected the hospice benefit on 5/12/11. Review of the medical record and electronic medical record revealed no plan of care had been developed to address how the facility would coordinate care with hospice. The plan of care, last updated 5/13/11, did not address the resident's advance directives, pain medications or alternatives to pain medications or her election of the hospice benefit. The plan did not address how the facility and hospice would coordinate services. In addition, the plan of care did not indicate who was responsible for implementation of the focus areas that had a plan. Further review of the plan of care revealed goals had not been developed to address the resident's bathing needs, bed mobility needs, bowel and bladder needs, cognitive deficits, communication needs, dressing needs, fall risk, nutritional needs, oral needs, or transfer needs. In addition, some of the interventions implemented by the facility would not appear on the plan of care to ensure the interdisciplinary team could evaluate the effectiveness at the next meeting.	F 279	Measures put into place to ensure the deficient practice does not recur: 1- Met with Hospice staff to establish a better means of communication & coordination of care between Hospice staff & facility staff 2- Audit Care Plans on all residents for measurable goals.	05/26/11 06/16/11

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F 279	Continued From page 2 Resident #118 was considered at high risk for nutritional deficits upon admission to the facility. On 5/10/11, the resident began to refuse all food, fluids and medications. Review of the nutrition plan of care, last updated 5/16/11, revealed no goal had been developed to address her nutritional needs or eating concerns. Although the facility had implemented some dietary interventions, they did not appear on the plan of care so the effectiveness could be evaluated. Interview with Minimum Data Set (MDS) Coordinators #1 and #2 on 5/18/11 at 8:26 a.m., revealed they were in the process of completing a significant change assessment for Resident #118 and not yet updated the plan of care to address hospice services. MDS Coordinator #1 said, "I guess we have more informal communication with them." The MDS Coordinators indicated the hospice nurse had not attended the last care plan meeting for Resident #118, since she was not receiving hospice services at that time. MDS Coordinator #1 indicated she thought the facility's computer system would not allow the care plan to print fully, since Resident #118's record had been closed. The facility attempted to obtain direction from their Corporate Office, but was unable to provide documentation of an individualized plan of care with measurable goals and objectives. 2. Resident #91 was admitted to the facility 1/14/11 with diagnoses of Protein Calorie Malnutrition, Anemia and Anorexia. On 1/15/11, the resident measured 62 inches in height and her weight was 97 pounds(Body Mass Index 18). On 1/27/11, the resident's weight was 92 pounds (Body Mass Index 17), a 5.15% weight loss in	F 279	QA Monitoring 1- Designated staff will review all Hospice orders daily x1 week, then weekly x4 weeks, then monthly x2 months. 2- Review facility & Hospice Care Plans on residents receiving Hospice services weekly x4, then bimonthly x1 month, then monthly x1 month. 3- Members of the facility Care Plan Team & Director of Nursing will audit the separate disciplines sections on the facility Care Plan to ensure all goals are measurable weekly x4 weeks, then bimonthly x1 month, then monthly x1 month.	

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AUTUMN CARE OF MYRTLE GROVE	6725 CAROLINA BEACH ROAD WILMINGTON, NC 28406

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F 279	Continued From page 3 twelve (12) days. Review of the medical record revealed the resident needed continuous cues for all activities of daily living, including eating. On 1/17/11, the Certified Dietary Manager (CDM), estimated the resident's nutritional needs were as follows: 1229-1475 calories, 44-53 grams of protein and 1100-1540 cubic centimeters of fluid. Interview with the CDM on 5/18/11 at 10:23 a.m. revealed she used a formula, based on the resident's height and weight to determine her estimated needs. On 1/27/11, the CDM recommended Resident #91 be placed in the restorative dining program and receive Med Pass 2.0 (3 ounces) twice per day. Review of the plan of care, developed 2/2/11, revealed the following plan to address the resident's nutritional status: Focus (Problem): Nutritional Needs. Diagnosis: Thrush Goal/Evaluation Date: NONE Intervention: Dietary- FullAsmt V02 once for one days Enteral Asmt V02 once for 1 days Dietary- Make Admit Note once for 1 days Nursing-Print ADL Care Guides once for 1 days I&O- 8 hour totals q shift Dietary- Make PPS progress note once for 1 days The plan of care was not resident centered and did not address the resident's strengths, needs or preferences. In addition, the plan had no measureable goals and/or objectives for the resident.	F 279		

