	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION		TE SURVEY MPLETED
		345507	B. WING		0	C 3/26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 000	INITIAL COMMENTS	1	F 00	00		
	from 3/25/25 through	ation was conducted on-site 3/26/25. The following ed: NC00228403. Event ID				
	1 of the 1 complaint a deficiency. Quality of Care CFR(s): 483.25	allegation resulted in	F 68	34		4/16/25
	applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profi- practice, the compret care plan, and the resident This REQUIREMENT by: Based on record rev Practitioner and Physi- failed to comprehens failed to identify or re- external rotation and pain, and inability to B resident had external rotation of the thigh a body), was unable to experienced pain from through 3/10/25 at wite Emergency Room and comminuted right inter (most common type of bone of the thigh breat	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices. T is not met as evidenced iew and staff, Nurse sician interviews, the facility ively assess a resident and cognize the significance of shortening of the leg, severe bear weight after a fall. The rotation (an outward nd knee away from the bear weight and n 3/4/25 (the day after a fall) nich time he was sent to the		Resident #2 no longer resides in facility. On April 11, 2025 the Director of or designee assessed all current with a fall since March 26, 2025 t there were no physical injuries th unreported or unidentified on the physical assessment. The Director of Nursing or design educate all nurses on ensuring a assessment is completed after ea incident, the significance of exter rotation and shortening of a lowe extremity on assessment and rep	Nursing residents to ensure at were initial nee will physical ach nal r	
BORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					04/11/202

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.

STATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. ( (X3) DATE SU COMPLE	RVEY
			A. BUILDING	3	С	
		345507	B. WING		03/26	2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 684	Continued From page	e 1	F 68	34		
	pain in the hip, inabili affected leg, and shou of the leg). The reside nailing of the right fer metal rod is inserted is stabilize the fracture) result of the surgery. comprehensively ass for 1 of 4 residents re (Resident #2). Findings included: A review of Resident summary dated 3/3/2 diagnosed with weak present illness indicat knee replacement on hospitalization and wa at home. The resident control on 2/28/25 an indicated the resident with the resident's pa made slow progress of hospital and was disc facility to continue wit Resident #2 was adm diagnoses which inclu- knee replacement sur unsteadiness on feet, was discussed in Resident was discharge summary by	ty to bear weight on the rtening and external rotation ent underwent intermedullary nur (a procedure in which a into the long thigh bone to with no complications as a This failure to ess a resident was observed viewed for accidents #2's hospital discharge 5 indicated the resident was ness. The history of the ted Resident #2 had a total e week prior to as unable to make progress nt was admitted for pain d the hospital course t was stable upon discharge in improved. Resident #2 with physical therapy at the charged to the skilled nursing th therapy. hitted on 3/3/25 with uded: aftercare following rgery, muscle weakness and . A diagnosis of dementia		the findings to the provi The education was com 4/14/2025. The Director of Nursing review the electronic m Monday-Friday for 12 w residents with a fall to e was assessed and that injuries, including extern shortening of the extrer reported to the provider identified will result in ir notification to the provide and re-education or pro- disciplinary action for th audits will be reviewed months in the Quality A Performance Improvem meeting.	or designee will edical record veeks for all ensure the resident any physical nal rotation and nities have been the Any issues nomediate der for follow up ogressive he nurse. The monthly for 3 ssurance	
	written by Nurse #1 ir	ote dated 3/3/25 at 5:40 PM ndicated that Resident #2 rcare following a right total				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				INTED: 04/14/2025 FORM APPROVED IB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		) DATE SURVEY COMPLETED
		345507	B. WING			C 03/26/2025
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP (	CODE	
			5	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE	v	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	oriented to person, pliconfusion. Resident and pivot assistance with orders for weight progress note indicate as continent of bowel using a urinal and bear Resident #2 wore glas which he left at home. A nursing progress not dated 3/3/25 at 11:54 had a fall in the room. Resident #2 reported urinal for toileting, but out of bed. The resident #2 reported urinal for toileting. But out of bed. The resider The right knee, which a dressing in place ar slight swelling. Reside injuries or increased p of head trauma. Vital normal limits. A mech assist the resident ba was to continue for ar note indicated every 4 were initiated and the contacted. A focused head to toe 11:45 PM completed to bservation was mad up to a fall. The observation was all press strength, a test asked to push agains	esident #2 was alert and ace and event with some #2 transferred with stand with one person assistance bearing as tolerated. The ed Resident #2 was noted and bladder and had been dpan prior to admission. sses and had a hearing aid . the completed by Nurse #4 PM indicated Resident #2 . The note indicated that he was supplied with a the spilled it before slipping ent was alert and oriented. . was recently replaced, had not showed old bruises and tent #2 reported no new pain. There were no signs signs remained within anical lift was used to safely ck to bed. Close monitoring ny changes in condition. The 4 hour neurological checks on-call provider was e observation dated 3/3/25 at by Nurse #4 indicated an e of Resident #2 as a follow ervation indicated that t to person, place, time and pilateral hand grasps. Foot in which the resident is t resistance as part of a on, was not assessed due to	F 684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5725 CAROLINA BEACH R	OAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684		3 tion of Resident #2's right lower extremities equal in	F 684	4			
	length.						
	completed by Nurse # had an unwitnessed f	ed 3/3/25 at 11:58 PM 4 indicated Resident #2 all with no injuries. Resident					
		oom on the floor. The report did not complain of or the fall. The report					
	indicated the nurse w of motion of his right l	as unable to complete range ower extremity and a					
	right lower extremity v	hortening of Resident #2's vas observed (an abnormal ed with a femur fracture).					
	-	n the 11:45 PM observation					
	completed by Nurse #	4 which indicated Resident					
	#2's lower extremities	were equal in length.					
	3/25/25 at 3:00 PM.	ducted with Nurse #4 on Nurse #4 stated she worked					
		at Resident #2 had an 25) in which he slipped out					
		ising the urinal. Nurse #4					
		ed the resident, and he did					
	the bed using a mech	o he was transferred back to anical lift. Resident #2					
	stated he did not hit h that throughout the ni	is head. Nurse #4 indicated ght. Resident #2					
	J. J	s in his back, and he was					
	unable to get comforta	able. Nurse #4 stated she					
		Iministered pain medication					
		ted that she and the staff					
		ent frequently to try to make					
		se #4 could not explain why					
		I:45 PM on 3/3/25 that xtremities were equal in					
		58 PM on the event report					
		on deformity or shortening of					

