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 04/18/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification/Complaint Investigation survey was conducted on 4/14/19 through 4/18/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# YYV011	E 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		5/2/19

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

Electronically Signed | 05/02/2019

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and record review the facility failed to provide written summaries of grievance resolutions for 1 of 1 residents reviewed (Resident #28). Findings included: Resident #28 was admitted to the facility on 07/26/18 with diagnoses that included a history of falls, urinary incontinence, thyroid disorder, anxiety and depression. A quarterly Minimum Data Set Assessment (MDS) dated 02/10/19 revealed Resident #28 had intact cognition. She had no documented moods	F 585	F585 1. Resident #28 will be provided a written summary of grievance resolutions filed since the facility's last annual recertification date. This to be completed by the administrator or designee by 5-2-19. 2. To identify other residents that have the potential to be affected, the administrator will look back at the grievances for the last two weeks to identify what grievances were filed , when they were resolved, and provide a written	

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F 585	Continued From page 3 or behaviors. She was independent with all activities of daily living except transfers, dressing, toileting and personal hygiene for which she required supervision only. She was occasionally incontinent of bladder and always continent of bowel. She had no wounds. She used a walker and a wheelchair for independent mobility. During an interview conducted with Resident #28 on 04/15/19 at 3:00 PM she stated that she had filed many complaints with the facility but had never received an explanation in writing regarding the outcome of the investigations. Record review of grievances filed by Resident #28 since the facility's last annual recertification date revealed that the resident had filed concerns on: 08/2/18, 10/16/18, 10/23/18, 11/7/18, 02/5/18, and 02/8/18. Review of the "resolution of complaint" section of the facility investigations for the grievances filed by Resident #28 revealed that the Resident Signature section on each form was blank and had not been signed by the resident. None of the investigations indicated that the resident had been notified in writing of the grievance resolutions. In an interview conducted with the Grievance Officer on 04/16/19 at 1:40 PM she stated that she had been employed at the facility for 3 years. She reported that a concern form could be filled out by any staff member, resident or guest to voice a grievance. She said the original form went to the administrator, and a copy was given to the department named in the concern for that department to resolve. Once the concern was resolved the facility notified the complainant	F 585	summary of the grievance resolution to the resident/reporting person. 3. To prevent this from recurring, the Regional Director of Clinical Services has reeducated the administrator concern the F585 regulation specifically that the regulation includes that the resident has to be provided a written decision regarding his or her grievance. 4. To monitor and maintain ongoing compliance of providing a written resolution regarding his or her grievance, the administrator or designee will document on the grievance log the completion date and that a written resolution was provided. The administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the timeframe of the monitoring period or as it is amended by the committee.	

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F 585	Continued From page 4 one-to-one or by telephone of the resolution. She commented that she had made personal contact to relay complaint resolutions but had never given a complainant a written summary of a complaint resolution. She stated that she was not aware of the regulation that a written statement must be given to the complainant regarding the resolution of a grievance. In an interview conducted with the Administrator on 04/16/19 at 1:51 PM he stated when the facility received a grievance it was recorded on a concern form. A copy was given to him and the person responsible for resolving the grievance. Once the grievance was resolved he recorded the outcome on the concern log. He commented that the grievance log was reviewed monthly at the Quality Assurance meeting. He reported that the resident was notified of the resolution face-to-face or by phone. He stated that he was not aware that a written summary of the resolution was required to be provided to the complainant and that the facility had not been providing written statements. He stated that he would fix the process to include written statements of grievance resolutions to be provided to the complainant or the resident going forward.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to code information correctly on the	F 641	1. Minimum data set (MDS) assessments were corrected for identified	4/24/19

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F 641	Continued From page 5 minimum data set (MDS) assessments for 2 of 21 sampled residents (Resident #57 and Resident #69) whose MDS assessments were reviewed. Findings included: 1. Record review revealed Resident #57 was admitted to the facility on 02/13/14. The resident's documented diagnoses included history of falls, hypotension, heart disease, long term use of anticoagulants, and Alzheimer's dementia. Review of Resident #57's minimum data set (MDS) assessments revealed she had a quarterly assessment completed on 02/20/19. A 02/28/19 progress note documented, "This writer heard a pt (patient) yelling down hall went to hall to assess situation and noted pt (Resident #57) at bedside on floor mat with left arm wrapped around bed rail, pt unable to state what happened due to confusion, pt assisted back to bed x 2 staff with gait belt. Bruising noted to left upper and forearm..." Resident #57's 03/31/19 significant change MDS documented she had short and long term memory impairment, her decision making skills were severely impaired, and she had experienced no falls since her last MDS assessment (on 02/20/19). During an interview with the facility's Director of Nursing (DON) on 04/18/19 at 9:30 AM she stated it was her expectation that MDS assessments be coded accurately. During an interview with MDS Nurse #1 on 04/18/19 at 1:10 PM she stated she looked at progress notes and risk management	F 641	residents #57 section J on 3-31-19 and #69 section K on 4-8-19 by the Minimum Data Set Nurse. 2. To identify other residents that have the potential to be affected, an audit of the coding completed for MDS assessments that were completed in the last 30 days for residents that have had falls, have therapeutic diets, or are on hospice. This to be completed by the MDS Nurse by 4-24-19. 3. To prevent this from recurring, the Regional Reimbursement Specialist reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines concerning the expectation that all assessments are accurate. This was completed on 4-24-19. 4. To monitor and maintain ongoing compliance, the MDS nurses will audit 3 completed assessments each week for 12 weeks. Nurses will not audit their own work. The MDS nurses will report the results of the audit to the administrator each week for review. The MDS Coordinator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 641	Continued From page 6	F 641		

documentation to gather information about falls when coding information on resident MDS assessments. She also reported that falls and fall interventions were discussed in the morning meetings. After reviewing Resident #57's progress notes, MDS Nurse #1 stated the resident's 03/31/19 significant change MDS included some inaccurately coded fall information. She explained instead of documenting that the resident had no falls since her 02/20/19 quarterly MDS, she should have coded that the resident experienced one fall with non-major or minor injury since there was bruising associated with the 02/28/19 fall. She commented the miscoding on falls in Resident #57's 03/31/19 MDS assessment was due to human error, possibly because there could have been a delay in finalizing the resident's risk management documentation.

2. Resident #69 was admitted to the facility on 01/01/19 with diagnoses that included cholecystitis, anemia in chronic kidney disease, hypertension, acute respiratory failure with hypoxia, acute systolic congestive heart failure, mycordial infarct, ischemic cardiomyopathy, anemia, acute kidney failure, urine retention, acute gastritis with bleeding, fracture of head of right femur, displaced intertrochangeric fracture of left femur, and stage 5 chronic kidney disease.

Review of physician orders revealed Resident #69 had a diet order for a "NAS" (no added salt) therapeutic diet that was ordered on 01/09/19.

Review of Resident #69's MDS assessment dated 04/08/19 documented in Section K (D) that Resident #69 was not on a therapeutic diet.

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F 641	Continued From page 7 An interview conducted with MDS Nurse #1 on 04/18/19 at 1:10 PM she revealed that the quarterly assessment dated 04/08/19 was coded incorrectly indicating that Resident #69 was not on a therapeutic diet as the resident had been on a no added salt therapeutic diet since 01/09/19. She stated that she would modify the assessment to correct the error. In an interview conducted with the Director of Nursing on 04/18/19 at 9:30 AM she stated she expected the MDS assessment information to be accurate.	F 641		