

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER August Healthcare at Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Physician Assistant (PA) and Physician interviews, the facility failed to have a system in place to inform and provide written information to the residents/representatives pertaining to their right to accept or refuse medical/surgical treatment and to formulate an advanced directive (a form that indicates a resident's wish and what action to take for their health if the residents were no longer able to make their own decision) for 15 of 22 sampled residents (Resident #1, #21, #71, #80, #105, #126, #5, #11 #20, #55, #14, #17, #7, #10, and #43.) Findings included: A review of the facility Advanced Directives Policy dated 11/02/22 indicated that: Code status (an intervention if a resident's heart stops beating) shall be discussed with every resident or the resident's representative upon admission and readmission to the facility. The policy further stated that the nursing staff shall review existing advanced directives, DNR (do not resuscitate - no cardiopulmonary resuscitation if heart stops beating) orders, or other legally recognized documents. The admitting nurse shall notify the attending practitioner of the resident's code status. Advanced care planning discussions shall occur upon admission and re-admission, following a significant change in condition, following hospitalization, and upon request of the resident or resident representative. The policy indicated that the medical record shall include documentation of advanced care planning discussions. a. Resident #126 was admitted on [DATE]. A physician order dated 1/12/26 indicated Resident #126 was a Full Code (if a resident heart stopped beating, resuscitation would be done in an attempt to save the life). Resident #126's admission Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact. Resident #126's Full Code order was discontinued on 2/26/26. Review of Resident #126's electronic health record revealed that the resident was transferred to the emergency department on 2/26/26. A hospital Discharge summary dated [DATE] indicated that Resident #126's code status was Do Not Resuscitate (DNR). (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 2/27/26 indicated Resident #126 was a Do Not Resuscitate status. There was no indication in Resident # 126's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. b. Resident #21 was admitted on [DATE]. A physician order dated 2/14/25 indicated Resident #21 was a DNR status. Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a severe cognitive impairment. There was no indication in Resident # 126's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. c. Resident #1 was admitted on [DATE]. Review of Resident #1's physician orders revealed an order dated 12/11/25 which indicated the resident was a Full Code. Resident #1's quarterly MDS dated [DATE] indicated the resident had severe cognitive impairment. A Social Service progress note dated 5/29/26 indicated advanced directives were Do Not Resuscitate. An interview was conducted with Resident #1's Responsible Party (RP) on 7/16/26 at 9:50 AM. The RP stated that the facility did not discuss or provide information concerning formulating an advanced directive for the resident. There was no indication in Resident # 1's electronic medical record that the facility provided written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. d. Resident #71 was admitted on [DATE]. A physician order dated 7/5/24 indicated that Resident #71 was listed as DNR status. Resident #71's quarterly MDS dated [DATE] indicated the resident had a cognitive impairment. There was no indication in Resident # 71's electronic medical record that the facility provided written (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. An interview with the Director of Nursing (DON) was conducted on 07/15/26 at 9:15 AM. The DON stated that the facility relied on the medical documentation provided by the hospital to determine a resident's code status. She explained that the hospital's advanced directive documentation was referred to as the Golden Rod form—a goldenrod-colored document indicating that, in the event of cardiac and/or pulmonary arrest, cardiopulmonary resuscitation should not be initiated. The DON stated that the Golden Rod form was used by the facility to identify residents with a Do Not Resuscitate (DNR) status and was placed in the resident's medical record upon admission. The DON further stated that if a Golden Rod form was not sent with the admission paperwork, the facility assumed the resident's code status to be Full Code. An interview was conducted with the Physician on 07/15/26 at 12:45 PM. The Physician stated that he referred to the advanced directives from the hospital documentation and wrote and signed orders for the residents' code status as needed. The Physician stated that sometimes he would discuss advanced directives or goals of care with a resident or responsible party as needed. The Physician stated that sometimes the Social Worker informed him of the advanced directives and if orders were needed. An interview was conducted with Nurse #8 on 07/15/26 at 3:50 PM. Nurse #8 indicated that upon admission to the facility, the staff looked for a Golden Rod form and if the resident had one, this meant the resident's code status was Do Not Resuscitate. If the resident did not have a Golden Rod form, it meant the resident was a Full Code. Nurse #8 indicated that she was not sure who discussed advanced directives with a resident or the resident's representative but thought it was either the Social Worker, Physician Assistant or the Physician who discussed advanced directives. Nurse #8 stated the Golden Rod form would get placed in a book at the nurse's station and whenever the resident was discharged from the facility, the Golden Rod form would go along with them. An interview was conducted with the Physician Assistant (PA) on 07/16/26 at 10:45 AM. The PA stated she referred to the advanced directive order that was documented on the hospital record. The PA explained that if the resident was admitted with a Golden Rod form from the hospital, she assumed the resident wished to continue to be a DNR and she wrote the order in the electronic record for DNR status. The PA indicated that she considered the Golden Rod the resident's advanced directives and was unaware that further discussion or written information should be provided to the resident or representative. An interview with the Social Worker on 07/16/26 at 12:57 PM revealed that usually upon admission the residents were admitted with an advanced directive and he would go by what the hospital had written or the Golden Rod form. He stated if the resident was admitted with a Golden Rod form, he would upload the form on the computer. The Social Worker stated the Golden Rod form indicated the resident was a DNR and that form would go with the resident whenever they would go to the hospital or when they were discharged. The Social Worker stated if there was no documentation on the hospital record indicating what the code status of the resident was upon admission, then the Physician or Physician Assistant would speak with the resident with their initial visit. The Social (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Responsible Party (RP) interviews and Physician and Physician Assistant interviews, the facility failed to accurately document the administration of insulin when two Medication Aides (Medication Aide #1 and Medication Aide #2) signed the medication administration record which indicated they administered physician ordered insulin instead of the assigned Nurses (Nurse #11 and Nurse #1) for 1 of 5 residents (Resident #5) reviewed for unnecessary medications; failed to accurately document the completion of weekly skin assessments (Nurse #5); and when Medication Aide #3 documented in the electronic medical record that she had completed the weekly skin assessment instead of the assigned Nurse (Unit Manager #2) for 1 of 1 resident (Resident #43) reviewed for bilateral leg wounds; and failed to accurately document consent and education of the RP in advance of the risks and benefits of taking psychotropic medications (medications that alter mood, thoughts, feelings or behavior) for 1 of 5 residents (Resident #1) reviewed for unnecessary medications. Findings included: Resident #5 was admitted to the facility on [DATE]. Diagnoses included diabetes. a). Review of the July Medication Administration Record (MAR) revealed on 07/04/26, Medication Aide (MA) #1's initials were recorded indicating the administration of 5 units of insulin before meals at 8:00 AM, 11:30 AM, and 4:30 PM. On 07/04/26 at 8:00 AM Resident #5's blood sugar was recorded as 212 milligrams/deciliter (mg/dL). MA #1 