DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		345507	B. WING		0.	C 4/24/2025
NAME OF PF	ROVIDER OR SUPPLIER	1		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F 00	0		
F 565 SS=E	4/22/25 through 4/24, The following compla NC00226909, NC002 NC00229164. 2 of the 14 allegation: Immediate Jeopardy CFR 483.10 at tag F5 (J) CFR.483.25 at tag F6 (J) CFR 483.35 at tag F7 (J) The tag F693 constitu Care. Immediate Jeopardy removed on 4/25/25. A partial extended su Resident/Family Grou CFR(s): 483.10(f)(5)( §483.10(f)(5) The res and participate in res (i) The facility must po group, if one exists, wit to make residents an upcoming meetings in (ii) Staff, visitors, or o resident group or fam the respective group's (iii) The facility must p	ints were investigated: 226683, NC00224823, and s resulted in deficiency. was identified at: 580 at a scope and severity 593 at a scope and severity 726 at a scope and severity 726 at a scope and severity 404 Substandard Quality of began on 1/25/25 and was rvey was conducted. up and Response i)-(iv)(6)(7) sident has a right to organize ident groups in the facility. rovide a resident or family with private space; and take th the approval of the group, d family members aware of n a timely manner. ther guests may attend iily group meetings only at	F 56	5		5/14/25
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE
Electroni	cally Signed					05/16/2025

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CC AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
AND TEAN OF CORRECTION ADDITION NOMBER. A. BUILDING		с		
345507 B. WING		04/24/2025		
NAME OF PROVIDER OR SUPPLIER STRE	REET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD			
	LMINGTON, NC 28412			
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
interviews, the facility failed act upon concerns5that were reported by the resident council and7communicate the efforts to address concerns that7were reported during Resident Council Meetings6for 6 of 6 months (November 2024, December62024, January 2025, February 2025, March 20256and April 2025) reviewed.6Findings included:6a. The Resident Council meeting minutes dated6November 27, 2024, recorded by the Activity5	EFICIENCY) DEFICIENCY) Food Committee Meeting was held on 5/6/2025 to review dietary concerns. The Administrator will review all resider council minutes since 11/1/2024 and ensure all concerns were transcribed to concern forms, addressed by the appropriate department and presented the resident council president by 5/13/2 Education will be provided by the Nursi Home Administrator by 5/13/2025 to the Social Worker, Life Enrichment	to 5.		
Director indicated a concern expressed at the	Coordinator and the Interdisciplinary tea on the Grievance/Concern Policy and o			

Event ID: 705411

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	S FOR MEDICARE & I				OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345507			04/24/2025
NAME OF P	ROVIDER OR SUPPLIER		:	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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
E 565	Continued From page	<u>, )</u>			
F 565	tickets not matching v minutes indicated a c November meeting m response was provide the concern form and facility completed. The signed by the Adminis b. The Resident Cour December 13, 2024, 1 Director indicated a c the previous month's of the food. The minu was informed that stat the taste of the food. minutes did not indicated facility completed. c. The Resident Cour January 14, 2025, rec Director indicated a c the previous month's tickets not matching v having enough staff a The January minutes response was provide the concern form that that the facility comple were signed by the Ac 2025. d. The Resident Cour February 11, 2025, re Director indicated a c the previous month's tickets not matching v	what was served. The oncern form was filed. The inutes did not indicate that a ed to the council regarding any follow-up that the e meeting minutes were strator on 11/27/24. Ancil meeting minutes dated recorded by the Activity oncern was expressed at meeting regarding the taste utes indicated the council ff were spoken to regarding The December meeting ate any follow-up that the	F 565	<ul> <li>ensuring resident council concern being addressed timely and prese back to the resident council or the resident council president.</li> <li>The Nursing Home Administrator all resident council meeting minut monthly for three months to ensur concerns are transcribed onto grie forms, addressed and presented to resident council or resident counce president for approval. The result audit will be presented to the Qua Assurance Improvement Committ monthly for 3 months. The QA tea change the plan of correction or e the monitoring period to ensure or compliance.</li> </ul>	ented will audit es re any evance to the il is of the lity ee am may xtend

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345507	B. WING				C / <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 565	the concern form that that the facility compli- indicated that the Om- meeting. The meetin- the Administrator on 2 attendees at the mee Administrator did not e. The Resident Cour March 18, 2025, reco- indicated a concern w previous month's mee available menu items March minutes did not was provided to the co- form that was filed, on facility completed. Th- indicated that the Om- meeting. The meetin the Administrator on I attendees at the mee Administrator did not f. The Resident Courn April 14, 2025, indica- expressed at the prev- regarding the meal tid served and the alway not available. The Ap- indicate that a respon- council regarding the the month prior, or an completed. An interview was con Council President on Resident Council Pre-	was filed, or any follow-up eted. The meeting minutes ibudsman attended the g minutes were signed by 2/11/25. The list of ting indicated that the attend the meeting. And the meeting minutes dated orded by the Activity Director vas expressed at the eting regarding the anytime were not available. The ouncil regarding the concern r any follow-up that the ne meeting minutes budsman attended the g minutes were signed by March 18, 2025. The list of ting indicated that the attend the meeting. And the meeting cli meeting minutes dated ted a concern was vious month's meeting ckets not matching what was s available menu items were oril meeting minutes did not ase was provided to the concern form that was filed by follow-up the facility ducted with the Resident 4/23/25 at 4:00 PM. The sident stated that the a monthly, and the Activity	F	565			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 24/2025
NAME OF P	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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	expressed. The Resi indicated that nothing concerns that were ex The Resident Council attended all the Resid was frustrated with th he felt that managem concerns of the counce was not provided with concerns that were ex stated the Regional V Resident Council meet but she was unable to were not addressed. An interview was con Vice President on 4/2 Regional Vice President Council meeting on A Vice President stated was made aware that meetings were not ad months. The Regional following the meeting residents' concerns a had no process in plat expressed in the Ress Regional Vice President forms were not being Resident Council Meet follow up to ensure the addressed. The Region there was not a syste concerns or grievance this was not acceptate	dent Council President was done about the spressed in the meetings. I President stated he dent Council meetings and e lack of follow up because ent did not address the cil. He stated the council a resolution to the spressed each month. He fice President attended the eting held on April 14, 2025, o explain why the concerns ducted with the Regional 4/25 at 9:00 AM. The ent stated that she was is to attend the Resident pril 14, 2025. The Regional it was at that meeting she is concerns expressed in the dressed for the past several al Vice President stated , she investigated the nd learned that the facility ce to address the concerns ident Council Meetings. The ent indicated that concern addressed following the etings and there was no at the concerns were onal Vice President stated m in place to address e voiced at the meetings and	F	565			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345507	B. WING				C 24/2025
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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	Director indicated she Resident Council Mee at the meeting. The A at each meeting, the A previous meeting wer concerns. The Activit completed a concern expressed by the Res and she gave these for from the current meet follow up on. The Act past several months to previous meetings wer the residents were frue Director stated that sh Ombudsman attended meetings to assist wit concerns. The Activit Ombudsman attended meetings recently and concerns were not be Director stated she ha forms after she comp An interview was con Services Director on A Social Services Direct any forms from the Re was not involved in an attended a Resident of An interview was con Administrator on 4/24 Administrator stated to Director left the facility	e conducted the monthly etings and took the minutes Activity Director stated that old concerns from the re discussed as well as new ty Director stated she form with each concern sident Council members, orms as well as the minutes ting to the Administrator to tivity Director stated for the the concerns from the ere not being addressed and ustrated by this. The Activity the requested that the he Resident Council th addressing the residents' ty Director indicated that the d the Resident Council d was aware that the being addressed. The Activity ad not seen the concern leted them. ducted with the Social 4/24/25 at 2:05 PM. The tor stated she had not seen esident Council Meetings, ny follow-up and she had not Council meeting. ducted with the /25 at 3:20 PM. The he Social Services Director ddressing the concerns of	F	565			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345507	B. WING				24/2025
NAME OF P	ROVIDER OR SUPPLIER		•		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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565 F 580 SS=J	to her leaving. The A he did not attend the l and he was not involv concerns that were ex The Administrator ack implemented measure expressed by the Res he should have addre were given to him. The documentation that sh reported during the m meetings for the past The Administrator ack monthly meeting minu- explain if he was awa expressed as the meet Notify of Changes (Inj CFR(s): 483.10(g)(14) \$483.10(g)(14) Notified (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h- physician intervention (B) A significant chang- mental, or psychosoc deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue	dministrator indicated that Resident Council meetings, red with addressing the spressed at the meetings. showledged he should have es to address the concerns sident Council members and essed the concern forms that he Administrator had no howed that the grievances onthly Resident Council 6 months were addressed. showledged he signed the utes but was unable to re of the repeated concerns etings. jury/Decline/Room, etc.) )(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a h, mental, or psychosocial reatening conditions or ); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the		565			5/14/25

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	CARE OF MYRTLE GRO	ME		5	725 CAROLINA BEACH ROAD		
		VL	WILMINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	(14)(i) of this section, all pertinent informati is available and provi physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must n update the address (n phone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi the Medical Director, (NP), the facility failed physician on 1/25/25 dislodged jejunostom surgically inserted int deliver nutrition and r not communicate with	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations • is not met as evidenced iew and interviews with staff, and the Nurse Practitioner d to immediately notify the of a resident's (Resident #1)	F	580	On January 25,2025, the facility failed immediately notify the physician of Resident #1's dislodgement of a jejunostomy tube (a tube surgically inserted into the small intestine to deliv nutrition and medications). Nurse Aide identified a tube on the floor of Resider #1's bathroom at approximately 9:00ar She did not communicate this informat	/er e #1 nt n.	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO.	PPROVE
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345507	B. WING		C 04/24	/2025
NAME OF PF	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	Continued From page	e 8	F 58	30		
F 300	replace the j-tube with replacement tube bed j-tube site on 1/25/25 resident to the hospit #1 went to the Operatevening of 1/27/25 are placed. This delayed high likelihood of resur- Resident #1 from the the wrong place, perfi- sepsis (life-threatenin due to anticoagulant of deficient practice affer reviewed for notification Nurse #1 failed to not Resident #1's dislodg Immediate jeopardy to Nurse #1 failed to not Resident #1's dislodg Immediate jeopardy to when the facility imple credible allegation of removal. The facility to at a lower scope and harm with potential for that is not immediate education is completed put into place are effet The findings included The hospital discharg dated 1/14/25 indicated hospital on 1/2/25 and surgically into the sm the main source for m	hout a physician's order. The came dislodged from the and Nurse #1 sent the al for reinsertion. Resident ting Room (OR) on the nd the j-tube was surgically physician notification had a ulting in serious harm for risks of placing the j-tube in foration of the small intestine, ag infection), and bleeding (blood thinner) use. This acted 1 of 2 residents for. began on 1/25/25 when tify the physician regarding yed jejunostomy tube. was removed on 4/25/25 emented an acceptable immediate jeopardy will remain out of compliance severity level of D (no actual or more than minimal harm jeopardy) to ensure ed and monitoring systems active. I: ge summary for Resident #1 ed he was admitted to the d a j-tube was placed all intestine on 1/10/25 as neeting his nutritional needs. to the facility on 1/14/25 for		to Nurse #1. At approximately Nurse #1 identified Resident #1 dislodged j-tube. Nurse #1 repl Resident #1's dislodged j-tube we catheter and did not notify the p The j-tube then became dislodg second time on January 25, 20 approximately 12:45 pm. Nurse notified the physician at 1:15 pm the resident the resident to hos reinsertion. Surgical residents of to place a foley into the tract in Emergency Room (ER). Interve Radiology (IR) attempted place January 27, 2025 but were not place. Resident #1 returned to on February 4, 2025. During the remainder of Resident #1's time the j-tube did not dislodge again Resident #1 was discharged fro facility on March 28, 2025. After determining there was a knowled deficit, a plan to re-educate all the established. The facility review circumstances of the deficient p and reviewed the findings with the team on April 24, 2025. On April 23, 2025 the Director of conducted a 30 day look back to other residents identified with a condition to verify physician and provider notification was made manner. No additional concern identified.	I's laced with a foley obysician. ged a 25 at e #1 n and sent pital for were able the entional ment on able to the facility re e at facility re e at facility, n. om the er edge nurses was red the practice the QA of Nursing o review change in d/or in a timely as were	
	rehabilitation services Resident #1 was adm			All residents with change of cor at risk for the same deficient pro The Director of Nursing (DON)	actice.	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING			~	
		345507	B. WING			C 04/24/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	24/2023	
				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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 500		0					
F 580	Continued From page		F 58				
	1/14/25 with diagnose	es including cerebral usion or stenosis of left		a 30 day look back to review othe			
	middle cerebral arter			residents identified with a change condition to verify Physician and/			
		, and aphasia (absence of		Provider was notified in a timely n			
	speech).	,		This review was completed by the			
				on April 23, 2025 and consisted o			
		rs for Resident #1 revealed		thorough review of change of con	dition		
		: 1) j-tube 16 French (size),					
	2) tube feeding at a c			Prevention to ensure deficient pra	actice		
		r for 22 hours to allow for		does not occur again: The DON,			
		g, and 3) apixaban tablet (an grams (mg) twice a day per		Assistant Director of Nursing (AD Unit Managers re-educated Licen			
		vas not a physician's order to		Nurses and Nurse Aides (NA) on	seu		
	change the j-tube.			"Resident Change in Condition Po	olicy"		
				with emphasis on changes that re	-		
	The Physician's Histo	ory and Physical dated		immediate provider notification ar			
	-	#1 indicated that he was		documentation on April 24, 2025.			
	admitted to the facility	y with right-sided weakness		nurse aides were educated to not	ify the		
		cerebral artery occlusion.		charge nurses if any devices, suc			
		esident #1 was status		enteral feeding tubes were displa			
		ent of a j-tube on 1/10/25 to		not in resident at time of care. No			
	meet his nutritional ne	eeds due to dysphagia.		licensed Nurses, Agency Nurses			
	The admission Minim	um Data Set (MDS)		Nurse Aides will be educated by t or ADON during the orientation pr			
		17/25 revealed Resident #1			00000		
		rely impaired. He was coded		Ongoing Compliance Monitoring:	DON		
		and receiving greater than		and/or designee will audit Change			
		nd over 500 ml of water		Condition 5x week for 12 weeks t			
		eding daily. He was coded		physician notification was made in			
	for receiving an antic	oagulant.		timely manner. DON/designee w			
				interview 5 STNA a week to valid			
		BAR (Situation, Background,		understanding of charge nurse no			
	Appearance, and Rev	-		of any change of conditions. Resu			
		ation tool used to transmit tion) communication form in		audits will be reported in QAPI me monthly x 3 months by DON.	eeung		
		25 and signed by Nurse #1					
		as: The change in condition,					
		bserved and evaluated were					
		but his j-tube 2 times and the					

