STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 04/24/2025

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AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 4/22/25 through 4/24/25. The following complaints were investigated: NC00226909, NC00226683, NC00224823, and NC00229164. 2 of the 14 allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR.483.25 at tag F693 at a scope and severity (J) CFR 483.35 at tag F726 at a scope and severity (J) The tag F693 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/25/25 and was removed on 4/25/25. A partial extended survey was conducted.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family	F 565		5/14/25

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

Electronically Signed | 05/16/2025

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F 565	Continued From page 1 group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed act upon concerns that were reported by the resident council and communicate the efforts to address concerns that were reported during Resident Council Meetings for 6 of 6 months (November 2024, December 2024, January 2025, February 2025, March 2025 and April 2025) reviewed. Findings included: a. The Resident Council meeting minutes dated November 27, 2024, recorded by the Activity Director indicated a concern expressed at the previous month's meeting regarding the meal	F 565	Food Committee Meeting was held on 5/6/2025 to review dietary concerns. The Administrator will review all resident council minutes since 11/1/2024 and ensure all concerns were transcribed to concern forms, addressed by the appropriate department and presented to the resident council president by 5/13/25. Education will be provided by the Nursing Home Administrator by 5/13/2025 to the Social Worker, Life Enrichment Coordinator and the Interdisciplinary team on the Grievance/Concern Policy and on	

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F 565	Continued From page 2 tickets not matching what was served. The minutes indicated a concern form was filed. The November meeting minutes did not indicate that a response was provided to the council regarding the concern form and any follow-up that the facility completed. The meeting minutes were signed by the Administrator on 11/27/24. b. The Resident Council meeting minutes dated December 13, 2024, recorded by the Activity Director indicated a concern was expressed at the previous month's meeting regarding the taste of the food. The minutes indicated the council was informed that staff were spoken to regarding the taste of the food. The December meeting minutes did not indicate any follow-up that the facility completed. c. The Resident Council meeting minutes dated January 14, 2025, recorded by the Activity Director indicated a concern was expressed at the previous month's meeting regarding the meal tickets not matching what was served and not having enough staff assisting during mealtimes. The January minutes did not indicate that a response was provided to the council regarding the concern form that was filed or any follow-up that the facility completed. The meeting minutes were signed by the Administrator on January 14, 2025. d. The Resident Council meeting minutes dated February 11, 2025, recorded by the Activity Director indicated a concern was expressed at the previous month's meeting regarding the meal tickets not matching what was served and the always available menu items were not available. The February minutes did not indicate that a response was provided to the council regarding	F 565	ensuring resident council concerns are being addressed timely and presented back to the resident council or the resident council president. The Nursing Home Administrator will audit all resident council meeting minutes monthly for three months to ensure any concerns are transcribed onto grievance forms, addressed and presented to the resident council or resident council president for approval. The results of the audit will be presented to the Quality Assurance Improvement Committee monthly for 3 months. The QA team may change the plan of correction or extend the monitoring period to ensure ongoing compliance.	

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F 565	Continued From page 3	F 565		

the concern form that was filed, or any follow-up that the facility completed. The meeting minutes indicated that the Ombudsman attended the meeting. The meeting minutes were signed by the Administrator on 2/11/25. The list of attendees at the meeting indicated that the Administrator did not attend the meeting.

e. The Resident Council meeting minutes dated March 18, 2025, recorded by the Activity Director indicated a concern was expressed at the previous month's meeting regarding the anytime available menu items were not available. The March minutes did not indicate that a response was provided to the council regarding the concern form that was filed, or any follow-up that the facility completed. The meeting minutes indicated that the Ombudsman attended the meeting. The meeting minutes were signed by the Administrator on March 18, 2025. The list of attendees at the meeting indicated that the Administrator did not attend the meeting.

f. The Resident Council meeting minutes dated April 14, 2025, indicated a concern was expressed at the previous month's meeting regarding the meal tickets not matching what was served and the always available menu items were not available. The April meeting minutes did not indicate that a response was provided to the council regarding the concern form that was filed the month prior, or any follow-up the facility completed.

An interview was conducted with the Resident Council President on 4/23/25 at 4:00 PM. The Resident Council President stated that the Resident Council met monthly, and the Activity Director recorded the concerns that were

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expressed. The Resident Council President indicated that nothing was done about the concerns that were expressed in the meetings. The Resident Council President stated he attended all the Resident Council meetings and was frustrated with the lack of follow up because he felt that management did not address the concerns of the council. He stated the council was not provided with a resolution to the concerns that were expressed each month. He stated the Regional Vice President attended the Resident Council meeting held on April 14, 2025, but she was unable to explain why the concerns were not addressed.

An interview was conducted with the Regional Vice President on 4/24/25 at 9:00 AM. The Regional Vice President stated that she was asked by the residents to attend the Resident Council meeting on April 14, 2025. The Regional Vice President stated it was at that meeting she was made aware that concerns expressed in the meetings were not addressed for the past several months. The Regional Vice President stated following the meeting, she investigated the residents' concerns and learned that the facility had no process in place to address the concerns expressed in the Resident Council Meetings. The Regional Vice President indicated that concern forms were not being addressed following the Resident Council Meetings and there was no follow up to ensure that the concerns were addressed. The Regional Vice President stated there was not a system in place to address concerns or grievance voiced at the meetings and this was not acceptable.

An interview was conducted with the Activity Director on 4/24/25 at 12:10 PM. The Activity

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Director indicated she conducted the monthly Resident Council Meetings and took the minutes at the meeting. The Activity Director stated that at each meeting, the old concerns from the previous meeting were discussed as well as new concerns. The Activity Director stated she completed a concern form with each concern expressed by the Resident Council members, and she gave these forms as well as the minutes from the current meeting to the Administrator to follow up on. The Activity Director stated for the past several months the concerns from the previous meetings were not being addressed and the residents were frustrated by this. The Activity Director stated that she requested that the Ombudsman attend the Resident Council meetings to assist with addressing the residents' concerns. The Activity Director indicated that the Ombudsman attended the Resident Council meetings recently and was aware that the concerns were not being addressed. The Activity Director stated she had not seen the concern forms after she completed them.

An interview was conducted with the Social Services Director on 4/24/25 at 2:05 PM. The Social Services Director stated she had not seen any forms from the Resident Council Meetings, was not involved in any follow-up and she had not attended a Resident Council meeting.

An interview was conducted with the Administrator on 4/24/25 at 3:20 PM. The Administrator stated the Social Services Director was responsible for addressing the concerns of the Resident Council Meetings. The Administrator stated the previous Social Services Director left the facility a few months ago and she had stopped addressing the concern forms prior

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F 565	Continued From page 6 to her leaving. The Administrator indicated that he did not attend the Resident Council meetings, and he was not involved with addressing the concerns that were expressed at the meetings. The Administrator acknowledged he should have implemented measures to address the concerns expressed by the Resident Council members and he should have addressed the concern forms that were given to him. The Administrator had no documentation that showed that the grievances reported during the monthly Resident Council meetings for the past 6 months were addressed. The Administrator acknowledged he signed the monthly meeting minutes but was unable to explain if he was aware of the repeated concerns expressed as the meetings.	F 565		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		5/14/25

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F 580	Continued From page 7 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the Medical Director, and the Nurse Practitioner (NP), the facility failed to immediately notify the physician on 1/25/25 of a resident's (Resident #1) dislodged jejunostomy tube (j-tube [a tube surgically inserted into the small intestine to deliver nutrition and medications]). Nurse #1 did not communicate with the physician and she inserted an indwelling urinary catheter tube to	F 580	On January 25,2025, the facility failed to immediately notify the physician of Resident #1's dislodgement of a jejunostomy tube (a tube surgically inserted into the small intestine to deliver nutrition and medications). Nurse Aide #1 identified a tube on the floor of Resident #1's bathroom at approximately 9:00am. She did not communicate this information	

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replace the j-tube without a physician's order. The replacement tube became dislodged from the j-tube site on 1/25/25 and Nurse #1 sent the resident to the hospital for reinsertion. Resident #1 went to the Operating Room (OR) on the evening of 1/27/25 and the j-tube was surgically placed. This delayed physician notification had a high likelihood of resulting in serious harm for Resident #1 from the risks of placing the j-tube in the wrong place, perforation of the small intestine, sepsis (life-threatening infection), and bleeding due to anticoagulant (blood thinner) use. This deficient practice affected 1 of 2 residents reviewed for notification.