signed off with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. On 07/04/26 at 11:30 AM Resident #5's blood sugar was recorded as 293 mg/dL. MA #1 signed off with her initials in the MAR indicating the administration of 4 units of insulin per the sliding scale. On 07/04/26 at 4:30 PM Resident #5's blood sugar was recorded as 204 mg/dL. MA #1 signed off with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. Review of the July MAR revealed on 07/05/26, MA #1's initials were recorded indicating the administration of 5 units of insulin before meals at 8:00 AM, 11:30 AM, and 4:30 PM. On 07/05/26 at 8:00 AM Resident #5's blood sugar was recorded as 208 mg/dL. MA #1 signed off with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. On 07/05/26 at 11:30 AM Resident #5's blood sugar was recorded as 219 mg/dL. MA #1 signed off with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. On 07/05/26 at 4:30 PM Resident #5's blood sugar was recorded as 210 mg/dL. MA #1 signed off (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. An interview was conducted with Medication Aide #1 on 07/17/26 at 11:15 AM. MA #1 stated that she did not actually administer the scheduled 5 units of insulin before each meal on 07/04/26 and 07/05/26 or the insulin given according to the sliding scale on 07/04/26 and 07/05/26, but she did sign off with her initials in the MAR instead of having Nurse #11 sign it off after Nurse #11 administered the insulin. MA #1 stated she should have signed out of the electronic record and Nurse #11 should have signed in under her name when she administered the scheduled 5 units of insulin and the sliding scale insulin so that her initials would have been recorded on the Medication Administration Record. Nurse #11 who worked on 07/04/26 and 07/05/26 was unavailable for an interview. b). Review of the July MAR revealed on 07/08/26, MA #2's initials were recorded indicating the administration of 5 units of insulin before meals at 8:00 AM, 11:30 AM, and 4:30 PM. On 07/08/26 at 4:30 PM Resident #5's blood sugar was recorded as 213 mg/dL. MA #2 signed off with her initials in the MAR indicating the administration of 2 units of insulin per the sliding scale. An interview was conducted with MA #2 on 07/16/26 at 11:52 AM. MA #2 stated she did not administer the scheduled 5 units of insulin or the insulin based on the sliding scale on 07/08/26. She stated Nurse #1 administered the insulin. MA #2 stated she should not have signed it off with her initials as it looked as though she administered the insulin. MA #2 stated she was told she could not leave any blank spots on the Medication Administration Record so she just signed the MAR off instead of signing out of the electronic record and having Nurse #1 sign into the electronic record so her initials would have been recorded after she administered the insulin. Attempted to interview Nurse #1 via text message on her phone on 07/16/26 at 1:31 PM and 07/17/26 at 11:11 AM. Nurse #1 received the text messages indicating she would call back, but she did not return the calls. An interview was conducted with the Director of Nursing (DON) on 07/17/26 at 11:42 AM. The DON stated the nurses should always be signing into the electronic record with their password anytime they are going to sign off a medication to accurately document with their initials the administration of a medication. The DON added the Medication Aides were leaving their screen accessed and signed the administration of the insulin for the nurses after the insulin was given. The DON stated the Medication Aides should not be signing off the administration of insulin and that was inaccurate documentation and looked as though they administered the insulin which was not within their scope of practice. The DON added that the assigned nurses needed to take the time to sign into the electronic record to ensure their initials would be recorded as given the medication. 2) Resident #43 was admitted to the facility on [DATE] with a most recent readmission on [DATE]. Record review showed Nurse #5 had documented on the Medication Administration Record that skin assessments had been completed for Resident #43 on 05/05/26, 05/19/26, and 07/07/26. However, (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, resident and Physician Assistant (PA) interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of taking psychotropic medications prior to the administration and/or dosage change of the medications for 3 of 5 residents reviewed for unnecessary medications (Resident #5, #1, #14). Findings included: 1). Resident #5 was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, depression and anxiety. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #5 was cognitively intact, demonstrated no behaviors, and received the following psychotropic medications: antipsychotic, antianxiety and antidepressant medications. Review of Resident #5's electronic health record revealed physician orders for the following psychotropic medications: Sertraline (a medication to treat depression) 50 milligrams (mg); one tablet once per day written on 08/28/25. This order was discontinued on 04/21/26. On 4/22/26, a physician order was written for Sertraline 100 mg; one tablet once per day. Lamictal (a medication to treat moods related to bipolar disorder) 25 mg; give one tablet daily written on 04/24/26. This order was discontinued on 05/20/26. On 05/21/26 a physician order was written for Lamictal 25 mg; give 2 tablets (50 mg) daily. Buspirone (a medication to treat anxiety) 5 mg; give two tablets (10 mg) daily written on 04/21/26. Review of a psychotropic medication informed consent form dated and signed by Resident #5 on 06/08/26 and completed by Nurse #8 revealed the following medications were recorded on the consent: Lamictal 25 mg. The correct order at the time this consent was signed was Lamictal 25 mg; 2 tablets daily = 50 mg., the Sertraline medication had no dose documented on the consent form. The correct order at the time this consent was signed was Sertraline 100 mg; one tablet daily, and Buspirone 5 mg. The correct order at the time this consent was signed was Buspirone 5 mg; give two tablets daily = 10 mg. The consent form indicated, in part, that no medication will be administered without resident being informed and written consent. The consent also indicated that alternative modes of treatment other than or in addition to the medications included a check mark under environmental or staff changes and use of behavior intervention techniques. Review of Resident #5's medication administration record for July 2026 revealed Resident #5 was receiving the psychotropic medications Lamictal, Sertraline and Buspirone as physician ordered. An interview with Resident #5 on 07/16/26 at 11:22 AM revealed he received a consent form for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER August Healthcare at Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Wellington Avenue Wilmington, NC 28401	
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications to sign about a month ago (he could not recall the exact date) but he did not recall any discussion about the medication dose changes. Resident #5 stated this was the first consent he was asked to sign regarding his medications since his admission. An interview with the Director of Nursing (DON) was conducted on 07/15/26 at 9:15 AM. The DON stated that there was a lot of staff turnover and some things in the facility such as the obtaining psychotropic consents had not been getting done. The DON stated that the psychotropic consents were now being completed by Nurse #8 who was recently hired. The DON indicated Nurse #8 was responsible for completing the education with the resident or responsible party regarding the psychotropic medication and discussing alternate treatments prior to the administration of the medication. The DON indicated that at this time, the expectation was that education would be provided by Nurse #8 regarding each psychotropic medication to include the current dose and alternate treatments prior to the medication being given to a resident and whenever there were any changes to the psychotropic medications, a new psychotropic consent would be completed. An interview with the Physician Assistant on 07/16/26 at 11:03 AM revealed that with any psychotropic medications, the residents should be educated about the risks verses benefits of the medications prior to administration so that the resident has an understanding of the effects of the medications. An interview with Nurse #8 on 07/16/26 at 2:00 PM revealed the psychotropic consent form should have been completed on 08/28/25 upon admission to the facility for Resident #5 and each psychotropic medication should have been discussed by the admitting nurse prior to administration of the medication to make sure Resident #5 understood the effects of each drug. Nurse #8 stated she started working at the facility in March 2026 and was responsible for obtaining psychotropic consents for any residents who were currently receiving psychotropic medications. Nurse #8 stated consents should be obtained prior to the administration of the psychotropic medications but that did not always happen. Nurse #8 added that when she obtained a consent for a resident or responsible party, she would inform them what the medication was, the dose of the medication, and how it was helping the resident and what would happen to the resident if it was discontinued. Nurse #8 stated she was unaware that a new psychotropic consent needed to be obtained if there were any changes to the psychotropic medications. 