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED			
		345507	B. WING		_		C 24/2025			
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•				
		-	5	5725 CAROLINA BEACH ROAD						
AUTUMN	CARE OF MYRTLE GRO	VE	v	WILMINGTON, NC 2841	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 580	resident consistently i tube. There was no of except that the Respon notified at 12:51 PM at notified at 12:51 PM at notified at 1:12 PM. T transfer to the hospital An incomplete Hospita Resident #1 listed the name, date of admiss primary diagnosis. It finotified of the situation hospital. The reason find pulled out j-tube. The anticoagulation, aspir medications crushed, checked. The form wa and no other informat A telephone interview #1 on 4/23/25 at 10:0 nurse, stated she wor January for approxima no longer employed the 1/25/25 she was assig and at approximately administer Resident # feeding tube and the abdomen. Nurse #1 s was scheduled for on for activities of daily li and she had not had at tube feeding that more there was no bleeding that she went and asis she knew what happen feeding tube. Nurse #	s occurring before due to oblaying and tugging on the ther information listed onsible Party (RP) was and the on-call provider was he box to call for 911 for al was checked. al Transfer Form for following information: His ion, date of birth, and further listed the RP was in and of the transfer to the for the transfer was listed as risk alert boxes for ation, high fall risk, needs and pain level were as not signed by facility staff ion was noted. was conducted with Nurse 0 AM. Nurse #1, an agency ked for the facility in ately 3 weeks, but she was here. She stated that on gned to care for Resident #1 12:15 PM she went into 41 his medications per tube was not in his tated that the tube feeding ly 22 hours a day to allow ving (ADL) care and therapy a chance to reconnect the ning. She indicated that g at that time. She reported ked Nurse Aide (NA) #1 if	F 580							

Facility ID: 960602

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		345507	B. WING _				C 24/2025	
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
A		<i></i>		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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 580	not reported it to the r that NA #1 informed h with Resident #1 in th morning around 9:15 after speaking with N/ Resident #1's room an on the bathroom floor been a nurse for 21 ye experienced in reinse the stomach). She exp unaware Resident #1 assumed it was a gas stated that instead of had consulted the Wo Manager on duty that Wound Nurse had ins an enteral feeding tub for an indwelling urina indicated she had rep French indwelling urina indicated that if she ha a j-tube and not a gas have sent him to the r dislodged. She stated of anyone reinserting Nurse #1 stated she r Nursing (DON) the se dislodged, and she ins provider and transfer #1 indicated that after the hospital she had a Occupational Therapy noticed if the feeding	2-3 hours ago, but she had hurse. She further stated hurse. She further stated hurse she further stated her that therapy was working e bathroom early that AM. Nurse #1 indicated that A#1 she had gone back to hd found the feeding tube . She indicated she had ears and she was rting gastrostomy tubes (in plained that she was had a j-tube and she had trostomy tube. Nurse #1 calling the physician she hund Nurse, who was the weekend. She stated the tructed her to replace it with the of the same size or a tube ary catheter. Nurse #1 laced the j-tube with a 16 hary catheter tube. Nurse #1 ad known Resident #1 had strostomy tube she would hospital the first time it that she had never heard a j-tube in a nursing facility. hotified the Director of cond time the tube was structed her to notify the him to the hospital. Nurse transferring Resident #1 to asked the Certified / Assistant (COTA) if he had tube was dislodged during hroom and he stated he was slodged. She further was the last day she	F	580				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		345507	B. WING		_		C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
				5725 CAROLINA BEACH F	ROAD		
AUTUMIN	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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page A telephone interview on 4/23/25 at 12:23 P 1/25/25 she had notic like a tube lying on Re after she observed the Resident #1 at approx stated she was busy a not stopped to examin She further stated she that something was ly A telephone interview Wound Nurse on 4/23 Wound Nurse on 4/23 Wound Nurse stated she that something was ly A telephone interview Wound Nurse stated she tube was dislodged. T she could not recall if j-tube. She further ind Nurse #1 that she could tube and that if the fac size tube, she could u urinary catheter tube stated that she instruct provider for an order. A telephone interview COTA who was assig 1/25/25. The COTA st working with Resident toilet transfers. The C out of the ordinary oct and he did not know h dislodged. He further	<ul> <li>12</li> <li>was completed with NA #1</li> <li>M. NA #1 stated that on ed something that looked esident #1's bathroom floor e COTA working with kimately 9:15 AM. She and was in a hurry and had he the object on the floor.</li> <li>a had not notified the nurse ing on the floor.</li> <li>was completed with the 8/25 at 12:28 PM. The she was the Manager on further stated she</li> <li>1 telling her that a feeding The Wound Nurse indicated Nurse #1 told her it was a licated that she did tell uld replace a gastrostomy cility didn't have the correct use the same size indwelling instead. The Wound Nurse cted Nurse #1 to call the</li> <li>was completed with the ned to Resident #1 on tated that on 1/25/25 he was t #1 in the bathroom with OTA indicated that nothing curred during the transfer,</li> </ul>	F 58				
	or any sign of pain. The saw a tube on the bat	he COTA stated he never hroom floor, but if he had I have notified the nurse.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345507	B. WING				_ 24/2025
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
AUTUMN	CARE OF MYRTLE GRO	VE					
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 13	F	580			
	1/25/25 at 2:00 PM in call from floor nurse t out. Nurse #1 was ad call and send to the h j-tube. An interview with the 4/23/25 at 4:10 PM. T documented the note 1/25/25 from her hom stated that when Nurs Resident #1's j-tube w instructed her to call to to send him to the hom	ote written by the DON on dicated that she received a hat Resident #1's j-tube fell vised to call the Provider on rospital or placement of DON was completed The DON stated she had related to Resident #1 on the computer. She further se #1 notified her that vas dislodged she had the provider to get an order spital. The DON indicated entioned something about					
	reinserting the tube a that resident's with di- the hospital to have it Nurse #1 should have the j-tube was initially indicated that Nurse # and never returned to j-tubes were inserted	nd she had informed her slodged j-tubes were sent to replaced. She stated that e notified the physician when dislodged. The DON #1 was suspended that day the facility. The DON stated					
	Department (ED) End Physician dated 1/25, #1 presented to the h j-tube. The note indic approximately two we and replaced with ten it became dislodged a were able to place a tract in the Emergence Interventional Radiological	eeks old and it was dislodged nporary urinary catheter, and again. Surgical Residents urinary catheter tube into the by Room (ER).					

Facility ID: 960602

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	-	ID HUMAN SERVICES MEDICAID SERVICES			I	INTED: 06/03/2025 FORM APPROVED IB NO. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3)	) DATE SURVEY COMPLETED
		345507	B. WING			C 04/24/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
				725 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 PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 580	the evening of 1/27/25 successfully placed. T related to the surgery the facility on 2/4/25. An interview was come Practitioner (NP) on 4 stated that it was not change the j-tube. Sh risk perforation (pokin the intestine) and an it a serious infection by abdomen. The NP ind an anticoagulant that bleeding. She further order would be needed NP stated it was out to to replace a tube with indicated Nurse #1 sh on-call provider before tube. An interview with the completed on 4/23/25 Director stated that it a nurse to replace a j- further stated that sind inserted on 1/10/25 th mature (a jejunostomy form a stable track be jejunum [small intestin intestinal contents and weeks) and there wou perforation, the tissue (tissue that is easily in	he Operating Room (OR) on 5 and the j-tube was There were no complications and Resident #1 returned to ducted with the Nurse //23/25 at 10:43 AM. The NP appropriate for a nurse to e further stated there was ig a hole through the wall of increased chance of causing pushing bacteria into the dicated Resident #1 was on put him at higher risk of indicated a physician's ed to change any tube. The he nurse's scope of practice out a physician's order. She nould have notified the e reinserting a replacement Medical Director was 5 at 11:47 AM. The Medical was totally inappropriate for -tube in the facility. She ce the tube was surgically he site was probably not y site needs to mature to etween the skin and the he] to prevent leakage of d this takes approximately 4 ald be higher risk for bowel e would be more friable ritated, which makes it more	F 580		ENCY)	
	cause more bleeding,	<ul> <li>bleeding, and tearing) and</li> <li>and the fact that he was</li> <li>vould definitely increase the</li> </ul>				

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
			(X2) MUUT				0.0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
			A. BOILDI				С
		345507	B. WING				24/2025
NAME OF P	ROVIDER OR SUPPLIER	L		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		• _ •
					5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		١	WILMINGTON, NC 28412		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	AIE	
F 580	Continued From page	e 15	F !	580			
	1 5	Medical Director indicated		000			
		high likelihood of harm due					
		ding, and perforation for a					
		ube in a nursing facility. She					
	stated that Nurse #1	should not have attempted					
	to reinsert the j-tube v						
	1.	I Director indicated that					
		t the hospital using x-ray or					
	computed tomograph	y (CT) scan guidance.					
	An interview was com	poleted with the					
	Administrator on 4/24						
		ne expected the nursing staff					
		policies and procedures					
	regarding feeding tub						
	physician.						
	jeopardy on 4/23/25 a	s notified of immediate					
		at 4.00 T W.					
	The Administrator pro	vided the following credible					
		te Jeopardy removal:					
	-	ts who have suffered, or are					
	-	ous adverse outcome as a					
	result of the noncomp	bliance:					
	On January 25, 2025	the facility failed to					
		e physician of Resident #1's					
		unostomy tube (a tube					
		o the small intestine to					
		nedications). Nurse Aide #1					
	identified a tube on th	e floor of Resident #1's					
		nately 9:00 AM. She did not					
		ormation to Nurse #1. At					
		PM Nurse #1 identified					
	Resident #1's dislodg	-					
		's dislodged j-tube and she gurinary catheter tube to					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C <b>24/2025</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MYRTLE GRO			5	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 580	The j-tube then becar on January 25, 2025 and Nurse #1 notified and sent the resident Surgical Residents we the tract in the Emerg Interventional Radiolo placement on January to place. Resident #1 Room (OR) on the ev and j-tube was succes returned to the facility During the remainder facility, the j-tube did #1 was discharged fro 2025. The Director of Nursin day look back to revie with a change in conce and/or Provider was or This review was comp 23, 2025 and consiste change of condition a electronic medical rec titled "Interact SBAR" Situation, Background Recommendation), "If Hospital Transfer Fort was sent to the Medic residents that experie condition during that to change of condition is improvement in the re 1. Will not normally intervention by staff or	did not notify the physician. ne dislodged a second time at approximately 12:45 PM, the physician at 1:15 PM to hospital for reinsertion. ere able to place a foley into ency Room (ER). py (IR) attempted y 27, 2025 but were not able went to the Operating ening of January 27, 2025 ssfully placed. Resident #1 r on February 4, 2025. of Resident #1's time at not dislodge again. Resident om the facility on March 28, ng (DON) conducted a 30 ew other residents identified lition to verify Physician notified in a timely manner. pleted by the DON on April ed of a thorough review of ssessments identified in our cord through observations (an SBAR stands for d Assessment, nteract Nursing Home to m", and "Events". An email cal Director with a list of all nced a significant change of ime period. A significant s identified as a decline or	F	580			
	Situation, Background Recommendation), "In Hospital Transfer Fort was sent to the Medic residents that experie condition during that t change of condition is improvement in the re 1. Will not normally intervention by staff o	d Assessment, nteract Nursing Home to m", and "Events". An email cal Director with a list of all nced a significant change of time period. A significant is identified as a decline or esident's status that: resolve itself without r by implementing standard					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345507	B. WING				C 24/2025
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	2. Impacts more that health status; and/or of 3. Requires interdist revision to the care pland of the care of the process of the care pland of the process of the care of the process of the	an one area of the resident's one that ciplinary review and/or an. As were identified. The ed to the email sent by the at she had reviewed the list rns on April 24, 2025. A entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete: Director of Nursing (ADON), e-educated Licensed Nurses ) on "Resident Change in a emphasis on changes that ysician notification and ril 24, 2025. Changes ication include a decline or esident's status that will not f without intervention by staff andard disease-related s), impacts more than one health status, and/or ary review or revision to the e Aides were educated to ses if any devices, such as , were displaced or not in re. The Director of Nursing iat employees with in leave of absence (FMLA), f or PRN staff will be	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C /24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				5	5725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		١	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 580	2025, the Director of I Facility Activity Report Interact Nursing Hom Forms, or any Events Morning Meeting, whi week, to verify promp notification is communand/or Provider. If no has not occurred, the physician at that time Alleged immediate jeo 25, 2025. The immediate jeopar validated on 4/24/25. residents who were re Director for notificatio condition on 4/24/25. 4/24/24 at 12:15 PM of had sent the list of res Director and the provi and no other concern education sign in she in-services conducted 4/23/25 and 4/24/25 r in Condition Policy" a prompt notification of interviews with nurses regarding significant of when to notify the pro- Interviews completed confirmed education of nurses if any devices, tubes, were displaced 4/24/25 at 12:22 PM f would be reviewing th	process. Effective April 24, Nursing will review the t for any Interact SBAR, e to Hospital Transfer in the morning Clinical ch will be held seven days a t and/or immediate nicated to the Physician DON will notify the  opardy removal date: April rdy removal plan was The DON provided a list of eviewed by the Medical n of a significant change in An interview with the NP on confirmed that the facility sidents to the Medical iders had reviewed the list s were identified. The ets were reviewed for the d with the nursing staff on regarding "Resident Change nd "Changes requiring the nurse or provider". Staff is confirmed education changes in condition and ovider was provided. with the Nurse Aides on notifying the charge , such as enteral feeding	F	580			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C / <b>24/2025</b>
NAME OF P	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Transfer Forms, and a morning Clinical Meet was notified. She stat held in person Monda conducted remotely o meeting on Saturday immediate jeopardy re validated.	any Events identified in the ting to verify the provider ed the meetings would be y through Friday and n a virtual computer and Sunday. The facility's emoval date of 4/25/25 was		580			E (4.4/0E
F 622 SS=D	§483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must per remain in the facility, a discharge the residen (A) The transfer or dis resident's welfare and cannot be met in the facility, because the resident's ufficiently so the resident's services provided by facility (C) The safety of indivi- endangered due to the status of the resident; (D) The health of indivi- otherwise be endange (E) The resident has fa appropriate notice, to under Medicare or Medicaid resident refuses to par resident who become	i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the t the resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; viduals in the facility is e clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party		622			5/14/25