Immediate jeopardy began on 1/25/25 when Nurse #1 failed to notify the physician regarding Resident #1's dislodged jejunostomy tube. Immediate jeopardy was removed on 4/25/25 when the facility 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 and 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

to Nurse #1. At approximately 12:15 pm Nurse #1 identified Resident #1's dislodged j-tube. Nurse #1 replaced Resident #1's dislodged j-tube with a foley catheter and did not notify the physician. The j-tube then became dislodged a second time on January 25, 2025 at approximately 12:45 pm. Nurse #1 notified the physician at 1:15 pm and sent the resident the resident to hospital for reinsertion. Surgical residents were able to place a foley into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on January 27, 2025 but were not able to place. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28, 2025. After determining there was a knowledge deficit, a plan to re-educate all nurses was established. The facility reviewed the circumstances of the deficient practice and reviewed the findings with the QA team on April 24, 2025.

On April 23, 2025 the Director of Nursing conducted a 30 day look back to review other residents identified with a change in condition to verify physician and/or provider notification was made in a timely manner. No additional concerns were identified.

All residents with change of condition are at risk for the same deficient practice. The Director of Nursing (DON) conducted

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F 580	Continued From page 9 1/14/25 with diagnoses including cerebral infarction due to occlusion or stenosis of left middle cerebral artery (stroke), dysphagia (difficulty swallowing), and aphasia (absence of speech). 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 anticoagulant) 5 milligrams (mg) twice a day per feeding tube. There was not a physician's order to change the j-tube. The Physician's History and Physical dated 1/16/25 for Resident #1 indicated that he was admitted to the facility with right-sided weakness related to left medial cerebral artery occlusion. The note indicated Resident #1 was status post-surgical placement of a j-tube on 1/10/25 to meet his nutritional needs due to dysphagia. The admission Minimum Data Set (MDS) assessment dated 1/17/25 revealed Resident #1 was severely cognitively impaired. He was coded as having no speech and receiving greater than 51% of his nutrition and over 500 ml of water from enteral (tube) feeding daily. He was coded for receiving an anticoagulant. A partially filled out SBAR (Situation, Background, Appearance, and Review and Notify is a structured communication tool used to transmit clear concise information) communication 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 j-tube 2 times and the	F 580	a 30 day look back to review other residents identified with a change in condition to verify Physician and/or Provider was notified in a timely manner. This review was completed by the DON on April 23, 2025 and consisted of a thorough review of change of condition Prevention to ensure deficient practice does not occur again: The DON, Assistant Director of Nursing (ADON), and Unit Managers re-educated Licensed Nurses and Nurse Aides (NA) on "Resident Change in Condition Policy" with emphasis on changes that require immediate provider notification and documentation on April 24, 2025. The nurse aides were educated to notify the charge nurses if any devices, such as enteral feeding tubes were displaced or not in resident at time of care. New licensed Nurses, Agency Nurses and Nurse Aides will be educated by the DON or ADON during the orientation process. Ongoing Compliance Monitoring: DON and/or designee will audit Changes in Condition 5x week for 12 weeks to ensure physician notification was made in a timely manner. DON/designee will also interview 5 STNA a week to validate understanding of charge nurse notification of any change of conditions. Results of audits will be reported in QAPI meeting monthly x 3 months by DON.	

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condition was listed as occurring before due to resident consistently playing and tugging on the tube. There was no other information listed except that the Responsible Party (RP) was notified at 12:51 PM and the on-call provider was notified at 1:12 PM. The box to call for 911 for transfer to the hospital was checked.

An incomplete Hospital Transfer Form for Resident #1 listed the following information: His name, date of admission, date of birth, and primary diagnosis. It further listed the RP was notified of the situation and of the transfer to the hospital. The reason for the transfer was listed as pulled out j-tube. The risk alert boxes for anticoagulation, aspiration, high fall risk, needs medications crushed, and pain level were checked. The form was not signed by facility staff and no other information was noted.

A telephone interview was conducted with Nurse #1 on 4/23/25 at 10:00 AM. Nurse #1, an agency nurse, stated she worked for the facility in January for approximately 3 weeks, but she was no longer employed there. She stated that on 1/25/25 she was assigned to care for Resident #1 and at approximately 12:15 PM she went into administer Resident #1 his medications per feeding tube and the tube was not in his abdomen. Nurse #1 stated that the tube feeding was scheduled for only 22 hours a day to allow for activities of daily living (ADL) care and therapy and she had not had a chance to reconnect the tube feeding that morning. She indicated that there was no bleeding at that time. She reported that she went and asked Nurse Aide (NA) #1 if she knew what happened to Resident #1's feeding tube. Nurse #1 stated that NA #1 reported she had seen something that looked like a tube

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on the bathroom floor 2-3 hours ago, but she had not reported it to the nurse. She further stated that NA #1 informed her that therapy was working with Resident #1 in the bathroom early that morning around 9:15 AM. Nurse #1 indicated that after speaking with NA #1 she had gone back to Resident #1's room and found the feeding tube on the bathroom floor. She indicated she had been a nurse for 21 years and she was experienced in reinserting gastrostomy tubes (in the stomach). She explained that she was unaware Resident #1 had a j-tube and she had assumed it was a gastrostomy tube. Nurse #1 stated that instead of calling the physician she had consulted the Wound Nurse, who was the Manager on duty that weekend. She stated the Wound Nurse had instructed her to replace it with an enteral feeding tube of the same size or a tube for an indwelling urinary catheter. Nurse #1 indicated she had replaced the j-tube with a 16 French indwelling urinary catheter tube. Nurse #1 indicated that if she had known Resident #1 had a j-tube and not a gastrostomy tube she would have sent him to the hospital the first time it dislodged. She stated that she had never heard of anyone reinserting a j-tube in a nursing facility. Nurse #1 stated she notified the Director of Nursing (DON) the second time the tube was dislodged, and she instructed her to notify the provider and transfer him to the hospital. Nurse #1 indicated that after transferring Resident #1 to the hospital she had asked the Certified Occupational Therapy Assistant (COTA) if he had noticed if the feeding tube was dislodged during the transfer in the bathroom and he stated he was unaware that it had dislodged. She further indicated that 1/25/25 was the last day she worked for the facility.

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A telephone interview was completed with NA #1 on 4/23/25 at 12:23 PM. NA #1 stated that on 1/25/25 she had noticed something that looked like a tube lying on Resident #1's bathroom floor after she observed the COTA working with Resident #1 at approximately 9:15 AM. She stated she was busy and was in a hurry and had not stopped to examine the object on the floor. She further stated she had not notified the nurse that something was lying on the floor.

A telephone interview was completed with the Wound Nurse on 4/23/25 at 12:28 PM. The Wound Nurse stated she was the Manager on Duty on 1/25/25. She further stated she remembered Nurse #1 telling her that a feeding tube was dislodged. The Wound Nurse indicated she could not recall if Nurse #1 told her it was a j-tube. She further indicated that she did tell Nurse #1 that she could replace a gastrostomy tube and that if the facility didn't have the correct size tube, she could use the same size indwelling urinary catheter tube instead. The Wound Nurse stated that she instructed Nurse #1 to call the provider for an order.

A telephone interview was completed with the COTA who was assigned to Resident #1 on 1/25/25. The COTA stated that on 1/25/25 he was working with Resident #1 in the bathroom with toilet transfers. The COTA indicated that nothing out of the ordinary occurred during the transfer, and he did not know how the tube became dislodged. He further indicated there had not been any indications from Resident #1 that the tube was dislodged such as grimacing, pointing, or any sign of pain. The COTA stated he never saw a tube on the bathroom floor, but if he had seen a tube, he would have notified the nurse.

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A nurse's progress note written by the DON on 1/25/25 at 2:00 PM indicated that she received a call from floor nurse that Resident #1's j-tube fell out. Nurse #1 was advised to call the Provider on call and send to the hospital or placement of j-tube.

An interview with the DON was completed 4/23/25 at 4:10 PM. The DON stated she had documented the note related to Resident #1 on 1/25/25 from her home computer. She further stated that when Nurse #1 notified her that Resident #1's j-tube was dislodged she had instructed her to call the provider to get an order to send him to the hospital. The DON indicated that Nurse #1 had mentioned something about reinserting the tube and she had informed her that resident's with dislodged j-tubes were sent to the hospital to have it replaced. She stated that Nurse #1 should have notified the physician when the j-tube was initially dislodged. The DON indicated that Nurse #1 was suspended that day and never returned to the facility. The DON stated j-tubes were inserted at the hospital using radiographic (x-ray) guidance or surgically placed.

The hospital record included an Emergency Department (ED) Encounter note by the ED Physician dated 1/25/25 that revealed Resident #1 presented to the hospital with a dislodged j-tube. The note indicated the j-tube was approximately two weeks old and it was dislodged and replaced with temporary urinary catheter, and it became dislodged again. Surgical Residents were able to place a urinary catheter tube into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on 1/27/25 but were not able to place.