2. Resident #1 was admitted to the facility on [DATE] with diagnosis which included severe dementia with behavioral disturbance and anxiety. Review of Resident #1's electronic health record revealed physician orders for the following psychotropic medications: A physician order dated 1/29/26 for alprazolam (antianxiety medication) 0.5 milligrams (mg) twice per day for anxiety for 30 days. The order was discontinued on 2/16/26. A physician order dated 2/16/26 for alprazolam 0.25 mg twice daily for 30 days. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 2/23/26 for alprazolam 0.5 mg twice per day for anxiety. A review of the February 2026 electronic Medication Administration Record for Resident #1 revealed that the resident received the psychotropic medication alprazolam as ordered by the physician. A physician order dated 3/13/26 for quetiapine (antipsychotic medication) 12.5 milligrams (mg) every evening at 5:00 PM for dementia with behaviors. A review of the March 2026 electronic Medication Administration Record for Resident #1 revealed that the resident received the psychotropic medications alprazolam and quetiapine as ordered by the physician. A review of the April 2026 electronic Medication Administration Record for Resident #1 revealed that the resident received the psychotropic medications alprazolam and quetiapine as ordered by the physician. Review of a psychotropic medication informed consent form dated and signed by Resident #1's Responsible Party on 5/26/26 and completed by Nurse #7 revealed the following medications were recorded on the consent: alprazolam 0.5 mg and quetiapine 12.5 mg. The consent form indicated, in part, that no medication will be administered without resident being informed and written consent provided. The consent also indicated that alternative modes of treatment other than or in addition to the medications included a check mark under environmental or staff changes and use of behavior intervention techniques. A review of the May 2026 electronic Medication Administration Record for Resident #1 revealed that the resident received the psychotropic medications alprazolam and quetiapine as ordered by the physician. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was moderately cognitively impaired, demonstrated no behaviors and received the following psychotropic medications: an antipsychotic and antianxiety medications during the lookback period. A review of the July 2026 electronic Medication Administration Record for Resident #1 revealed that the resident received the psychotropic medications alprazolam and quetiapine as ordered by the physician. An interview was conducted with Nurse #7 on 7/15/26 at 2:42 PM. Nurse #7 stated that she had not completed a psychotropic consent form nor had she provided educational information regarding psychotropic medication to Resident #1's Responsible Party. Nurse #7 revealed that she was not aware of the requirement to complete education and consent with the resident or Responsible Party prior to the initial administration of a psychotropic medication. An interview with the Director of Nursing (DON) was conducted on 07/15/26 at 9:15 AM. The DON stated that there was a lot of staff turnover and some things in the facility such as the obtaining psychotropic consents had not been getting done. The DON stated that the psychotropic consents (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were now being completed by Nurse #8 who was recently hired. The DON indicated Nurse #8 was responsible for completing the education with the resident or responsible party regarding the psychotropic medication and discussing alternate treatments prior to the administration of the medication. The DON indicated that at this time, the expectation was that education would be provided by Nurse #8 regarding each psychotropic medication to include the current dose and alternate treatments prior to the medication being given to a resident and whenever there were any changes to the psychotropic medications, a new psychotropic consent would be completed by Nurse #8. An interview with the Physician Assistant on 07/16/26 at 11:03 AM revealed that with any psychotropic medications, the residents should be educated about the risks verses benefits of the medications prior to administration so that the resident has an understanding of the effects of the medications. An interview with Nurse #8 on 07/16/26 at 2:00 PM revealed that she started at the facility in March 2026 and was responsible for obtaining the consents for psychotropic medications. Nurse #8 stated that the psychotropic consent forms should be completed prior to the administration of the psychotropic medications but that did not always happen. Nurse #8 indicated that she worked only 4 days per week and was still trying to learn the electronic health record system. Nurse #8 added that when she obtained consent from a resident or responsible party, she would inform them what the medication was, the dose of the medication, and how it was helping the resident and what would happen to the resident if it was discontinued. Nurse #8 stated that she did not inform them of alternate treatment options. Nurse #8 stated she was unaware that a new psychotropic consent needed to be obtained if there were any changes to the psychotropic medications. An interview conducted via phone with Resident #1's Responsible Party (RP) on 7/17/26 at 10:48 AM revealed that the nursing staff had not discussed the psychotropic medications alprazolam and quetiapine with her. Resident #1's Responsible Party indicated that she recently asked one of the nurses, she did not recall which nurse, about Resident #1's medications and was informed that the resident was receiving alprazolam and quetiapine. The RP did not recall signing the consent form dated 05/26/26. 3. Resident #14 was admitted to the facility on [DATE] with diagnoses which included dementia with behavioral disturbance and anxiety. Review of Resident #14's electronic health record revealed physician orders for the following psychotropic medications: A physician order dated 2/23/26 for quetiapine 25 milligrams (mg) by mouth every 12 hours for compulsive behaviors and wandering related to Alzheimer's disease with late onset. A physician order dated 12/23/25 for lorazepam tablet 0.5 mg tablet by mouth two times a day related to anxiety disorder. A physician order dated 6/1/26 for lorazepam oral concentrate 2 mg per milliliter (ml) by mouth every (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6 hours as needed for anxiety. This order was discontinued on 7/3/26. A physician order dated 3/16/26 for mirtazapine tablet 7.5 mg give 2 tablets by mouth at bedtime for appetite stimulus. A physician order dated 12/16/26 for buspirone hydrochloride (HCl) 15 mg tablet by mouth two times a day for anxiety. A physician order dated 12/20/25 for sertraline HCl 100 mg tablet by mouth one time a day for anxiety. A review of the June 2026 electronic Medication Administration Record revealed the resident received the psychotropic medications mirtazapine, quetiapine, sertraline HCL, buspirone HCl, and lorazepam as ordered by the physician. A review of the July 2026 electronic Medication Administration Record for Resident #14 revealed the resident received the psychotropic medications mirtazapine, quetiapine, sertraline HCl, buspirone HCl, and lorazepam as ordered by the physician. Review of the electronic health record for Resident #14 did not reveal a consent form for psychotropic medications. