STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Wilmington	820 Wellington Avenue Wilmington, NC 28401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on record review, and staff, family and physician interviews, the facility failed to obtain orders from a Pulmonologist for the appropriate setting for a resident's (Resident #189) Continuous Positive Airway Pressure (CPAP) machine (used as a type of ventilator with diagnoses of obstructive sleep apnea; a health condition that causes brief pauses in breathing during sleep) upon resident's admission and during the resident's stay at the facility for 8 days. This was for 1 of 1 resident reviewed that utilized a CPAP machine. Findings included: Review of the discharge summary from the hospital Resident #189 was discharged from on 11/23/24 revealed there were no orders written for Resident #189 for a CPAP machine. Resident #189 was admitted to the facility on [DATE] and discharged to the hospital on 12/02/24. Diagnoses included, in part, obstructive sleep apnea (OSA). The admitting physician orders revealed there were no orders written for CPAP use. The physician orders dated 11/23/24 included: Advair discus 100-50 microgram (mcg) per dose - 1 inhalation orally one time daily for shortness of breath Albuterol Sulfate 108 mcg - 2 puffs inhale orally every 4 hours as needed for shortness of breath or wheezing Albuterol Sulfate 2.5 milligrams (mg) /3 milliliters (ml) 0.083% nebulization solution inhale 3 ml by mouth every 6 hours as needed for bronchospasm Spiriva Respimat 2.5 mcg -1 inhalation inhale orally twice a day for shortness of breath. A nursing note written on 11/23/24 by Nurse #4 revealed Resident was alert and oriented and was able to make all his needs known with clear speech. Resident was aware of his medication list and vital signs were stable. Resident vocalized no discomforts. Nurse will ask for an order for resident's CPAP that he brought from home. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was attempted with Nurse #4 who wrote the nursing note on 11/23/24 regarding obtaining an order for the resident's CPAP that he brought in from home. A voicemail message and text message were left for a returned call on 05/15/25 at 9:48 AM. Nurse #4 did not respond to voicemail message or text message. Review of Resident #189's care plan dated 11/23/24 revealed a plan of care was in place for altered respiratory status related to obstructive sleep apnea, shortness of breath, and bronchospasm (constriction of the smooth muscle layers of the small airways that can cause swelling or irritation of the airway). Interventions included administering medications as ordered and monitor, elevate head of bed to prevent shortness of breath, pace and schedule activities providing rest periods. There was no plan of care in place for the use of a CPAP machine. Review of a hand written form titled Resident Personal Possessions Inventory dated 11/23/24 under the clothing and shoes section the following was included: 1 pair of shoes, 3 bibs, 8 shirts, 9 pair of pants, 1 underwear, 9 socks, 3 tanks. In the equipment section of the form the list included a knee Brace, phone and charger. In the other personals section, the list included CPAP, electric razor, shoe horn and wedge. The form was not signed by staff or resident. A physician note written on 11/27/24 revealed, in part, resident was feeling okay overall and denied any shortness of breath. Resident knew his history and had been asking about his prescribed medications. Resident stated he had obstructive sleep apnea and has a CPAP machine next to his bed but did not use it last night because it was too far away for him to reach. Resident stated he has had the same settings on his CPAP for four years and used the machine while in hospital with no changes. Will recommend he start CPAP at night. The Minimum Data Set admission assessment dated [DATE] revealed Resident #189 was alert and cognitively intact. Resident #189 was coded as having shortness of breath and required extensive assistance with one staff physical assistance with bed mobility, and supervision with two staff physical assistance with transfers. A physician note written on 11/29/24 revealed, in part, resident stated he has not used his CPAP as yet. Discussed CPAP issue with nursing and they will be getting a hold of resident's pulmonary doctor to see what his settings are supposed to be. Resident denied any current shortness of breath or complaints of pain. Resident stated he has had same settings for four years and used the CPAP machine while in the hospital with no changes. Will recommend he start CPAP at night and discussed with nursing to reach out to his pulmonary doctor. Review of the hospital emergency room (ER) admission note on 12/02/24 revealed the resident presented with increased confusion. Resident had a history of sleep apnea and reportedly uses CPAP at night but did not use it last night (12/01/24). The emergency note indicated that the facility reported resident was refusing CPAP, resident reported facility denied giving CPAP. Under the Past Medical History section of the ER note sleep apnea was listed as a diagnosis with a sentence in italics pt. states that he does not wear CPAP. There were no other notes regarding use of CPAP at this local hospital. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Physician who wrote the progress notes on 11/27/24 and 11/29/24 on 05/14/25 at 11:20 AM. The Physician stated that anytime a resident was on a CPAP machine, the settings for the CPAP had to be ordered by a Pulmonologist. The Physician stated the nursing staff had called the pulmonologist and were waiting to hear back from the office to get the settings so that the order could be entered. The Physician stated he was not able to set the settings and although Resident #189 was aware of the settings for his CPAP, the settings needed to be confirmed with a pulmonologist. The Physician stated the nurses did their due diligence to obtain the settings. The Physician stated Resident #189 was discharged to the hospital for acute kidney injury and it was not related to not using his CPAP. The Physician also added that the resident was known to be non-compliant with the CPAP. The Physician stated when the resident was sent to the local hospital on 12/02/24 there were notes indicating that he was non-compliant. An interview with a family member via phone on 05/14/25 at 2:44 PM stated Resident #189 was using the CPAP machine at the hospital prior to his admission to the facility and he was admitted to the facility with his CPAP machine. The family member stated whenever she visited, the CPAP machine was unplugged and Resident #189 stated he had not been using it. The family member stated Resident #189 had been using the CPAP for 4 years and used it every night. An interview was attempted with Nurse #6 who worked with Resident #189 on the night of 11/27/24 and 11/29/24. A voicemail message and text message were left for a returned call on 05/15/25 at 10:17 AM. Nurse #6 did not response to voicemail message or text message. An interview was conducted with the Unit Manager on 05/15/25 at 12:45 PM. The Unit Manager stated there were no orders for the residents' CPAP so the nursing staff could not allow the resident to use it. She stated there were no orders written on the discharge summary from the hospital. The Unit Manager stated she believed the resident was not admitted with the CPAP and that the family member had brought it in a couple days after Resident #189 was admitted . She stated the family member gave her the number to the Pulmonologist. The Unit Manager stated she tried to contact the Pulmonologist to get the settings for the CPAP machine and had left a message but no one returned her call. The Unit Manager stated she only tried one time to reach the Pulmonologist. She stated she did not remember who the Pulmonologist was, which day she tried to call or the phone number of the pulmonologist, but that it was in Onslow County. The Unit Manager stated she should have followed up with the pulmonology office, but the resident was discharged after only a short stay at the facility. An interview was conducted with the Director of Nursing on 05/15/25 at 4:30 PM. The Director of Nursing stated she believed that the family brought the CPAP in after the resident was at the facility for a few days and that he was not admitted with the CPAP. She stated she thought the nurses were making an effort to reach the Pulmonologist to get the settings for the CPAP machine and did not realize the Unit Manager only tried once. The DON stated she would have expected the nursing staff to follow up with the Pulmonologist until they obtained the settings for the CPAP.