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345507	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this chap exercises his or her ri discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility trans resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific ro be met, facility attemp needs, and the servic facility to meet the ne (ii) The documentation (2)(i) of this section m (A) The resident's phy discharge is necessat (A) or (B) of this section	the charges under Medicaid; as to operate. but transfer or discharge the beal is pending, pursuant to obter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified 0(A) through (F) of this ust ensure that the transfer nented in the resident's opropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot ots to meet the resident e available at the receiving ed(s). n required by paragraph (c) ry under paragraph (c) (1)	F	622			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345507	B. WING				C 24/2025	
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	this section. (iii) Information provid must include a minimu (A) Contact information responsible for the ca (B) Resident represent contact information (C) Advance Directive (D) All special instruct ongoing care, as appr (E) Comprehensive ca (F) All other necessat copy of the resident's consistent with §483.2 any other documentat a safe and effective tr This REQUIREMENT by: Based on record revit facility failed to comminformation to the hos (Resident #1) reviewed The findings included Resident #1 was admin 1/14/25 with diagnose infarction due to occlumiddle cerebral artery (difficulty swallowing), speech). The physician's order 1/14/25 included a jeji placed feeding tube th medications directly in	agraph (c)(1)(i)(C) or (D) of led to the receiving provider um of the following: on of the practitioner re of the resident. Intative information including e information tions or precautions for ropriate. are plan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ansition of care. is not met as evidenced ew and staff interview, the unicate all required pital for 1 of 1 resident ed for hospital transfers.	F	622	Resident #1 is no longer in the facility The DON/designee will audit the med record for all facility residents that are admitted to the hospital to ensure all required information was communicat to the hospital by 5/8/2025. The DON/designee will educate all nu on completing the Nursing Home to Hospital Transfer form and sending th Continuity of Care Document (CCD) v the resident upon transfer. The educat will be completed by 5/13/2025. The includes the following: demographics medications, problem list, diagnosis, vitals, allergies, Advanced Directives, insurances, immunizations, goals, soch	ical still ed rses e vith ation CCD		
	French (size).				history and encounters.			

Facility ID: 960602

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETED
		245507	B. WING		С
	ROVIDER OR SUPPLIER	345507	B. WING	STREET ADDRESS, CITY, STATE, ZIP	04/24/2025
NAME OF P	ROVIDER OR SUPPLIER			5725 CAROLINA BEACH ROAD	CODE
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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 622	Continued From page	e 22	F 62	22	
	The admission Minim assessment dated 1/ was severely cognitiv speech. A nurse's progress no Nursing on 1/25/25 a received a call from ti #1's jejunostomy tube was advised to call th to the hospital or place An incomplete 2-page Resident #1 listed the page 1: His name, da birth, and primary dia Responsible Party wa and of the transfer to the transfer was lister form indicated that Re disoriented, could nor he required a proxy for he was incontinent of date of his last bowel 1 of the form was miss relevant diagnoses, a page 2 of the form the anticoagulation, aspin medications crushed, checked. His diet was The sections for resp devices, isolation pre were not completed. and dated.	hum Data Set (MDS) 17/25 revealed Resident #1 rely impaired and had no bete written by the Director of t 2:00 PM indicated that she he floor nurse that Resident e (j-tube) fell out. Nurse #1 he Provider on call and send cement of j-tube. e Hospital Transfer Form for e following information on ate of admission, date of ignosis. It further listed the as notified of the situation the hospital. The reason for d as pulled out j-tube. The esident #1 was alert, t follow/simple commands, or decision making capacity, i bowel and bladder, and the movement was noted. Page ssing the code status, and functional status. On e risk alert boxes for ration, high fall risk, needs , and pain level were s listed as enteral feeding. iratory, medications, cautions, and vital signs The form was not signed		The DON/designee will au transfers 5x week for 12 v required information is co the hospital and documer electronic medical record. DON/designee will comple Home to Hospital Transfe provide the CCD to the hor resident that was discharg document. The nurse that responsible for sending the discharge will be re-educat DON/designee. The audi reviewed monthly for 3 me	weeks to ensure mmunicated to need in the . The ete the Nursing or form and ospital for any ged without the at was ne document on ated by the ts will be
	4/23/25 at 10:00 AM. the nurse assigned to	Nurse #1 stated she was o care for Resident #1 on be became dislodged. She			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345507	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD NILMINGTON, NC 28412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 622 F 693 SS=J	further stated the resi care for that day were requiring closer monit i.e. tracheostomy tube and she had not comp related to the incident Director of Nursing (D times to return to the paperwork, but she no facility. An interview with the 4/23/25 at 4:00 PM. T call Nurse #1 multiple back to the facility to regarding Resident # but she never came b expected the nursing complete and accurat Tube Feeding Mgmt/F CFR(s): 483.25(g)(4)-(5) Entr (Includes naso-gastric both percutaneous en percutaneous endosc enteral fluids). Based comprehensive asses ensure that a resident §483.25(g)(4) A resid eat enough alone or v enteral methods unles condition demonstrate clinically indicated and resident; and	dents she was assigned to a high acuity (residents coring and treatments with es, feeding tubes, wounds) obted the documentation a. Nurse #1 indicated that the DON) called her multiple facility to complete the ever went back to the DON was completed on the DON stated she tried to a times to get her to come complete the paperwork 1's transfer to the hospital, back. She indicated she staff documentation to be re. Restore Eating Skills (5) eral Nutrition c and gastrostomy tubes, ndoscopic gastrostomy and on a resident's ssment, the facility must te- ent who has been able to with assistance is not fed by ss the resident's clinical es that enteral feeding was		622			5/14/25

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OLIVIEN		MEDICAID SERVICES			1	<u> 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
	CONTRACTION		A. BUILDI	NG		
		345507	B. WING			С
		345507	D. WING			/24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	JODE	
AUTUMN	CARE OF MYRTLE GRO	DVE		5725 CAROLINA BEACH ROAD		
	1			WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 693	Continued From pag	e 24	F	693		
		appropriate treatment and				
		f possible, oral eating skills				
		lications of enteral feeding				
		ted to aspiration pneumonia,				
		ehydration, metabolic				
		asal-pharyngeal ulcers.				
		T is not met as evidenced				
	by:				· <b>f</b> - 111 + -	
		view, Nurse Practitioner (NP), iff, and Responsible Party		On January 25, the facility ensure Resident #1 was p		
		facility failed to ensure a		necessary treatment to rep		
		1) was provided with the		dislodged jejunostomy tub		
		to replace his dislodged		placed feeding tube that d		
		surgically placed feeding		and medications directly in		
		trition and medications		intestine). Nurse #1 did no		
	directly into the smal	ll intestine). On 1/25/25,		need for hospital treatmen	t to replace the	
	Nurse #1 did not ide	ntify the need for hospital		dislodged j-tube and she in	nserted a foley	
		the dislodged jejunostomy		catheter to replace the tub		
		e inserted an indwelling		then became dislodged as		
	-	to replace the j-tube without		January 27, 2025 but was		
		The replacement tube		re-place. Resdent #1 wen		
	_	om the j-tube site on 1/25/25,		operating room on the eve		
		he resident to the hospital for		27, 2025 and the j-tube wa	-	
		t #1 went to the Operating vening of 1/27/25 and the		placed. Resident #1 return facility on February 4, 202		
	j-tube was successfu			remainder of Resident #1's		
		ted a high likelihood of		the j-tube did not dislodge		
	•	g serious harm from the risks		Resident #1 was discharge	-	
	of placing the j-tube	-		facility on March 28, 2025.		
	perforation of the sm					
		ction), and bleeding due to		All residents with j-tubes a		
		thinner) use. This deficient		same deficient practice.		
	•	ed for 1 of 3 residents		2025, the Director of Nursi	- , ,	
	reviewed for feeding	tubes.		reviewed all residents that		
	lucius all'at d'un			facility from January 25, 20		
		began on 1/25/25 when		23, 2025 and no additiona		
	-	lesident #1's dislodged		identified with a j-tube in th	ie lacility at this	
		nmediate jeopardy was when the facility		time.		

Facility ID: 960602

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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		A. BUILDING		C
	345507	B. WING		04/24/2025
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CARE OF MYRTLE GRO	VE			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLET
implemented an acce immediate jeopardy r remain out of complia severity level of D (no for more than minima jeopardy) to ensure e monitoring systems p The findings included The hospital discharg dated 1/14/25 indicat hospital on 1/2/25 witi infarction due to occlu artery (stroke), global oropharyngeal dysph and right hemiparesis side of the body). A j into the small intestin source for meeting hi discharged to the fac rehabilitation services Resident #1 was adm 1/14/25 with diagnost infarction due to occlu middle cerebral artery The physician's order orders dated 1/14/25 2) tube feeding at a c milliliters (ml) an hour activities of daily livin	eptable credible allegation of removal. The facility will ance at a lower scope and o actual harm with potential al harm that is not immediate education is completed and out into place are effective.	F 693	<ul> <li>Prevention to ensure deficient practices not occur again: The Director of Nursing (DON), Assistant Director of Nursing (ADON), the Unit Manager provide education to Licensed Nurse Enteral Feeding Tube(s) policy, to it what to do if a j-tube becomes dislot to include physician notification, no attempt reinsertion of a j-tube, and sending the resident to the hospital surgical reinsertion. Training was completed by April 24, 2025. New and Agency Nurses will be educated the Director of Nursing and/or Assis Director of Nursing during the orient process.</li> <li>Ongoing Compliance Monitoring: DON/designee will interview 5 nurse weekly x 12 weeks to validate understanding of how to handle a dislodged j-tube. Results of interview</li> </ul>	es
	Continued From page implemented an acce immediate jeopardy r remain out of complia severity level of D (not for more than minima jeopardy) to ensure e monitoring systems p The findings included The hospital discharg dated 1/14/25 indicat hospital on 1/2/25 wit infarction due to occl artery (stroke), globa oropharyngeal dysph and right hemiparesis side of the body). A into the small intestin source for meeting hi discharged to the fac rehabilitation services Resident #1 was adm 1/14/25 with diagnos infarction due to occl middle cerebral arter The physician's order orders dated 1/14/25 2) tube feeding at a c milliliters (ml) an hou activities of daily livin	DE DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345507         ROVIDER OR SUPPLIER         CARE OF MYRTLE GROVE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25 implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.         The findings included:         The hospital discharge summary for Resident #1 dated 1/14/25 indicated he was admitted to the hospital on 1/2/25 with diagnoses of cerebral artery (stroke), global aphasia (unable to speak), oropharyngeal dysphagia (difficulty swallowing), and right hemiparesis (muscle weakness on one side of the body). A j-tube was placed surgically into the small intestine on 1/10/25 as the main source for meeting his nutritional needs. He was discharged to the facility on 1/14/25 for rehabilitation services.         Resident #1 was admitted to the facility on 1/14/25 with diagnoses including cerebral infarction due to occlusion or stenosis or left middle cerebral artery, dysphagia, and aphasia.         The physician's orders for Resident #1 revealed orders dated 1/14/25: 1) j-tube 16 French (size), 2) tube feeding at a continuous rate of 70 milliliters (ml) an hour for 22 hours to allow for activities of daily living, and 3) apixaban tablet (an	IDENTIFICATION NUMBER:       A BUILDING         345507       B. WING         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 25 implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.       F 693 The hospital discharge summary for Resident #1 dated 1/14/25 indicated he was admitted to the hospital on 1/2/25 with diagnoses of cerebral artery (stroke), global aphasia (unable to speak), oropharyngeal dysphagia (difficulty swallowing), and right hemiparesis (muscle weakness on one side of the body). A j-tube was placed surgically into the small intestine on 1/10/25 as the main source for meeting his nutritional needs. He was discharged to the facility on 1/14/25 for rehabilitation services.         Resident #1 was admitted to the facility on 1/14/25 with diagnoses including cerebral infarction due to occlusion or stenosis or left middle cerebral artery, dysphagia, and aphasia.         The physician's orders for Resident #1 revealed orders dated 1/14/25: 1) j-tube 16 French (size), 2) tube feeding at a continuous rate of 70 milliliters (mil) an hour for 22 hours to allow for activities of daily living, and 3) apixaban tablet (an	PFDEFICIENCIES       (X1) PROVIDERSUPPLIERCLIA       (X2) MULTIPLE CONSTRUCTION         A BUILDING