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 04/14/2025 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345507	B. WING			C 03/26/2025
NAME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP	, CODE	
	CARE OF MYRTLE GRO			725 CAROLINA BEACH ROAD		
AUTOWIN	CARE OF MITRILE GRO	VE	1	WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 684	knew that rotation and abnormal, but she wa did not report the obs provider nor did she r spasms in his back al that she should have. An interview was com Assistant (NA) #1 on stated she was assign 3/3/25 from 3:00 PM f 7:00 AM to 7:00 PM a 7:00 PM. NA #1 state and cooperative wher and did not complain she came in on 3/4/25 previous NA that the that day when she wa Resident #2 yelled ou rolled him in bed. NA complained of pain in the pain as pulling or stated it took 2 people Resident #2 due to th leg. NA #1 indicated to tolerate sitting up in time due to the pain. swelling in Resident # or 2 after he was adm to the floor nurse who NA #1 stated Resider during care due to the upper leg. Resident # was not receiving the inability to sit comforts	ity. Nurse #4 stated she d shortening of the leg was s unable to explain why she ervation to the on-call eport that he complained of though she acknowledged ducted with Nursing 3/25/25 at 2:30 PM. NA #1 ned to Resident #2 on to 7:00 PM, on 3/4/25 from and 3/8/25 from 7:00 AM to ed Resident #2 was pleasant in he was admitted on 3/3/25 of pain. NA #1 stated when 5 she was told by the resident had a fall. Later as providing care for him, it in pain when she turned or a #1 stated Resident #2 the right leg and described a burning pain. NA #1 e to provide care for e pain he had in his right Resident #2 was only able in a wheelchair for a short NA #1 stated she observed 42's right thigh about a day inted, and she reported this is she thought was Nurse #4. it #2 would get aggravated e pain in his groin area and #2 stayed in bed when he rapy due to the pain and the ably in a wheelchair. NA #1 ry to position the resident in	F 684			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 1 APPROVED 0. 0938-0391
STATEMENT OF DEFIC	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_	( 03//	C 26/2025
NAME OF PROVIDER	R OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	OF MYRTLE GRO	/=		5725 CAROLINA BEACH R	OAD		
		۲L		WILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
An init 3/25/2 worke assig and 3 on 3/2 assist Prior fine a obser the ni the fa stated talk to NA #// restle his pa but sh pain r Resid plan o verba const shin v ambu pain l unabl during admis stand	25 at 5:00 PM. Need from 7:00 PM ined to Resident 3/9/25. NA #4 sta 3/25 he had pain tance to get him to fall, NA #4 sta and did not have rved that his righ ights she was as all, and he compli- d she checked on o him to calm hin 4 stated that she ess due to pain. ain to the floor nu- he did not know i medication or as dent #2's physica of care dated 3/4 alized a pain leve tant and sharp pa which limited mol ulation. Resident level at rest and le to bear weight g transfers, which ssion on 3/3/25 v and pivot assist terview was conc apist (PT) on 3/20 he was aware that 5 after admission a lot of pain and o tated Resident #2	<ul> <li>5</li> <li>ducted with NA #4 on NA #4 indicated that she to 7:00 AM and was #2 on 3/3/25, 3/7/25, 3/8/25 ated when Resident #2 fell and required 2-person up and provide his care.</li> <li>ted Resident #2 seemed pain. NA #4 indicated she t thigh area had swelling on signed to Resident #2 after ained of hip pain. NA #4 n Resident #2 often, tried to n down and reassure him.</li> <li>thought Resident #2 was NA #4 stated she reported urse each time she worked f the nurse administered sessed the resident.</li> <li>I therapy evaluation and /25 indicated the resident I of 10 out of 10 with ain to the right knee and bility, standing and #2 reported a 10 out of 10 with movement and was on the right lower extremity h was a change from his when he transferred with ance of 1 person.</li> <li>ducted with the Physical 5/25 at 10:26 AM. PT stated at Resident #2 had a fall on n. PT stated Resident #2 difficulty with weight shifting.</li> <li>2 had cognitive impairment discern if the resident's pain</li> </ul>	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				5725 CAROLINA BEACH F	ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	as it seemed or if it wa indicated he did not re not bearing weight wh during his therapy sea problem. PT stated F be modified due to his to bear weight. PT st Resident #2 did not p health therapy so he a probably would not do facility. PT indicated externally rotated (a c outwardly rotated with away from the body) v sign of a fracture, but caused by the resider not participating in the did not report Resider inability to bear weigh his right leg to the nur provider. PT stated h noted that Resident # to his dementia and w PT stated that some r demonstrate intense p exaggerated response assumed that was the An interview was contor Therapy Assistant (PT PTA stated that she w therapy during his stat right leg was very pail Resident #2 could not pain and was not able leg. PTA stated Reside with, but she assumed	to the activity or as intense as more behavioral. PT ecognize that Resident #2 een he was evaluated and asions as an indication of a tesident #2's therapy had to a pain level and his inability ated from what he was told, rogress at home with home assumed the resident o well with the therapy in the Resident #2's right leg was condition in which the leg is the thigh and knee pointed which he acknowledged is a he assumed this was at staying in bed a lot and erapy at home. PT stated he at #2's increased pain level, t or the external rotation of sing staff or the medical e assumed the pain he 2 demonstrated was related vas not an abnormal finding. esidents with dementia pain but it is more of an the than actual pain and he e case with Resident #2.	F 684	4			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				5725 CAROLINA BEACH F	ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284 <sup>,</sup>	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	the therapist or the nut this was normal for the she had not noticed F externally rotated or s Review of Resident # revealed that on 3/4/2 progress note regardi Resident #2 post fall, with the therapy evalu- weight on the right low A physician progress PM by Physician #1 d indicated he had 8 ou progress note did not that occurred on 3/3/2 made due to the fall. for Resident #2 was to management with the prescribed from the h An interview was con- 3/25/25 at 2:00 PM. I nurse assigned to Re and 3/9/25 from 7:00 stated she did not kno fall on 3/3/25 and that was normally commu- report. Nurse #5 state Resident #2 was trans- he had fallen. Nurse lot of pain and require for him. Nurse #5 state complaints of pain we were related to his de medication or further	or inability to bear weight to irrsing staff as she assumed e resident. PTA indicated Resident #2's leg to be shortened. 2's electronic health record 25 there was no nursing ng an assessment of his pain level, participation iations or ability to bear ver extremity. note dated 3/4/25 at 7:58 focumented Resident #2 t of 10 right leg pain. The reference Resident #2's fall 25 nor was an assessment The progress note indicated to continue pain pain medications that were ospital. ducted with Nurse #5 on Nurse #5 was an agency sident #2 on 3/4/25, 3/8/25 PM to 7:00 AM. Nurse #5 ow that Resident #2 had a to information regarding falls nicated verbally during shift ed she found out after sferred to the hospital that #5 stated Resident #2 had a to 2 people to provide care ted she assumed that his re more of a behavior or mentia and did not require evaluation. Nurse #5	F 684	4			
	he had fallen. Nurse lot of pain and require for him. Nurse #5 sta complaints of pain we were related to his de medication or further	#5 stated Resident #2 had a ed 2 people to provide care ted she assumed that his re more of a behavior or mentia and did not require					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	to Resident #2 once the complaint of pain wass being difficult. Nurse yelled at her one of the his room, so she did the assessment. Nurse # assessed Resident #2 his upper thigh or hip notified the provider. probably should have evaluated his pain. A Nurse Practitioner p at 6:50 AM indicated Resident #2 due to the giving the Nursing As with care. The progree #2 was agitated and i indicated Resident #2 prescribed pain media resident's mild demer to comply with therap recovery. The progree Resident #2's fall that an assessment made progress note did not assessment of Reside extremity. An interview was com Practitioner (NP) on 3 NP stated she went ir on the morning of 3/5 hollering and screami stated Resident #2 we incontinence care wa he was exhibiting ber dementia. The NP st	because she assumed his a behavior and he was just #5 stated Resident #2 he nights when she entered not attempt to complete an t5 indicated that if she had 2 and observed swelling in area she would have Nurse #5 stated she assessed Resident #2 and brogress note dated 3/5/25 in part that she evaluated e resident screaming and sistant and Nurse difficulty ss note indicated Resident ncontinent. The note 2 was to continue with the cation and stated that the ntia was affecting his ability y and was impacting his ess note did not reference coccurred on 3/3/25 nor was a due to the fall. The reference a pain level or an ent #2's right lower ducted with the Nurse b/26/25 at 10:00 AM. The nto Resident #2's room early /25 when she heard him ng during care. The NP as calm after the s provided so she assumed	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
<u>_</u>				5725 CAROLINA BEACH F	ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	his right leg and that h rotated with shortenin not complete a full ph The NP stated if she h Resident #2's pain int bear weight she would resident further as the condition such as a fr A care plan for falls w revealed Resident #2 to pain. The intervent to administer medicat mobility as needed, a wearing non-skid foot A skilled nursing note Nurse #1 indicated Re cooperative, anxious, to care with no chang 24 hours. The note g Resident #2's pain lev or assessment of his not previously docum resistive to care. An interview was con 3/26/25 at 8:40 AM. I worked from 3:00 PM assigned to Resident that when she attemp care, Resident #2 beg stated she did not kno could tell Resident #2 stated she asked ano they were able to prov	unable to bear weight on his leg was externally g. The NP stated she did ysical exam of the resident. had been made aware of ensity of 10 and inability to d have evaluated the ese are signs of a serious acture. as created on 3/5/25 and was at risk for falls related tions dated 3/5/25 included ions as ordered, assist with nd ensure the resident was wear when out of bed. dated 3/5/25 at 7:49 PM by esident #2 was pleasant, and combative or resistive es in condition in the past ave no indication of /el, participation with therapy right leg. Resident #2 was ented as combative or	F 684				