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F 279	Continued From page 4 Interview with the Director of Nursing (DON) on 5/18/11 at 11:15 a.m. revealed the facility utilized a computer system to generate care plans. The DON indicated when developing the plan of care, the staff member would have the option to add additional inoformation to the plan. The DON confirmed the plan had no measureable goal and the interventions were for staff to complete paperwork. 3. Resident #82 was admitted to the facility 4/13/11 with diagnoses of Anxiety, Depressive Disorder, Anemia and Status Post Amputation of Toe. The resident was assessed to require 1272-1527 calories, 46-55 grams of protein and 1150-1527 cubic centimeters of fluid on 4/20/11, by the Certified Dietary Manager (CDM). Review of the Minimum Data Set (MDS) dated 4/20/11 revealed the resident had severe cognitive impairment and required supervison while eating. The resident was observed in the restorative dining room on 5/17/11 at 12:30 p.m. and 5/18/11 at 12:24 p.m. The resident consumed approimately 10% at both observed meals and was at risk for weight loss due to her poor intake. On 4/14/11, the resident weighed 102 pounds. On 4/27/11 the resident weighed 96 pounds, representing a 5.88% loss. Review of the nutritional plan of care, developed 4/20/11 revealed the following: Focus (Problem): Limited assist needed, Keep MD and family informed, Keep staff and family informed of changes, monitor nutritional status, observe for changes in skin integrity, obtain labs as ordered, obtain nutritional consult as indicated,	F 279		

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F 279	Continued From page 5 offer adequate intake, r/t stage II, receives ordered supplements, weigh as needed. Goals Resident will experience no skin break down through next review. Resident will not have significant weight loss through next reveiw. Will maintain adequate nutrition with eating daily through next review. Interventions Dietary Make PPS progress note once for 1 days Dietary Make PPS progress note once for 1 days Dietary QTR ASMT V04 once for 1 days The plan of care was not resident centered and did not address the resident's strengths, needs or preferences. In addition, the plan had no measureable objectives for the resident. Interview with the Director of Nursing (DON) on 5/18/11 at 11:15 a.m. revealed the facility utilized a computer system to generate care plans. The DON confirmed the plan had no measureable goal and the interventions were for staff to complete paperwork. See F309 and hospice.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Corrective action for residents affected & for residents having the potential to be affected by the deficient practices: 1- There was no evidence that any resident was adversely affected by the deficient practices.	

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record reveiw and staff interview, the facility failed to ensure coordinated hospice services were provided and the effect of pain medication was monitored and documented for one (1) of two (2) sampled residents reviewed for hospice (Resident #118). The findings include: Resident #118 was admitted to the facility on 4/5/11 with diagnoses of Hypertension, Diarrhea, Anemia, and Dysphagia. Review of the Minimum Data Set (MDS), dated 4/12/11, revealed she had moderately impaired cognitive skills, and required extensive assistance for all activities of daily living. Resident #118 was observed on 5/16/11, at 2:58 p.m. She was lying in bed and non-responsive to verbal stimuli. The resident's family was at bedside. The family member communicated the resident had recently had a decline in status and the family had elected the hospice benefit. Review of the medical record revealed the facility nursing staff assessed the resident with no pain 5/4-10/11. On 5/10/11, review of the electronic pain assessment revealed the nurse had selected "yes" to indicate the resident was in pain. Further review revealed the nursing staff assessed the resident with no pain from 5/11-14/11. Interview with the Director of Nursing (DON) on 5/17/11 at 4:10 p.m. revealed the pain assessment allowed	F 309	2- The facility will work with the Hospice staff to ensure coordinated Hospice services. 3- The nursing staff will administer PRN &/or scheduled pain medication to Hospice residents as ordered & will then monitor for medication effectiveness. The nurse will also document the administration & follow up of the pain medication as per protocol. Measures put in place to ensure deficient practices will not recur: 1- Met with Hospice staff to establish a better means of communication & coordination between Hospice staff & facility staff. 2- In-service held for nursing staff regarding better communication skills between facility staff & Hospice staff & also the administration, documentation & follow up of pain medication. QA Monitoring 1- Designated staff will review all Hospice orders daily x1 week, then weekly x4 weeks, then monthly x2 months. 2- Review facility & Hospice Care Plans of Hospice residents weekly x4 weeks, bimonthly x1 month & monthly x1 month. 3- Designated staff will perform QA on pain medication administration, documentation & follow up 3x week for 1 month, once a week x1 month, then monthly x1.	5/26/11 6/16/11 5/26/11 6/01/11