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C / <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF MYRTLE GRO	VE		5	5725 CAROLINA BEACH ROAD		
ACTOMIN				V	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 693	Continued From page decline, dehydration, to recent stroke result aphasia, and 100% re nutrition/hydration wit free of signs and sym overload, and electrol next review. The inter monitoring for signs a dehydration, checking administering tube fee feeding as ordered by of care for impaired s Resident #1 was adm surgical wounds from distal (far) right upper abdomen in four quar [navel or bellybutton] upper quadrant, umbi quadrant with a goal to without complications dehiscence [wound o included observing ar infection (pain, rednes and providing treatment A nurse progress note by the Wound Nurse seen that day for new assessments and j-tu incisions were noted to j-tube placement and with surgical glue in p signs or symptoms of small, scabbed area of j-tube site with surgical	e 26 weight fluctuations related ting in dysphagia and eliance on tube feeding for h a goal that he would be ptoms of dehydration, fluid yte imbalances through the ventions included: and symptoms of g for residual prior to eding; administering tube y the physician. Another plan kin integrity related to itted with abdominal j-tube placement in the quadrant (divides the ters with the umbilicus in the middle), the right licus and left upper that the wounds would heal (infection, hemorrhage, pens up]). The interventions and reporting signs of ss, swelling, tenderness), ents as ordered. e dated 1/15/25 at 10:21 AM revealed Resident #1 was admission wound be care. Four surgical to abdomen status post the areas were scabbed lace, and open to air. No infection were noted. A was observed near the		693	DEFICIENCY)		
	The Physician's Histo	ry and Physical dated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 24/2025
NAME OF PI	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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 693	admitted to the facility related to left medial of The note indicated Re post-surgical placeme meet his nutritional ne The admission Minim assessment dated 1/7 was severely cognitiv as having no speech 51% of his nutrition and from enteral (tube) fea as dependent on staff transferring, and bed incontinent of bowel as assessment listed that therapy, occupational therapy. He was code anticoagulant. A partially filled out SI Appearance, and Rev structured communica clear concise informa the chart dated 1/25/2 listed the Situation was symptoms, or signs o Resident #1 pulling of condition was listed a resident consistently p tube. There was no of except that the RP was the on-call provider w box to call for 911 for checked. An incomplete Hospit	<ul> <li>#1 indicated that he was with right-sided weakness cerebral artery occlusion.</li> <li>esident #1 was status ent of a j-tube on 1/10/25 to eeds due to dysphagia.</li> <li>um Data Set (MDS)</li> <li>17/25 revealed Resident #1 ely impaired. He was coded and receiving greater than nd over 500 ml of water eding daily. He was coded f assistance with toileting, mobility and he was always and bladder. The the was receiving speech therapy, and physical ed for receiving an</li> <li>BAR (Situation, Background, view and Notify is a ation tool used to transmit tion) communication form in 25 and signed by Nurse #1 as: The change in condition, bserved and evaluated were but his j-tube 2 times and the s occurring before due to playing and tugging on the ther information listed as notified at 12:51 PM and ras notified at 1:12 PM. The transfer to the hospital was</li> </ul>	F	693			
		e following information: His					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE COMF	SURVEY PLETED	
		345507	B. WING				C <b>24/2025</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MYRTLE GRO			5	725 CAROLINA BEACH ROAD		
AUTUWIN	CARE OF MIRILE 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 693	notified of the situation hospital. The reason of pulled out j-tube. The anticoagulation, aspir medications crushed, checked. The form wa and no other informat A telephone interview #1 on 4/23/25 at 10:00 that on 1/25/25 she w Resident #1. She stat nurse with 21 years of further stated she had January for approximat administer Resident # feeding tube, and the abdomen. Nurse #1 s was scheduled for on for activities of daily li and she had not had a tube feeding that more there was no bleeding that she went and ask she knew what happen feeding tube. Nurse # she had seen someth on the bathroom floor not reported it to the r that NA #1 informed h with Resident #1 in th morning around 9:15 after speaking with Na	ion, date of birth, and further listed the RP was n and of the transfer to the for the transfer was listed as risk alert boxes for ation, high fall risk, needs and pain level were as not signed by facility staff ion was noted. was conducted with Nurse 0 AM. Nurse #1 indicated as assigned to care for red she was an agency f experience. Nurse #1 d worked for the facility in ately 3 weeks, but she was here. She stated that on tely 12:15 PM she went into #1 his medications per tube was not in his tated that the tube feeding ly 22 hours a day to allow ving (ADL) care and therapy a chance to reconnect the ning. She indicated that g at that time. She reported ted Nurse Aide (NA) #1 if ened to Resident #1's en stated that NA #1 reported ing that looked like a tube 2-3 hours ago, but she had hurse. She further stated her that therapy was working	F	593			
	that she went and ask she knew what happe feeding tube. Nurse # she had seen someth on the bathroom floor not reported it to the r that NA #1 informed h with Resident #1 in th morning around 9:15 after speaking with NA Resident #1's room a	ked Nurse Aide (NA) #1 if ened to Resident #1's 1 stated that NA #1 reported ing that looked like a tube 2-3 hours ago, but she had nurse. She further stated her that therapy was working e bathroom early that AM. Nurse #1 indicated that A #1 she had gone back to					

Facility ID: 960602

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	S FOR MEDICARE &						0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(C	X3) DATE S COMPL	
			A. BUILDI	NG	_	С	
		345507	B. WING				4/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		04/2	4/2025
	NOWDER ON SOLT EIER			5725 CAROLINA BEAC			
AUTUMN	CARE OF MYRTLE GRO	VE		8412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETIO DATE
F 693	to replace it with an esame size or a tube f catheter. Nurse #1 in the j-tube with a 16 F catheter tube. She st was a j-tube and had gastrostomy tube (in indicated that if she h a j-tube and not a gas have sent him to the dislodged. She stated of anyone reinserting She further indicated administer any medic through the tube afte because Resident #1 30 minutes later. She Resident #1 was the second time the tube tube was laying on the and there was blood the floor. Nurse #1 st of Nursing (DON) the dislodged and she ins provider and transfer indicated that the res care for that day were requiring closer moni i.e. tracheostomy tub and she had not com	I Nurse, who was the d that she had instructed her enteral feeding tube of the for an indwelling urinary dicated she had replaced rench indwelling urinary ated she was unaware that it assumed it was a the stomach). Nurse #1 had known Resident #1 had strostomy tube she would hospital the first time it d that she had never heard a j-tube in a nursing facility. she never had a chance to cations or tube feeding r replacing it the first time pulled it out approximately e indicated the RP for one that found him the was dislodged and that the ne floor beside his wheelchair on his abdomen, legs, and ated she notified the Director e second time the tube was structed her to notify the him to the hospital. She idents she was assigned to e high acuity (residents toring and treatments with es, feeding tubes, wounds) pleted the documentation	F	393			
	and she had not com related to the inciden after transferring Res had asked the Certific Assistant (COTA) if h tube was dislodged of bathroom and he stat						

Facility ID: 960602

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ΔΗΤΗΜΝ	CARE OF MYRTLE GRO	VE		5725 CAROLINA BEACH R	ROAD		
				WILMINGTON, NC 2841	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 693	Continued From page was the last day shew A telephone interview on 4/23/25 at 12:23 P 1/25/25 she had notice like a tube lying on Re after she observed the Resident #1 at approx stated she was busy a not stopped to examin She further stated she that something was ly A telephone interview Wound Nurse on 4/23 Wound Nurse stated a Duty on 1/25/25. She remembered Nurse # tube was dislodged. T she could not recall if j-tube. She further ind Nurse #1 that she could tube and that if the far size tube, she could u urinary catheter tube	e 30 worked for the facility. was completed with NA #1 M. NA #1 stated that on ed something that looked esident #1's bathroom floor e COTA working with kimately 9:15 AM. She and was in a hurry and had he the object on the floor. e had not notified the nurse ring on the floor. was completed with the 8/25 at 12:28 PM. The she was the Manager on	F 693				
	COTA who was assig 1/25/25. The COTA si working with Residen toilet transfers. He sta Resident #1 had a fee the gait belt up higher around the abdomen feeding tube. The CO	was completed with the ned to Resident #1 on tated that on 1/25/25 he was t #1 in the bathroom with ted that he was aware eding tube, so he had placed around the chest instead of to prevent dislodging the TA indicated that nothing curred during the transfer now the tube became					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING		_		C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	725 CAROLINA BEACH R	OAD		
AUTUMN	CARE OF MYRTLE GRO	VE	v	VILMINGTON, 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-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	been any indications if tube was dislodged st or any sign of pain. Th saw a tube on the bat seen a tube, he would A telephone interview on 4/24/25 at 10:54 A 1/25/25 at approximat into Resident #1's roo his wheelchair and the the floor beside the w that Resident #1 had to stop the bleeding. was on his abdomen, indicated she called for Resident #1. She furth placed a bandage over to have him transferred A nurse's progress not 1/25/25 at 2:00 PM in call from floor nurse th out. Nurse #1 was ad call and send to the h j-tube. An interview with the 4/23/25 at 4:10 PM. T documented the note 1/25/25 from her hom stated that when Nurse Resident #1's j-tube w instructed her to call t to send him to the hos that Nurse #1 had me reinserting the tube at	indicated there had not from Resident #1 that the uch as grimacing, pointing, he COTA stated he never throom floor, but if he had d have notified the nurse. Twas completed with the RP M. The RP stated that on tely 12:45 PM she walked on and found him sitting in e feeding tube was lying on heelchair. She further stated his finger in the hole trying The RP indicated that blood his legs, and the floor. She or the nurse to come help her indicated Nurse #1 er the wound and called 911 ed to the hospital. te written by the DON on dicated that she received a hat Resident #1's j-tube fell vised to call the Provider on ospital or placement of DON was completed the DON stated she had related to Resident #1 on e computer. She further se #1 notified her that vas dislodged she had he provider to get an order spital. The DON indicated entioned something about nd she had informed her	F 693				
	-	nd she had informed her slodged j-tubes were sent to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED			
		345507	B. WING				C / <b>24/2025</b>			
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD					
	Ι			V	WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 693	the hospital to have it indicated that Nurse # and never returned to she had called Nurse get her to come by th paperwork and docur involving Resident #1 indicated that j-tubes using radiographic (x- placed. The DON sta procedures allowed n gastrostomy tubes in order, but not j-tubes. the nurses to follow th procedures. The hospital record in Department (ED) Enc Physician dated 1/25/ #1 presented to the h j-tube. The note indica approximately two we and replaced with ten it became dislodged a were able to place a to tract in the Emergence Interventional Radiolo placement on 1/27/25 Resident #1 went to t the evening of 1/27/25 successfully placed. T related to the surgery the facility on 2/4/25. An interview was con Practitioner (NP) on 4 stated that it was not change the j-tube. Sh	replaced. She further *1 was suspended that day the facility. The DON stated #1 multiple times to try to e facility and complete the nentation about the incident on 1/25/25. The DON were inserted at the hospital tray) guidance or surgically ated the facility policy and surses to change a facility with a physician's She stated she expected all he facility's policies and he facility's policies and he facility's policies and he facility with a dislodged ated the j-tube was beks old and it was dislodged aporary urinary catheter, and again. Surgical Residents urinary catheter tube into the ty Room (ER). by (IR) attempted 5 but were not able to place. he Operating Room (OR) on	F	693						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			5725 CAROLINA BEACH ROAD NILMINGTON, 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 693	the intestine) and an ia a serious infection by abdomen. The NP ind an anticoagulant that bleeding. She further order would be neede NP stated it was out t to replace a tube with An interview with the completed on 4/23/25 Director stated that it a nurse to replace a j- further stated that sin inserted on 1/10/25 th mature (a jejunostom form a stable track be jejunum [small intestin intestinal contents an weeks) and there wou perforation, the tissue (tissue that is easily in prone to inflammation cause more bleeding, on an anticoagulant w risk of bleeding. There likelihood of harm due and perforation. An interview was com Administrator on 4/24 Administrator stated h to follow the facility's regarding feeding tub The Administrator wa jeopardy on 4/23/25 a	increased chance of causing pushing bacteria into the dicated Resident #1 was on put him at higher risk of indicated a physician's ed to change any tube. The he nurse's scope of practice out a physician's order. Medical Director was 5 at 11:47 AM. The Medical was totally inappropriate for -tube in the facility. She ce the tube was surgically he site was probably not y site needs to mature to etween the skin and the he] to prevent leakage of d this takes approximately 4 uld be higher risk for bowel e would be more friable ritated, which makes it more h, bleeding, and tearing) and and the fact that he was yould definitely increase the e was definitely a high e to risk or sepsis, bleeding, mpleted with the /25 at 9:35 AM. The he expected the nursing staff policies and procedures es.	F	693			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	`, ´				PLETED
				_			с
		345507	B. WING			04/	24/2025
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE OF MYRTLE GRO	VE		5	725 CAROLINA BEACH ROAD		
		VE		v	VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page allegation of Immedia Identify those residen likely to suffer, a serio result of the noncomp On January 25, 2025 Resident #1 was prov treatment to replace h tube (a tube surgically delivers nutrition and small intestine). Nurs need for hospital treat dislodged j-tube and s urinary catheter tube tube then became dis January 25, 2025, an to hospital for reinser were able to place an tube into the tract in til Interventional Radiolo placement on January able to place. Reside Room (OR) on the ev and the j-tube was su #1 returned to the fac During the remainder facility, the j-tube did	e 34 the Jeopardy removal: the Jeopardy remo	TAG		CROSS-REFERENCED TO THE APPROPRIA		
	reviewed all residents from January 25, 202 no additional resident j-tube in the facility at						
	specify the action the	e entity will take to alter the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345507	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF MYRTLE GRO			5	725 CAROLINA BEACH ROAD		
AUTUMIN	CARE OF MITRILE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 693	adverse outcome from when the action will b The Director of Nursin of Nursing (ADON), a provide education to I Feeding Tube(s) Polici j-tube becomes disloc notification, not to atte j-tube, and sending th surgical reinsertion. April 24, 2025. The D and verify that employ on leave of absence ( staff or PRN staff will returning to duty by th hires and Agency Nur Director of Nursing or Nursing during the ori Effective April 24, 202 review all new admiss Meeting on Monday th any pending weekend any admissions have all Licensed Nursing s presence of a j-tube a physician notification becomes dislodged. made aware of reside j-tube via the Admissi provided by the Admissi delivered to the admitt discharge summary b prior to resident arriva	lure to prevent a serious n occurring or recurring, and e complete: ng (DON), Assistant Director nd Unit Managers will Licensed Nurses on Enteral ey, to include what to do if a lged to include physician empt reinsertion of the re resident to the hospital for Training will be completed by Director of Nursing will track vees with scheduled time off, FMLA), vacation, agency be re-educated prior to the DON or ADON. New ses will be educated by the Assistant Director of entation process. 25, the DON or ADON will sions in the Clinical Morning nrough Friday, as well as d admissions, to determine if a j-tube present and ensure staff are made aware of the and the process for and treatment if a j-tube Licensed nurses will be ints that are admitted with a on Notification Form that is asion Director for all pending on Notification Form will be ting nurse with the hospital y the Admission Director	F	693			
	Alleged immediate jed	opardy removal date: April					