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	). 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMF	LETED
		245507	B. WING				C
	ROVIDER OR SUPPLIER	345507	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	26/2025
	ROVIDER OR SUPPLIER				5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE			WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #2 was havi NA #6 stated she did evaluated the resident anything different above An interview was cort 3/26/25 at 8:15 AM. If agency nurse that wo facility. Nurse #2 was 3/5/25 from 7:00 PM if she did not recall any Nurse #2 stated she of interaction with the re- administering medica the NA reported that If Review of Resident # revealed that on 3/5/2 progress note regardit Resident #2 post fall, reported the resident demonstrating increas care. A skilled nursing note Nurse #4 indicated Re- oriented to person, pl had no changes in co The note gave no ind level, participation with his right leg. An interview was cort 3/25/25 at 2:50 PM. N Resident #2 on the 7: 3/5/25 and 3/6/25. N	d nurse, Nurse #2, that ng severe pain during care. not know if the nurse it. NA #6 did not notice but Resident #2's leg. nducted with Nurse #2 on Nurse #2 stated she was an rked as needed at the is assigned to Resident #2 on to 7:00 AM. Nurse #2 stated thing about Resident #2. did not have much sidents other than tion and she did not recall if Resident #2 had pain. 2's electronic health record 25 there was no nursing ng an assessment of his pain level, or that NA #6 was screaming or sed pain during incontinence dated 3/6/25 at 2:36 PM by	F	684			
	Resident #2 on the 7: 3/5/25 and 3/6/25. No recall much about Re	00 AM to 3:00 PM shift on A #2 indicated she did not					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2025 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C /26/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD		
				V	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	9 11	F	684			
	•	sident #2's pain to the floor they already knew since he ı for several days.					
	An interview was com 3/26/25 at 8:50 AM. I on the 3:00 PM to 11: 7:00 AM shifts. NA #5 worked together on th Resident #2 resided. provided care to Resi and 3/6/25 from 11:00 stated she recalled wi 3/3/25 and indicated to after the fall. NA #5 st required 2 person ass reposition and inconti- resident screamed an incontinence care and NA #5 stated Resider in the thigh area, and NA #5 stated she and be gentle and provide NA #5 stated she and be gentle and provide NA #5 stated it was d comfortable, but she o nurse as she thought NA #5 could not recal externally rotated. Review of Resident # revealed that on 3/6/2 AM there was no nurs an assessment of Resi that he was screamin incontinence care. A Minimum Data Set	ducted with NA #5 on NA #5 indicated she worked 00 PM and 11:00 PM to 5 stated she and NA #4 he rehabilitation unit where NA #5 indicated that she dent #2 on 3/3/25, 3/4/25 0 PM to 7:00 AM. NA #5 hen Resident #2 fell on that he was very agitated stated that Resident #2 sistance with turning and nence care. NA #5 stated nd hollered during d would become combative. If #2's right leg had swelling he was having a lot of pain. If the other NA would try to e increased time with care. ifficult to get Resident #2 did not report this to the the nurses already knew. I if Resident #2's leg was 2's electronic health record 25 from 11:00 PM to 7:00 sing progress note regarding sident #2, his pain level or g and agitated during					
		S Nurse on 3/7/25 at 8:16 ht #2 had pain in the last 5					

Facility ID: 960602

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING _				C 26/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 684	sleep, therapy and da Resident #2 rated his Resident #2's electron no nursing progress r regarding resident's p of the medical provide the resident. An interview was com 3/25/25 at 1:14 PM. If facility and was assig 3/7/25 from 7:00 AM to on 3/7/25 Resident #2 of bed or participate in it was her first day as she did not know wha #3 stated nothing was previous shift regardin increased pain. Nurse did not attempt to det not want to get up or During the shift on 3/7 eventually, Resident # bed to the wheelchair During the shift on 3/7 administered Resider did not complete a ful as she was busy with other duties, being ne learning. Nurse #3 st anything about Resider right lower extremity, affected the pain.	ly and the pain affected his ny to day activities frequently. pain intensity as 10. hic health record revealed note by the MDS Nurse that level of 10, notification er or further assessment of ducted with Nurse #3 on Nurse #3 was new to the ned to Resident #2 on to 7:00 PM. Nurse #3 stated 2 did not want to get up out in therapy. Nurse #3 stated signed to Resident #2 and it his baseline was. Nurse is reported to her by the ng resident's condition or e #3 acknowledged that she ermine why Resident #2 did participate in therapy. 7/25, Nurse #3 indicated #2 was assisted up out of	F	584			
		sident #2 on 3/6/25 and					

Facility ID: 960602

If continuation sheet Page 13 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
Αυτυμη	CARE OF MYRTLE GRO	VE		5	5725 CAROLINA BEACH ROAD		
				V	WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	she did not know much only was assigned to Nurse #6 stated Reside was combative with p stated that she assum baseline as that was y staff, but she could not members told her this thought that his behaves she thought she admi medication, and this se #6 stated she did not source of the pain or Resident #2 as she th seemed to help. An interview was con 3/25/25 at 5:15 PM. I worked from 7:00 AM assigned to Resident #2 and leg. Resident #2 and seemed scared to informed the floor nur and stated the nurse i hurting. Resident #2's electron no nursing progress r #3 regarding resident. A skilled nursing note Nurse #1 indicated Re person, was pleasant resistive to care and h	to 7:00 AM. Nurse #6 stated ch about Resident #2 as she him a couple of times. dent #2 was confused and versonal care. Nurse #2 hed that was Resident #2's what she was told by other of recall which staff s. Nurse #6 stated she vior might be due to pain, so inistered his PRN pain seemed to help him. Nurse attempt to identify the complete an assessment of hought the pain medication hducted with NA #3 on NA #3 indicated that she to 3:00 PM and was #2 on 3/7/25. NA #3 P had a lot of pain in his hip did not want to move his leg o move it. NA #3 stated she rse of Resident #2's pain knew that his leg was	F	684			

Facility ID: 960602

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 // APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>` `</i>	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				5725 CAROLINA BEACH R	OAD		
AUTUMN	CARE OF MYRTLE GRO	/E		WILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	E PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	therapy or assessment Resident #2's 5-day M dated 3/9/25 indicated cognitive impairment of care 1 to 3 days. F limitation in range of m side of the lower extrest assistance with bed m Resident #2 had freque and bladder, had a dia	level, participation with ht of his right leg. Animum Data Set (MDS) d the resident had moderate and demonstrated rejection Resident #2 had functional notion with impairment on 1 emity and required moderate nobility and transfers. uent incontinence of bowel	F 684	1			
	almost constant pain therapy and day-to-da rated his pain a 10. A skilled nursing prog Nurse #1 indicated Re person, was pleasant resistive to care and h in the past 24 hours. of Resident #2's pain therapy or assessmen An interview was cond 3/26/25 at 3:30 PM. hard time recalling sp Resident #2, as the re primary assignment a turnover of residents. Resident #2 had pain	that interfered with sleep, ay activities. Resident #2 ress note dated 3/9/25 by esident #2 was oriented to , anxious, combative or had no change in condition The note gave no indication level, participation with ht of his right leg. ducted with Nurse #1 on Nurse #1 stated she had a ecific information about ehabilitation hall was her nd there was a high rate of Nurse #1 recalled that with movement, but she did					
	expressing where the stated he would say r any movement or acti describe where the pa with transfers, bed mo	esident #2 had difficulty pain was, but Nurse #1 epeatedly "Oh my leg" with vity. It was hard for him to ain was. She reported that obility, and incontinence nonstrated non-verbal signs					

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE COMF	SURVEY PLETED
		345507	B. WING _				C 26/2025
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				57	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		w	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	wincing. Nurse #1 stat therapy reported that 10 pain, was unable to Nurse #1 stated she of that Resident #2 had as he had some demo- provider knew. A physician progress PM written by Physici physician was asked was not participating if following admission to #2's family member th was not acting right a was concerned. Resi examined with the resi right groin was in a lo Resident #2 stated it touched the area. An interview was con 3/26/25 at 2:42 PM. If he was asked to see to the resident not pai increased pain. Physi #2 stated he had pain stated he and 2 of the Resident #2 seemed reported since his fall was concerned that R fracture, and this nee away so he ordered for the hospital. Physicia resident's increased p bear weight should has	included grimacing or ated she did not recall that Resident #2 had 10 out of o stand or bear weight. did not inform the provider intense pain with movement entia, and she assumed the note dated 3/10/25 at 1:31 an #2 indicated the to see Resident #2 as he in therapy, and he had a fall o the facility. Per Resident he resident was not himself, nd she (the family member) dent #2 was seen and sident complaining that his t of pain down into this thigh. hurt whenever anyone ducted with Physician #2 on Physician #2 indicated that Resident #2 on 3/10/25 due rticipating in therapy and cian #2 indicated Resident in his groin. Physician #2 e therapists assisted Physician #2 stated worse from what staff . Physician #2 stated he Resident #2 may have a ded to be addressed right or the resident to be sent to an #2 stated that the bain level and inability to ave been reported to the	F 6	84			
TAG	Continued From page of intense pain which wincing. Nurse #1 stat therapy reported that 10 pain, was unable to Nurse #1 stated she of that Resident #2 had as he had some demo provider knew. A physician progress PM written by Physici physician was asked was not participating if following admission to #2's family member th was not acting right a was concerned. Resi examined with the resi right groin was in a lo Resident #2 stated it touched the area. An interview was con 3/26/25 at 2:42 PM. If he was asked to see to the resident not pai increased pain. Physi #2 stated he had pain stated he and 2 of the Resident #2 seemed reported since his fall was concerned that R fracture, and this nee away so he ordered for the hospital. Physicia resident's increased p	ASC IDENTIFYING INFORMATION) a 15 included grimacing or ated she did not recall that Resident #2 had 10 out of o stand or bear weight. did not inform the provider intense pain with movement entia, and she assumed the note dated 3/10/25 at 1:31 an #2 indicated the to see Resident #2 as he in therapy, and he had a fall o the facility. Per Resident he resident was not himself, nd she (the family member) dent #2 was seen and sident complaining that his t of pain down into this thigh. hurt whenever anyone ducted with Physician #2 on Physician #2 indicated that Resident #2 on 3/10/25 due rticipating in therapy and cian #2 indicated Resident n his groin. Physician #2 e therapists assisted Physician #2 stated worse from what staff . Physician #2 stated he Resident #2 may have a ded to be addressed right or the resident to be sent to an #2 stated that the bain level and inability to ave been reported to the	TAG		CROSS-REFERENCED TO THE APPROPR		