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Resident #1 went to the Operating Room (OR) on the evening of 1/27/25 and the j-tube was successfully placed. There were no complications related to the surgery and Resident #1 returned to the facility on 2/4/25.

An interview was conducted with the Nurse Practitioner (NP) on 4/23/25 at 10:43 AM. The NP stated that it was not appropriate for a nurse to change the j-tube. She further stated there was risk perforation (poking a hole through the wall of the intestine) and an increased chance of causing a serious infection by pushing bacteria into the abdomen. The NP indicated Resident #1 was on an anticoagulant that put him at higher risk of bleeding. She further indicated a physician's order would be needed to change any tube. The NP stated it was out the nurse's scope of practice to replace a tube without a physician's order. She indicated Nurse #1 should have notified the on-call provider before reinserting a replacement tube.

An interview with the Medical Director was completed on 4/23/25 at 11:47 AM. The Medical Director stated that it was totally inappropriate for a nurse to replace a j-tube in the facility. She further stated that since the tube was surgically inserted on 1/10/25 the site was probably not mature (a jejunostomy site needs to mature to form a stable track between the skin and the jejunum [small intestine] to prevent leakage of intestinal contents and this takes approximately 4 weeks) and there would be higher risk for bowel perforation, the tissue would be more friable (tissue that is easily irritated, which makes it more prone to inflammation, bleeding, and tearing) and cause more bleeding, and the fact that he was on an anticoagulant would definitely increase the

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risk of bleeding. The Medical Director indicated there was definitely a high likelihood of harm due to risk or sepsis, bleeding, and perforation for a nurse to change a j-tube in a nursing facility. She stated that Nurse #1 should not have attempted to reinsert the j-tube without notifying the provider. The Medical Director indicated that j-tubes were placed at the hospital using x-ray or computed tomography (CT) scan guidance.

An interview was completed with the Administrator on 4/24/25 at 9:35 AM. The Administrator stated he expected the nursing staff to follow the facility's policies and procedures regarding feeding tubes and notifying the physician.

The Administrator was notified of immediate jeopardy on 4/23/25 at 4:00 PM.

The Administrator provided the following credible allegation of Immediate Jeopardy removal:

Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On January 25, 2025, the facility failed to immediately notify the physician of Resident #1's dislodgement of a jejunostomy tube (a tube surgically inserted into the small intestine to deliver nutrition and medications). Nurse Aide #1 identified a tube on the floor of Resident #1's bathroom at approximately 9:00 AM. She did not communicate this information to Nurse #1. At approximately 12:15 PM Nurse #1 identified Resident #1's dislodged j-tube. Nurse #1 replaced Resident #1's dislodged j-tube and she inserted an indwelling urinary catheter tube to

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replace the tube and did not notify the physician. The j-tube then became dislodged a second time on January 25, 2025 at approximately 12:45 PM, and Nurse #1 notified the physician at 1:15 PM and sent the resident to hospital for reinsertion. Surgical Residents were able to place a foley into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on January 27, 2025 but were not able to place. Resident #1 went to the Operating Room (OR) on the evening of January 27, 2025 and j-tube was successfully placed. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28, 2025.

The Director of Nursing (DON) conducted a 30 day look back to review other residents identified with a change in condition to verify Physician and/or Provider was notified in a timely manner. This review was completed by the DON on April 23, 2025 and consisted of a thorough review of change of condition assessments identified in our electronic medical record through observations titled "Interact SBAR" (an SBAR stands for Situation, Background Assessment, Recommendation), "Interact Nursing Home to Hospital Transfer Form", and "Events". An email was sent to the Medical Director with a list of all residents that experienced a significant change of condition during that time period. A significant change of condition is identified as a decline or improvement in the resident's status that:
1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention(s); and/or one that

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2. Impacts more than one area of the resident's health status; and/or one that
3. Requires interdisciplinary review and/or revision to the care plan.

No additional concerns were identified. The Medical Director replied to the email sent by the Director of Nursing that she had reviewed the list without further concerns on April 24, 2025.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The DON, Assistant Director of Nursing (ADON), and Unit Managers re-educated Licensed Nurses and Nurse Aides (NA) on "Resident Change in Condition Policy" with emphasis on changes that require immediate physician notification and documentation by April 24, 2025. Changes requiring prompt notification include a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions(s), impacts more than one area of the resident's health status, and/or requires interdisciplinary review or revision to the care plan. The Nurse Aides were educated to notify the charge nurses if any devices, such as enteral feeding tubes, were displaced or not in resident at time of care. The Director of Nursing will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff or PRN staff will be re-educated prior to returning to duty. New Licensed Nurses, Agency Nurses, and Nurse Aides will be educated by the DON or ADON

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during the orientation process. Effective April 24, 2025, the Director of Nursing will review the Facility Activity Report for any Interact SBAR, Interact Nursing Home to Hospital Transfer Forms, or any Events in the morning Clinical Morning Meeting, which will be held seven days a week, to verify prompt and/or immediate notification is communicated to the Physician and/or Provider. If notification to the physician has not occurred, the DON will notify the physician at that time.

Alleged immediate jeopardy removal date: April 25, 2025.

The immediate jeopardy removal plan was validated on 4/24/25. The DON provided a list of residents who were reviewed by the Medical Director for notification of a significant change in condition on 4/24/25. An interview with the NP on 4/24/24 at 12:15 PM confirmed that the facility had sent the list of residents to the Medical Director and the providers had reviewed the list and no other concerns were identified. The education sign in sheets were reviewed for the in-services conducted with the nursing staff on 4/23/25 and 4/24/25 regarding "Resident Change in Condition Policy" and "Changes requiring prompt notification of the nurse or provider". Staff interviews with nurses confirmed education regarding significant changes in condition and when to notify the provider was provided. Interviews completed with the Nurse Aides confirmed education on notifying the charge nurses if any devices, such as enteral feeding tubes, were displaced. The DON stated on 4/24/25 at 12:22 PM that effective 4/24/25 she would be reviewing the Facility Activity Report for any Interact SBAR, Nursing Home to Hospital

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F 580	Continued From page 19 Transfer Forms, and any Events identified in the morning Clinical Meeting to verify the provider was notified. She stated the meetings would be held in person Monday through Friday and conducted remotely on a virtual computer meeting on Saturday and Sunday. The facility's immediate jeopardy removal date of 4/25/25 was validated.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622		5/14/25

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resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is

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F 622	Continued From page 21 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to communicate all required information to the hospital for 1 of 1 resident (Resident #1) reviewed for hospital transfers. The findings included: Resident #1 was admitted to the facility on 1/14/25 with diagnoses that included cerebral infarction due to occlusion or stenosis of left middle cerebral artery (stroke), dysphagia (difficulty swallowing), and aphasia (absence of speech). The physician's orders for Resident #1 dated 1/14/25 included a jejunostomy tube (a surgically placed feeding tube that delivers nutrition and medications directly into the small intestine) 16 French (size).	F 622	Resident #1 is no longer in the facility. The DON/designee will audit the medical record for all facility residents that are still admitted to the hospital to ensure all required information was communicated to the hospital by 5/8/2025. The DON/designee will educate all nurses on completing the Nursing Home to Hospital Transfer form and sending the Continuity of Care Document (CCD) with the resident upon transfer. The education will be completed by 5/13/2025. The CCD includes the following: demographics, medications, problem list, diagnosis, vitals, allergies, Advanced Directives, insurances, immunizations, goals, social history and encounters.	

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F 622	Continued From page 22 The admission Minimum Data Set (MDS) assessment dated 1/17/25 revealed Resident #1 was severely cognitively impaired and had no speech. A nurse's progress note written by the Director of Nursing on 1/25/25 at 2:00 PM indicated that she received a call from the floor nurse that Resident #1's jejunostomy tube (j-tube) fell out. Nurse #1 was advised to call the Provider on call and send to the hospital or placement of j-tube. An incomplete 2-page Hospital Transfer Form for Resident #1 listed the following information on page 1: His name, date of admission, date of birth, and primary diagnosis. It further listed the Responsible Party was notified of the situation and of the transfer to the hospital. The reason for the transfer was listed as pulled out j-tube. The form indicated that Resident #1 was alert, disoriented, could not follow/simple commands, he required a proxy for decision making capacity, he was incontinent of bowel and bladder, and the date of his last bowel movement was noted. Page 1 of the form was missing the code status, relevant diagnoses, and functional status. On page 2 of the form the risk alert boxes for anticoagulation, aspiration, high fall risk, needs medications crushed, and pain level were checked. His diet was listed as enteral feeding. The sections for respiratory, medications, devices, isolation precautions, and vital signs were not completed. The form was not signed and dated. An interview with Nurse #1 was completed on 4/23/25 at 10:00 AM. Nurse #1 stated she was the nurse assigned to care for Resident #1 on 1/25/25 when his j-tube became dislodged. She	F 622	The DON/designee will audit all hospital transfers 5x week for 12 weeks to ensure required information is communicated to the hospital and documented in the electronic medical record. The DON/designee will complete the Nursing Home to Hospital Transfer form and provide the CCD to the hospital for any resident that was discharged without the document. The nurse that was responsible for sending the document on discharge will be re-educated by the DON/designee. The audits will be reviewed monthly for 3 months.	

