

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect a resident's right to be free from neglect when Resident #1, a resident with severely impaired cognition and known behavioral symptoms, requested as needed pain medication from Nurse #1 and the nurse disregarded the resident's pain and withheld the medication in response to the resident spitting at her when she (the nurse) entered the resident's room. This occurred for 1 of 3 residents reviewed for abuse and neglect. Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included severe vascular dementia with psychotic disturbance, cognitive communication deficit, anxiety, delusional disorder and depression, chronic pain with peripheral neuropathy. Review of Resident #1's physician orders revealed orders dated 10/9/25 for acetaminophen 325 milligrams (mg) administer 2 tablets every 6 hours as needed and tramadol 50 mg administer one tablet every 6 hours as needed for pain. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a short-term and long-term memory impairment, severely impaired decision making, and exhibited physical behavioral symptoms directed towards others, verbal behavioral symptoms, and other behavioral symptoms not directed towards others on 1 to 3 days during the 7-day assessment look back period. Resident #1 rejected care on 4-6 days during the 7- day look back period. Resident #1 had moderate difficulty hearing and sometimes made herself understood and sometimes was able to understand others. Resident #1 had moderately impaired vision. Resident #1 received opioid and as needed pain medication during the look back period. A pain assessment interview was completed with the staff. Resident #1 complained of or exhibited signs of pain 1-2 days during the assessment look back period. Resident #1's care plan, last updated on 10/27/25, included a problem of behavioral symptoms with resistance to care at times. The interventions indicated to allow the resident to make choices about her treatment regimen, encourage the resident to participate in activities of daily living, reapproach if the resident refuses care and give a clear explanation of care activities. A care plan dated 10/27/25 indicated Resident #1 had pain due to immobility and interventions included to administer pain medication as ordered, assess for pain and attempt to utilize non-pharmacological interventions to relieve pain. A review of Resident #1's November 2025 electronic Medication Administration Record (eMAR) revealed that Nurse #1 documented on 11/13/25 for the 7:00 PM to 7:00 AM night shift entry that the resident exhibited behavior of scratching, biting and spitting. Nurse #1 documented that the non-pharmacological intervention of reassurance was utilized in response to the behavior. Further review of Resident #1's November 2025 eMAR indicated that Nurse #1 documented that the resident had a pain level of 6 out of 10 with 0 indicating no pain and 10 indicating the worst pain ever on 11/13/25 for the 7:00 PM to 7:00 AM night shift. The eMAR contained no documentation of administration of the ordered as needed tramadol 50 milligrams (mg) one tablet every 6 hours as needed for pain. The Controlled Medication Utilization Record for Resident #1 for as needed tramadol 50 mg revealed an entry on 11/13/25 at 10:00 PM for one dose signed by Nurse #1 with an entry that indicated that the dose was wasted. The entry was checked by Nurse #3 as wasted. A phone interview was conducted with Nurse #1 on 12/2/25 at 1:38 PM. Nurse #1 stated that Resident #1 was cognitively impaired but was able to report a pain level and request pain medication. Nurse #1 stated that Resident #1 requested pain medication on the evening of 11/13/25 and when she went in the room to administer the ordered medication, the resident spit at her as she came into the room, so she (the nurse) immediately left the room without making any effort to calm the resident with known behaviors. Nurse #1 stated that she wasted the medication, did not administer it and did not attempt to administer the medication later. Nurse #1 indicated that she was aware that Resident #1 demonstrated combative and agitated behaviors and that she (the nurse) was not tolerating it and did not attempt to give Resident #1 pain medication later in the shift. Nurse #1 stated that she thought Resident #1 eventually went to sleep but she did not evaluate her pain again later in the shift and did not reattempt to administer the medication. Nurse #1 stated that she did not think her action was abuse or neglect, she just did not tolerate the behavior that Resident #1 exhibited. Attempts via phone to interview Nurse #3 on 12/2/25 and 12/3/25 were unsuccessful. Attempts via phone to interview NA #4, the NA assigned to Resident #1 on 11/13/25 from 11:00 PM to 7:00 AM, were unsuccessful. Review of Resident #1's electronic MAR revealed a pain rating of 0 out of 10 on 11/14/25 on the day shift from 7:00 AM to 7:00 PM. An interview with the Director of Nursing (DON) on 12/3/25 at 1:40 PM revealed that it was not appropriate for Nurse #1 to not administer the ordered as needed pain medication to a resident that</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	

