STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 05/07/2015

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Responsible Party (RP) and hospice of a change in condition for 1 of 1	F 157	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. Preparation and	5/31/15

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

Electronically Signed | 05/22/2015

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F 157	Continued From page 1 hospice residents reviewed (Resident #31). The findings included: Review of the clinical record revealed Resident #31 was admitted to the facility on 9/9/03 and had diagnoses of Dementia, Adult Failure to Thrive, and Chronic Obstructive Airway Disease. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/15/15 revealed the resident was severely cognitively impaired and received hospice care. The Hospice Care Plan dated 2/11/15, under Interventions read: " Reinforce with facility staff to call hospice with any change in patient condition. " The resident ' s Care Plan for Terminal/Palliative Care dated November 20, 2013 and updated on 3/5/15 read: " Resident is receiving Hospice services. " The Care Plan instructed staff to consult with hospice as needed regarding care. A nursing progress note dated 3/3/15 at 2:30PM revealed the physician was in the facility and was made aware the resident sounded congested and had increased fatigue and decreased appetite. A progress note dated 3/3/15 at 8:24PM by the physician revealed the physician was asked to see and evaluate the patient by the nursing staff because of a change in behavior. The note revealed the resident was sleeping a lot, had decreased appetite and sounded congested. There was no documentation the responsible party (RP) was notified. Record review revealed orders dated 3/3/15 for a chest x-ray, blood tests and a urinalysis. Review of the record revealed the resident ' s RP and telephone number was listed in the record. There was no documentation the RP was notified of the resident ' s change in condition or that hospice was notified. A nursing progress note dated 3/4/15 at 3:28AM	F 157	submission of the plan is in response to CMS-2567 and is not an admission by Autumn Care of Myrtle Grove that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1. Corrective Action Taken The responsible party was notified of the resident change in condition on 3/4/2015 at 11:30am. Hospice was notified of the resident change in condition on 3/4/2015 at 3:28am. Nurse #1 was re-educated and disciplined by the DON on RP/Hospice notification after a resident change in condition on 3/11/2015 (Attachment #1). 2. Potential to Affect Residents by the Same Deficient Practice Licensed nursing staff and providers were re-educated on Responsible party and Hospice notification of a resident change in condition as well as how to identify a hospice resident in the electronic health record by the DON and/or designee to be completed by 5/31/2015. (Attachment 2. New licensed nursing staff and providers will be educated on Responsible party and Hospice notification of a resident change in condition as well as how to identify a hospice resident in the electronic health record by the DON and/or designee during orientation or first visit to the facility if a provider. 3. Systematic Changes Events and new physician orders will be	

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F 157	Continued From page 2 revealed the resident ' s oxygen saturation was 85% and the on-call physician was notified of the x-ray results (bilateral pneumonia). The note revealed there was a new order for supplemental oxygen and the hospice nurse was notified of the resident ' s current condition. There was no documentation the RP was notified. A progress note dated 3/4/15 at 10:03AM revealed the Nurse Practitioner evaluated the resident. It was noted the resident was a hospice patient and all lab tests ordered were discontinued and hospice was called to come in and evaluate the resident. A progress note dated 3/4/15 at 11:18AM revealed a message was left for the RP to make her aware of the resident ' s change in condition and the RP returned the call on 3/4/15 at 12Noon. An interview was conducted on 5/6/15 at 10:07AM with Nurse #1 who was assigned to Resident #31 on the 7AM-3PM shift on 3/3/15 and 3/4/15. The Nurse stated she was a float nurse and did not know Resident #31 was on hospice. When asked why she did not call the RP and hospice on 3/3/15, the nurse stated she did call hospice and the RP on 3/4/15. When asked how often she worked with this resident, the Nurse stated: " Randomly. " An interview was conducted with the Administrator, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/6/15 at 10:17AM. The ADON stated the protocol was for the nurse to notify hospice and the physician of a change in condition. The Administrator stated hospice residents were red flagged in the computer system that would alert staff that the resident was on hospice. The Administrator stated the nurse and the physician was not aware the resident was on hospice care. The DON stated she re-educated all the staff	F 157	reviewed daily M-F x 4 weeks by the DON and/or designees to ensure RP and/or Hospice notification of a resident change in condition. (Attachment 3) 4. Performance Monitoring Findings of the above audits will be reviewed monthly for two months by the QA committee for recommendations and further follow up as indicated. If substantial compliance has been met and no areas of concerns are identified, review of the audits will be discontinued.	