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F 622	Continued From page 23 further stated the residents she was assigned to care for that day were high acuity (residents requiring closer monitoring and treatments with i.e. tracheostomy tubes, feeding tubes, wounds) and she had not completed the documentation related to the incident. Nurse #1 indicated that the Director of Nursing (DON) called her multiple times to return to the facility to complete the paperwork, but she never went back to the facility. An interview with the DON was completed on 4/23/25 at 4:00 PM. The DON stated she tried to call Nurse #1 multiple times to get her to come back to the facility to complete the paperwork regarding Resident #1's transfer to the hospital, but she never came back. She indicated she expected the nursing staff documentation to be complete and accurate.	F 622		
F 693 SS=J	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral	F 693		5/14/25

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F 693	Continued From page 24 means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner (NP), Medical Director, staff, and Responsible Party (RP) interviews, the facility failed to ensure a resident (Resident #1) was provided with the necessary treatment to replace his dislodged jejunostomy tube (a surgically placed feeding tube that delivers nutrition and medications directly into the small intestine). On 1/25/25, Nurse #1 did not identify the need for hospital treatment to replace the dislodged jejunostomy tube (j-tube) and she inserted an indwelling urinary catheter tube to replace the j-tube without a physician's order. The replacement tube became dislodged from the j-tube site on 1/25/25, and Nurse #1 sent the resident to the hospital for reinsertion. Resident #1 went to the Operating Room (OR) on the evening of 1/27/25 and the j-tube was successfully placed. This noncompliance created a high likelihood of Resident #1 suffering serious harm from the risks of placing the j-tube in the wrong place, perforation of the small intestine, sepsis (life-threatening infection), and bleeding due to anticoagulant (blood thinner) use. This deficient practice was identified for 1 of 3 residents reviewed for feeding tubes. Immediate jeopardy began on 1/25/25 when Nurse #1 replaced Resident #1's dislodged jejunostomy tube. Immediate jeopardy was removed on 4/25/25 when the facility	F 693	On January 25, the facility failed to ensure Resident #1 was provided with the necessary treatment to replace his dislodged jejunostomy tube (a surgically placed feeding tube that delivers nutrition and medications directly into the small intestine). Nurse #1 did not identify the need for hospital treatment to replace the dislodged j-tube and she inserted a foley catheter to replace the tube. The j-tube then became dislodged a second time on January 27, 2025 but was not able to re-place. Resdent #1 went to the operating room on the evening of January 27, 2025 and the j-tube was successfully placed. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28, 2025. All residents with j-tubes are at risk for the same deficient practice. On April 23, 2025, the Director of Nursing (DON) reviewed all residents that resided in the facility from January 25, 2025 until April 23, 2025 and no additional residents were identified with a j-tube in the facility at this time.	

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F 693	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 infarction due to occlusion of left middle 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 anticoagulant) 5 milligrams (mg) twice a day per feeding tube. There was not a physician's order to change the j-tube. The Care Plan for Resident #1 dated 1/14/25 revealed a plan of care for risk for nutritional	F 693	Prevention to ensure deficient practice does not occur again: The Director of Nursing (DON), Assistant Director of Nursing (ADON), the Unit Managers will provide education to Licensed Nurses on Enteral Feeding Tube(s) policy, to include what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of a j-tube, and sending the resident to the hospital for surgical reinsertion. Training was completed by April 24, 2025. New hires and Agency Nurses will be educated by the Director of Nursing and/or Assistant Director of Nursing during the orientation process. Ongoing Compliance Monitoring: DON/designee will interview 5 nurses weekly x 12 weeks to validate understanding of how to handle a dislodged j-tube. Results of interviews will be reported in QAPI meeting monthly x 3 months by DON.	

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decline, dehydration, weight fluctuations related to recent stroke resulting in dysphagia and aphasia, and 100% reliance on tube feeding for nutrition/hydration with a goal that he would be free of signs and symptoms of dehydration, fluid overload, and electrolyte imbalances through the next review. The interventions included: monitoring for signs and symptoms of dehydration, checking for residual prior to administering tube feeding; administering tube feeding as ordered by the physician. Another plan of care for impaired skin integrity related to Resident #1 was admitted with abdominal surgical wounds from j-tube placement in the distal (far) right upper quadrant (divides the abdomen in four quarters with the umbilicus [navel or bellybutton] in the middle), the right upper quadrant, umbilicus and left upper quadrant with a goal that the wounds would heal without complications (infection, hemorrhage, dehiscence [wound opens up]). The interventions included observing and reporting signs of infection (pain, redness, swelling, tenderness), and providing treatments as ordered.

A nurse progress note dated 1/15/25 at 10:21 AM by the Wound Nurse revealed Resident #1 was seen that day for new admission wound assessments and j-tube care. Four surgical incisions were noted to abdomen status post j-tube placement and the areas were scabbed with surgical glue in place, and open to air. No signs or symptoms of infection were noted. A small, scabbed area was observed near the j-tube site with surgical glue in place. The jejunostomy site was cleansed and new split gauze in place.

The Physician's History and Physical dated

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1/16/25 for Resident #1 indicated that he was admitted to the facility with right-sided weakness related to left medial cerebral artery occlusion. The note indicated Resident #1 was status post-surgical placement of a j-tube on 1/10/25 to meet his nutritional needs due to dysphagia.

The admission Minimum Data Set (MDS) assessment dated 1/17/25 revealed Resident #1 was severely cognitively impaired. He was coded as having no speech and receiving greater than 51% of his nutrition and over 500 ml of water from enteral (tube) feeding daily. He was coded as dependent on staff assistance with toileting, transferring, and bed mobility and he was always incontinent of bowel and bladder. The assessment listed that he was receiving speech therapy, occupational therapy, and physical therapy. He was coded for receiving an anticoagulant.

A partially filled out SBAR (Situation, Background, Appearance, and Review and Notify is a structured communication tool used to transmit clear concise information) communication 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 j-tube 2 times and the condition was listed as occurring before due to resident consistently playing and tugging on the tube. There was no other information listed except that the RP was notified at 12:51 PM and the on-call provider was notified at 1:12 PM. The box to call for 911 for transfer to the hospital was checked.

An incomplete Hospital Transfer Form for Resident #1 listed the following information: His

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name, date of admission, date of birth, and primary diagnosis. It further listed the RP was notified of the situation and of the transfer to the hospital. The reason for the transfer was listed as pulled out j-tube. The risk alert boxes for anticoagulation, aspiration, high fall risk, needs medications crushed, and pain level were checked. The form was not signed by facility staff and no other information was noted.

A telephone interview was conducted with Nurse #1 on 4/23/25 at 10:00 AM. Nurse #1 indicated that on 1/25/25 she was assigned to care for Resident #1. She stated she was an agency nurse with 21 years of experience. Nurse #1 further stated she had worked for the facility in January for approximately 3 weeks, but she was no longer employed there. She stated that on 1/25/25 at approximately 12:15 PM she went into administer Resident #1 his medications per feeding tube, and the tube was not in his abdomen. Nurse #1 stated that the tube feeding was scheduled for only 22 hours a day to allow for activities of daily living (ADL) care and therapy and she had not had a chance to reconnect the tube feeding that morning. She indicated that there was no bleeding at that time. She reported that she went and asked Nurse Aide (NA) #1 if she knew what happened to Resident #1's feeding tube. Nurse #1 stated that NA #1 reported she had seen something that looked like a tube on the bathroom floor 2-3 hours ago, but she had not reported it to the nurse. She further stated that NA #1 informed her that therapy was working with Resident #1 in the bathroom early that morning around 9:15 AM. Nurse #1 indicated that after speaking with NA #1 she had gone back to Resident #1's room and found the feeding tube on the bathroom floor. Nurse #1 stated she had

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consulted the Wound Nurse, who was the Manager on duty, and that she had instructed her to replace it with an enteral feeding tube of the same size or a tube for an indwelling urinary catheter. Nurse #1 indicated she had replaced the j-tube with a 16 French indwelling urinary catheter tube. She stated she was unaware that it was a j-tube and had assumed it was a gastrostomy tube (in the stomach). Nurse #1 indicated that if she had known Resident #1 had a j-tube and not a gastrostomy tube she would have sent him to the hospital the first time it dislodged. She stated that she had never heard of anyone reinserting a j-tube in a nursing facility. She further indicated she never had a chance to administer any medications or tube feeding through the tube after replacing it the first time because Resident #1 pulled it out approximately 30 minutes later. She indicated the RP for Resident #1 was the one that found him the second time the tube was dislodged and that the tube was laying on the floor beside his wheelchair and there was blood on his abdomen, legs, and the floor. Nurse #1 stated she notified the Director of Nursing (DON) the second time the tube was dislodged and she instructed her to notify the provider and transfer him to the hospital. She indicated that the residents she was assigned to care for that day were high acuity (residents requiring closer monitoring and treatments with i.e. tracheostomy tubes, feeding tubes, wounds) and she had not completed the documentation related to the incident. Nurse #1 indicated that after transferring Resident #1 to the hospital she had asked the Certified Occupational Therapy Assistant (COTA) if he had noticed if the feeding tube was dislodged during the transfer in the bathroom and he stated he was unaware that it had dislodged. She further indicated that 1/25/25

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was the last day she worked for the facility.