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was severely cognitively impaired and displaced inattentive behavior and received the following psychotropic medications: antianxiety, antipsychotic, and antidepressant medications. An interview with Nurse #8 was completed on 7/15/26 at 3:43 PM. Nurse #8 revealed that she started at the facility in March 2026 as the Support Nurse, and she was responsible for obtaining the consents for psychotropic medications. Nurse #8 indicated that the consent form was on paper but was going to be on computer. She stated that if there was not a consent form on Resident #14's chart it must have been overlooked. Nurse #8 indicated that she worked 4 days per week and was still learning the computer health system. Nurse #8 added that when she obtained consent from a resident or responsible party, she would inform them what the medication was, the dose of the medication, and how it was helping the resident and what would happen to the resident if it was discontinued. Nurse #8 stated that she did not inform them of alternate treatment options. Nurse #8 stated she was unaware that a new psychotropic consent needed to be obtained if there were any changes to the psychotropic medications. An interview with the Director of Nursing (DON) was conducted on 07/15/26 at 9:15 AM. The DON stated that there was a lot of staff turnover and some things in the facility such as the obtaining psychotropic consents had not been getting done. The DON stated that the psychotropic consents were now being completed by Nurse #8 who was recently hired. The DON indicated Nurse #8 was responsible for completing the education with the resident or responsible party regarding the psychotropic medication and discussing alternate treatments prior to the administration of the medication. The DON indicated that at this time, the expectation was that education would be (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by Nurse #8 regarding each psychotropic medication to include the current dose and alternate treatments prior to the medication being given to a resident and whenever there were any changes to the psychotropic medications, a new psychotropic consent would be completed by Nurse #8. An interview via phone with Resident #14's Responsible Party (RP) on 7/16/26 at 10:09 AM revealed the RP was aware Resident #14 was receiving psychotropic medications. She explained that she was told the names of the medications, but they did not discuss the side effects associated with the antipsychotic. The RP indicated she had questions regarding the side effects and risks and benefits of taking an antipsychotic and she would be reaching out to the nursing staff for answers. An interview with the Physician Assistant on 07/16/26 at 11:03 AM revealed that with any psychotropic medications, the residents should be educated about the risks versus benefits of the medications prior to administration so that the resident has an understanding of the effects of the medications. A follow up interview was conducted with the DON on 7/17/26 at 9:40 AM. The DON stated that she was unable to find the psychotropic medication consent for Resident #14. She explained that Nurse #8 must have forgotten to get the consent prior to the administration of the psychotropic medications.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, physician and physician assistant interviews, the facility failed to notify the physician of a change in status related to bilateral lower leg wounds that were open and weeping for 1 of 2 residents (Resident #43) reviewed for wound care; and failed to provide notification to the Responsible Party (RP) of the resident's death. This was for 1 of 1 resident (Resident #126) reviewed for death in facility. Findings included: 1) Resident #43 was admitted to the facility on [DATE] with a most recent readmission on [DATE]. Diagnoses included, in part: Chronic peripheral venous insufficiency, varicose veins of unspecified lower extremity with ulcer of unspecified site, and Type 2 Diabetes Mellitus with diabetic polyneuropathy. Record review revealed that weekly skin assessments were completed on [DATE] and [DATE]. Both assessments identified bilateral lower leg edema and discoloration with no open areas. No other weekly skin assessments were documented in the electronic medical record in [DATE]. Record review revealed a weekly skin assessment was completed on [DATE] by Nurse #10. She documented that Resident #43 had weeping, turgid, open, and blistered skin over the front of the right lower leg and weeping, turgid, open and blistered skin over the front of the left lower leg. An interview was conducted with Nurse #10 on [DATE] at 11:30 AM. Nurse #10 stated that she had completed a skin assessment on Resident #43 on [DATE]. Nurse #10 explained she had not notified the oncoming shift, nor had she notified the physician or the nurse practitioner that Resident #43 had untreated bilateral open, weeping wounds on both lower legs. Nurse #10 stated that she normally would initiate a treatment and notify the physician if she assessed an untreated open wound but in this instance she had not notified any other staff members of the wounds or initiate a treatment. An interview was conducted with Nurse #5 on [DATE] at 8:30 AM. Nurse #5 remembered she had assessed Resident #43's leg wounds on [DATE] and recalled he had yellow craters on both lower legs. Nurse #5 explained that because she had not seen any oozing from the wounds that she had not initiated a treatment or notified the physician or treatment nurse of the open areas. On [DATE] at 11:47 AM Resident #43 was observed to have large cluster wounds that ran together on both lower legs that were weeping a yellow colored fluid. The wounds were open to air. Review of the physician orders on [DATE] at 12:15 PM revealed there was no treatment orders for Resident #43's right or left lower leg vascular wounds. In an interview with Resident #43 on [DATE] at 1:30 PM he stated his legs had been open and weeping for a little over a month. He stated he had asked for his legs to be wrapped but no one had (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided him wound care. An interview was conducted with the physician on [DATE] at 12:48 PM. He stated he had been on vacation from [DATE] through [DATE]. He had not received any notification that Resident #43 had open wounds on his lower legs. An interview was conducted with the Physician Assistant on [DATE] at 12:45 PM. She stated she had covered the physician during his vacation. She explained she had not received any notification that Resident #43 had open wounds on his legs. She expected that Nurse #10 would have initiated a temporary treatment and notified the physician until the treatment nurse could assess the wound and obtain a wound care order. An interview was conducted with the Director of Nursing on [DATE] at 3:10 PM. She stated that she expected that Nurse #10 would have initiated a treatment and then notified the physician and the treatment nurse of the wound to continue treatment. 2. Resident #126 was admitted on [DATE]. A nursing progress note dated [DATE] written by Nurse #13 at 8:15 PM indicated that Resident #126 had no measurable vital signs and the medical provider was notified. A nursing progress note dated [DATE] at 8:35 PM written by Nurse #13 indicated that Resident #126's emergency contacts were called, and two numbers did not go through to a caller or a voice mail. The note indicated that a voice mail message was left to call the facility on one number (the note did not specify what phone number, or which contact). An interview with Nurse #13 was conducted via phone on [DATE] at 1:35 PM. Nurse #13 stated that she did not recall who she notified on [DATE] when Resident #126 passed away. Nurse #13 stated to refer to her progress note and that it would provide information regarding who she attempted to contact. The Nurse stated that she no longer worked at the facility and did not feel comfortable providing any additional information. A nursing progress note dated [DATE] at 9:53 PM written by Nurse #13 indicated that the Director of Nursing was notified that Resident #126 expired and the nurse was unable to reach a family member. An interview was conducted via phone with the previous Director of Nursing (DON) on [DATE] at 12:30 PM. The previous DON stated that she started in the position at the facility on February 16, 2026, and was the DON when Resident #126 passed away at the facility. The previous DON stated that Nurse # 13 called her and informed her that Resident #126 had passed away. Nurse # 13 reported to the DON that she placed a call to the Responsible Party on Resident #126's electronic health record and received no answer. The previous DON stated she instructed Nurse #13 to continue to call the Responsible Party. The previous DON stated that she was new to the position and unfamiliar with the facility protocol for a death in the facility, so she called the Administrator. The previous DON stated that she reported to the Administrator that Resident #126 had passed away and the RP was not contacted. The previous DON indicated that she did not attempt to notify Resident #126's RP and did (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not follow up later to determine if the RP was contacted. She