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F 157	Continued From page 3 including the physician on identifying hospice residents by the red flags in the computer system. The DON and Administrator stated they would have expected the nurse to notify the RP when the physician ordered the lab tests and chest x-ray.	F 157		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, record reviews and facility documentation, the facility failed to administer 18 out of 70 doses of Ativan (an antianxiety medication) from 4/10/15 to 5/5/15 in accordance with the physician ' s orders in one of five sampled residents (#173) with MD orders for Ativan. The findings included: Resident #173 was admitted to the facility on 1/16/2015. Her diagnoses included dementia, anxiety, depression and rehabilitation after hip replacement surgery and stroke. On 4/10/15 a routine and as needed physician ' s order was written for Ativan. A physician order dated 4/10/15 was documented as Lorazepam (Ativan) 0.5 milliliters (ml) topical cream as needed (prn) anxiety/agitation at hour of sleep (HS). A physician order dated 4/10/15 was documented Ativan 0.5 milligrams (mg) tablet by mouth every HS. On 4/13/15 the routine order was cut in half and changed to Ativan 0.25 mg tablet by mouth at HS. A new, routine physician order dated 4/15/15 was documented as Ativan 0.25 mg topical gel twice a	F 281	1. Corrective Action The narcotic sheet for resident #173 was corrected to match the physician order dated 4/21/2015 on 5/5/2015 by the RN Supervisor. (Attachment #4). The facility received Ativan packaged in .5mg/1ml syringes on 5/7/15. Nurse #2 was re-educated on medication administration on 5/5/2015. (Attachment #5) 2. Potential to Affect Residents by the Same Deficient Practice Nursing staff are being re-educated by DON and/or designee on medication administration starting on 5/20/2015 to be completed on 5/31/2015. (Attachment #6). New licensed staff will be educated by the DON and/or designee on medication administration during orientation upon hire. All residents physician orders and medication cards have been audited for dosage discrepancies by the DON, ADON and RN Supervisor completed on 5/24/15	6/4/15

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F 281	Continued From page 4 day (7 a.m. and 2 p.m.) On 4/21/15 the medication order increased the morning dosage and changed the times of the Ativan topical gel to 0.5 mg daily at 6 a.m. and Ativan topical gel 0.25mg daily at 1 p.m. Review of the medical records revealed the physician orders were not followed for Resident #173 as evidenced by the following: 4/10/15 Ativan gel 0.5 mg ordered for HS dose and the nurse signed out she gave Ativan gel 0.25 mg at 10 p.m. in the narcotic log instead. 4/13/15 Ativan 0.25 mg by mouth ordered for HS dose and the nurse signed out she gave Ativan 0.5mg by mouth at 10:15 p.m. in the narcotic log instead. 4/14/15 Ativan 0.25 mg by mouth ordered for HS dose and the nurse signed out she gave Ativan 0.25mg topical gel at 9 p.m. in the narcotic log instead. 4/15/15 Ativan 0.25 mg by mouth ordered for HS dose and the nurse signed out Ativan 0.25 mg topical gel at 10:15 p.m. in the narcotic log instead. 4/16/15 Ativan gel 0.25 mg ordered for 7 a.m. dose and the nurse signed out she gave Ativan gel 0.125 mg at 8:20 a.mm in the narcotic log instead. 4/16/15 Ativan gel 0.25 mg ordered for 2 p.m. dose and the nurse signed out she gave Ativan gel 0.125 mg at 3 p.m. in the narcotic log instead. 4/16/15 Ativan 0.25 mg by mouth ordered for HS and nurse signed out she gave Ativan 0.5 mg at 10 p.m. by mouth instead. 4/17/15 Ativan 0.25 mg by mouth ordered for HS and the nurse signed out she gave Ativan 0.5 mg at 10 p.m. by mouth in the narcotic log instead. 4/18/15 Ativan 0.25 mg by mouth ordered for HS and the nurse signed out she gave Ativan 0.5 mg by mouth at 10:20 p.m. in the narcotic log	F 281	(Attachment 7). Medication pass audits will be completed by 6/4/2015 by DON and/or designee for all nurses that routinely pass medications. 3. Systematic Changes New physician orders will be reviewed M-F x 4 weeks by the DON and/or designee beginning on 5/19/2015. Dosage increases or decreases will be addressed by the DON and/or designee beginning on 5/19/2015. 3 medication audits will be conducted weekly x 4 weeks by the DON and or designee. 4. Performance Monitoring Findings of the above audits will be reviewed monthly for two months by the QA committee for recommendations and further follow up as indicated. If substantial compliance has been met and no areas of concerns are identified, review of the audits will be discontinued.	