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STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	10. 0938-039 TE SURVEY MPLETED
	CONNECTION					C
		345507	B. WING		•	4/24/2025
NAME OF PR	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
	CARE OF MYRTLE GRO	VE		725 CAROLINA BEACH ROAD		
			N	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 693	5 - · · · · · · · · · · · · · · · · · ·	36	F 693			
	25, 2025					
F 726 SS=J	residents with feeding no other residents with education sign in she in-services conducted and 4/24/25 regarding policy and what to do dislodged. Staff interv on gastrostomy tubes jejunostomy becomes stated on 4/24/25 at a effective 4/24/25 the new admissions in the on Monday through F weekend admissions admissions have a j-t licensed nursing staff presence of a j-tube a notification and treatm dislodged. The facilit removal date of 4/25/ Competent Nursing S	The audit of 100% of g tubes verified there were h j-tubes identified. The ets were reviewed for the d with the nurses on 4/23/25 g enteral feeding tubes if a j-tube becomes views confirmed education s, j-tubes, and what to do if a d dislodged. The DON 12:22 PM stated that DON or ADON will review all e Clinical Morning Meeting riday, as well as pending to determine if any ube present and ensure all are made aware of the and the process of physician ment if a j-tube becomes y's immediate jeopardy 25 was validated. taff	F 726			5/14/25
	the appropriate comp provide nursing and r resident safety and a practicable physical, i well-being of each res resident assessments and considering the r	e sufficient nursing staff with etencies and skills sets to elated services to assure itain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in				

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				PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED	
	345507	B. WING		C 04/24/2025
ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
	VE	ŧ	5725 CAROLINA BEACH ROAD	
	V L	۱ ا	WILMINGTON, NC 28412	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
Continued From page at §483.71.	<del>9</del> 37	F 726		
licensed nurses have and skill sets necessa needs, as identified th assessments, and de §483.35(a)(4) Providi limited to assessing, a implementing resident to resident's needs. §483.35(c) Proficience The facility must ensu to demonstrate comp techniques necessary needs, as identified th assessments, and de This REQUIREMENT by: Based on record revi Responsible Party, N Director and staff, the system in place to tra their competency to p with a jejunostomy tu placed in the small in Resident #1's j-tube k did not identify the ne replace the dislodged by inserting a urinary site. Nurse #1 stated j-tube was a gastrosto stomach for nutritiona j-tube requires radiog surgical placement ar	the specific competencies ary to care for residents' prough resident escribed in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding ey of nurse aides. Ure that nurse aides are able etency in skills and y to care for residents' prough resident escribed in the plan of care. To met as evidenced iew and interviews with the urse Practitioner, Medical e facility failed to have a in agency nurses and verify provide care for a resident be (j-tube [a feeding tube testine]). On 1/25/25 when became dislodged, Nurse #1 ed for hospital treatment to l j-tube and she replaced it catheter tube into the j-tube she assumed Resident #1's pony tube (tube placed in the al support). Replacing a iraphic (x-ray) guidance or nd Nurse #1 performing this		The facility failed to ensure Nurse trained and competent to provide th necessary care and treatment for residents with jejunostomy tubes (j Nurse #1 did not identify the need hospital treatment to replace Resid #1's dislodged j-tube and she inser foley catheter to replace the tube. Surgical residents were able to pla foley in the tract in the Emergency (ER). Interventional Radiology (IR) attempted placement on January 2 and the j-tube was successfully pla Resident #1 returned to the facility February 4, 2025. During the rema Resident #1's time at facility, the j-f	ne -tubes). for lent ted a ce a Room ) 7, 2025 iced. on inder of ube did
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER CARE OF MYRTLE GRO SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page at §483.71. §483.35(a)(3) The fac licensed nurses have and skill sets necessa needs, as identified th assessments, and de §483.35(a)(4) Providi limited to assessing, f implementing resident to resident's needs. §483.35(c) Proficience The facility must ensult to demonstrate comp techniques necessary needs, as identified th assessments, and de This REQUIREMENT by: Based on record rev Responsible Party, N Director and staff, the system in place to tra their competency to p with a jejunostomy tu placed in the small in Resident #1's j-tube to did not identify the ner replace the dislodged by inserting a urinary site. Nurse #1 stated j-tube was a gastrosto stomach for nutritiona j-tube requires radiog surgical placement and action at the facility c	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345507         ROVIDER OR SUPPLIER         CARE OF MYRTLE GROVE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 37 at §483.71.         §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.         §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.         §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING.         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       B. WING         Continued From page 37 at §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.       F 726         §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.       F         §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party, Nurse Practitioner, Medical Director and staff, the facility failed to have a system in place to train agency nurses and verify their competency to provide care for a resident with a jejunostomy tube (j-tube [a feeding tube placed in the small intestine]). On 1/25/25 when Resident #1's j-tube became dislodged, Nurse #1 did not identify the need for hospital treatment to replace the dislodged j-tube and she replaced it by inserting a urinary catheter tube into the j-tube site. Nurse #1 stated she assumed Resident #1's j-tube requires radiographic (x-ray) guidance or surgical placement and Nurse #1 performing this action at the facility created a high likelihood of	S FOR MEDICARE & MEDICAID SERVICES         OF DEFIDENCIES       (x1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER       (x2) MULTIFLE CONSTRUCTION A BUILDING         A BUILDING       A BUILDING         CARE OF MYRTLE GROVE       STREETADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412         SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)       D PREFIX TAG         Continued From page 37 at \$483.371.       F 726         S483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. \$483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. \$483.35(c) Proficiency of nurse aides. The facility failed to ensure Nurse trained and competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party, Nurse Practitioner, Medical Director and staff, the facility failed to have a system in jace to train agency nurses and werify their competency to provide care for a resident with a jejunostomy tube (j-tube (a feeding tube placed in the small intestrine), On 1/25/25 when Resident #11's istude be assumed Resident #1's site. Nurse #1 did not identify the need for hospital treatment to replace the dislodged j-tube and she replaced it by inserting a urinary catheter tube into the j-tube stomach for nutritional support). Replacing a file Nu

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		MEDICAID SERVICES	(Y2) MILL T	וףו ר	CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	`, ´			· /	PLETED
							С
		345507	B. WING				/24/2025
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				57	725 CAROLINA BEACH ROAD		
AUTUMN	CARE OF MYRTLE GRO	VE		W	/ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From non	- 20		700			
F /20				726	0005		
	of placing the j-tube in perforation of the small				2025.		
		tion), and bleeding due to			All residents with j-tubes are at risk for		
		thinner) use. This deficient			same deficient practice. On April 23,		
		d for 1 of 3 nurses reviewed			2025, the Director of Nursing (DON)		
	for competency.				reviewed all residents that resided in th	е	
					facility from January 25, 2025 until Apri	I	
	Immediate jeopardy b	began on 1/25/25 when			23, 2025 and no additional residents we	ere	
	Nurse #1 failed to der	monstrate competency to			identified with a j-tube in the facility at th	his	
	care for a resident wi	-			time.		
		's dislodged j-tube with an					
		heter tube. Immediate			Prevention to ensure deficient practice		
	jeopardy was remove			does not occur again: The Director of			
		an acceptable credible			Nursing (DON), Assistant Director of		
		ite jeopardy removal. The t of compliance at a lower			Nursing (ADON) and Unit Managers wi provide education to Licensed Nurses of		
		evel of D (no actual harm with			Gastrostomy Tube Reinsertion Policy to		
		in minimal harm that is not			include what to do if a j-tube becomes	,	
		to ensure education is			dislodged to include physician notificati	on	
		oring systems put into place			not to attempt reinsertion of the j-tube a		
	are effective.	5 7 1 1			risks and sending the resident to the		
					hospital for surgical insertion. New hire	es	
	The findings included	1:			and agency nurses will be educated by		
					the DON and ADON during the orientat	ion	
	This Tag is cross refe	erenced to:			process using the Gastrostomy Tube		
					Reinsertion Policy and what to do if a		
		rd review, Nurse Practitioner			j-tube becomes dislodged to include		
		or, staff, and Responsible s, the facility failed to ensure			physician notification, not to attempt		
		#1) was provided with the			reinsertion of the j-tube with risks and sending the resident to the hospital for		
		to replace his dislodged			surgical reinsertion.		
		surgically placed feeding					
		rition and medications			Ongoing Compliance Monitoring:		
		intestine). On $1/25/25$ ,			DON/designee will interview 5 nurses		
	-	ntify the need for hospital			weekly x 12 weeks to validate		
		the dislodged jejunostomy			understanding of how to handle a		
		inserted an indwelling			dislodged j-tube. Results of interviews	will	
		to replace the j-tube without			be reported in QAPI meeting monthly x	3	
	a physician's order.	The replacement tube			months by DON.		1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	
		345507	B. WING				C <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
Αυτυμη	CARE OF MYRTLE GRO	VE	5725 CAROLINA BEACH ROAD				
					WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	REFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 726	became dislodged fro and Nurse #1 sent the reinsertion. Resident 1 Room (OR) on the ev j-tube was successful noncompliance create Resident #1 suffering of placing the j-tube in perforation of the sma (life-threatening infect anticoagulant (blood to practice was identified reviewed for feeding to Review of Nurse #1's she was hired by the agency licensed pract no evidence of comper regarding j-tubes in he Review of the facility of did not identify specifi for j-tubes. An interview was com 1/23/25 at 10:00 AM. experienced nurse, and training regarding gas jejunostomy tubes at worked at. She furthe completing training sp when she was in orient An interview was com Nursing (DON) on 4/2 stated the agency wa nurse's training and c employment by the fa	m the j-tube site on 1/25/25, e resident to the hospital for #1 went to the Operating ening of 1/27/25 and the ly placed. This ed a high likelihood of serious harm from the risks in the wrong place, all intestine, sepsis tion), and bleeding due to thinner) use. This deficient d for 1 of 3 residents tubes. employee record verified facility on 1/10/25 as an tical nurse (LPN). There was betency and training er file. training for agency nurses to training and competency expleted with Nurse #1 on Nurse #1 stated she was an and she had completed strostomy tubes and other facilities she had r stated she did not recall becifically regarding j-tubes intation at this facility. expleted with the Director of 23/25 at 4:10 PM. The DON s responsible for verifying a	F	726	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING				C 24/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, 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 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
F 726	j-tubes at the time of I The Administrator was jeopardy on 4/23/25 a The Administrator pro- allegation of Immedia Identify those recipier are likely to suffer, a s a result of the noncom The facility failed to e and competent to pro- treatment for resident (j-tubes). Nurse #1 d hospital treatment to r dislodged j-tube and s urinary catheter tube Surgical Residents we indwelling urinary cath the Emergency Room Radiology (IR) attemp 27, 2025 but were no- went to the Operating of January 27, 2025 a successfully placed. facility on February 4, remainder of Resident j-tube did not dislodge discharged from the fit On April 23, 2025, the reviewed all residents from January 25, 202	etency and training for Nurse #1's employment. s notified of immediate at 4:00 PM. vided the following credible te Jeopardy removal: the Interventional to replace the tube. the Interventional to replace the tube. the Jeopardy the tract in the Jeopardy the Interventional to the Jeopardy and the Jeopare and the	F 726				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345507	B. WING				C / <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN	JTUMN CARE OF MYRTLE GROVE				5725 CAROLINA BEACH ROAD NILMINGTON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From page	e 41	F	726			
	process or system fai adverse outcome from when the action will b The Director of Nursin of Nursing (ADON), a provide education to I Gastrostomy Tube Re what to do if a j-tube I include physician noti reinsertion of the j-tub resident to the hospita quiz was created to v of the material that wa cannot answer the qui will be retrained by th material. Training wil 2025. The Director of verify that employees leave of absence (FW	ng (DON), Assistant Director nd Unit Managers will Licensed Nurses on einsertion Policy, to include					
	New hires and Agence the DON or ADON du using the Gastrostom The quiz will be given to validate understand becomes dislodged to notification, not to atte and risks and sending for surgical reinsertion	empt reinsertion of the j-tube g the resident to the hospital n. opardy removal date: April rdy removal plan was					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345507	B. WING				C /24/2025
NAME OF P	ROVIDER OR SUPPLIER		•	ŝ	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)		(X5) COMPLETION DATE
F 726 F 757 SS=D	residents with feeding no other residents with educations sign in she in-services conducted and 4/24/25 regarding Tube Reinsertion Poli education regarding w becomes dislodged in notification, not attem j-tube, risks involved if the resident to the hor reinsertion. Staff inter and a quiz on gastros what to do if a jejunos The validation quizzes concerns. The DON s PM that all the nurses agency nurses, would quiz for competency r facility's immediate je 4/25/25 was validated Drug Regimen is Free CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug r unnecessary drugs. A drug when used- §483.45(d)(2) For exc §483.45(d)(3) Withou	tubes verified there were h j-tubes identified. The eets were reviewed for d with the nurses on 4/23/25 g the facility's "Gastrostomy cy" which included what to do if a j-tube necluding physician pting reinsertion of the in reinsertion, and sending spital for surgical views confirmed education tomy tubes, j-tubes, and stomy becomes dislodged. Is were reviewed with no stated on 4/24/25 at 12:22 s, including new hires and d have to pass the validation regarding feeding tubes. The opardy removal date of d. e from Unnecessary Drugs cf(6) mary Drugs-General. regimen must be free from An unnecessary drug is any ssive dose (including y); or		726			5/14/25