indicated that she expected that the nurse would have attempted more than once to contact an emergency contact when a resident passed away. A nursing progress note written by Nurse #13 dated [DATE] at 1:26 AM revealed that Resident #126's body was released to the funeral home. Review of Resident #126's electronic health record revealed there were no further attempts to contact Emergency Contact #1/ RP, Emergency Contact #2 or Emergency Contact #3. An interview was conducted via phone with Resident #126's Emergency Contact #2 on [DATE] at 10:40 AM. Emergency Contact #2 stated that she was not notified by the facility of Resident #126's death. Emergency Contact #2 stated that she had voice mail set up on her cell phone on [DATE]. Emergency Contact #2 stated that she checked her phone for missed calls or a voice mail message from the facility on [DATE] and [DATE] and found neither one. An interview was conducted via phone on [DATE] at 8:45 AM with Resident #126's Emergency Contact #1/Responsible Party (RP)/Power of Attorney. Emergency Contact #1/RP indicated that she had voice mail set up on her cell phone on [DATE]. Emergency Contact #1/RP stated that she received a phone call from a funeral home on the morning of [DATE] and was informed that Resident #126's body had been taken there. Emergency Contact #1/RP indicated that she checked her phone for missed calls or a voice mail message from the facility regarding Resident #126's demise and found neither one. Emergency Contact #1/RP stated that she was not notified by the facility of Resident #126's death. An interview was conducted by phone with Emergency Contact #3 on [DATE] at 9:45 AM. Emergency Contact #3 reported that on the morning of [DATE], he was informed by Emergency Contact #1/RP that Resident #126's body had been taken to the funeral home. He also stated that he had voicemail set up on his phone on [DATE]. Emergency Contact #3 noted that he checked his phone for any missed calls or voicemail messages from the facility but found none. Emergency Contact #2 stated that she was not notified by the facility of Resident #126's death. An interview conducted with the Administrator on [DATE] at 4:50 PM revealed that she would expect that the RP would be notified of a resident's death. The Administrator indicated that she expected that the assigned nurse would continue to call the emergency contacts in the electronic health record until one of the contacts was notified.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and Responsible Party and staff interviews, the facility failed to obtain informed consent for a contactless monitoring system installed in resident rooms above the bed to monitor resident information for 2 of 9 residents reviewed for privacy (Resident #21 and Resident #1). Findings included: Review of an informed consent form indicated that the facility contracted with a private communication technology-based company to provide contactless remote monitoring. The form indicated that by signing the document the resident/Responsible Party consented to allowing the company to provide monthly services such physiological monitoring (healthcare teams tracking vital signs including heart rate and respirations remotely) and communication of health information with other health care providers. a. Resident #21 was admitted to the facility on [DATE] with diagnosis which included dementia. Resident #21's admission Minimum Data Set (MDS) dated [DATE] indicated that the resident was severely cognitively impaired. Resident #21's quarterly MDS dated [DATE] indicated that the resident was severely cognitively impaired. The facility provided an informed consent form which indicated in part: the facility has contracted with a private communication technology-based company to provide contactless remote monitoring. These services provide clinical information and insights. By signing this consent, you allow the company to provide chronic care management. The form was dated 9/23/25 and had a check in a box which indicated I have read and understood the information and consent to the above. The form included a typed entry which stated that Resident #21 verbally consented to the monitoring service. An observation of Resident #21's room on 7/15/26 at 3:10 PM indicated a small white device was mounted on the wall above the resident's bed. An interview with Resident #21 on 7/15/26 at 3:15 PM revealed that the resident was not oriented to time or place and was unaware of the device above the bed or the purpose of the device. An interview with the Clinical Services Director on 7/16/26 at 11:50 AM indicated that Resident #21's room was one of nine rooms in the facility that were being monitored and that a representative from the company obtained the consent form from Resident #21. The Clinical Services Director stated that she spoke with the representative from the company via phone on 7/16/26 and obtained clarification that the representative reviewed Resident #21's admission Minimum Data Set (MDS) assessment that indicated that the resident was moderately cognitively impaired. The Clinical Services Director stated that the representative should not have obtained a consent form from a cognitively impaired resident. b. Resident #1 was admitted on [DATE]. Resident #1's medical diagnosis included severe dementia with behavioral disturbance. A review of Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] indicated that the resident was severely cognitively impaired. The facility provided an informed consent form which indicated in part: the facility has contracted with a private communication technology-based company to provide contactless remote monitoring. These services provide clinical information and insights. By signing this consent, you allow the company to provide chronic care management. The form was dated 2/20/26 and had a check in a box which indicated I have read and understood the information and consent to the above. The form included a typed entry which stated that Resident #1 verbally consented to the monitoring service. An observation of Resident #1's room on 7/15/26 at 3:00 PM indicated a small white device was mounted on the wall above the resident's bed. An interview with Resident #1 on 7/15/26 at 3:05 PM revealed that the resident was not oriented to time or place and was unaware of the device above the bed or the purpose of the device. An interview was conducted with Resident #1's Responsible Party on 7/16/26 at 9:50 AM. The Responsible Party indicated that she was unaware that a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER August Healthcare at Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Wellington Avenue Wilmington, NC 28401	
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring device was being used in Resident #1's room. Resident #1's RP stated that the facility had not contacted her about the monitoring device. She stated that she had noticed the device in the room and wondered what it was. During an interview with the Clinical Services Director on 7/16/26 at 11:50 AM she indicated that only some resident rooms in the facility were being monitored. The Clinical Services Director confirmed that Resident #1's room was one of the nine rooms in the facility that were being monitored. She stated that a representative from the company obtained the consent form from the resident. The Clinical Services Director stated that she spoke with the representative from the company via phone on 7/16/26 and obtained clarification that the representative reviewed Resident #1's admission Minimum Data Set (MDS) assessment that indicated that the resident was cognitively intact. The Clinical Services Director stated that the representative should not have obtained a consent form from a cognitively impaired resident. The Clinical Services Director stated that the representative was unaware that Resident #1 had a change in cognition with quarterly MDS assessment dated [DATE] which indicated severely cognitively impaired. The Clinical Services Director indicated that the process for the use of the monitoring device was that the devices were installed in all the resident rooms in the facility. The devices were mounted above the beds in the resident rooms, but monitoring was turned off until the consent was obtained. The Clinical Services Director stated that the facility contacted the representative from the company and then the representative came to the facility to obtain the consent. An interview conducted with the Administrator on 7/17/26 at 4:50 PM revealed that the facility must obtain informed consent prior to the use of the monitoring device being initiated. The Administrator stated that consent should be obtained from the Responsible Party if the resident was cognitively impaired. The Administrator stated that this device was confusing, and she acknowledged that she did not know much about it. The Administrator stated that the facility did not have a process in place to educate and inform the family members and residents about the monitoring device.