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F 281	Continued From page 5 instead. 4/21/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan 0.25 mg gel at 10:05 p.m. in the narcotic log instead. 4/23/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 6 a.m. in the narcotic log instead. 4/25/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 5:30 a.m. in the narcotic log instead. 5/1/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 6:20 a.m. in the narcotic log instead. 5/2/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 6 a.m. in the narcotic log instead. 5/3/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 6 a.m. in the narcotic log instead. 5/4/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 5:30 a.m. in the narcotic log instead. 5/5/15 Ativan gel 0.5 mg ordered for 6 a.m. and the nurse signed out she gave Ativan gel 0.25 mg at 6 a.m. in the narcotic log instead. 5/5/15 Ativan topical cream 0.5 mg ordered for prn anxiety/agitation at HS (hour sleep) and the nurse signed out she gave Ativan gel 0.25 mg at 9:15 a.m. An incident report dated 5/5/15 at 10:30 a.m. stated that on 5/5/15 at 9:15 a.m. topical Ativan was not administered as ordered. Ativan gel 0.25 mg was given as a prn medication and the order was for Ativan gel 0.5mg topically HS prn. The report stated that Nurse #2 overlooked that the prn order for Ativan was for HS. The Physician was notified at 10:50 a.m. On 5/5/15 at 11 a.m. Resident #173 was observed being awake, alert and self-propelling	F 281		

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F 281	Continued From page 6 her own wheelchair down the hallway. During an interview on 5/5/15 at 10:15 a.m., Nurse #2 revealed that she had just administered a prn dose of Ativan at 9:15 a.m. to Resident #173 and it was a medication error. She stated she should not have given the Ativan gel at that time. Nurse #2 stated she did not look at the Medication Administration Record (MAR) thoroughly. During an interview on 5/5/15 at 10:33 a.m., the Unit Manager revealed the Ativan gel 0.25 mg dose given at 9:15 a.m. by nurse #2 was not a dose that should have been given. She further stated it was half of the dose of the prn medication that was ordered for HS prn. In an interview with the physician on 5/5/15 at 12:06 pm it was revealed that the physician had been made aware of the prn Ativan being given at the wrong time. The Physician stated that if too much Ativan was given you would watch for over-sedation or resident becoming agitated. If too little Ativan was given you would worry about her being overactive enough to get out of her wheelchair or show aggressive tendencies. The Physician had seen Resident #173 on 5/5/15 at 10:50 a.m. and she was not over-medicated or too sedated at that time. The physician had told staff to hold her 1 p.m. dose of Ativan on 5/5/15 to be on the safe side. On 5/6/15, the Unit Manager compiled a list of Ativan orders and what dose Ativan was actually given by the nurses on the unit based on physician orders, MAR, and narcotic sign out sheets. There were 17 dosages that did not correspond with the MD orders. In an interview with the Administrator and Director of Nursing (DON) on 5/7/15 at 10:38 a.m., it was revealed that there had been multiple changes in Resident #173 ' s Ativan orders. The	F 281		

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F 281	Continued From page 7 Administrator stated there had been two different doses of Ativan gel in the locked box in the refrigerator (Ativan 0.5 mg/1ml and Ativan 0.25 mg/0.5cc). Presently, the facility only has Ativan 0.25mg/0.5cc in the locked refrigerator for the resident. In an interview with the Administrator and the Unit manager 5/7/15 at 10:50 a.m. it was stated that giving the wrong doses of Ativan was an honest, unfortunate error and there was no intent for harm. They further stated that measures were already being discussed and put in place to prevent any future incidents of this kind. In an interview with the Physician on 5/6/15 at 4:12 pm it was revealed that the facility had made her aware of the Ativan not always being given to the resident in the right dosage since 4/10/15 and had talked with the facility about how this can be prevented in the future. The Physician further stated that the resident has had several medication changes in the course of her stay and in her opinion the resident was not harmed by the medications not being given in the correct dosage.	F 281		
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. This REQUIREMENT is not met as evidenced by:	F 309		5/31/15