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345507	B. WING		C 04/24/2025
NAME OF PF	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 757	Continued From page	e 43	F 757	7	
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be			
	stated in paragraphs section. This REQUIREMENT by:	mbinations of the reasons (d)(1) through (5) of this r is not met as evidenced iew, staff and the Medical		The survey findings, including the	e insulin
	Director's interviews t fast-acting insulin (ins within 15 minutes afte by the physician for a 150. Resident #4 wa sliding scale insulin w	the facility failed to hold a sulin that begins working er administration) as ordered a blood sugar level less than is administered 2 units of vith a blood sugar of 103.		administration to resident #4 that administered outside of the written ordered parameters, were reporte Medical Director on May 13, 2025 Resident #4 is no longer in the fac	was n ed the 5.
	This occurred for 1 of reviewed for unneces Findings included.	f 1 resident (Resident #4) ssary medications.		On April 30, 2025 the Regional Di Clinical Services reviewed the Apr Medication Administration Record current residents receiving insulin	ril ∣for all
	·	nitted to the facility on 1/6/25 ling diabetes.		reported all omissions to the provi May 1, 2025. There were no new from the provider.	ider on
	and discontinued on Regular insulin U-100 milliliter. Administer	or Resident #4 dated 1/6/25 1/31/25 revealed Humulin R 0 insulin 100units per per sliding scale as follows: arage for blood sugar less		Education was provided by the As Director of Nursing to all nurses o following physician orders and me administration by May 11, 2025.	n
	than 150.			A determination was made on Ma 2024 to monitor medication	
	The Minimum Data S			administrations and review the au	dits
		12/25 revealed Resident #4		monthly in the Quality Assurance	vittaa
		nable to assess cognition.		Performance Improvement Comm	
	He received insulin.			meeting. To ensure ongoing com the Director of Nursing or designe	
	Review of the Medica	ation Administration Record		conduct three medication adminis	

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			()(0)			O. 0938-039			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · /	E SURVEY IPLETED			
			J. BOILDING			С			
		345507	B. WING		04	4/24/2025			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•				
	CARE OF MYRTLE GRO	WE		5725 CAROLINA BEACH ROAD					
AUTOMIN	CARE OF MITRILE GRO	VYE		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 SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE			
F 757	Continued From page	e 44	F 75	7					
	revealed Humulin R sliding scale insulin was signed off by Nurse #1 as 0 (zero) units administered at 11:00 AM on 1/25/25. The blood sugar reading was 103.			observations will be reviewed mo QAPI for 3 months.	onthly in				
	Nurse #1 stated she Resident #4 in error of 1/25/25 she checked and recalled his bloo or 100's, and she told room at the time that sliding scale insulin. the medication cart a approached her with her. She then drew u administered it to Re administered it to Re administered the insu thought he didn't nee then that he wasn't si that she had just administered the then that he wasn't si that she had just administered the error to the Director of Nurse #1 stated if sh administered then it to she did give 2 units of 1/25/25. She stated she that date and Reside	problems which distracted p 2 units of insulin and sident #4. Once she ulin the family stated they d insulin, and she realized upposed to get the 2 units ninistered. She stated she 's blood sugar following the his blood sugar remained re reported the medication of Nursing (DON) that day. e documented 0 units was signed in error because of insulin at 11:00 AM on she worked until 7:00 PM on nt #4 never had any signs or bod sugar. She stated the							
	the Medical Director of sliding scale insuli #4 any harm and the	view on 4/23/25 at 11:55 AM stated administering 2 units n would not cause Resident re were no reports made to his insulin or his blood							

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/03/202 FORM APPROVE OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING	
		345507	B. WING		C 04/24/2025
NAME OF PF	ROVIDER OR SUPPLIER	l	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	CARE OF MYRTLE GRO	VE	5	725 CAROLINA BEACH ROAD	
		•=	v	VILMINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 757	Continued From page	e 45 ative outcome from receiving	F 757		
	insulin when it was no wanted to be notified reported concerns. S orders for administeri should have been foll	ot needed she would have but there had been no he stated the physician ng sliding scale insulin lowed.			
	Director of Nursing (E aware of the medicat 1/25/25. She stated N employed with the fac unable to contact Nur stated Nurse #1 shou Resident #4 sliding so sugar reading less the #4 did not experience receiving the insulin i that time she had pro		F 770		5/14/25
	laboratory services to residents. The facility and timeliness of the (i) If the facility provid services, the services requirements for labor of this chapter.	cility must provide or obtain meet the needs of its is responsible for the quality services.			
	Based on record rev Practitioner and Phys	iew, staff, the Nurse ician interviews, the facility lered urinalysis and culture		The provider was notified on May 10, 2025 that the urinalysis ordered on Ap 15, 2025 for resident #3 was not	ril

Event ID: 705411

Facility ID: 960602

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		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 06/03/2028 FORM APPROVED 1B NO: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345507	B. WING _			C 04/24/2025
	ROVIDER OR SUPPLIER	VE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	presence of bacteria. presence and type of infection. Sensitivity t antibiotics are effective resident experiencing urgency and decreas resident (Resident #3 services. Findings included. Resident #3 was adm 4/10/25 with diagnosid disease. A physician progress Resident #3 was assurinary tract infection urination), urinary free plan of care was to te for urinary tract infect A physician's order da was entered by Nurse obtain a urinalysis an evaluation of urinary complaints of dysuria urgency. A physician's order da Resident #3 revealed milligrams (mg) three urinary tract infection A nursing progress me written by Nurse #4 in culture and sensitivity	e test obtained to identify the A urine culture identifies the bacteria causing an ests determine which ye against the bacteria ) for a symptoms of burning, ed urinary output for 1 of 1 b) reviewed for laboratory note dated 4/15/25 revealed essed due to suspected due to dysuria (painful quency and urgency. The est a urine culture to evaluate ion. ated 4/15/25 at 11:07 AM e #4 for Resident #3 to d culture and sensitivity for tract infection due to h, frequent urination, and ated 4/15/25 at 11:12 AM for I Cephalexin (antibiotic) 500 times a day due to possible	F 7	<ul> <li>collected. No ne no longer at the f</li> <li>On May 9, 2025 or reviewed all urina 2025 to ensure the completed as orce provider. There or urinalysis that we findings were reported to the physicians orders timely and report provider by 5/9/2</li> <li>The DON/designee to physicians orders timely and report provider by 5/9/2</li> <li>The DON/designe results are given review. Any issue reported to the physic collection to the QAPI team</li> </ul>	the DON/designee alysis orders since April 1 he urinalysis was dered and reported to the were two addition ere not collected. The ported to the provider on th no new orders. e provided by the o all nurses on following s completing urinalysis ting the findings to the 2025. we will review all new for 12 weeks to ensure all are followed and the to the provider for us identified will be rovider and re-education to the nurse. The facility	,

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/03/2025 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345507	B. WING				C 24/2025
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 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 770	output. An antibiotic w physician's order. The Minimum Data Se assessment dated 4/1 had moderately impai frequently incontinent A Nurse Practitioner r Resident # 3 remaine suspected urinary trac of intermittent discom Nurse Practitioner ind a suspected urinary tr urinary frequency, and Review of Resident # record from 4/15/25 th results from the urinal sensitivity report. During an interview of Nurse Practitioner sta and sensitivity was or 4/15/25 by Physician get the lab results bac 4/23/25 that the urine refrigerator in the faci by lab services. She s	nd a small amount of urine vas started according to the et (MDS) admission 16/25 indicated Resident #3 ired cognition and was to f bowel and bladder. The dated 4/22/25 indicated d on antibiotics for ct infection with complaints fort with urination. The licated that Resident #3 had ract infection due to dysuria, d urgency. 3's electronic medical hrough 4/24/25 revealed no lysis and culture and n 4/24/25 at 12:15 PM the tted a urinalysis with culture dered for Resident #3 on #2. She stated they did not ck and then discovered on sample was still in the lity and was never picked up	F 77(		DEFICIENCY)		
	did obtain the urine sa urinary catheterization urinalysis should have the lab when the orde Resident #3 continue he did not want to be time. The plan now w	ample (Nulse #4) told her she ample from Resident #3 via in on 4/15/24. She stated the e been obtained and sent to er was written. She stated d with mild symptoms, but catheterized again at this as to reevaluate Resident 5 and a urinalysis would be					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/03/2025 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345507	B. WING			-		C 24/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	CARE OF MYRTLE GRO			57	725 CAROLINA BEACH RO	DAD		
AUTOWIN	CARE OF MITRILE GRO	VE		W	ILMINGTON, NC 2841	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 770	Continued From page obtained at that time i	f needed.	F	770				
	Nurse #4 stated she r urinalysis on 4/15/25 sample from Residen she entered the inform							
	Unit Manger stated R was obtained on 4/15 order was entered inter record and into the lat collect the urine. She that once the order was medical record by the to enter the order into and print a requisition what tests to perform) book which was kept the lab company com the lab book to determ collected. She stated order was not entered the lab did not pick up indicated she usually ensure the labs were done in error.	h 4/24/25 at 1:00 PM the esident #3's urine sample /25 by Nurse #4 and the o the electronic medical b services database to stated the process included as entered into the residents nurse, the nurse then had the lab services website form (informs the lab of and then record it in the lab at the nurses station. When es to the facility they review nine what needed to be the breakdown was that the d into the lab book therefore o the urine sample. She checked the lab book to recorded. She stated it was						
	Director of Nursing sta the urine sample obta picked up from the lat stated a process was and the process was	n 4/24/25 at 2:00 PM the ated she was not aware of ined for urinalysis not being o for Resident #3. She in place for obtaining labs not followed. She stated is entered into the resident's						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/03/2025 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	CARE OF MYRTLE GRO			57	725 CAROLINA BEACH ROAD		
AUTUMIN	CARE OF MIRILE 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	Continued From page medical record it also book and that was no education would be p During an interview of Physician #2 stated s urinalysis not being or there had been no sig obtaining the urinalys sensitivity. She stated antibiotics for urinary expected lab orders to results made available Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to accordance with a cor agrees not to use or o except to the extent th to do so. §483.70(h) Medical re §483.70(h) Medical re	<ul> <li>4.49</li> <li>had to be written in the lab t done. She stated rovided.</li> <li>n 4/24/25 at 3:00 PM</li> <li>he was made aware of the oblected today. She indicated on tract infection and she to be entered correctly, and that was not done.</li> <li>dentifiable Information 483.70(h)(1)-(5)</li> <li>nt-identifiable information that is to the public.</li> <li>lease information that is to the public.</li> <li>lease information that is to an agent only in thract under which the agent disclose the information the facility itself is permitted</li> <li>ecords.</li> <li>rdance with accepted s and practices, the facility al records on each resident</li> </ul>	F	342			5/14/25
		sility must keep confidential ned in the resident's records,					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345507	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER				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)		(X5) COMPLETION DATE
F 842	regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research pur medical examiners, fu a serious threat to heal by and in compliance §483.70(h)(3) The fact record information ag- unauthorized use. §483.70(h)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea- legal age under State §483.70(h)(5) The me (i) Sufficient information (ii) A record of the ress (iii) The comprehensiv provided;	a or storage method of the release is- r their resident permitted by applicable law; yment, or health care red by and in compliance stativities, reporting of abuse, violence, health oversight administrative proceedings, roses, organ donation urposes, or to coroners, ineral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Sility must safeguard medical ainst loss, destruction, or I records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. edical record must contain- on to identify the resident; ident's assessments; ye plan of care and services r preadmission screening valuations and cted by the State;	F	842	2		

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CENTER STATEMENT ( AND PLAN OF NAME OF PP	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	A. BUILDING B. WING 57	CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 725 CAROLINA BEACH ROAD /ILMINGTON, NC 28412	FOF OMB N (X3) DAT COM	ED: 06/03/2025 RM APPROVED O. 0938-0391 E SURVEY IPLETED C 4/24/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	services reports as re This REQUIREMENT by: Based on record revi facility failed to mainta medical records for 2 medical records were Resident #4). Findings included. 1.) Resident #1 was a 1/14/25. The physician's order orders dated 1/14/25 - a jejunostomy tube tube that delivers nutr directly into the small - tube feeding at a cor (ml) an hour for 22 ho daily living - amlodipine (used to milligrams (mg) tablet day for hypertension ( - cetirizine 10 mg tabl tube for anticoagulant - loratadine 10 mg tabl tube for Res Loratadine, Amlodipin administered via j-tub	as notes; and ogy and other diagnostic quired under §483.50. is not met as evidenced ew and staff interview, the ain complete and accurate of 11 residents whose reviewed (Resident #1 and dmitted to the facility on s for Resident #1 revealed for: (a surgically placed feeding ition and medications intestine) 16 French (size) ntinuous rate of 70 milliliters urs to allow for activities of treat high blood pressure) 5 per feeding tube, once a (high blood pressure) et once a day per feeding rgies t twice a day per feeding (blood thinner) olet once a day for allergies edication Administration sident #1 listed Eliquis,	F 842	Progress notes were entered in for #1 and #4 by the RDCS (Reg Director of Conical Services) do the errors. Completed on 5/9/20 On 5/8/2025 the ADON observer nurses that were currently in the community administer medicatio least one resident to ensure the documentation was an accurate of the medication administration The DON/designee will educate on medical record accuracy with emphasis on MAR accuracy by 3 In addition, the DON/designee will observe each nurse administer medications to at least one resid ensure the medication administer consistent with the nurse docum The education and competencie completed by 5/9/2025. To ensure ongoing compliance to DON/designee will observe 3 nu administer medications to at least resident weekly for 12 weeks to the medical records are accurate audits will be reviewed by the Qa monthly for 3 months.	gional cumenting 025. d all ons to at reflection all nurses 5/9/2025. vill lent to ation is nentation. s will be he urses st one ensure e. The	