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Physician Assistant (PA) interviews, the facility failed to ensure a resident's (Resident #14) medication regime was free from unnecessary medications for administering an as needed antianxiety medication without a discontinue date. This deficient practice occurred for 1 of 5 residents reviewed for unnecessary medications. Findings included: Resident #14 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease with late onset and anxiety. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was severely cognitively impaired. The MDS documented Resident #14 had inattention and disorganized thinking present and fluctuated. The resident was documented as receiving antianxiety medication. Physician order dated 6/1/26 for lorazepam oral concentrate 2 milligrams (mg) per milliliter (ml). Give 0.5 mg by mouth every 6 hours as needed for anxiety. There was no discontinue date. The June 2026 Medication Administration Record (MAR) for Resident #14 revealed she was administered lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety on: 6/1/26 at 12:00 PM and it was effective 6/2/26 at 6:59 AM and it was effective 6/2/26 at 2:42 PM and it was effective 6/19/26 at 3:05 PM and it was effective 6/29/26 at 9:07 AM and it was effective. Resident #14's active care plan revised on 7/1/26 revealed a problem with mood related to dementia and anxiety. The goal for Resident #14 was for her to have a happier calmer appearance with no signs and symptoms of sadness. The interventions included administering medications as ordered and monitoring for effectiveness. During an interview with the Physician Assistant (PA) on 7/16/26 at 11:20 AM, the PA stated she had put a 14 day stop date on a previous order for lorazepam for Resident #14 and when she wrote the order on 6/1/26 she had written 14 ml for the amount to be dispensed but forgot to write a stop date. She indicated it was just an error on her part, and she was aware that as needed psychotropic medications needed a stop date. An interview with the Director of Nursing (DON) was conducted in the presence of the Administrator on 7/17/26 at 9:40 AM. The DON stated the PA had explained to her what happened when she ordered Resident #14's as needed lorazepam. The DON confirmed the PA had ordered 14 ml of lorazepam to be dispensed, but the PA had not written a stop date. She stated she expected all as needed psychotropic medications to have the correct stop date. The Administrator stated she was aware that psychotropic medications were supposed to have a stop date, and the PA had just forgotten to write one for Resident #14's as needed lorazepam.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interviews, Physician Assistant interview and Physician interview, the facility failed to provide wound care to a resident with bilateral lower extremity leg wounds that were open and weeping, for 1 of 1 resident reviewed for vascular wound care, Resident #43. Findings included: Resident #43 was admitted to the facility on [DATE] with a most recent readmission on [DATE]. Diagnoses included, in part: Chronic peripheral venous insufficiency, varicose veins of unspecified lower extremity with ulcer of unspecified site, and Type 2 Diabetes Mellitus with diabetic polyneuropathy. Review of a physician order dated 04/08/25 revealed the following order: Weekly skin observation every Tuesday 11-7, document assessment every night shift every Tuesday for skin monitoring complete head-to-toe skin check and document under assessment tab. Review of an annual Minimum Data Set assessment dated [DATE] revealed Resident #43 had intact cognition. He did not have any wounds during the assessment look back period. Review of the care plan for Resident #43 initiated 04/25/23 and revised on 04/20/26 revealed the following focus areas: Peripheral Vascular disease and potential impairment to skin integrity related to medication use, Diabetes Mellitus, obesity, incontinence, and decreased mobility. Goals included that Resident #43 would remain free of complications related to peripheral vascular disease and maintain or develop clean and intact skin by the review date. Interventions included to educate the resident of causative factors and measures to prevent skin injury, encourage good nutrition and hydration, follow facility protocols for treatment of injury, use caution during transfers, weekly skin checks by the nurse to monitor the extremities for signs of injury, infection or ulcers, and monitor/document/report any skin problems related to peripheral vascular disease. Weekly skin assessments for the past three (3) months were reviewed. A skin assessment completed on 05/27/26 documented pre-existing redness and edema to both legs more than usual with no open areas. No other skin assessments were completed in May 2026. Skin assessments completed on 06/02/26 and 06/09/26 documented bilateral edema with multiple areas of skin discoloration and no open areas. No other skin assessments were completed in June 2026. A weekly skin assessment was completed on 07/02/26 by Nurse #10. She documented that Resident #43 had weeping, turgid, open, and blistered skin over the front of the right lower leg and weeping, turgid, open and blistered skin over the front of the left lower leg. An interview was conducted with Nurse #10 on 07/15/26 at 11:30 AM. Nurse #10 stated that she had completed a skin assessment on Resident #43 on 07/02/26. She stated she did not initiate any treatments or notify anyone of her assessment findings. Nurse #10 explained she had not notified the oncoming shift, nor had she notified the physician or the nurse practitioner that Resident #43 had untreated bilateral open, weeping wounds on both lower legs. Nurse #10 stated that she normally would initiate a treatment and notify the physician if she assessed an untreated open wound but in this instance she had not notified any other staff members of the wounds or initiate a treatment. Record review showed Nurse #5 had documented on the Medication Administration Record that a skin assessment was completed on Resident #43 on 07/07/26. There was no documented skin assessment on 07/07/26. An interview was conducted with Nurse #5 on 07/17/26 at 8:30 AM. She stated she originally thought maybe she had completed the skin assessment in the computer but forgot to save it. She explained she had assessed Resident #43's leg wounds and recalled he had yellow craters on both lower legs. Nurse #5 stated she asked the resident why his legs were not covered and he had told her that his legs were supposed to be covered but no one was doing the treatment. Nurse #5 explained that because she had not seen any oozing from the wounds that she had not initiated a treatment or notified any other staff (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the open areas. She concluded her assignment that included the 600 hall along with covering the medication aide on the 500 hall was a little much and could have possibly been why she had not completed a weekly skin assessment document on 07/07/26 for Resident #43. On 07/14/26 at 1:30 PM Resident #43 was observed to have large cluster wounds that ran together on both lower legs that were weeping a yellow colored fluid. The wounds were open to air. In an interview with Resident #43 on 07/14/26 at 1:30 PM he stated his legs had been open and weeping for a little over a month. He stated he had asked for his legs to be wrapped but no one had provided him wound care. Resident #43 reported that he maintained a small garden in the courtyard and had been using the garden hose to wash the puss off his lower legs. An interview was conducted with the physician on 07/15/26 at 12:48 PM. He stated he had been on vacation from 07/02/26 through 07/13/26. He had not received any notification that Resident #43 had open wounds on his lower legs. An interview was conducted with the Physician Assistant on 07/16/26 at 12:45 PM. She stated she had covered the physician during his vacation. She explained she had not received any notification that Resident #43 had open wounds on his legs. She expected the first nurse to assess an open wound to initiate temporary treatment and notify the physician until the treatment nurse could assess the wound and obtain a wound care order. An interview was conducted with the Director of Nursing on 07/17/26 at 3:10 PM. She stated that she expected the first nurse to assess an open wound to initiate treatment and then notify the physician and the treatment nurse to continue treatment of the area.