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F 309	Continued From page 7 the nursing staff to give a "yes" or "no" answer regarding pain for Resident #118. Review of the hospice note, dated 5/13/11, revealed documentation Resident #118 was in pain. The hospice note documented, "Lying in bed. Moans and groans with repositioning or touch. No food or fluid intake X (times) four days per staff. Discussed pain management with Dr. (resident's physician) here at facility. Script written for Fentanyl Patch and Morphine Sulfate." Although the hospice nurse stated the resident was in pain, there was no reassessment by the facility staff to determine the resident's pain level, and the facility nursing staff continued to document the resident was not in pain until 5/14/11, when a "Pain Assessment" was completed. Review of the physician's orders revealed the following: "Continue Morphine Sulfate 10 mg/ml (milligram per milliliter). Give 1 (one) mg SQ (subcutaneously) every two hours PRN (as needed) pain X (times) 48 hours." Review of the MAR (medication administration record) revealed the as needed Morphine Sulfate was administered four (4) times on 5/13/11, five (5) times on 5/15/11 and one (1) time on 5/17/11. Review of the back of the MAR revealed there was no documentation of time the medication was given, the dosage, the reason or the results, except for the 5/13/11 dose, which only did not document the results. Interview with the DON on 5/17/11 at 4:10 p.m. revealed each time a PRN medication is administered, the nurse should document on the back of the MAR. Further review of the medical record and	F 309		

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F 309	Continued From page 8	F 309		

electronic medical record revealed no plan of care had been developed to address how the facility would coordinate care with hospice. The plan of care, last updated 5/13/11, did not address the resident's advance directives, pain medications or alternatives to pain medications or her election of the hospice benefit. The plan did not address how the facility and hospice would coordinate services. In addition, the plan of care did not indicate who was responsible for implementation of the focus areas that had a plan.

Interview with Minimum Data Set (MDS) Coordinators #1 and #2 on 5/18/11 at 8:26 a.m., revealed they were in the process of completing a significant change assessment for Resident #118 and not yet updated the plan of care to address hospice services. MDS Coordinator #1 said, "I guess we have more informal communication with them." The MDS Coordinators indicated the hospice nurse had not attended the last care plan meeting for Resident #118, since she was not receiving hospice services at that time.

Interview with Licensed Practical Nurse (LPN) #1 on 5/18/11 at 9:18 a.m. revealed when the hospice nurse came to visit residents, she would stop and ask the nurse if there had been any changes with the resident's status. LPN #1 further stated the hospice nurse would document in a book any changes she recommended.