Facility ID: 960602

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				725 CAROLINA BEACH F	ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	have had any outward and inability to bear w have been reported for Physician #2 indicated dementia with some of Physician #2 stated th may demonstrate incr agitation or combative Physician #2 stated h #2's leg was shorter of A nursing progress no written by Nurse #3 in sent to the emergency Resident #2's family r resident complained of since he had an unwit Resident #2's family r decreased mentation requested a urinalysis Tomography (CT) sca physician assessed th send Resident #2 to t pain in the hip/groin a An interview was con 3/25/25 at 1:14 PM. I with Resident #2 durin shift on 3/10/25. Nurse #2's family member in resident evaluated so of the family mem	ble that the fracture may not d signs, but increased pain veight was a sign that should or further evaluation. d that Resident #2 had mild cognitive impairment. that a resident with dementia reased behaviors including eness because of pain. e did not recall if Resident or externally rotated. the dated 3/10/25 at 1:43 PM indicated Resident #2 was y room for evaluation. the member stated that the of pain in his right hip area thessed fall on 3/3/25. member stated he had and the family member is and Computed in be completed. The the resident and decided to he emergency room due to	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/14/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345507	B. WING			_		C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
	CARE OF MYRTLE GRO	VE		5	5725 CAROLINA BEACH F	ROAD		
AUTOWIN	CARE OF MIRILE GRO	VE		V	WILMINGTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 17	F	684				
		Resident #2 to the hospital						
	3/10/25 indicated Res groin pain since an ur on 3/3/25. The note ir right groin tenderness deformity with externa extremity. Resident # than the left and was condition characterize accumulation of fluid injury. Two view x ray indicated a comminut femur fracture. Resid hospital on 3/10/25, u nailing of the right fen metal rod is inserted i stabilize the fracture) skilled nursing facility	al rotation of the right lower #2's right leg was shorter mildly edematous, a						
	3/26/25 at 2:00 PM. I she was not aware of fall on 3/3/25 or havin shortening of his leg. had been informed th 3/3/25 she would hav regarding the fall and #1 stated Resident #2 she attributed this to I replacement. During the nursing staff nor the increased pain level of weight. Physician #1	ducted with Physician #1 on Physician #1 indicated that Resident #2 sustaining a ig external rotation or Physician #1 stated if she at Resident #2 had a fall on e evaluated the resident possible injury. Physician 2 complained of pain, and his recent right total knee Resident #2's stay, neither he therapists reported or inability to stand or bear stated if the nursing staff or ed that Resident #2 had a						

Facility ID: 960602

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING _				C 26/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MYRTLE GRO			57	725 CAROLINA BEACH ROAD		
AUTOMIN				W	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	weight, she would have evaluated the residen stated that she expect therapists would have there seemed to be a Physician #1 stated s Resident #2 was diag intertrochanteric femu to the hospital for eva An interview was com #2 on 3/26/25 at 3:00 stated she was not av increased pain, not painability to bear weigh she did not assess the consult with the provid pain or external rotation Unit Manager #2 state expected to report cha and she reported cha An interview was com Nursing on 3/25/25 at that Resident # 2 had facility and the staff as did not evaluate to de The DON indicated sh #2 was not participatin staff assumed it was j behavior and did not a change in condition su	10, inability to stand or bear ve ordered x rays and t further. Physician #1 ted that the nursing staff or e reported the changes and lack of communication. he was not aware that nosed with an ir fracture when he was sent luation on 3/10/25. ducted with Unit Manager PM. Unit Manager #2 vare of Resident #2 having articipating in therapy or t. Unit Manager #2 stated e resident at any time or der regarding the resident's on or shortening of his leg. ed that the floor nurses were anges in the residents to her nges to the NP or Physician. ducted with the Director of 3:40 PM. The DON stated pain during his stay in the ssumed it was his knee and termine where the pain was. he was aware that Resident ng well with therapy, but the ust the resident and his attribute it to the pain or a uch as an injury or fracture. on was that the nursing staff its for pain, assessed the d increased pain and	F	584	DEFICIENCY)		
	An interview was con	ducted with the					

Facility ID: 960602

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345507	B. WING		C 03/26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/20/2023
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	missed something. T that communication c between the nursing s provider. The Admini #2 should have had a changes including ext shortening of the leg, changes in weight be	/25 at 1:45 PM. The Resident #2 was a I the facility may have he Administrator indicated ould have been better staff, therapy staff and the strator stated that Resident complete assessment and ternal rotation and	F 684		
F 697 SS=G	provided to residents consistent with profes the comprehensive pe and the residents' goa This REQUIREMENT by: Based on record revi family, Nurse Practitio	who require such services, ssional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced ew and staff, resident, oner and Physician	F 697	Resident #2 no longer resides in the facility	4/16/25
	and ongoing pain ass identifying the source a resident's pain regir medication was not er resident's pain. The r from the hospital on 3 for pain control follow replacement. The init admission to the facili 5 (on a 0 to 10 scale imaginable). The resi	failed to provide thorough essments that included of the pain and to evaluate men when the prescribed ffectively managing the resident was discharged 3/3/25 after being admitted ing a total knee tial pain assessment on ity indicated a pain rating of with 10 being the worst pain ident experienced a fall on . The following day (3/4/25),		The Director of Nursing or designee interviewed all cognitively intact resider on 3/27/2025 as it relates to pain management or increase in acute pain and assessed all cognitively impaired residents on 3/27/2025 for signs of pair and reviewed the medical record for increased documentation of pain or increase in pain medication requiremen (What are the findings?) On 3/27/2025 the Director of Nursing of	n its.

Facility ID: 960602

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	S FOR MEDICARE &					NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY
						С
		345507	B. WING			)3/26/2025
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH ROAD		
		•=		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 697	Continued From page	e 20	F 69	7		
		ced increased pain with a		designee educated all staff c	n the pain	
		m 6 to 10 through 3/10/25.		management policy with emp		
		ent was evaluated at the		identifying the source of the		
		ntified with a comminuted		reported increased pain to th	e provider.	
	right intertrochanteric			- · ·		
		racture which the long bone to multiple pieces caused by		To ensure ongoing complian		
		ized by severe pain in the		Director of Nursing or design interview 5 cognitively intact		
		veight on the affected leg,		weekly for 12 weeks to ensu		
		xternal rotation of the leg).		no reports of uncontrolled pa		
	-	ent intermedullary nailing of		increases in acute pain that l		
		cedure in which a metal rod		unaddressed by the facility.		
		ng thigh bone to stabilize the		of Nursing or designee will a		
		plications as a result of the		and review the electronic me		
		t practice was observed for		for 5 cognitively impaired res	-	
	(Resident #2).	ed for pain management		for 12 weeks to ensure all signification networks for the second		
				reported to the provider and	•	
	Findings included:			appropriately by the staff. The be reviewed in the quality as	e audits will	
	A review of Resident	#2's hospital discharge		performance improvement m		
		5 indicated the resident was		monthly for 3 months. The Q		
		ness. The history of the		may change the plan of corre		
		ted Resident #2 had a total		extend the audits to ensure o	ongoing	
	knee replacement on	•		compliance.		
		as unable to make progress nt was admitted for pain				
		ne hospital course indicated				
		le upon discharge and the				
		nproved. Resident #2 made				
	slow progress with pr					
		harged to the skilled nursing				
	facility to continue wit	h therapy.				
	Resident #2 was adm	nitted on 3/3/25 with				
		uded: aftercare following				
		rgery, muscle weakness,				
	unsteadiness on feet					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C /26/2025
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				4	5725 CAROLINA BEACH ROAD		
AUTUMIN	CARE OF MYRTLE GRO	VE		· 1	WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Resident #2's electron physician order dated hydrocodone-acetami tablets every 6 hours moderate to severe p in 24 hours. A physici indicated Resident #2 50 milligrams every 6 severe pain not to exc hours. A nursing progress no written by Nurse #1 in was admitted for after knee replacement. R oriented to person, pl confusion. Resident # and pivot assistance with orders for weight Resident #2 was note bladder and had beer prior to admission. R and had a hearing aid A pain assessment da Nurse #1 indicated a conducted and indica pain in the past 5 day sleep, participation wi activities. Resident # a 5 (out of 10). A nursing progress no dated 3/3/25 at 11:54 had a fall in the room. oriented. The right kr replaced, had a dress bruises and slight swe	nic health record indicated a 3/3/25 for inophen 5-325 milligram 2 as needed (PRN) for ain not to exceed 8 tablets an order dated 3/3/25 2 was also ordered tramadol hours PRN for moderate to ceed 200 milligrams in 24 bete dated 3/3/25 at 5:40 PM recare following a right total esident #2 was alert and ace and event with some #2 transferred with stand with one person assistance bearing as tolerated. d as continent of bowel and n using a urinal and bedpan esident #2 wore glasses d which he left at home.	F	697			