A telephone interview was completed with NA #1 on 4/23/25 at 12:23 PM. NA #1 stated that on 1/25/25 she had noticed something that looked like a tube lying on Resident #1's bathroom floor after she observed the COTA working with Resident #1 at approximately 9:15 AM. She stated she was busy and was in a hurry and had not stopped to examine the object on the floor. She further stated she had not notified the nurse that something was lying on the floor.

A telephone interview was completed with the Wound Nurse on 4/23/25 at 12:28 PM. The Wound Nurse stated she was the Manager on Duty on 1/25/25. She further stated she remembered Nurse #1 telling her that a feeding tube was dislodged. The Wound Nurse indicated she could not recall if Nurse #1 told her it was a j-tube. She further indicated that she did tell Nurse #1 that she could replace a gastrostomy tube and that if the facility didn't have the correct size tube, she could use the same size indwelling urinary catheter tube instead. The Wound Nurse stated that she told Nurse #1 to call the provider for an order.

A telephone interview was completed with the COTA who was assigned to Resident #1 on 1/25/25. The COTA stated that on 1/25/25 he was working with Resident #1 in the bathroom with toilet transfers. He stated that he was aware Resident #1 had a feeding tube, so he had placed the gait belt up higher around the chest instead of around the abdomen to prevent dislodging the feeding tube. The COTA indicated that nothing out of the ordinary occurred during the transfer and he did not know how the tube became

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dislodged. He further indicated there had not been any indications from Resident #1 that the tube was dislodged such as grimacing, pointing, or any sign of pain. The COTA stated he never saw a tube on the bathroom floor, but if he had seen a tube, he would have notified the nurse.

A telephone interview was completed with the RP on 4/24/25 at 10:54 AM. The RP stated that on 1/25/25 at approximately 12:45 PM she walked into Resident #1's room and found him sitting in his wheelchair and the feeding tube was lying on the floor beside the wheelchair. She further stated that Resident #1 had his finger in the hole trying to stop the bleeding. The RP indicated that blood was on his abdomen, his legs, and the floor. She indicated she called for the nurse to come help Resident #1. She further indicated Nurse #1 placed a bandage over the wound and called 911 to have him transferred to the hospital.

A nurse's progress note written by the DON on 1/25/25 at 2:00 PM indicated that she received a call from floor nurse that Resident #1's j-tube fell out. Nurse #1 was advised to call the Provider on call and send to the hospital or placement of j-tube.

An interview with the DON was completed 4/23/25 at 4:10 PM. The DON stated she had documented the note related to Resident #1 on 1/25/25 from her home computer. She further stated that when Nurse #1 notified her that Resident #1's j-tube was dislodged she had instructed her to call the provider to get an order to send him to the hospital. The DON indicated that Nurse #1 had mentioned something about reinserting the tube and she had informed her that resident's with dislodged j-tubes were sent to

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the hospital to have it replaced. She further indicated that Nurse #1 was suspended that day and never returned to the facility. The DON stated she had called Nurse #1 multiple times to try to get her to come by the facility and complete the paperwork and documentation about the incident involving Resident #1 on 1/25/25. The DON indicated that j-tubes were inserted at the hospital using radiographic (x-ray) guidance or surgically placed. The DON stated the facility policy and procedures allowed nurses to change gastrostomy tubes in a facility with a physician's order, but not j-tubes. She stated she expected all the nurses to follow the facility's policies and procedures.

The hospital record included an Emergency Department (ED) Encounter note by the ED Physician dated 1/25/25 that revealed Resident #1 presented to the hospital with a dislodged j-tube. The note indicated the j-tube was approximately two weeks old and it was dislodged and replaced with temporary urinary catheter, and it became dislodged again. Surgical Residents were able to place a urinary catheter tube into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on 1/27/25 but were not able to place. Resident #1 went to the Operating Room (OR) on the evening of 1/27/25 and the j-tube was successfully placed. There were no complications related to the surgery and Resident #1 returned to the facility on 2/4/25.

An interview was conducted with the Nurse Practitioner (NP) on 4/23/25 at 10:43 AM. The NP stated that it was not appropriate for a nurse to change the j-tube. She further stated there was risk perforation (poking a hole through the wall of

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the intestine) and an increased chance of causing a serious infection by pushing bacteria into the abdomen. The NP indicated Resident #1 was on an anticoagulant that put him at higher risk of bleeding. She further indicated a physician's order would be needed to change any tube. The NP stated it was out the nurse's scope of practice to replace a tube without a physician's order.

An interview with the Medical Director was completed on 4/23/25 at 11:47 AM. The Medical Director stated that it was totally inappropriate for a nurse to replace a j-tube in the facility. She further stated that since the tube was surgically inserted on 1/10/25 the site was probably not mature (a jejunostomy site needs to mature to form a stable track between the skin and the jejunum [small intestine] to prevent leakage of intestinal contents and this takes approximately 4 weeks) and there would be higher risk for bowel perforation, the tissue would be more friable (tissue that is easily irritated, which makes it more prone to inflammation, bleeding, and tearing) and cause more bleeding, and the fact that he was on an anticoagulant would definitely increase the risk of bleeding. There was definitely a high likelihood of harm due to risk or sepsis, bleeding, and perforation.

An interview was completed with the Administrator on 4/24/25 at 9:35 AM. The Administrator stated he expected the nursing staff to follow the facility's policies and procedures regarding feeding tubes.

The Administrator was notified of immediate jeopardy on 4/23/25 at 4:00 PM.

The Administrator provided the following credible

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allegation of Immediate Jeopardy removal:

Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On January 25, 2025, the facility failed to ensure Resident #1 was provided with the necessary treatment to replace his dislodged jejunostomy tube (a tube surgically placed feeding tube that delivers nutrition and medications directly into the small intestine). Nurse #1 did not identify the need for hospital treatment to replace the dislodged j-tube and she inserted an indwelling urinary catheter tube to replace the j-tube. The tube then became dislodged a second time on January 25, 2025, and Nurse #1 sent the resident to hospital for reinsertion. Surgical Residents were able to place an indwelling urinary catheter tube into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on January 27, 2025, but were not able to place. Resident #1 went to the Operating Room (OR) on the evening of January 27, 2025, and the j-tube was successfully placed. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28, 2025.

On April 23, 2025, the Director of Nursing (DON) reviewed all residents that resided in the facility from January 25, 2025, until April 23, 2025, and no additional residents were identified with a j-tube in the facility at this time.

Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers will provide education to Licensed Nurses on Enteral Feeding Tube(s) Policy, to include what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of the j-tube, and sending the resident to the hospital for surgical reinsertion. Training will be completed by April 24, 2025. The Director of Nursing will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff or PRN staff will be re-educated prior to returning to duty by the DON or ADON. New hires and Agency Nurses will be educated by the Director of Nursing or Assistant Director of Nursing during the orientation process.

Effective April 24, 2025, the DON or ADON will review all new admissions in the Clinical Morning Meeting on Monday through Friday, as well as any pending weekend admissions, to determine if any admissions have a j-tube present and ensure all Licensed Nursing staff are made aware of the presence of a j-tube and the process for physician notification and treatment if a j-tube becomes dislodged. Licensed nurses will be made aware of residents that are admitted with a j-tube via the Admission Notification Form that is provided by the Admission Director for all pending admissions. Admission Notification Form will be delivered to the admitting nurse with the hospital discharge summary by the Admission Director prior to resident arrival.