If continuation sheet Page 52 of 61

								FORM	D: 06/03/2025
345507         B. WING         04/24/2025           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         STREET ADDRESS, CITY, STATE, ZIP CODE           AUTUMN CARE OF MYRTLE GROVE         STREET ADDRESS, CITY, STATE, ZIP CODE         STREET ADDRESS, CITY, STATE, ZIP CODE           VAIL         SUMMARY STATEMENT OF DEFICIENCIES         DIP         PROVIDER'S PLAN OF CORRECTION         (PS)           PREETX         REGULATORY OR LSC IDENTIFYING INFORMATION)         DI         PREFIX         CROSS-REFERENCED TO THE APPROPRIATE         COMPONENTS         DATE           PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX         F 842         F 842         Continued From page 52         F 842         F 842         F 842         F 842         Continued From page 52         F 842         F 842 <td< td=""><td>STATEMENT C</td><td>T OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td>. ,</td><td></td><td></td><td></td><td>(X3) DATE</td><td>SURVEY</td></td<>	STATEMENT C	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,				(X3) DATE	SURVEY
STATE OF MYRTLE GROVE       IVAJ 10 PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)     000000000000000000000000000000000000			345507	B. WING					
AUTURN CARE OF MYRTLE GROVE         WILMINGTON, NC 28412           Virging PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDER'S CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 52 A partially filled out SBAR (Situation, Background, Appearance, Review and Notify is a structured communication tool used to transmit clear concise information) 4 page form in the chart dated 1/25/25 and signed by Nurse #1 listed the Situation was: The change in condition, symptoms, or signs observed and evaluated were Resident #1 pulling out his jejunostomy tube (j-tube) twice and the condition was listed as occurring before due to resident consistently playing and tugging on the tube. In the section under Background: the box was checked that the resident was in the facility for long-term care. The areas that were not completed were the primary diagnosis, other pertinent history. Medication Alerts for changes, anticoagulants, hypoglycemics, allergies, and vital signs including pulse oximetry (measures the oxygen saturation in the blood cells). The Resident Evaluation, respiratory evaluation, cardiovascular evaluation, abdominal/gastrointestinal (GI) evaluation, Genitourinary/Urine evaluation, sike evaluation, abdominal/gastrointestinal (GI) evaluation, denitourinary/Urine evaluation, sike evaluation, denity denity denity de	NAME OF P	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP COD	ЭЕ		
(M) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES INCLUENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (00)       F 842     Continued From page 52 A partially filled out SBAR (Situation, Background, Appearance, Review and Notify is a structured communication tool used to transmit clear concise information) 4 page form in the chart dated 1/25/25 and signed by Nurse #1 lised the Situation was: The change in condition, symptoms, or signs observed and evaluated were Resident #1 pulling out his jejunostomy tube (j-tube) twice and the condition was listed as occurring before due to resident consistently playing and tugging on the tube. In the section under Background: the box was checked that the resident was in the facility for long-term care. The areas that were not completed were the primary diagnosis, other pertinent history, Medication Alerts for changes, anticoagulants, hypoglycemics, allergies, and vital signs including pulse oximetry (measures the oxygen saturation in the blood cells). The Resident Evaluation, explicitory evaluation, cardiovascular evaluation, abdominal/gastrointestinal (GI) evaluation, Genitourinary/Urine evaluation, sit evaluation, Bernitourinary/Urine evaluation, site evaluation, Bernitourinary/Urine evaluation, site evaluation, Bernite					5	725 CAROLINA BEACH ROAD			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMMENT TAG         F 842       Continued From page 52       F 842         A partially filled out SBAR (Situation, Background, Appearance, Review and Notify is a structured communication tool used to transmit clear concise information) 4 page form in the chart dated 1/25/25 and signed by Nurse #1 listed the Situation was: The change in condition, symptoms, or signs observed and evaluated were Resident #1 pulling out his jejunostomy tube (j-tube) bytice and the consistently playing and tugging on the tube. In the section under Background: the box was checked that the resident was in the facility for long-term care. The areas that were not completed were the primary diagnosis, other pertinent history, Medication Alerts for changes, anticoagulants, hypoglycemics, allergies, and vital signs including pulse oximetry (measures the oxygen saturation in the blood cells). The Resident Evaluation was not completed regarding his mental and functional status, behavioral evaluation, abdominal/gastrointestinal (GI) evaluation, Genitourinary/Urine evaluation, skin evaluation,	AUTUMIN	N CARE OF MYRILE GRO	VE		N	VILMINGTON, NC 28412			
A partially filled out SBAR (Situation, Background, Appearance, Review and Notify is a structured communication tool used to transmit clear concise information) 4 page form in the chart dated 1/25/25 and signed by Nurse #1 listed the Situation was: The change in condition, symptoms, or signs observed and evaluated were Resident #1 pulling out his jejunostomy tube (j-tube) twice and the condition was listed as occurring before due to resident consistently playing and tugging on the tube. In the section under Background: the box was checked that the resident was in the facility for long-term care. The areas that were not completed were the primary diagnosis, other pertinent history, Medication Alerts for changes, anticoagulants, hypoglycemics, allergies, and vital signs including pulse oximetry (measures the oxygen saturation in the blood cells). The Resident Evaluation was not completed regarding his mental and functional status, behavioral evaluation, abdominal/gastrointestinal (GI) evaluation, Genitourinary/Urine evaluation, skin evaluation,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
plan information. There was a box at the top of the evaluations to check if the area was not clinically applicable to the change in the condition being reported. The Section regarding Appearance was not filled out. In the section to Review and Notify the box to call for 911 for transfer to the hospital was checked. Resident #1's name was listed on the form, the Responsible Party (RP) was notified at 12:51 PM, the on-call provider was notified at 1:12 PM and the form was signed and dated by Nurse #1 on 1/25/25 at 12:51 PM. An interview with Nurse #1 was completed on	F 842	A partially filled out SI Appearance, Review communication tool u concise information) 4 dated 1/25/25 and sig Situation was: The ch symptoms, or signs o Resident #1 pulling of (j-tube) twice and the occurring before due playing and tugging o under Background: th resident was in the fa areas that were not or diagnosis, other pertin Alerts for changes, ar hypoglycemics, allerg pulse oximetry (meas in the blood cells). Th not completed regard functional status, beh respiratory evaluation abdominal/gastrointes Genitourinary/Urine e pain evaluation, neuro plan information. The the evaluations to che clinically applicable to being reported. The S Appearance was not Review and Notify the transfer to the hospita #1's name was listed Responsible Party (R the on-call provider w the form was signed a 1/25/25 at 12:51 PM.	BAR (Situation, Background, and Notify is a structured sed to transmit clear 4 page form in the chart gned by Nurse #1 listed the hange in condition, bserved and evaluated were ut his jejunostomy tube condition was listed as to resident consistently on the tube. In the section he box was checked that the cility for long-term care. The ompleted were the primary nent history, Medication hticoagulants, gies, and vital signs including sures the oxygen saturation he Resident Evaluation was ling his mental and avioral evaluation, h, cardiovascular evaluation, stinal (GI) evaluation, ological evaluation, and care re was a box at the top of eck if the area was not b the change in the condition Section regarding filled out. In the section to b box to call for 911 for al was checked. Resident on the form, the .P) was notified at 12:51 PM, vas notified at 1:12 PM and and dated by Nurse #1 on	F	342				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/03/2025 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	· · ·	TE SURVEY MPLETED C
		345507	B. WING			o	4/24/2025
NAME OF PI	ROVIDER OR SUPPLIER				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	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 842	4/23/25 at 10:00 AM. the nurse assigned to 1/25/25 when his j-tut further stated the resi- care for that day were requiring closer monit i.e. tracheostomy tube and she had not comp related to the incident Director of Nursing (D times to return to the paperwork, but she ne facility. Nurse #1 also administer Eliquis, Lo Cetirizine to Resident 7:00 AM to 11:00 AM stated that she must h medications off on the when she pulled them but she did not admin An interview with the 4/23/25 at 4:00 PM. T call Nurse #1 multiple back to the facility to o regarding Resident #7 but she never came b expected the nursing complete and accurat 2.) Resident #4 was a 1/6/25 with diagnoses A physician's order fo and discontinued on 7 Regular insulin U-100 milliliter. Administer p	Nurse #1 stated she was o care for Resident #1 on be became dislodged. She dents she was assigned to a high acuity (residents toring and treatments with es, feeding tubes, wounds) pleted the documentation t. Nurse #1 indicated that the DON) called her multiple facility to complete the ever went back to the o stated she did not tratadine, Amlodipine, and t #1 on 1/25/25 during the medication pass. She have checked the e MAR as administered in from the medication cart, hister the medications. DON was completed on The DON stated she tried to the times to get her to come complete the paperwork 1's transfer to the hospital, back. She indicated she staff documentation to be te. admitted to the facility on a including diabetes.	F	842			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345507	B. WING				_ 24/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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)		(X5) COMPLETION DATE
F 842	Review of the Medica (MAR) dated January revealed Humulin R s signed off by Nurse # administered at 11:00 sugar reading was 10 During a phone interv Nurse #1 stated she a Resident #4 in error of 1/25/25 she checked and recalled his blood or 100's. She stated s medication cart and th approached her with her. She then drew up administered it to Res administered the insu thought he didn't need then that he wasn't su that she had just adm she documented 0 (ze it was signed in error units of insulin at 11:0 stated she should hav of insulin was administ During an interview o Director of Nursing (D aware of the medicati 1/25/25. She stated N administered Resider with a blood sugar rea was not aware that sh the MAR. She stated documented on the M units of insulin to Res	tion Administration Record 2025 for Resident #4 sliding scale insulin was 1 as 0 (zero) units 0 AM on 1/25/25. The blood 3. riew on 4/23/25 at 9:10 AM administered insulin to on 1/25/25. She stated on Resident #4's blood sugar d sugar was in the low 90's she went back to the nree nurse aides problems which distracted o 2 units of insulin and sident #4. Once she lin the family stated they d insulin, and she realized upposed to get the 2 units inistered. Nurse #1 stated if ero) units administered then because she did give 2 00 AM on 1/25/25. She ve documented that 2 units stered to Resident #4. In 4/23/25 at 2:00 PM the DON) stated she was made on error by Nurse #1 on lurse #1 should not have at #4 sliding scale insulin ading less than 150 and she he documented in error on Nurse #1 should have IAR that she administered 2 ident #4. She indicated rovided regarding accurately	F	842			

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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:			E CONSTRUCTION	(X3) DATE COMF	
		345507	B. WING				24/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MYRTLE GRO	VE			3725 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880 SS=E	CFR(s): 483.80(a)(1)( §483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must estal and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev	(2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the hsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.71 and following ndards; standards, policies, and ogram, which must include, llance designed to identify ble diseases or c can spread to other ; n possible incidents of se or infections should be hsmission-based precautions ent spread of infections; plation should be used for a	F	880			5/14/25

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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 LETED
		345507	B. WING				C 24/2025
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ΔΗΤΗΜΝ	CARE OF MYRTLE GRO	VE		5	5725 CAROLINA BEACH ROAD		
AUTOMIN					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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	involved, and (B) A requirement that least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on observation interviews the facility infection control policy Enhanced Barrier Pre- providing direct care a #2 and Nurse #3 prov opening surgically cre- tube into the trachea enter the lungs direct tracheal suctioning (a	ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed ect resident contact. Im for recording incidents icility's IPCP and the en by the facility. Ite, store, process, and to prevent the spread of riew. It an annual review of its r program, as necessary. is not met as evidenced ins, record review, and staff failed to implement the y and procedures for recautions (EBP) when activities to residents. Nurse rided tracheostomy (an eated in the neck to insert a (windpipe) allowing for air to y) care which included	F	880	The facility failed to implement enhance barrier precautions for resident #2 and resident #5. This was reported to the Medical Director along with the other survey findings on May 13, 2025. Resident #2 and resident #5 were assessed by the Assistant Director of Nursing on 5/2/25. No signs or symptot of infection were identified. All residents with an enteral tube or a		

Facility ID: 960602

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
		345507	B. WING			С
	ROVIDER OR SUPPLIER	345507	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		4/24/2025
NAME OF P	ROVIDER OR SUPPLIER			5725 CAROLINA BEACH ROAD	JDE	
AUTUMN	CARE OF MYRTLE GRO	DVE		WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 880			F 88			
		ube feeding through a		tracheostomy were assesse	•	
		feeding tube placed directly ne nurses donned gloves and		ADON on 5/2/25 to ensure symptoms of an infection th	•	
	a mask but no gown	during the procedures. This aff members (Nurse #2, and		result of improper protective		
		observed for infection control		Education was provided to a	all staff on	
	practices.			Enhanced Barrier Precaution		
				Personal Protective Equipm	ent by the	
	Findings included:			ADON by May 11, 2025.		
				The DON/designee will obs	erve care	
	The facility's Infectior	n Control Policy revised		5xweek for 12 weeks for res		
	03/15/25 revealed Er	nhanced Barrier Precautions		require EBP to ensure appr		
		to prevent transmission of		being utilized. The determine		
	-	organisms (MDRO's) via and clothing to high-risk		made on May 12, 2025 that protective equipment would		
		Barrier Precautions were		for residents requiring Enha		
		ntact care activities for		Precautions. The audits wil		
		c wounds or indwelling		by the QAPI team monthly f	for 3 months.	
		heostomies and gastrostomy				
	tubes.					
	1.) A blue Enhanced	Barrier Precautions (EBP)				
		de Resident #2's door. The				
		rform hand hygiene with				
		ub (ABHR) or wash with				
		re entering and leaving room oves for the following High				
	• •	re Activities which include:				
	Dressing, bathing/sh	owering, Transferring,				
		nging briefs or assisting with				
	-	care or use; central lines,				
	Wound care: any ski	ding tubes, tracheostomy, n opening requiring a				
	dressing.	ש פיייישף - י פייייי י				
	An observation of Nu	ırse #2 performina				
		gically created hole through				
		hea (windpipe) to allow air to				