Facility ID: 960602

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C / <b>26/2025</b>
NAME OF PRO	VIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUTUMN CA	RE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
ir ir A1 ou Fspann ri ir k k Ach# ir e ir or ri fi T C # A3 nu or ir	A focused head to toe 1:45 PM completed I bservation was made p to a fall. The observation was made p to a fall. The observation with strong b ress strength, a test sked to push againsi- eurological evaluation ght knee surgery. The mpaired range of more- nee and leg with the ength. A fall event report data ompleted by Nurse # ad an unwitnessed fail 2 was found in his re- ndicated Resident #22 whibit pain related to ndicated the nurse was f motion of his right I botation deformity or s ight lower extremity w nding often associated his was different that ompleted by Nurse # 2's lower extremities an interview was condor /25/25 at 3:00 PM. M ight shift the night th- nwitnessed fall (3/3/2 f bed when he was un- ndicated she assessed	r neurological checks were all provider was contacted. e observation dated 3/3/25 at by Nurse #4 indicated an e of Resident #2 as a follow ervation indicated that to person, place, time and bilateral hand grasps. Foot in which the resident is t resistance as part of a on, was not assessed due to he observation noted tion of Resident #2's right lower extremities equal in ed 3/3/25 at 11:58 PM f4 indicated Resident #2 all with no injuries. Resident toom on the floor. The report t did not complain of or	F	697			

Facility ID: 960602

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	MAPPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345507	B. WING				C 26/2025
NAME OF PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN CARE OF MYRTLE GROV	15			5725 CAROLINA BEACH ROAD		
AUTOWIN CARE OF WITKILE GROV	E		1	WILMINGTON, NC 28412		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
complained of spasms not get comfortable. N recall if she administer night, but she thought repositioned the reside him comfortable. Resident #2's electron Administration Record AM revealed resident in hydrocodone-acetamin The eMAR indicated th effective. The pain lev medication was admin Resident #2's occupati and plan of treatment I Therapist (OT) dated 3 behavior exhibited, the pain level of 10 out of indicated nursing was pain and was providing Resident #2 participate Resident #2's physical plan of care dated 3/4/ verbalized a pain level constant and sharp pa shin which limited mot ambulation. Resident pain level at rest and v unable to bear weight during transfers.	anical lift. Nurse #4 but the night, Resident #2 is in his back and he could Nurse #4 stated she did not red pain medication that that she and the staff ent frequently to try to get ic Medication (eMAR) for 3/4/25 at 9:23 received PRN nophen for a pain level of 9. the medication was vel recorded after the sistered was a 9. ional therapy evaluation by the Occupational 3/4/25 indicated based on a resident demonstrated a 10. The evaluation aware of Resident #2's g medication as prescribed. ed in the evaluation and /25 indicated the resident l of 10 out of 10 with in to the right knee and	F	697			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING _				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	had a lot of pain and o PT stated Resident #2 and it was difficult to o out of proportion or as was more behavioral. not bearing weight wa indication of a problem therapy had to be mo and his inability to bea what he was told, Res home with home heal the resident probably indicated Resident #2 rotated, but he assum caused by staying in P not report Resident #2 inability to bear weigh medical provider since to his dementia. An interview was com Therapy Assistant on stated that she worke therapy during his sta painful. PTA indicated tolerate standing due bear weight on the rig #2 was difficult to wor this was because he w stated she did not rep inability to bear weigh nursing staff. A physician progress PM by Physician #1 d indicated he had 8 ou Resident #2 was to co	h. PT stated Resident #2 difficulty with weight shifting. 2 had cognitive impairment discern if resident's pain was a intense as it seemed or if it PT indicated Resident #2 as not necessarily an n. PT stated Resident #2's diffed due to his pain level ar weight. PT stated from sident #2 did not progress at th therapy so he assumed would not do well here. PT t's right leg was externally ned this could have been bed a lot. PT stated he did 2's increased pain level or it to the nursing staff or the e he assumed it was related ducted with the Physical 3/26/25 at 10:40 AM. PTA d with Resident #2 for y and his right leg was very d Resident #2 could not to pain and was not able to that leg. PTA stated Resident k with, but she assumed was not motivated. PTA port Resident's pain level or it to the therapist or the note dated 3/4/25 at 7:58 locumented Resident #2 t of 10 right leg pain.	F 6	97			

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CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		FORM	0: 04/14/2025 1 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:			-	COMP	
		345507	B. WING				26/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH I WILMINGTON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page prescribed from the h An interview was con	ospital.	F 69	7			
	Assistant (NA) #1 on stated she was assign 3/3/25 from 3:00 PM to 7:00 AM to 7:00 PM a	3/25/25 at 2:30 PM. NA #1					
	and did not complain she came in on 3/4/25 previous NA that the r	h he was admitted on 3/3/25 of pain. NA #1 stated when 5 she was told by the resident had a fall. Later as providing care for him,					
	Resident #2 yelled ou rolled him in bed. NA complained of pain in the pain as a pulling of	It in pain when she turned or #1 stated Resident #2 the right leg and described or a burning pain. NA #1					
	leg. NA #1 indicated to tolerate sitting up in	e to provide care for e pain he had in his right Resident #2 was only able n a wheelchair for a short NA #1 stated she observed					
	swelling in Resident # or 2 after he was adm to the floor nurse who	<sup>4</sup> 2's right thigh about a day nitted, and she reported this she thought was Nurse #4. nt #2 would get aggravated					
	during care due to the upper leg. Resident # was not receiving the	<ul> <li>approximate provide a second se second second se</li></ul>					
	-	ry to position the resident in					
	at 6:50 AM indicated i Resident #2 due to th giving the Nursing As with care. Resident #	progress note dated 3/5/25 in part that she evaluated e resident screaming and sistant and Nurse difficulty 2 was agitated and e indicated Resident #2 was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	028 0201
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	LETED
		345507	B. WING			_		C 26/2025
NAME OF PF	ROVIDER OR SUPPLIER	-		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
					5725 CAROLINA BEACH F	ROAD		
AUTUMIN	CARE OF MYRTLE GRO	VE		۱ ا	WILMINGTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page to continue with the pr and stated that the re- affecting his ability to was impacting his rec An interview was cond Practitioner (NP) on 3 NP stated she went in on the morning of 3/5/ hollering and screami stated Resident #2 wa incontinence care was she was not aware the pain at an intensity of was not able to bear w NP stated if she had to Resident #2's pain int bear weight she would resident further as the condition such as a fra Resident #2's eMAR in hydrocodone-acetami on 3/5/25 at 8:02 AM eMAR indicated the m The pain level after th administered was a 6 Resident #2's eMAR in hydrocodone-acetami on 3/5/25 at 2:13 PM eMAR indicated the m The pain level after th administered was a 6	e 26 rescribed pain medication sident's mild dementia was comply with therapy and covery. ducted with the Nurse 8/26/25 at 10:00 AM. The noto Resident #2's room early /25 when she heard him ing during care. The NP as calm after the s provided. The NP stated at Resident #2 was having 10 out of 10 and that he weight on his right leg. The been made aware of tensity of 10 and inability to d have evaluated the ese are signs of a serious acture. indicated PRN inophen was administered for a pain level of 6. The nedication was effective. he medication was effective. he medication was effective. he medication was effective.		697				
	to pain. The intervent	was at risk for falls related tions dated 3/5/25 included ions as ordered, assist with						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH WILMINGTON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	wearing non-skid foot A skilled nursing note Nurse #1 indicated Re cooperative, anxious, to care with no chang 24 hours. The note g Resident #2's pain lev or assessment of his An interview was cond 3/26/25 at 8:40 AM. I worked from 3:00 PM assigned to Resident that when she attemp care, Resident #2 beg stated she did not kno could tell Resident #2 stated she asked ano they were able to prov Resident #2 by provid support with moving h informed the assigned was having severe pa stated she did not kno resident. An interview was cond 3/26/25 at 8:15 AM. I agency nurse that wo facility. Nurse #2 was 3/5/25 from 7:00 PM to she did not recall any Nurse #2 stated she co interaction with the re	nd ensure the resident was wear when out of bed. dated 3/5/25 at 7:49 PM by esident #2 was pleasant, and combative or resistive es in condition in the past ave no indication of vel, participation with therapy right leg. ducted with NA #6 on NA #6 indicated that she to 11:00 PM and was #2 on 3/5/25. NA #6 stated ted to provide incontinence gan screaming. NA #6 ow what was wrong but was in a lot of pain. NA #6 ther NA to assist her and wide incontinence care to ling increased time and him. NA #6 indicated she d nurse that Resident #2 hin during care. NA #6 ow if the nurse evaluated the ducted with Nurse #2 on Nurse #2 stated she was an rked as needed at the s assigned to Resident #2. did not have much sidents other than tion and she did not recall if	F 69	7			