Interview with Certified Nursing Assistant (CNA) #3 on 5/18/11, at 9:10 a.m. revealed she had taken care of residents who elected the hospice benefit. CNA #3 stated usually hospice would put a sign on the resident's closet door indicating a

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F 309	Continued From page 9 schedule of what day they would visit. CNA #3 said, "I take care of the residents on hospice just like any other." Interview with the DON on 5/17/11 at 4:10 p.m. confirmed there was no coordinated plan of care with hospice for Resident #118. The DON called the hospice nurse assigned to the facility during the interview and confirmed no coordinated plan had been developed, and the hospice had not given a copy of their plan to the facility. The DON said, "Yes. There should be a combined plan."	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	Corrective action for residents affected & for residents having the potential to be affected by the deficient practices: 1- There was no evidence that any resident was adversely affected by the deficient practices. 2- Staff assisting residents during their meals will not handle food with their bare hands. 3- Staff who provide direct patient care will have clean, neat & trimmed natural nails. Measures put into place to ensure the deficient practices will not recur: 1- Verbal in-service was held regarding artificial nails & length of natural nails allowed. 2- Amended dress code policy to include "no artificial nails" & provided copy of policy to all staff.	6/01/11 6/16/11 6/01/11 6/03/11

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F 441	Continued From page 10 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the policy entitled "Hand Hygiene," the facility failed to ensure two (2) of six (6) Certified Nursing Assistants (CNA) did not handle food with their bare hands for one (1) of two (2) meal observations. The findings include: During the meal observation conducted 5/16/11, beginning at 11:55 a.m., the following concerns were identified: 1. CNA #1 picked up the roll for Resident #45 with her bare hand and used her acrylic nail to open the roll, and then used a knife to apply butter to the roll. The CNA then moved to a different table in the restorative area and completed the same task for another unsampled resident. 2. At 12:03 p.m., CNA #2 held Resident #122's	F 441	3- Staff who handle food will wear disposable gloves in good condition & that are changed after each use to help reduce the spread of microorganisms. QA Monitoring 1- Designated RN Managers will conduct random mealtime observations 3x week for 1 month, then once a week for 1 month, then monthly x1 month. 2- Designated RN managers will conduct random fingernail checks on employees who provide direct patient care 3x week for 1 month, then once a week for 1 month, then monthly x1 month.	

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F 441	Continued From page 11 roll with her bare hand and used a knife to apply butter to the roll. CNA #2 assisted another resident with her plate then picked up a piece of chicken, again with her bare hand, and requested Resident #122 eat the chicken. CNA #2 also assisted Resident #62 with her soup. CNA #2 removed crackers from the wrapper and used her bare hands to crumble them in the soup. 3. Review of the "Hand Hygiene" policy revealed the following direction for staff, "Staff who have direct contact with residents or who hand food must be free of communicable diseases...All staff involved in direct resident contact should maintain fingernails that are clean, neat, and trimmed. Wearing intact disposable gloves in good condition and that are changed after each use to help reduce the spread of microorganisms." 4. Interview with the Director of Nursing (DON) on 5/17/11 at 5:00 p.m., revealed nurse aides should not use their bare hands to handle resident's food.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 6/15/2011 it was determined that the facility filed to provide a Fire Alarm Control Panel (FACP) in proper working order. Findings include: The FACP when tested after disconnecting normal power to system failed to have any reading as the battery back-up power failed to supply power to the FACP. CFR#: 42 CFR 483.70 (a)	K 052	Preparation and submission of this plan of correction does not constitute an admission or agreement by the facility of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under state and federal law. I am signing the document below to signify I have received this document and that the plan of correction being submitted on this document is accurate. My signature does not indicate the facility has accepted the allegations contained in this 2567 or the deficiencies in which the alleged deficiencies were cited. Corrective action for residents found to be affected by the deficient practice & corrective action for those residents having potential to be affected by the same deficient practice. Batteries were found to be defective & were replaced. Measures put into place to ensure deficient practice does not recur. 1-The fire Alarm Control Panel (FACP) will be tested quarterly by disconnecting normal power to the system which will ensure the battery back-up power supplies the FACP. Any functional concerns will be addressed immediately. QA Monitoring The FACP will be tested monthly x3, then ongoing quarterly. Any functional concerns will be reported to our Service Provider immediately & findings will be reported to the Safety Committee quarterly.	06/16/11 quarterly quarterly

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CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faye M. Kenny	Administrator	7/1/11

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.