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F 309	Continued From page 8 Based on record review and staff and physician interviews the facility failed to notify the resident ' s Responsible Party and Hospice of a change in condition that resulted in unnecessary testing procedures for 1 of 1 hospice residents reviewed (Resident #31). The Findings included: Review of the clinical record revealed Resident #31 was admitted to the facility on 9/9/03 and had diagnoses of Dementia, Adult Failure to Thrive and Chronic Obstructive Pulmonary Disease. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/15/15 revealed the resident was severely cognitively impaired and received hospice care. The Hospice Care Plan dated 2/11/15, under Interventions read: " Reinforce with facility staff to call hospice with any change in patient condition. " The resident ' s Care Plan for Terminal/Palliative Care Needs dated 11/20/13 and updated 3/5/15 revealed the resident received hospice services and to provide hospice services as ordered. The interventions included to check pulse oximetry every shift and call if less than 90%. Review of the progress notes for Resident #31 revealed a nurse ' s note dated 3/3/15 at 2:30PM revealed the physician was in the building and made aware the resident had chest congestion, increased fatigue and decreased appetite. There was no documentation the Responsible Party (RP) or Hospice was notified. A nurse ' s note dated 3/3/15 at 2:33PM revealed a chest x-ray had been scheduled per physician orders. There were no notes that the RP or hospice was notified. Review of the physician ' s orders dated 3/3/15 revealed orders for a chest x-ray, blood tests and a urinalysis. A physician ' s progress notes dated 3/3/15 at	F 309	1. Corrective Action Taken The responsible party was notified of the resident change in condition on 3/4/2015 at 11:30am. Hospice was notified of resident change in condition on 3/4/205 at 3:28am. Nurse #1 was re-educated and disciplined on 3/11/2015 by the DON on Hospice and RP notification after a resident change in condition (Attachment 1). 2. Potential to Affect Residents by the Same Deficient Practice Licensed nursing staff and providers were re-educated on Responsible party and hospice notification of a resident change in condition as well as how to identify a hospice resident in the electronic health record by the DON and/or designee to be completed by 5/31/2015 (attachment #2). New licensed staff will be educated on Responsible party and hospice notification of a resident change in condition as well as how to identify a hospice resident in the electronic health record by the DON and/or designee to be completed during orientation. 3. Systematic changes Events and new physicians orders will be reviewed daily M-F x 4 weeks to ensure either the responsible party and/or hospice was notified of a resident change in condition (Attachment #3) Any new hospice resident will be audited for four weeks to determine if the chart is appropriately flagged (Attachment #9) 4. Performance Monitoring	

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F 309	Continued From page 9 8:24PM revealed the physician was asked to see and evaluate the resident by the nursing staff because of a change in her behavior. The note revealed the resident was sleeping a lot, had decreased appetite and sounded congested. The note revealed no obvious cardiorespiratory distress and the resident did not have a fever. A nurse ' s note dated 3/4/15 at 3:28AM revealed the resident ' s oxygen saturation was 85%. The note revealed the on-call physician was notified of the resident ' s condition and the results of the chest x-ray (Bilateral Pneumonia). The note revealed a telephone order for supplemental oxygen at 2 liters per minute by nasal cannula. The note revealed the hospice on-call nurse was notified of the resident ' s current condition and new orders. The note revealed the resident had been catheterized twice in an attempt to obtain a urine sample without success. A nurse ' s note dated 3/4/15 at 10:30AM revealed the nurse practitioner was in to evaluate the resident. The note revealed the resident was a hospice patient and all labs ordered were discontinued. The note revealed hospice was called to have their staff come and evaluate the resident. A nurse ' s note dated 3/4/15 at 11:25AM revealed a message was left for the RP to make her aware of the resident ' s change in condition. A note dated 3/4/15 at 12Noon revealed the RP returned the call. Nurse #1 stated she was a float nurse in the facility and did not know Resident #31 was a hospice resident. The Nurse stated she did notify hospice and the RP on 3/4/15. An interview was conducted with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing on 5/6/15 at 10:17AM. The ADON stated when there was a	F 309	Findings of the above audits will be reviewed monthly for two months by the QA committee for recommendations and further follow up as indicated. If substantial compliance has been met and no areas of concerns are identified, review of the audits will be discontinued.	

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F 309	Continued From page 10	F 309		

change in the condition of a hospice resident, the protocol was for the nurse to notify hospice and the physician. The Administrator stated when a resident ' s name was pulled up on the computer there was a red flag if the resident was on hospice. The Administrator stated Nurse #1 and the physician did not know the resident was on hospice and the physician ordered laboratory test and x-rays on the resident. The DON stated she had in-serviced all the staff including the physician regarding the red flag and how to know if a resident was on hospice. The Administrator stated she would have expected the nurse to call the RP at the time the physician ordered the laboratory tests and x-rays.

On 5/6/15 at 11:00AM the Physician stated in an interview she was in the facility on 3/3/15 and was asked to look at the resident and she went right in to see the resident because it sounded somewhat urgent. The Physician stated she did not know the resident was hospice or what the red flag in the computer represented but if she had known, she would have still have seen the resident and ordered the same tests. The Physician stated she had been told in the past in the case of a hospice resident, nursing would call the RP to make them aware and find out how much the RP wanted to be done. The Physician stated she was later told the RP was concerned that tests had been ordered and asked why they did the tests when the resident was on hospice. The Physician stated she spoke with the RP and apologized if they had put the resident through uncomfortable procedures.

The DON stated in an interview on 5/6/15 at 1:47PM when the physician saw a hospice resident and ordered tests, it was up to the nurse to call the RP and let the RP decide how much they wanted to be done. The DON stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 05/07/2015

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 309	Continued From page 11 sometimes the physician would call the RP but it was ultimately the nurse ' s responsibility.	F 309		