Facility ID: 960602

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Automatic of percentation     (x1) PROVINERAUPPLIER     (x2) MULTIPLE CONSTRUCTION     (x3) DATE BURCH COMPLETED       MB FLAN OF CONFECTION     345507     8 WNO     (x3) DATE SUBJECT       NAME OF PROVIDER OR SUPPLIER     345507     8 WNO     (x3) DATE SUBJECT       AUTUMN CARE OF MWRTLE GROVE     STREET ADDRESS. CITY: STATE, 2IP CODE 5725 CAROLINA BEACH ROAD WILLINGTON, NC 28412     (x4) DATE SUBJECT       AUTUMN CARE OF MWRTLE GROVE     STREET ADDRESS. CITY: STATE, 2IP CODE 5725 CAROLINA BEACH ROAD WILLINGTON, NC 28412     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     SUMMARY STREMENT OF DEFICIENCIES PREFIX     (x4) DATE SUBJECT     (x4) DATE SUBJECT       PREFIX TAG     Continued From page 28 A skilled number of Date Subject T     (x4) DATE SUBJECT       A Interview was conducted w		-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER     314507     8. WING     00326/2015       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE, 2P CODE       CODE </td <td>STATEMENT C</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td></td> <td>(X3) DATE</td> <td>E SURVEY PLETED</td>	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	E SURVEY PLETED
NMME OF PROVIDER OR SUPPLIER         STREET ADDRESS. CTV STRE. 2 P CODE           AUTUMN CARE OF MYRTLE GROVE         5735 CAROLINA BEACH ROAD           (M) D PREFIX         SUMMARY STREMENT OF DEPICIENCIES (EACH EDERIDEVY DWS TE REPCEEPE OF VILL RECULTORY OR LSC IDENTIFYING INFORMATION)         PROVIDER OF MYRTLE OF DEPICIENCIES (EACH EDERIDEVY DWS TE REPCEEPE OF VILL RECULTORY OR LSC IDENTIFYING INFORMATION)         PROVID PREFIX (EACH EDERIDEVY DWS TE REPCEEPE OF VILL RECULTORY OR LSC IDENTIFYING INFORMATION)         PROVID PREFIX (EACH EDERIDEVY DWS TE ADDRESS OF VILL RECULTORY OR LSC IDENTIFYING INFORMATION)         PROVIDER OF CORRECTION SHOLD B (EACH EDERIDEVY DWS TE ADDRESS OF VILL DEFICIENCY)         Comment (EACH EDERIDEVY DWS TERE 2000)         DOR (EACH EDERIDEVY DWS TERE 200			345507	B. WING			03	•
AUTUNIX CARE OF MYRTLE GROVE     WILMINGTON, NC 28412       (M) D PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH EDGRESS PLAN OF CORRECTION SHOLLD BE (EACH EDGRESS PLAN OF CORRECTION SHOULD SHOU	NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Willington, roc 2442           Way ID MEERX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST DE PRECEDED BY FULL REGULATORY OR UST DE PRECEDED BY FULL REGULATORY OR UST DE PRECEDED BY FULL REGULATORY OR UST DEMTIFYING INFORMATION)         D PREFX TAG         PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION IMPREENT TAG           F 697         Continued From page 28 A skilled nursing note dated 3/6/25 at 2:36 PM by Nurse #4 indicated Resident #2 was alert, oriented to person, place, time and situation and had no changes in condition in the past 24 hours. The note gave no indication of Resident #2 spain level, participation with therapy or assessment of his right leg.         F 697           An interview was conducted with Nurse #4 on 325/25 at 3:00 PM. Nurse #4 stated she was assigned to Resident #2 a couple of days after his 3/3/25 fill and he was unable to participate with therapy. Nurse #4 indicated she did not recall the NAs reporting any swelling in Resident #2 stated when she observed that Resident #2 had pain, she administered as needed pain medication, and it seemed to be effective for a short time but he required it frequently to ty to manage his pain or inability to participate in therapy to the 7:00 AM to 3:00 PM shift on 3/5/25 and 3/6/25. NA #2 indicated she did not recall much about Resident #2's carebut She did recall he had a lot of pain in his leg on the did recall he had a lot of pain in his leg no the did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's pain to the did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's pain to the did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's pain to the did recall he had a lot o						5725 CAROLINA BEACH ROAD		
PREFX TVG     CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFX TVG     CEACH OCREECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLETION INFO       F 697     Continued From page 28 A skilled nursing note dated 3/6/25 at 2:36 PM by Nurse #4 indicated Resident #2 was alert, oriented to person, place, time and situation and had no changes in condition in the past 24 hours, The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.     F 697       An interview was conducted with Nurse #4 and shuted she was assigned to Resident #2 couple of days after his 3/3/25 fall and he was unable to participate with therapy. Nurse #4 indicated she did not recall the NAs reporting any swelling in Resident #2's thigh or pain in his groin or hip area. Nurse #4 stated when she observed that Resident #2' had pain, she administered as needed pain medication, and it seemed to be effective for a short time but he required it frequently to try to manage his pain. Nurse #4 stated she did not report Resident #2's pain to hability to participate in therapy to the physician but she probably should have.     An interview was conducted with NA #2 on 3/25/25 at 2:50 PM. NA #2 was assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 3/5/25 and 3/6/25. NA #2 indicated she did not recall much about Resident #2's carbot type is de did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's carbot type is de did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's carbot type is de did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's pain to the floor nurse as she thought they already knew since he	AUTUMIN	CARE OF MIRILE GRO	VE			WILMINGTON, NC 28412		
A skilled nursing note dated 3/6/25 at 2:36 PM by Nurse #4 indicated Resident #2 was alert, oriented to person, place, time and situation and had no changes in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg. An interview was conducted with Nurse #4 on 3/25/25 at 3:00 PM. Nurse #4 stated she was assigned to Resident #2 a couple of days after his 3/325 fall and he was unable to participate with therapy. Nurse #4 indicated she did not recall the NAs reporting any swelling in Resident #2's thigh or pain in his groin or hip area. Nurse #4 stated when she observed that Resident #2 had pain, she administered as needed pain medication, and it seemed to be effective for a short time but he required it frequently to try to manage his pain. Nurse #4 stated she did not report Resident #2's pain or inability to participate in therapy to the physician but she probably should have. An interview was conducted with NA #2 on 3/25/25 at 2:50 PM. NA #2 was assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 3/51/25 and 3/60/25. NA #2 indicated she did not recall much about Resident #2's care but she did recall much about Resident #2's pain to the floor nurse as she thought they already knew wince he	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/6/25 at 9:03 PM for a pain level of 6. The eMAR indicated the medication was effective. The pain level after the medication was	F 697	A skilled nursing note Nurse #4 indicated Re oriented to person, pl had no changes in co The note gave no ind level, participation with his right leg. An interview was con 3/25/25 at 3:00 PM. If assigned to Resident his 3/3/25 fall and he with therapy. Nurse # recall the NAs reportin #2's thigh or pain in h #4 stated when she of had pain, she administ medication, and it see short time but he requir manage his pain. Nur report Resident #2's p in therapy to the physis should have. An interview was con 3/25/25 at 2:50 PM. Ni Resident #2 on the 7: 3/5/25 and 3/6/25. Ni recall much about Re recall he had a lot of p she did not report Resinurse as she thought had been having pain Resident #2's eMAR hydrocodone-acetam on 3/6/25 at 9:03 PM eMAR indicated the m	dated 3/6/25 at 2:36 PM by esident #2 was alert, ace, time and situation and indition in the past 24 hours. ication of Resident #2's pain th therapy or assessment of ducted with Nurse #4 on Nurse #4 stated she was #2 a couple of days after was unable to participate #4 indicated she did not ing any swelling in Resident is groin or hip area. Nurse ibserved that Resident #2 stered as needed pain emed to be effective for a uired it frequently to try to urse #4 stated she did not bain or inability to participate sician but she probably ducted with NA #2 on NA #2 was assigned to 00 AM to 3:00 PM shift on A #2 indicated she did not sident #2's care but she did pain in his leg. NA #2 stated sident #2's pain to the floor they already knew since he of or several days. indicated PRN inophen was administered for a pain level of 6. The nedication was effective.	F	697	7		