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and Physician Assistant (PA) interviews, the facility failed to follow the physician order for the administration of insulin. Nurse #1 was observed obtaining a blood sugar (a blood sample indicating the concentration of sugar in the blood) for a resident after the resident's meal and then administered scheduled insulin and sliding scale (a scale used to measure amount of insulin to be given based on residents' blood sugar results) insulin based on the blood sugar result for 1 of 5 residents (Resident #5) observed for Unnecessary Medications. Findings included: Resident #5 was admitted to the facility on [DATE]. Diagnoses included diabetes. A physician order written on 10/02/25 for Novolog Flex pen 100 units/milliliter solution pen injector. Inject 5 units subcutaneous (applied under the skin) before meals for diabetes. A physician order written on 10/02/25 for NovoLog Flex pen 100 units/milliliter solution pen injector. Inject per sliding scale. The sliding scale for amount of insulin to administer was as follows: If the blood sugar was 0 - 200 = 0 units of insulin 201 - 250 = 2 units of insulin 251 - 300 = 4 units of insulin 301 - 350 = 5 units of insulin 351 - 400 = 8 units of insulin 401 and over give 10 units of insulin and notify physician. Give insulin according to sliding scale subcutaneously before meals for Diabetes Mellites. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #5 was cognitively intact and received 7 injections of insulin medications during this assessment. An interview with Resident #5 on 07/13/26 at 8:30 AM was conducted. Resident #5 reported he had finished all of his breakfast. An observation of Resident #5's food tray on 07/13/26 at 8:30 AM revealed 100% of his meal tray had been consumed. An observation of Nurse #1 on 07/13/26 at 9:08 AM revealed Nurse #1 was taking Resident #5's blood sugar and reported to Resident #5 that his blood sugar reading was 372. Nurse #1 returned with an insulin pen and told Resident #5 he was getting a total of 10 units of insulin and administered the insulin to Resident #5. An interview with Nurse #1 on 07/13/26 at 9:10 AM revealed she knew the physician order was to administer the scheduled insulin and check his blood sugar for the sliding scale insulin before Resident #5 ate his meal, but she had so many blood sugars to check on her hall that she was not able to administer the insulin and do the blood sugars before the breakfast trays came out. Nurse #1 stated she, more often than not, would have to administer the insulin and check his blood sugar after Resident #5 ate because she did not have enough time in the morning to get them before the breakfast trays were delivered between 8:15 AM and 8:30 AM. Nurse #1 stated she knew it was wrong, but that was how she had to do it due to time. An interview was conducted with the Physician Assistant (PA) on 07/16/26 at 10:45 AM. The PA stated she would have expected Nurse #1 to obtain the blood sugar before Resident #5 ate and administer the required / ordered dose of insulin before Resident #5 ate as the order was written. The PA stated getting a blood sugar reading and giving the insulin after his meal could have caused Resident #5 to potentially require more insulin than he needed because the food would raise the blood sugar reading. An interview was conducted with the Director of Nursing (DON) on 07/17/26 at 4:29 PM. The DON stated the nurses should be prioritizing their medication administration during their medication pass for all the residents that have orders to obtain a blood sugar before meals or to administer insulin before meals. The DON stated Nurse #1 should not have checked Resident #5's blood sugar after he ate and then give the ordered insulin. She added, Nurse #1 should have followed the physician order as written.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Physician Assistant (PA) interviews, the facility failed to follow up on a urine analysis (U/A) that was ordered for 1 of 1 resident (Resident #124) reviewed for laboratory services. Findings included: Resident #124 was admitted to the facility on [DATE]. Diagnoses included altered mental status. The Minimum Data Set 5 day assessment dated [DATE] revealed resident was moderately cognitively impaired, demonstrated no behaviors, and was frequently incontinent of bladder. A physician order entered by the Physician Assistant was written on 12/22/25 for nursing to collect urine via in and out catheter (a process to obtain urine without inserting an indwelling urinary catheter) one time only for 2 days; laboratory company to transport to laboratory for completion of urine analysis (U/A), and culture and sensitivity (C & S). Review of a progress note documented as late entry by the Physician Assistant (PA) on 12/23/25 revealed, in part, Resident's responsible party (RP) was asking about a possible hospice consult on 12/22/25. The progress note indicated the PA and RP discussed checking for a urinary tract infection (UTI). The progress note indicated the U/A was pending. A nursing progress note written by the Unit Manager #2 on 12/23/25 at 6:04 PM revealed 2 attempts were made to obtain urine; 1st attempt, resident was in day room and refused to be returned to room for short period to obtain urine; 2nd attempt, resident sitting in Geri chair in another resident's room visiting and refused to return to room for this nurse to obtain urine and return her back to her visitor afterward. An interview with Unit Manager #2 on 07/16/26 at 3:30 PM revealed she really did not remember Resident #124 even after she reviewed the progress note she had written. Unit Manager #2 stated if the order was for two days then the nurses would have had the full two days to obtain the U/A and report to the PA whether we were able to obtain it. Unit Manager #2 stated since she was not able to obtain the U/A on her shift; the task would then get passed on to the next shift. She stated usually if she needed to notify a provider about anything she would text, call or put a note in the provider's notification book. She stated she would not have put a note in the book on 12/23/25 since the order was put in for 2 days. A nursing progress note written by Nurse #3 on 12/24/25 at 5:33 AM revealed Resident refused in and out catheter times 2 attempts to obtain urine sample. A phone interview was conducted with Nurse #3 on 07/17/26 at 5:17 AM. Nurse #3 revealed she could not recall Resident #124 or trying to obtain a U/A but if her progress notes indicated she could not obtain it, then she did not obtain the U/A and she would have passed the task on the next shift nurse. Nurse #3 stated she could not recall telling Nurse #9 (who she reported off too) the morning of 12/24/25 that she could not get the U/A. Nurse #9 added there have been a lot of problems with the lab company in getting results back to the facility. Nurse #9 continued and stated they lose samples, tell the facility they never received the sample, or the lab staff do not call the facility to let staff know what the results were. Nurse #9 stated she did not know who was responsible for following up on the labs that were sent because she worked night shift. Nurse #9 stated she would have left a note for the PA or MD if she could not obtain the U/A and would have passed it on in report after the two days per the order. Review of the Medication Administration Record (MAR) revealed the urine analysis was signed of as being obtained by Nurse #9 at 8:31 AM on 12/24/25. Review of the laboratory services log book kept at the nurse's station for 12/24/25 revealed there was no documentation to support that a U/A had been obtained and sent to the lab on 12/24/25 for Resident #124. Review of the electronic medication record revealed there were no results for the UA that was drawn on 12/24/25. A phone interview with Nurse #9 on 07/17/26 at 10:12 AM. Nurse #9 stated he recalled Resident #124 and the order for the U/A. He stated Resident (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#124 did not want a male nurse to use an in an out catheter on her. He stated he asked a female nurse who was working near his hall (could not remember her name) do get the U/A for him. Nurse #9 stated he was present in the room when the nurse obtained the U/A just in case she needed any assistance but kept his distance. He stated the female nurse took the sample and said she would complete the paperwork and send it to the lab. Review of the schedule for 12/24/25 revealed Nurse #12 was assigned to the hall adjacent to the hall Resident #124 resided on. An interview was conducted with Nurse #12 (a female nurse who worked beside Resident #124's hall) on 07/17/26 at 2:57 PM. Nurse #12 stated she remembered Resident #124 but she did not collect a urine sample from her at the request of Nurse #9. Nurse #12 had no