Facility ID: 960602

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OVERTIGET OF THE OF DEPICIENCIES AND PLAN OF CORRECTION       (n1) PROVIDERSUMPLENCLA IDENTIFICATION NUMBER:       (n2) MULTIPLE CONSTRUCTION A BUILONG       (n3) APE SUMPLY COMPLETED C         AME OF PROVIDER OR SUPPLIER       346507       B WING       STREET ADDRESS, CITY, STATE, ZP CODE 5725 CARCINA BEACH ROAD WILMINGTON, NC 28412         (M) ID PREFIX TRG       SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST AE PRECEDED BY FULL RECOUNTORY OR LSS IDENTIFYING INFORMATION)       PREFIX TRG       STREET ADDRESS, CITY, STATE, ZP CODE 5725 CARCINA BEACH ROAD WILMINGTON, NC 28412         (M) ID PREFIX TRG       SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST AE PRECEDED BY FULL RECOUNTORY OR LSS IDENTIFYING INFORMATION)       PREFIX TRG       PROVIDERS PLAOF CORRECTIVE ATON SHOULD BE CROSSREPERSICED TO THE APPROPRIATE DEPICIENCY WILMINGTON, NC 28412         (M) ID PREFIX TRG       Continued From page 58 (11) the lungs) suctioning and providing bolus feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 performed hand hygiene with NUTS #2 removed hars oiled gloves and used ABIRS antilizer prior to donning clean gloves. Nurse #2 was observed providing bolus tube feeding through Resident #2's gastrostomy tube without a protective gown.       F 880       F         An interview with Nurse #2 was observed providing bolus tube feeding through Resident #2's 123 FIM. The ADONICP stated she had only worked at the facility for a about Condinator (SDC) prior to receiving ther SPICE training just a couple of weeks ago. The ADONICP Chartner stated she was the Staff Development Coordinator (SDC) prior to receiving ther SPICE training just a couple of weeks ago. The ADONICP Chartn		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
345507     B. WING     04/24/2025       NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       773 CAROLINA BEACH ROAD       WILMINGTON, NC 28412       (MI)DIP       SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECIDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PREFX (EACH ORECTONC MUST BE PRECIDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PREFX (EACH ORECTONC MUST BE PRECIDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX TAG     PREFX (EACH ORECTON RECTON (EACH ORECTON RECTON)     O(%) (CROSS-REFRENCED TO THE APPROPRIATE DEPICIENCY)     O(%) (DRIFT TAG       F 880       F 100       PREFX FUNCTION COLSPAN       F 880       Continued From page 58 fill the lungs) suctioning and providing bolus feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 parformed hand hygiene with ABHR prior to applying gloves and used ABHR sanitizer prior to donning clean gloves. Nurse #2 was conserved suctioning Resident #2's tracheostomy without a protective gown.     F 880       An interview with Nurse #2 was completed on 4/22/225 at 2:37 PM. Nurse #2 was completed on 4/22/225 at 2:25 PM. Nurse #2 was completed on 4/22/225 at 2:25 PM. Nurse #2 stated she was unaware she was supposed to be wasing a protective gown while performing procedures involving tracheostomy and tube feeding care.     An interview with Nurse #2 was complete	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
BZE CAROLINA BEACH ROAD WILMINGTON, NOC 28412       (MJ_ID] TAG     SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECIDENCY IN USE BERCEPUED BY FULL REQUIRED TO AN OF CORRECTION IEACH DEFICIENCY MUST BE PRECIDENCY IN USE BERCEPUED BY FULL REQUIRED TO ANOT CONTRECTION SHOULD BE CROSS-REFERENCE TO ANOT CONTRECTION DEFICIENCY     Image: Continued From page 58 full the lungs) suctioning and providing bolus feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 was conducted on 4/22/25 at 2:07 PM. Nurse #2 performed hand hygiene with ABHR prior to applying gloves and was observed suctioning Resident #2's tracheostomy without wearing a protective gown. Nurse #2 removed her soiled gloves and used ABHR sanitizer prior to donning clean gloves. Nurse #2 was completed on 4/22/25 at 2:25 PM. Nurse #2 stated she was unaware she was supposed to be wearing a protective gown. While performing protective gown. Surse #2 stated she was unaware she was supposed to be wearing a protective gown while performing protective gown. The ADONI/ICP on the ASISTANT Director of Nursing (ADON) /Infection Control Perventionist (ICP) on 4/22/25 at 2:31 PM. The ADONI/ICP stated she had only worked at the facility for a about 6 months. She stated she was the Staff Development Coordinator (SDC) prior to receiving her SPICE training just a couple of weeks ago. The ADONI/ICP further stated that the nursing staff were educated multiple times in the			345507	B. WING				-
AUTUMN CARE OF MYRTLE GROVE         WILMINGTON, NC 28412           (%) ID PREFIX TAG         SUMMARY STREMENT OF DEFICIENCIES (EACH OPRICENCY MUST ERRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDERS PLAN OF CORRECTION (EACH OPRICENTW AND NO F CORRECTION (EACH OPRICENTW AND NO F CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDERS PLAN OF CORRECTION (EACH OPRICENTW AND NO F CORRECTION (EACH OPRICENTW AND IDEN feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 vas conducted on 4/22/25 at 2:07 PM. Nurse #2 performed hand hygiene with ABHR prior to applying gloves and was observed providing bolus tube feeding through Resident #2's gastrostomy tube without a protective gown.         F 880         F 880           An interview with Nurse #2 was completed on 4/22/25 at 2:25 PM. Nurse #2 was completed on 4/22/25 at 2:35 PM. Nurse #2 stated she was unaware she was supposed to be wearing a protective gown while performing procedures involving tracheostomy and tube feeding care.         An interview was completed with the Assistant Director of Nursing (ADON) /Infection Control Preventionist (ICP) on 4/22/25 at 2:31 PM. The ADON/ICP stated she had only worked at the facility for a about 6 months. She stated she was the Staff Development Coordinator (SDC) prior to receiving her SPICE training just a couple of weeks ago. The ADON/ICP further stated that the nursing staff were educated multiple times in the	NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMINGTON, NC 28412           (X4) ID PREEN TX3         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         IP PREEN TX3         PROVIDENS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         0004 EACH OORSCRIPT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           F 880         Continued From page 58 fill the lungs) suctioning and providing bolus feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 performed hand hygiene with ABHR prior to applying gloves and was observed suctioning Resident #2's tracheostomy without wearing a protective gown. Nurse #2 was observed perioding bolus tube feeding through Resident #2's gastrostomy tube without a protective gown.         F 880           An interview with Nurse #2 was completed on 4/22/25 at 2:25 PM. Nurse #2 stated she was unaware she was supposed to be wearing a protective gown while performing procedures involving tracheostomy and tube feeding care.         An interview was completed with the Assistant Director of Nursing (ADON) /Infection Control Preventionist (CP) on 4/22/25 at 2:31 PM. The ADON/ICP stated she had only worked at the facility for a about 6 months. She stated she was the Staff Development Coordinator (SDC) prior to receiving her SPICE training just a couple of weeks ago. The ADON/ICP further stated that the nursing staff were educated multiple times in the						5725 CAROLINA BEACH ROAD		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLETION DEFICIENCY)         F 880       Continued From page 58 fill the lungs) suctioning and providing bolus feeding through a gastrostomy tube (a feeding tube place directly into the stomach) for Resident #2 was conducted on 4/22/25 at 2:07 PM. Nurse #2 performed hand hygiene with ABHR prior to applying gloves and was observed suctioning clean gloves. Nurse #2 removed her solled gloves and used ABHR sanitizer prior to donning clean gloves. Nurse #2 removed her solled gloves and use observed providing bolus tube feeding through Resident #2's gastrostomy tube without a protective gown.       An interview with Nurse #2 was completed on 4/22/25 at 2:25 PM. Nurse #2 stated she was unaware she was supposed to be wearing a protective gown while performing procedures involving tracheostomy and tube feeding care.         An interview was completed with the Assistant Director of Nursing (ADON) /Infection Control Preventionist (ICP) on 4/22/25 at 2:31 PM. The ADON/ICP stated she had only worked at the facility for a about 6 months. She stated she was the Staft Development Coordinator (SDC) prior to receiving her SPICE training just a couple of weeks ago. The ADON/ICP further stated that tthe nursing staff were educated multiple times in the	AUTUMN	CARE OF MYRTLE GRO	VE			WILMINGTON, NC 28412		
fill the lungs) suctioning and providing bolus         feeding through a gastrostomy tube (a feeding         tube place directly into the stomach) for Resident         #2 was conducted on 4/22/25 at 2:07 PM. Nurse         #2 performed hand hygiene with ABHR prior to         applying gloves and was observed suctioning         Resident #2's tracheostomy without wearing a         protective gown. Nurse #2 removed her soiled         gloves and used ABHR sanitizer prior to donning         clean gloves. Nurse #2 was observed providing         bolus tube feeding through Resident #2's         gastrostomy tube without a protective gown.         An interview with Nurse #2 was completed on         4/22/25 at 2:25 PM. Nurse #2 stated she was         unaware she was supposed to be wearing a         protective gown while performing procedures         involving tracheostomy and tube feeding care.         An interview was completed with the Assistant         Director of Nursing (ADON) /Infection Control         Preventionist (ICP) on 4/22/25 at 2:31 PM. The         ADON/ICP stated she had only worked at the         facility for a about 6 months. She stated she was         the Staff Development Coordinator (SDC) prior to         receiving her SPICE training just a couple of         weeks ago. The ADON/ICP further stated that the         nursing staff were educ	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
Precautions. She indicated the nursing staff were to follow the enhanced barrier precaution signs posted outside of the residents' rooms. The ADON/ICP stated Nurse #2 should have been wearing a protective gown while performing tracheostomy suctioning and providing bolus tube feeding for Resident #2. An interview with the Director of Nursing (DON)	F 880	fill the lungs) suctioning feeding through a gass tube place directly inte #2 was conducted on #2 performed hand by applying gloves and v Resident #2's trached protective gown. Nurse gloves and used ABH clean gloves. Nurse # bolus tube feeding the gastrostomy tube with An interview with Nurse 4/22/25 at 2:25 PM. N unaware she was sup protective gown while involving tracheostom An interview was com Director of Nursing (A Preventionist (ICP) or ADON/ICP stated she facility for a about 6 m the Staff Development receiving her SPICE to weeks ago. The ADO nursing staff were edu last 6 months involvin Precautions. She indi to follow the enhance posted outside of the ADON/ICP stated Nur- wearing a protective of tracheostomy suction feeding for Resident #	ng and providing bolus strostomy tube (a feeding o the stomach) for Resident 4/22/25 at 2:07 PM. Nurse ygiene with ABHR prior to vas observed suctioning ostomy without wearing a se #2 removed her soiled R sanitizer prior to donning 2 was observed providing rough Resident #2's nout a protective gown. se #2 was completed on Surse #2 stated she was oposed to be wearing a e performing procedures by and tube feeding care. npleted with the Assistant DON) /Infection Control n 4/22/25 at 2:31 PM. The e had only worked at the nonths. She stated she was at Coordinator (SDC) prior to training just a couple of N/ICP further stated that the ucated multiple times in the ng Enhanced Barrier cated the nursing staff were d barrier precaution signs residents' rooms. The rse #2 should have been gown while performing ing and providing bolus tube #2.	F	880			

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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:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345507	B. WING				C / <b>24/2025</b>
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 880	Nurse #2 was suppose Barrier Precautions we tracheostomy suction She further stated Nur- wearing a gown while for a resident with a tu- tube. The DON indica nursing staff to follow policies and procedur the residents. She state continue conducting a education to the nursi 2.) During an observation Nurse #3 was observed Nurse #3 was observed Nurse #3 was observed Nurse #3 was observed a mask but no gown we A sign was located ou indicating Resident #4 Precautions and to do mask prior to perform supply cart with gown outside of Resident # During an interview o #3 stated she should with the gloves and me Resident 5#'s trached had received education Precautions and using equipment. She state During an interview we Preventionist Nurse of stated Resident #5 we Precautions due to have indicated a sign was functions of the states we had received and the states During an interview we Precautions due to have indicated a sign was functions we have the states and the states of the states of the states of the states precautions due to have indicated a sign was functions of the states of the	sed to follow the Enhanced thile performing ing and bolus tube feeding. rse #2 should have been a performing hands on care racheostomy and a feeding ted she expected the the facility's infection control res while performing care for ated the facility needed to audits and providing ing staff. tion on 4/22/25 at 5:00 PM ed providing tracheostomy ning tracheal suctioning to 43 was wearing gloves, and while providing direct care. ttside of the residents room 5 was on Enhanced Barrier on gloves, gown, and a ing direct care activities. A is and gloves was located 5's room. n 4/22/25 at 5:00 PM Nurse have put on a gown along nask before providing botomy care. She stated she on on Enhanced Barrier	F	880			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345507		345507	B. WING			C 04/24/2025		
NAME OF PROVIDER OR SUPPLIER				s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	0 _ 0	
AUTUMN CARE OF MYRTLE GROVE				5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF		ULD BE COMPLETION		

Facility ID: 960602

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