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 26/2025
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			725 CAROLINA BEACH ROAD VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 697	on the 3:00 PM to 11: 7:00 AM shifts. NA #5 worked together on th Resident #2 resided. provided care to Resi and 3/6/25 from 11:00 stated she recalled wi 3/3/25 and indicated to after the fall. NA #5 states required 2 person ass reposition and inconti resident screamed and incontinence care and NA #5 stated it seems having a lot of pain so would try to be gentle with care. NA #5 state Resident #2 comforta this to the nurse as shalready knew. A Minimum Data Set completed by the MD AM indicated Residen days almost constant sleep, therapy and da Resident #2's electron no nursing progress m regarding resident's p of the medical provide Resident #2's eMAR in	ducted with NA #5 on NA #5 indicated she worked 00 PM and 11:00 PM to 5 stated she and NA #4 he rehabilitation unit where NA #5 indicated that she dent #2 on 3/3/25, 3/4/25 0 PM to 7:00 AM. NA #5 hen Resident #2 fell on that he was very agitated stated that Resident #2 sistance with turning and nence care. NA #5 stated id hollered during d would become combative. ed like Resident #2 was o she and the other NA and provide increased time ed it was difficult to get ble, but she did not report he thought the nurses (MDS) pain assessment S Nurse on 3/7/25 at 8:16 ht #2 had pain in the last 5 by and the pain affected his my to day activities frequently. pain intensity as 10. hic health record revealed note by the MDS Nurse pain level of 10 or notification fer.	F	697			
	hydrocodone-acetam	inophen was administered					

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CENTER STATEMENT (		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		FORM OMB NC (X3) DATE	0: 04/14/2025 1 APPROVED 0. 0938-0391 SURVEY LETED
		345507	B. WING		_		C 26/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				5725 CAROLINA BEACH F	ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	of 7. The eMAR indic effective. The pain le was administered was An interview was cond 3/25/25 at 1:14 PM. If facility and was assign 3/7/25 from 7:00 AM to on 3/7/25 Resident #2 of bed or participate in this was her first day a did not know what his stated nothing was re previous shift regardin increased pain. During #3 indicated eventual up out of bed to the w therapy. During the s stated she administer medication but did no assessment of the res passing medications a indicated she was new learning. Nurse #3 st anything about Reside regarding the area, th affected the pain. An interview was cond 3/25/25 at 5:15 PM. If worked from 7:00 AM assigned to Resident indicated Resident #2 and leg. Resident #2 and seemed scared to	A at 2:13 PM for a pain level cated the medication was evel after the medication is a 2. ducted with Nurse #3 on Nurse #3 was new to the ned to Resident #2 on to 7:00 PM. Nurse #3 stated 2 did not want to get up out in therapy. Nurse #3 stated assigned to Resident #2 and baseline was. Nurse #3 ported to her by the ng resident's condition or g the shift on 3/7/25, Nurse ly, Resident #2 was assisted theelchair and went to hift on 3/7/25, Nurse #3 ed Resident #2's pain t complete a full sident as she was busy with and other duties. Nurse #3 w to the facility and was still ated she did not recall ent #2's pain on 3/7/25 e pain level or factors that ducted with NA #3 on NA #3 indicated that she to 3:00 PM and was #2 on 3/7/25. NA #3 thad a lot of pain in his hip did not want to move his leg o move it. NA #3 stated she se of Resident #2's pain	F 697				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2025 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
		345507	B. WING				C /26/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	CARE OF MYRTLE GRO			57	725 CAROLINA BEACH ROAD		
AUTUMIN	CARE OF MITRILE GRO	VE		W	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Continued From page	31	F	697			
	Resident #2's eMAR i	ndicated PRN					
	hydrocodone-acetami on 3/7/25 by Nurse #3 of 10. The eMAR ind	nophen was administered 3 at 5:03 PM for a pain level icated the medication was vel after the medication was					
		•					
	3/25/25 at 4:51 PM. If nurse assigned to Re- 3/7/25 from 7:00 PM to she did not know much only was assigned to Nurse #6 stated Resid was combative at time Nurse #2 stated that so Resident #2's baselin told by other staff, but staff members told he thought that his behave she thought she admin medication, and this so #6 stated she did not source of the pain. N pain medication seem assess Resident #2 a	dent #2 was confused and es with personal care. she assumed that was e as that was what she was she could not recall which r this. Nurse #6 stated she vior might be due to pain so nistered his PRN pain seemed to help him. Nurse attempt to identify the urse #6 stated that since the ned to help, she did not ny further.					
	as administered by Ni from 7:00 PM to 7:00	nophen was not recorded urse #6 on 3/6/25 or 3/7/25 AM.					
	A skilled nursing note	dated 3/8/25 at 6:19 PM by					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 26/2025
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 697	Nurse #1 indicated Reperson, was pleasant resistive to care and P in the past 24 hours. To of Resident #2's pain therapy or assessment Resident #2's eMAR administered on 3/8/2 No pain level was rec administration of the P indicated the medicat Resident #2's 5-day M dated 3/9/25 indicated cognitive impairment of care 1 to 3 days. F limitation in range of r side of the lower extra assistance with bed in Resident #2 had frequand bladder, had a di weakness and unstea almost constant pain therapy and day-to-da rated his pain a 10. Resident #2's eMAR administration of the P indicated the medicat A skilled nursing date indicated Resident #2' was pleasant, anxious care and had no char 24 hours. The note g	esident #2 was oriented to , anxious and combative or nad no change in condition The note gave no indication level, participation with nt of his right leg. indicated PRN tramadol was 25 by Nurse #1 at 6:23 PM. orded prior to or following medication. The eMAR ion was effective. Minimum Data Set (MDS) d the resident had moderate and demonstrated rejection Resident #2 had functional motion with impairment on 1 emity and required moderate adjuess. Resident #2 had that interfered with sleep, ay activities. Resident #2 indicated PRN tramadol was 25 by Nurse #1 at 9:12 AM orded prior to or following medication. The eMAR ion was slightly effective. d 3/9/25 by Nurse #1 was oriented to person, s, combative or resistive to age in condition in the past	F	697	7		

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If continuation sheet Page 33 of 41