knowledge of Resident #124 needing a U/A sample. Nurse #12 stated if she had obtained the urine she would have labeled the container with the resident name and room number, date and time, filled out a lab reconciliation form indicating the urine was for a urine analysis and culture and sensitivity and refrigerated the urine until the lab company picked it up. Nurse #12 stated she would also document the information in the lab book located at the nurse's station the date and time she obtained the specimen along with resident's name and room number. An interview with the Physician Assistant on 07/16/26 at 10:45 AM revealed she reported she recalled having a discussion with the RP regarding getting a U/A to rule out a UTI due to her increased confusion. The PA stated the RP inquired about possibly admitting Resident #124 into hospice but it was decided by the RP that she would wait until the U/A was done first due to her confusion. The PA stated she put the order to obtain a U/A on 12/22/25 for 2 days to allow the staff time to get the urine. The PA stated she had followed up with the nursing staff (did not know which nurse or which day) about the result of the U/A but no one seemed to know if it was even obtained or if there was a result of the U/A. The PA stated she would have wanted to know whether the U/A was obtained and the result of it because she would have called the RP to let her either know the result or to see if the RP would want the facility to continue trying to obtain the U/A; or if the RP wanted Resident #124 to be sent to the hospital to obtain. The PA added that nursing staff would usually text her, call her or leave a note in the physician notification book. The PA stated she reviewed her physician notification book and did not see any documentation about staff not being able to obtain the U/A as ordered on 12/22/24, but the nurses had two days to obtain it and the MAR looked as though it was obtained. The PA stated she was not able to see the result of the U/A in the electronic medical record and would have expected a result within 72 hours. The PA confirmed there seemed to be some ongoing issues with the present lab company and she has had to reorder labs in the past because of missing labs. The PA added that when she followed back up with Resident #124 on 12/23/25 she seemed to be less confused and mental status was improved. She was seen up in her Geri chair and she was much more alert and was eating lunch. She answered yes and no questions but also offered additional conversation and at the time she did not feel she needed to order another U/A. An interview was conducted with the Director of Nursing (DON) on 07/16/26 at 1:00 PM. The DON confirmed the medication administration record indicated the U/A was obtained at 8:31 AM on 12/24/25 but she could not find any results for the U/A for Resident #124 anywhere in the electronic record or in the lab services log for 12/24/25. The DON stated the lab company the facility was using was having trouble with the company stating they never received the labs and the facility was having to redraw the labs because the paperwork was filled out incorrectly. She stated the current laboratory service they used came to the facility Monday thru Friday and for STAT (immediate) lab results, the nursing staff would send the sample to the nearby Hospital. The DON added she had noticed there were problems where the facility nursing staff were not following up with pending lab results and was trying to implement a system to ensure that they were getting followed up on. The DON stated she was not sure why the (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lab results were not getting follow up on but she was going to assign one person such as a supervisor or one of the Unit Managers to follow up on any pending labs. The DON stated she also felt it was a problem with the lab company and the hospital losing the specimens and stated she instructed the staff that whenever they dropped off a specimen at the hospital to make sure they got the name of the person in the lab that they left the specimen with.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and procedures when 1) a nurse (the Staff Development Coordinator) was observed not wearing a gown while administering medications through Resident #17's feeding tube; and 2) the Treatment Nurse was observed cleaning and dressing wounds at two different wound sites without washing her hands and wearing the same gloves during Resident #43's bilateral leg dressing changes. This deficient practice occurred for 2 of 5 staff members observed for infection control practices. Findings included: The Infection Control Policy dated 1/9/23 revealed Enhanced Barrier Precautions referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms by requiring the use of gown and gloves during high contact resident care activities. During an observation of administration of medications on 7/15/26 at 9:20 AM Resident #17 was lying in bed with the head of the bed up. There was an Enhanced Barrier Precautions sign observed on the door and personal protective equipment (PPE) was observed on the closed door of another resident 2 doors down on the same side of the hallway. The Staff Development Coordinator (SDC) was observed washing her hands and applying gloves and she did not apply a gown. The SDC then stopped Resident #17's tube feeding machine and disconnected the feeding tube from the administration set and administered the medications through the feeding tube without wearing a gown. An interview with the SDC was conducted on 7/15/26 at 9:52 AM. The SDC stated that she should have been wearing a gown while administering medications through Resident #17's feeding tube. She indicated she was just nervous and forgot to put on the gown. The SDC explained that she was the person responsible for identifying and implementing EBP for residents that required them. She stated staff were provided education during orientation and through their online healthcare education site. An interview with the Director of Nursing (DON) was completed on 7/17/26 at 9:43 AM. The DON stated that she expected the nursing staff to follow EBP when providing high contact care to residents. She explained that the SDC should have been wearing a gown when administering medications through Resident #17's feeding tube. 2. Review of the facility Handwashing/Hand Hygiene infection control policy last updated on 01/09/23 revealed in part to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before handling clean or soiled dressings, gauze pads, etc.; after contact with blood or bodily fluids; and after handling used dressings, contaminated equipment, etc. Wound care performed by the Treatment Nurse on 07/16/26 at 9:30 AM was observed. The Treatment Nurse put on a gown, washed her hands and put on gloves. The Treatment Nurse removed the old dressing from the right lower leg wounds and cleansed the wound area with a 4 x 4 gauze soaked in normal saline. The cluster of open vascular wounds on Resident #43's front right leg were open and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER August Healthcare at Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeping with a yellow drainage. The Treatment Nurse did not change her gloves or wash her hands and proceeded to remove the old dressing from the left lower leg and cleanse the wound area with a 4 x 4 gauze soaked in normal saline. The cluster of open vascular wounds on the left lower leg were open and weeping a yellow drainage. The Treatment Nurse discarded her gloves, washed her hands, and put on a new pair of gloves. The Treatment Nurse then applied the calcium alginate to the wounds on the right front lower leg and covered the wounds with a border gauze dressing and then applied the calcium alginate to the wounds on the left lower leg and covered the wounds with a border gauze dressing without changing her gloves or washing her hands. In an interview with the Treatment Nurse on 07/16/26 at 9:45 AM she stated she had not realized that she had not changed her gloves or washed her hands as she cleansed both wounds and applied the treatments to Resident #43's bilateral leg wounds. The Treatment Nurse explained that she knew to wash her hands and put on new gloves between wounds when treating multiple wounds. She stated she did not know why she had not treated the right leg wounds completely before treating the left leg wounds. In an interview with the Director of Nursing on 07/17/26 at 3:10 PM she stated that she was also the Infection Preventionist for the facility. She stated she expected one wound to be treated at a time and for the Treatment Nurse to wash her hands and change her gloves between wounds when treating multiple wounds. The Director of Nursing stated it was an infection control issue.		