Alleged immediate jeopardy removal date: April

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AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 36 25, 2025 The immediate jeopardy removal plan was validated on 4/24/25. The audit of 100% of residents with feeding tubes verified there were no other residents with j-tubes identified. The education sign in sheets were reviewed for the in-services conducted with the nurses on 4/23/25 and 4/24/25 regarding enteral feeding tubes policy and what to do if a j-tube becomes dislodged. Staff interviews confirmed education on gastrostomy tubes, j-tubes, and what to do if a jejunostomy becomes dislodged. The DON stated on 4/24/25 at 12:22 PM stated that effective 4/24/25 the DON or ADON will review all new admissions in the Clinical Morning Meeting on Monday through Friday, as well as pending weekend admissions, to determine if any admissions have a j-tube present and ensure all licensed nursing staff are made aware of the presence of a j-tube and the process of physician notification and treatment if a j-tube becomes dislodged. The facility's immediate jeopardy removal date of 4/25/25 was validated.	F 693		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		5/14/25

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F 726	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 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 was a gastrostomy tube (tube placed in the stomach for nutritional support). Replacing a j-tube requires radiographic (x-ray) guidance or surgical placement and Nurse #1 performing this action at the facility created a high likelihood of Resident #1 suffering serious harm from the risks	F 726	The facility failed to ensure Nurse #1 was trained and competent to provide the necessary care and treatment for residents with jejunostomy tubes (j-tubes). Nurse #1 did not identify the need for hospital treatment to replace Resident #1's dislodged j-tube and she inserted a foley catheter to replace the tube. Surgical residents were able to place a foley in the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on January 27, 2025 and the j-tube was successfully placed. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28,	

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F 726	Continued From page 38 of placing the j-tube in the wrong place, perforation of the small intestine, sepsis (life-threatening infection), and bleeding due to anticoagulant (blood thinner) use. This deficient practice was identified for 1 of 3 nurses reviewed for competency. Immediate jeopardy began on 1/25/25 when Nurse #1 failed to demonstrate competency to care for a resident with a j-tube when she replaced Resident #1's dislodged j-tube with an indwelling urinary catheter tube. Immediate jeopardy was removed on 4/25/25 when the facility 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: This Tag is cross referenced to: F693: Based on record review, Nurse Practitioner (NP), Medical Director, staff, and Responsible Party (RP) interviews, the facility failed to ensure a resident (Resident #1) was provided with the necessary treatment to replace his dislodged jejunostomy tube (a surgically placed feeding tube that delivers nutrition and medications directly into the small intestine). On 1/25/25, Nurse #1 did not identify the need for hospital treatment to replace the dislodged jejunostomy tube (j-tube) and she inserted an indwelling urinary catheter tube to replace the j-tube without a physician's order. The replacement tube	F 726	2025. All residents with j-tubes are at risk for same deficient practice. On April 23, 2025, the Director of Nursing (DON) reviewed all residents that resided in the facility from January 25, 2025 until April 23, 2025 and no additional residents were identified with a j-tube in the facility at this time. Prevention to ensure deficient practice does not occur again: The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Unit Managers will provide education to Licensed Nurses on Gastrostomy Tube Reinsertion Policy to include what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of the j-tube and risks and sending the resident to the hospital for surgical insertion. New hires and agency nurses will be educated by the DON and ADON during the orientation process using the Gastrostomy Tube Reinsertion Policy and what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of the j-tube with risks and sending the resident to the hospital for surgical reinsertion. Ongoing Compliance Monitoring: DON/designee will interview 5 nurses weekly x 12 weeks to validate understanding of how to handle a dislodged j-tube. Results of interviews will be reported in QAPI meeting monthly x 3 months by DON.	

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became dislodged from the j-tube site on 1/25/25, and Nurse #1 sent the resident to the hospital for reinsertion. Resident #1 went to the Operating Room (OR) on the evening of 1/27/25 and the j-tube was successfully placed. This noncompliance created a high likelihood of Resident #1 suffering serious harm from the risks of placing the j-tube in the wrong place, perforation of the small intestine, sepsis (life-threatening infection), and bleeding due to anticoagulant (blood thinner) use. This deficient practice was identified for 1 of 3 residents reviewed for feeding tubes.

Review of Nurse #1's employee record verified she was hired by the facility on 1/10/25 as an agency licensed practical nurse (LPN). There was no evidence of competency and training regarding j-tubes in her file.

Review of the facility training for agency nurses did not identify specific training and competency for j-tubes.

An interview was completed with Nurse #1 on 1/23/25 at 10:00 AM. Nurse #1 stated she was an experienced nurse, and she had completed training regarding gastrostomy tubes and jejunostomy tubes at other facilities she had worked at. She further stated she did not recall completing training specifically regarding j-tubes when she was in orientation at this facility.

An interview was completed with the Director of Nursing (DON) on 4/23/25 at 4:10 PM. The DON stated the agency was responsible for verifying a nurse's training and competencies prior to employment by the facility. She indicated the facility's orientation for agency nurses did not

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include specific competency and training for j-tubes at the time of Nurse #1's employment.

The Administrator was notified of immediate jeopardy on 4/23/25 at 4:00 PM.

The Administrator provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to ensure Nurse #1 was trained and competent to provide the necessary care and treatment for residents with jejunostomy tubes (j-tubes). Nurse #1 did not identify the need for hospital treatment to replace Resident #1's dislodged j-tube and she inserted an indwelling urinary catheter tube to replace the tube. Surgical Residents were able to place an indwelling urinary catheter tube into the tract in the Emergency Room (ER). Interventional Radiology (IR) attempted placement on January 27, 2025 but were not able to place. Resident #1 went to the Operating Room (OR) on the evening of January 27, 2025 and the j-tube was successfully placed. Resident #1 returned to the facility on February 4, 2025. During the remainder of Resident #1's time at facility, the j-tube did not dislodge again. Resident #1 was discharged from the facility on March 28, 2025.

On April 23, 2025, the Director of Nursing (DON) reviewed all residents that resided in the facility from January 25, 2025 until April 23, 2025 and no additional residents were identified with a j-tube in the facility at this time.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers will provide education to Licensed Nurses on Gastrostomy Tube Reinsertion Policy, to include what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of the j-tube and risks and sending the resident to the hospital for surgical reinsertion. A quiz was created to validate staff understanding of the material that was taught. Any nurse that cannot answer the quiz questions appropriately will be retrained by the DON or ADON on the material. Training will be completed by April 24, 2025. The Director of Nursing will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff or PRN staff will be re-educated prior to returning to duty.

New hires and Agency Nurses will be educated by the DON or ADON during the orientation process using the Gastrostomy Tube Reinsertion Policy. The quiz will be given at the end of their training to validate understanding on what to do if a j-tube becomes dislodged to include physician notification, not to attempt reinsertion of the j-tube and risks and sending the resident to the hospital for surgical reinsertion.

Alleged immediate jeopardy removal date: April 25, 2025.
The immediate jeopardy removal plan was validated on 4/24/25. The audit of 100% of

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F 726	Continued From page 42 residents with feeding tubes verified there were no other residents with j-tubes identified. The educations sign in sheets were reviewed for in-services conducted with the nurses on 4/23/25 and 4/24/25 regarding the facility's "Gastrostomy Tube Reinsertion Policy" which included education regarding what to do if a j-tube becomes dislodged including physician notification, not attempting reinsertion of the j-tube, risks involved in reinsertion, and sending the resident to the hospital for surgical reinsertion. Staff interviews confirmed education and a quiz on gastrostomy tubes, j-tubes, and what to do if a jejunostomy becomes dislodged. The validation quizzes were reviewed with no concerns. The DON stated on 4/24/25 at 12:22 PM that all the nurses, including new hires and agency nurses, would have to pass the validation quiz for competency regarding feeding tubes. The facility's immediate jeopardy removal date of 4/25/25 was validated.	F 726		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		5/14/25

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F 757	Continued From page 43 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and the Medical Director's interviews the facility failed to hold a fast-acting insulin (insulin that begins working within 15 minutes after administration) as ordered by the physician for a blood sugar level less than 150. Resident #4 was administered 2 units of sliding scale insulin with a blood sugar of 103. This occurred for 1 of 1 resident (Resident #4) reviewed for unnecessary medications. Findings included. Resident #4 was admitted to the facility on 1/6/25 with diagnoses including diabetes. A physician's order for Resident #4 dated 1/6/25 and discontinued on 1/31/25 revealed Humulin R Regular insulin U-100 insulin 100units per milliliter. Administer per sliding scale as follows: No sliding scale coverage for blood sugar less than 150. The Minimum Data Set (MDS) admission assessment dated 1/12/25 revealed Resident #4 was nonverbal and unable to assess cognition. He received insulin. Review of the Medication Administration Record (MAR) dated January 2025 for Resident #4	F 757	The survey findings, including the insulin administration to resident #4 that was administered outside of the written ordered parameters, were reported the Medical Director on May 13, 2025. Resident #4 is no longer in the facility. On April 30, 2025 the Regional Director of Clinical Services reviewed the April Medication Administration Record for all current residents receiving insulin and reported all omissions to the provider on May 1, 2025. There were no new orders from the provider. Education was provided by the Assistant Director of Nursing to all nurses on following physician orders and medication administration by May 11, 2025. A determination was made on May 12, 2024 to monitor medication administrations and review the audits monthly in the Quality Assurance Performance Improvement Committee meeting. To ensure ongoing compliance the Director of Nursing or designee will conduct three medication administration observations a week for 12 weeks. The	

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F 757	Continued From page 44	F 757		

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.