CENTER STATEMENT ( AND PLAN OF		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	. ,	E CONSTRUCTION	-	FORM OMB NO (X3) DATE COMP	LETED
AUTUMN	CARE OF MYRTLE GRO	νe		5725 CAROLINA BEACH F WILMINGTON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	3/26/25 at 3:30 PM. hard time recalling sp Resident #2, as the re primary assignment a turnover of residents. Resident #2 had pain #2 had difficulty expre- but Nurse #1 stated h my leg" with any move hard for him to descrift reported that with tran- incontinence care Res- non-verbal signs of in she did not recall that Resident #2 had 10 o stand or bear weight. not inform the provide intense pain with move dementia and she ass An interview was cone 3/25/25 at 5:00 PM. I worked from 7:00 PM assigned to Resident and 3/9/25. NA states 3/3/25 he had pain an assistance to get him Prior to the fall, NA #4 seemed fine and did r indicated she observe had swelling on the ni Resident #2 after the hip pain. NA #4 states #2 often, tried to talk to and reassure him. NA	right leg. ducted with Nurse #1 on Nurse #1 stated she had a ecific information about ehabilitation hall was her nd there was a high rate of Nurse #1 recalled that with movement. Resident essing where the pain was, e would say repeatedly "Oh ement or activity. It was be where the pain was. She asfers, bed mobility, sident #2 demonstrated therapy reported that ut of 10 pain, was unable to Nurse #1 stated she did er that Resident #2 had ement as he had some sumed the provider knew. ducted with NA #4 on NA #4 indicated that she to 7:00 AM and was #2 on 3/3/25, 3/7/25, 3/8/25 d when Resident #2 fell on dd required 2-person up and provide his care.	F 69	7			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 1 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 26/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH RC			
				WILMINGTON, NC 28412	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
	Continued From page stated she reported h each time she worked nurse administered pa the resident. An interview was cond 3/25/25 at 2:00 PM. If nurse assigned to Re- and 3/9/25 from 7:00 stated she did not kno fall on 3/3/25 and that was normally communi- report. Nurse #5 state Resident #2 was trans- he had fallen. Nurse lot of pain and it requi- for him. Nurse #5 state complaints of pain we were related to his de medication or further indicated she only add to Resident #2 once to complaint of pain was being difficult. Nurse yelled at her one of the the room, so she did na assessment. Nurse # assessed Resident #2 his upper thigh or hip notified the provider.	e 34 is pain to the floor nurse d but she did not know if the ain medication or assessed ducted with Nurse #5 on Nurse #5 was an agency sident #2 on 3/4/25, 3/8/25 PM to 7:00 AM. Nurse #5 ow that Resident #2 had a t information regarding falls nicated verbally during shift ed she found out after sferred to the hospital that #5 stated Resident #2 had a red 2 people to provide care ted she assumed that his ere more of a behavior or mentia and did not require evaluation. Nurse #5 ministered pain medication because she assumed his a behavior and he was just #5 stated Resident #2 the nights when she went into not attempt to complete an to indicated that if she had 2 and observed swelling in area she would have	F 697	DI		TΕ	DATE
	on 3/10/25 by Nurse #	inophen was administered #3 at 6:42 AM for a pain t indicated the medication ain level of 3 after the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 1 APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	-	(X3) DATE SURVEY COMPLETED		
		345507	B. WING		_	( 03/:	C 26/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
		-		5725 CAROLINA BEACH F	ROAD			
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 284	12			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER	S PLAN OF CORRECTION		(X5)	
PREFIX TAG	1	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 697	Continued From page	35	F 6	97				
	A physician progress	note dated 3/10/25 at 1:31						
	PM written by Physici							
		to see Resident #2 as he						
		n therapy, and he had a fall						
		the facility. Per Resident						
	•	ne resident was not himself, nd she (the family member)						
		dent #2 was seen and						
		sident complaining that his						
		t of pain down into this thigh.						
		hurt whenever anyone						
	touched the area.							
	An interview was con	ducted with Physician #2 on						
		Physician #2 indicated that						
		Resident #2 on 3/10/25 due						
		rticipating in therapy and						
		cian #2 indicated Resident						
		in his groin. Physician #2 he therapists assisted						
	Resident #2 into bed.	•						
	Resident #2 seemed							
	reported since his fall	. Physician #2 stated he						
		lesident #2 may have a						
		ded to be addressed right						
	-	or the resident to be sent to						
	the hospital. Physicia resident's increased r	pain level and inability to						
	-	ave been reported to the						
	physician or NP to ev							
	-	ble that the fracture may not						
		d signs, but increased pain						
		n #2 indicated that Resident						
	#2 had mild dementia	level should have been						
	addressed.							
	A nursing progress po	ote dated 3/10/25 at 1:43 PM						
	, that sing progress he							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		`, ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345507	B. WING				C /26/2025	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
					5725 CAROLINA BEACH ROAD			
AUTUMN	CARE OF MYRTLE GRO	VE		WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 697	sent to the emergence Resident's family mer complained of pain in had an unwitnessed f family member stated mentation and the far urinalysis and Compu- be completed. The ph resident and decided emergency room due area. An interview was com 3/25/25 at 1:14 PM. I with Resident #2 durin shift on 3/10/25. Nurs #2's family member in resident evaluated so of the family member in the order to transfer F for evaluation. Nurse Resident #2's legs an of resident's leg or a l The emergency depa 3/10/25 indicated Resident groin pain since an un	adicated Resident #2 was y room for evaluation. mber stated that Resident #2 his right hip area since he all on 3/3/25. Resident #2's he had decreased nily member requested a ted Tomography (CT) scan sysician assessed the to send Resident #2 to the to pain in the hip/groin ducted with Nurse #3 on Nurse #3 stated she worked ng the 7:00 AM to 7:00 PM se #3 stated that Resident ndicated that she wanted the she informed the physician s request. Nurse #3 stated #2 was in acute pain, could and was unable to sit up. dent #2 was only able to ed due to significant hip and stated Resident #2's pain rse #3 stated when the in and expressed concerns, sician of Resident #2's pain. The physician gave Resident #2 to the hospital #3 stated she looked at d did not observe a rotation eg length difference.	F	697				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345507	B. WING				C /26/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	deformity with externa extremity. Resident # than the left and was condition characterize abnormal accumulation tissues. A two view x indicated a comminut femur fracture. Resid hospital on 3/10/25, un nailing of the right fem metal rod is inserted i stabilize the fracture) skilled nursing facility indication of complication surgery. During a phone interview with Resident #2's far Resident #2 experien was not addressed. S medication provided the effective to manage the Resident #2's decrease therapy and inability to affected leg due to pate evaluated sooner. An interview was com- on 3/26/25 at 3:00 PM she was not aware of increased pain, not patinability to bear weights she did not assess the consult with the provide pain. An interview was com- Coordinator on 3/26/25/25/26/26/26/26/26/26/26/26/26/26/26/26/26/	al rotation of the right lower #2's right leg was shorter mildly edematous, a ed by swelling due to on of fluid in the body's -ray of the right femur result ed right intertrochanteric lent #2 was admitted to the inderwent intermedullary nur (a procedure in which a nto the long thigh bone to and was discharged to a on 3/20/25. There was no tions as a result of the riew on 3/25/25 at 9:45 AM mily member she reported ced pain at the facility that She indicated the pain to the resident was not he pain. She revealed that sed participation with o bear weight on the ain should have been ducted with Unit Manager #2 A. Unit Manager #2 stated "Resident #2 having articipating in therapy or at. Unit Manager #2 stated e resident at any time or der regarding the resident's	F	697			

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		MEDICAID SERVICES				IO. 0938-039			
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			PLE CONSTRUCTION						
		A. BUILDING	<u> </u>		COMPLETED				
						С			
		345507	B. WING		0;	3/26/2025			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE				
				5725 CAROLINA BEACH ROAD					
AUTUMN	CARE OF MYRTLE GRO	JVE		WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE			
F 697	Continued From pag	o 29	F 00						
F 097	Continued From page		F 69						
		with each resident, even if							
		agnosis of dementia. The							
	MDS Coordinator sta								
		ure scale was used to identify							
	-	The MDS Coordinator							
		f struggled to manage							
		When a resident reported a							
		quent pain or pain that							
	-	by or daily activities, the MDS							
		the resident's medical							
		e Unit Manager and medical							
		s of the interview. The MDS							
	-	d that the MDS Nurse was							
		out she should have informed							
	-	the medical provider of the							
	results of Resident #	2's pain assessment.							
	An interview was cor	nducted with Physician #1 on							
	3/26/25 at 2:00 PM.	Physician #1 indicated that							
	she was not aware o	f Resident #2 sustaining a							
	fall on 3/3/25. Physic	cian #1 stated she would							
	have expected the flo	oor nurse to notify her of the							
	fall. She indicated th	e on-call provider was							
	notified of the fall but	typically the floor nurse also							
	informed her (Physic	ian #1) of changes such as							
	recent falls when she	e was making her rounds.							
	Physician #1 stated i	f she had been informed that							
	Resident #2 had a fa	ll on 3/3/25 she would have							
	evaluated the resider	nt regarding the fall and							
	possible injury. Phys	sician #1 stated Resident #2							
	complained of pain a	nd she attributed this to his							
	-	e replacement. During							
		either the nursing staff nor							
		ed increased pain level or							
	inability to stand or b	ear weight. Physician #1							
	stated if the nursing	staff or therapists had							
		nt #2 had a pain level of 10							
	-	stand or bear weight, she							

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/14/2025 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345507	B. WING		-		C 26/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
A 1 17 1 1 A A A A				5725 CAROLINA BEACH RO	DAD			
AUTUMIN	CARE OF MYRTLE GRO	VE	WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 697	expected that the num have reported the char be a lack of communi- she was not aware the diagnosed with an inter- when he was sent to the on 3/10/25. An interview was com- Nursing on 3/25/25 at that Resident # 2 had facility and the staff as did not evaluate to de The DON indicated sh #2 was not participatin staff assumed it was j behavior and did not a change in condition. that the nursing staff of pain and reported incu- the physician for pain A follow-up interview of DON on 3/26/25 at 2: she reviewed Resider discharged to the hos pain was being mana- was not aware that the evaluation on 3/4/25 i had a pain level of 10 resident was unable to The DON stated she 10 out of 10 would be Nurse Practitioner to of she was not aware of on 3/7/25 that indicated intensity of 10 out of 10	sician #1 stated that she sing staff or therapists would anges and there seemed to cation. Physician #1 stated at Resident #2 was ertrochanteric femur fracture the hospital for evaluation ducted with the Director of : 3:40 PM. The DON stated pain during his stay in the ssumed it was his knee and termine where the pain was. he was aware that Resident ing well with therapy, but the ust the resident and his attribute it to the pain or a The DON's expectation was monitored the residents for reased pain and changes to management if indicated. was conducted with the 15 PM. The DON indicated in #2's record after he was pital, and she thought his ged. The DON stated she e Physical Therapy indicated that Resident #2 out of 10 and that the o stand and bear weight. expected that a pain level of reported to the physician or evaluate. The DON stated the MDS pain assessment ed Resident #2 had a pain 10 almost constantly that	F 69					
	resident was unable to The DON stated she 10 out of 10 would be Nurse Practitioner to she was not aware of on 3/7/25 that indicate	o stand and bear weight. expected that a pain level of reported to the physician or evaluate. The DON stated the MDS pain assessment ed Resident #2 had a pain 10 almost constantly that						

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04/14/2025 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345507	B. WING		_	C 03/26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
AUTUMN	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH RO WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIAT IEFICIENCY)	
F 697	activities. The DON s NP should have been #2's pain on the MDS DON indicated that the correction to address admission to ensure to assessments are com- risk for falls are identi are implemented upo facility. An interview was con- Administrator on 3/26 Administrator stated F complicated case and missed something. To that communication of between the nursing s	tated that the physician or a made aware of Resident b pain assessment. The ne facility initiated a plan of falls that occur after that preadmission hpleted, residents at high fied and safety interventions in the resident's arrival to the ducted with the 1/25 at 1:45 PM. The	F 69	7		

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