During a phone interview on 4/23/25 at 9:10 AM Nurse #1 stated she administered insulin to Resident #4 in error on 1/25/25. She stated on 1/25/25 she checked Resident #4's blood sugar and recalled his blood sugar was in the low 90's or 100's, and she told his family who were in his room at the time that he would not need the sliding scale insulin. She stated she went back to the medication cart and three nurse aides approached her with problems which distracted her. She then drew up 2 units of insulin and administered it to Resident #4. Once she administered the insulin the family stated they thought he didn't need insulin, and she realized then that he wasn't supposed to get the 2 units that she had just administered. She stated she checked Resident #4's blood sugar following the medication error and his blood sugar remained stable. She stated she reported the medication error to the Director of Nursing (DON) that day. Nurse #1 stated if she documented 0 units administered then it was signed in error because she did give 2 units of insulin at 11:00 AM on 1/25/25. She stated she worked until 7:00 PM on that date and Resident #4 never had any signs or symptoms of low blood sugar. She stated the insulin was administered in error.

During a phone interview on 4/23/25 at 11:55 AM the Medical Director stated administering 2 units of sliding scale insulin would not cause Resident #4 any harm and there were no reports made to her of concerns with his insulin or his blood sugar. She indicated if Resident #4 had

observations will be reviewed monthly in QAPI for 3 months.

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F 757	Continued From page 45 experienced any negative outcome from receiving insulin when it was not needed she would have wanted to be notified but there had been no reported concerns. She stated the physician orders for administering sliding scale insulin should have been followed. During an interview on 4/23/25 at 2:00 PM the Director of Nursing (DON) stated she was made aware of the medication error by Nurse #1 on 1/25/25. She stated Nurse #1 was no longer employed with the facility and she had been unable to contact Nurse #1 since that time. She stated Nurse #1 should not have administered Resident #4 sliding scale insulin with a blood sugar reading less than 150. She stated Resident #4 did not experience any negative outcome from receiving the insulin in error. She indicated since that time she had provided education to staff regarding medication administration and further education would be provided.	F 757		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff, the Nurse Practitioner and Physician interviews, the facility failed to obtain an ordered urinalysis and culture	F 770	The provider was notified on May 10, 2025 that the urinalysis ordered on April 15, 2025 for resident #3 was not	5/14/25

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F 770	Continued From page 46 and sensitivity (a urine test obtained to identify the presence of bacteria. A urine culture identifies the presence and type of bacteria causing an infection. Sensitivity tests determine which antibiotics are effective against the bacteria) for a resident experiencing symptoms of burning, urgency and decreased urinary output for 1 of 1 resident (Resident #3) reviewed for laboratory services. Findings included. Resident #3 was admitted to the facility on 4/10/25 with diagnosis including chronic kidney disease. A physician progress note dated 4/15/25 revealed Resident #3 was assessed due to suspected urinary tract infection due to dysuria (painful urination), urinary frequency and urgency. The plan of care was to test a urine culture to evaluate for urinary tract infection. A physician's order dated 4/15/25 at 11:07 AM was entered by Nurse #4 for Resident #3 to obtain a urinalysis and culture and sensitivity for evaluation of urinary tract infection due to complaints of dysuria, frequent urination, and urgency. A physician's order dated 4/15/25 at 11:12 AM for Resident #3 revealed Cephalexin (antibiotic) 500 milligrams (mg) three times a day due to possible urinary tract infection and dysuria. A nursing progress note dated 4/15/25 at 6:32 PM written by Nurse #4 indicated a urinalysis and culture and sensitivity test was pending to rule out a urinary tract infection. Resident #3 complained	F 770	collected. No new orders. Resident #3 is no longer at the facility. On May 9, 2025 the DON/designee reviewed all urinalysis orders since April 1, 2025 to ensure the urinalysis was completed as ordered and reported to the provider. There were two addition urinalysis that were not collected. The findings were reported to the provider on May 10, 2025 with no new orders. Education will be provided by the DON/designee to all nurses on following physicians orders completing urinalysis timely and reporting the findings to the provider by 5/9/2025. The DON/designee will review all new orders 5x week for 12 weeks to ensure all urinalysis orders are followed and the results are given to the provider for review. Any issues identified will be reported to the provider and re-education will be provided to the nurse. The facility made a determination to monitor urinalysis collection and submit the results to the QAPI team on April 12, 2025. The QAPI team will review the audits monthly for 3 months.	

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of burning, urgency and a small amount of urine output. An antibiotic was started according to the physician's order.

The Minimum Data Set (MDS) admission assessment dated 4/16/25 indicated Resident #3 had moderately impaired cognition and was frequently incontinent of bowel and bladder.

A Nurse Practitioner note dated 4/22/25 indicated Resident # 3 remained on antibiotics for suspected urinary tract infection with complaints of intermittent discomfort with urination. The Nurse Practitioner indicated that Resident #3 had a suspected urinary tract infection due to dysuria, urinary frequency, and urgency.

Review of Resident #3's electronic medical record from 4/15/25 through 4/24/25 revealed no results from the urinalysis and culture and sensitivity report.

During an interview on 4/24/25 at 12:15 PM the Nurse Practitioner stated a urinalysis with culture and sensitivity was ordered for Resident #3 on 4/15/25 by Physician #2. She stated they did not get the lab results back and then discovered on 4/23/25 that the urine sample was still in the refrigerator in the facility and was never picked up by lab services. She stated the nurse who obtained the urine sample (Nurse #4) told her she did obtain the urine sample from Resident #3 via urinary catheterization on 4/15/24. She stated the urinalysis should have been obtained and sent to the lab when the order was written. She stated Resident #3 continued with mild symptoms, but he did not want to be catheterized again at this time. The plan now was to reevaluate Resident #3 on Monday 4/28/25 and a urinalysis would be

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obtained at that time if needed.

During an interview on 4/24/25 at 12:30 PM Nurse #4 stated she received the order for the urinalysis on 4/15/25 and collected the urine sample from Resident #3 that day. She stated she entered the information into the electronic medical record and into the lab services website. She indicated that she did not recall if she recorded it in the lab book for pick up.

During an interview on 4/24/25 at 1:00 PM the Unit Manger stated Resident #3's urine sample was obtained on 4/15/25 by Nurse #4 and the order was entered into the electronic medical record and into the lab services database to collect the urine. She stated the process included that once the order was entered into the residents medical record by the nurse, the nurse then had to enter the order into the lab services website and print a requisition form (informs the lab of what tests to perform) and then record it in the lab book which was kept at the nurses station. When the lab company comes to the facility they review the lab book to determine what needed to be collected. She stated the breakdown was that the order was not entered into the lab book therefore the lab did not pick up the urine sample. She indicated she usually checked the lab book to ensure the labs were recorded. She stated it was done in error.

During an interview on 4/24/25 at 2:00 PM the Director of Nursing stated she was not aware of the urine sample obtained for urinalysis not being picked up from the lab for Resident #3. She stated a process was in place for obtaining labs and the process was not followed. She stated once the lab order was entered into the resident's

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F 770	Continued From page 49 medical record it also had to be written in the lab book and that was not done. She stated education would be provided. During an interview on 4/24/25 at 3:00 PM Physician #2 stated she was made aware of the urinalysis not being collected today. She indicated there had been no significant outcome from not obtaining the urinalysis with culture and sensitivity. She stated Resident #3 remained on antibiotics for urinary tract infection and she expected lab orders to be entered correctly, and results made available and that was not done.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records,	F 842		5/14/25

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 51 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete and accurate medical records for 2 of 11 residents whose medical records were reviewed (Resident #1 and Resident #4). Findings included. 1.) Resident #1 was admitted to the facility on 1/14/25. The physician's orders for Resident #1 revealed orders dated 1/14/25 for: - a jejunostomy tube (a surgically placed feeding tube that delivers nutrition and medications directly into the small intestine) 16 French (size) - tube feeding at a continuous rate of 70 milliliters (ml) an hour for 22 hours to allow for activities of daily living - amlodipine (used to treat high blood pressure) 5 milligrams (mg) tablet per feeding tube, once a day for hypertension (high blood pressure) - cetirizine 10 mg tablet once a day per feeding tube for seasonal allergies - apixaban 5 mg tablet twice a day per feeding tube for anticoagulant (blood thinner) - loratadine 10 mg tablet once a day for allergies The January 2025 Medication Administration Record (MAR) for Resident #1 listed Eliquis, Loratadine, Amlodipine, and Cetirizine as administered via j-tube by Nurse #1 on 1/25/25 during the 7:00 AM to 11:00 AM medication pass.	F 842	Progress notes were entered in the EMR for #1 and #4 by the RDCS (Regional Director of Conical Services) documenting the errors. Completed on 5/9/2025. On 5/8/2025 the ADON observed all nurses that were currently in the community administer medications to at least one resident to ensure the documentation was an accurate reflection of the medication administration. The DON/designee will educate all nurses on medical record accuracy with emphasis on MAR accuracy by 5/9/2025. In addition, the DON/designee will observe each nurse administer medications to at least one resident to ensure the medication administration is consistent with the nurse documentation. The education and competencies will be completed by 5/9/2025. To ensure ongoing compliance the DON/designee will observe 3 nurses administer medications to at least one resident weekly for 12 weeks to ensure the medical records are accurate. The audits will be reviewed by the QA team monthly for 3 months.	

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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, respiratory evaluation, cardiovascular evaluation, abdominal/gastrointestinal (GI) evaluation, Genitourinary/Urine evaluation, skin evaluation, pain evaluation, neurological evaluation, and care 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

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4/23/25 at 10:00 AM. Nurse #1 stated she was the nurse assigned to care for Resident #1 on 1/25/25 when his j-tube became dislodged. She further stated the residents she was assigned to care for that day were high acuity (residents requiring closer monitoring and treatments with i.e. tracheostomy tubes, feeding tubes, wounds) and she had not completed the documentation related to the incident. Nurse #1 indicated that the Director of Nursing (DON) called her multiple times to return to the facility to complete the paperwork, but she never went back to the facility. Nurse #1 also stated she did not administer Eliquis, Loratadine, Amlodipine, and Cetirizine to Resident #1 on 1/25/25 during the 7:00 AM to 11:00 AM medication pass. She stated that she must have checked the medications off on the MAR as administered when she pulled them from the medication cart, but she did not administer the medications.

An interview with the DON was completed on 4/23/25 at 4:00 PM. The DON stated she tried to call Nurse #1 multiple times to get her to come back to the facility to complete the paperwork regarding Resident #1's transfer to the hospital, but she never came back. She indicated she expected the nursing staff documentation to be complete and accurate.

2.) Resident #4 was admitted to the facility on 1/6/25 with diagnoses including diabetes.

A physician's order for Resident #4 dated 1/6/25 and discontinued on 1/31/25 revealed Humulin R Regular insulin U-100 insulin 100units per milliliter. Administer per sliding scale as follows: No sliding scale coverage for blood sugar less than 150.

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Review of the Medication Administration Record (MAR) dated January 2025 for Resident #4 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.

During a phone interview on 4/23/25 at 9:10 AM Nurse #1 stated she administered insulin to Resident #4 in error on 1/25/25. She stated on 1/25/25 she checked Resident #4's blood sugar and recalled his blood sugar was in the low 90's or 100's. She stated she went back to the medication cart and three nurse aides approached her with problems which distracted her. She then drew up 2 units of insulin and administered it to Resident #4. Once she administered the insulin the family stated they thought he didn't need insulin, and she realized then that he wasn't supposed to get the 2 units that she had just administered. Nurse #1 stated if she documented 0 (zero) units administered then it was signed in error because she did give 2 units of insulin at 11:00 AM on 1/25/25. She stated she should have documented that 2 units of insulin was administered to Resident #4.

During an interview on 4/23/25 at 2:00 PM the Director of Nursing (DON) stated she was made aware of the medication error by Nurse #1 on 1/25/25. She stated Nurse #1 should not have administered Resident #4 sliding scale insulin with a blood sugar reading less than 150 and she was not aware that she documented in error on the MAR. She stated Nurse #1 should have documented on the MAR that she administered 2 units of insulin to Resident #4. She indicated education would be provided regarding accurately documenting in the medical record.

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		5/14/25

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F 880	Continued From page 56 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to residents. Nurse #2 and Nurse #3 provided tracheostomy (an opening surgically created in the neck to insert a tube into the trachea (windpipe) allowing for air to enter the lungs directly) care which included tracheal suctioning (a procedure to remove excess secretions from the airway). Nurse #2	F 880	The facility failed to implement enhanced 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 symptoms of infection were identified. All residents with an enteral tube or a	

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F 880	Continued From page 57 also administered a tube feeding through a gastrostomy tube (a feeding tube placed directly into the stomach). The nurses donned gloves and a mask but no gown during the procedures. This occurred for 2 of 2 staff members (Nurse #2, and Nurse #3) who were observed for infection control practices. Findings included: The facility's Infection Control Policy revised 03/15/25 revealed Enhanced Barrier Precautions (EBP) were intended to prevent transmission of multi-drug-resistant organisms (MDRO's) via contaminated hands and clothing to high-risk residents. Enhanced Barrier Precautions were indicated for high contact care activities for residents with chronic wounds or indwelling devices such as tracheostomies and gastrostomy tubes. 1.) A blue Enhanced Barrier Precautions (EBP) sign was noted outside Resident #2's door. The sign read in part, "Perform hand hygiene with alcohol based handrub (ABHR) or wash with soap and water before entering and leaving room ...Wear gown and gloves for the following High Contact Resident Care Activities which include: Dressing, bathing/showering, Transferring, changing linens, changing briefs or assisting with toileting, and Device care or use; central lines, urinary catheter, feeding tubes, tracheostomy, Wound care: any skin opening requiring a dressing. An observation of Nurse #2 performing tracheostomy (a surgically created hole through the neck into the trachea (windpipe) to allow air to	F 880	tracheostomy were assessed by the ADON on 5/2/25 to ensure they had no symptoms of an infection that may be a result of improper protective equipment. Education was provided to all staff on Enhanced Barrier Precautions and Personal Protective Equipment by the ADON by May 11, 2025. The DON/designee will observe care 5xweek for 12 weeks for residents that require EBP to ensure appropriate PPE is being utilized. The determination was made on May 12, 2025 that personal protective equipment would be monitored for residents requiring Enhanced Barrier Precautions. The audits will be reviewed by the QAPI team monthly for 3 months.	

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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 educated multiple times in the last 6 months involving Enhanced Barrier 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) occurred on 4/24/25 at 9:20 AM. The DON stated

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Nurse #2 was supposed to follow the Enhanced Barrier Precautions while performing tracheostomy suctioning and bolus tube feeding. She further stated Nurse #2 should have been wearing a gown while performing hands on care for a resident with a tracheostomy and a feeding tube. The DON indicated she expected the nursing staff to follow the facility's infection control policies and procedures while performing care for the residents. She stated the facility needed to continue conducting audits and providing education to the nursing staff.
2.) During an observation on 4/22/25 at 5:00 PM Nurse #3 was observed providing tracheostomy care including performing tracheal suctioning to Resident # 5. Nurse #3 was wearing gloves, and a mask but no gown while providing direct care. A sign was located outside of the residents room indicating Resident #5 was on Enhanced Barrier Precautions and to don gloves, gown, and a mask prior to performing direct care activities. A supply cart with gowns and gloves was located outside of Resident #5's room.

During an interview on 4/22/25 at 5:00 PM Nurse #3 stated she should have put on a gown along with the gloves and mask before providing Resident 5#'s tracheostomy care. She stated she had received education on Enhanced Barrier Precautions and using personal protective equipment. She stated it was done in error.

During an interview with the Infection Control Preventionist Nurse on 4/23/25 at 11:00 AM she stated Resident #5 was on Enhanced Barrier Precautions due to having a tracheostomy. She indicated a sign was located outside of Resident #5's room along with a supply cart. She stated the nurses had received education on Enhanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 04/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60 Barrier Precautions and donning personal protective equipment (PPE) and were aware of the policy. She stated further education would be provided. During an interview on 4/24/25 at 2:00 PM the Director of Nursing (DON) stated staff had been trained on Enhanced Barrier Precautions and were aware that personal protective equipment including gloves, gown, and masks were required when providing direct care such a tracheostomy care. She stated Nurse #3 should have donned a gown along with gloves and a mask prior to providing care. She stated education would be provided.	F 880		