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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	
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 0604 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect a cognitively impaired resident (Resident #1) with agitated behaviors from being physically restrained by an employee during care when Nurse #1 was witnessed by two other employees (Nurse Aide #1 and Nurse Aide #2) to hold Resident #1's arms down to restrict her hand and arm movements. Resident #1 screamed while being restrained by Nurse #1 and sustained bruising and pain in her bilateral hands and wrists that was relieved with as needed medications for pain following this incident. Resident #1 also had scratches to the right forearm and wrist. This occurred for 1 of 1 resident reviewed for physical restraints. Findings included: Resident #1 was admitted on [DATE] with diagnosis which included severe vascular dementia with psychotic disturbance, cognitive communication deficit, anxiety, delusional disorder and depression, and chronic pain with peripheral neuropathy. A review of Resident #1's physician orders revealed orders dated 10/9/25 for acetaminophen 325 milligrams (mg) give 2 tablets every 6 hours as needed for pain and tramadol 50 mg every 6 hours as needed for pain and 50 mg every 6 hours as needed for pain. Resident #1's physician orders did not include anticoagulant medication. A review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a short- and long-term memory impairment with severely impaired decision making and exhibited physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing) 1 to 3 days during the 7-day assessment look back period. Resident #1 demonstrated verbal behaviors (threatening, screaming, cursing) 1 to 3 days and other behaviors not directed at others (hitting, scratching self, verbal vocal symptoms including screaming and disruptive sounds) 1 to 3 days in the 7- day look back period. Resident #1 rejected care 4-6 days in the 7-day look back period. Resident #1 had moderate difficulty hearing, had unclear speech, sometimes made herself understood and sometimes was able to understand others. Resident #1 had moderately impaired vision. Resident #1 received opioid and as needed pain medication during the look back period. A pain assessment interview was completed with the staff. Resident #1 complained of or exhibited signs of or exhibited signs of pain 1-2 days during the assessment look back period. Resident #1's care plan indicated a problem of behavioral symptoms with resistance to care at times. The care plan problem was last updated on 10/27/25 and the interventions indicated to allow the resident to make choices about her treatment regimen, encourage the resident to participate in activities of daily living, reapproach if the resident refuses care and give a clear explanation of care activities. Review of a facility investigation report revealed that on 11/14/25 at 4:10 PM Nurse Aide (NA) #1 and Nurse Aide (NA) #2 alleged that Nurse #1 physically restrained and cursed at Resident #1 and held her physically restraining her against her will during incontinence care on 11/13/25. The NAs stated that they witnessed verbal and physical abuse by Nurse #1 while they were providing care to Resident #1 on the night of 11/13/25 at approximately 10:00 PM. An interview was conducted with Nurse Aide (NA) #1 on 12/2/25 at 1:09 PM. NA #1 indicated that Resident #1 frequently screamed, hit, bit, spit and scratched staff during care. NA #1 stated that she attempted to talk to Resident #1 in a calm tone and explain all tasks and procedures, but it was still difficult at times to provide the needed care. NA #1 stated on the evening of 11/13/25, she was not assigned to Resident #1, but at approximately 10:00 PM NA #2 who was the assigned Nurse Aide asked her to assist with providing incontinence care. NA #1 stated that Resident #1 always required 2-person assistance with incontinence care due to her combative behaviors. NA #1 stated that while she and NA #2 were providing incontinence care to Resident #1, Nurse #1 entered the room to administer medication. NA #1 stated she did not know why, but Nurse #1 stayed in the room after she administered the medication. Nurse #1 went to the side of the bed where NA #2 was assisting with positioning Resident #1 on her side while NA #1 was cleaning the resident's buttock and perineal area. Nurse #1 was at the upper part of Resident #1's body and grabbed Resident #1's arms and held them against her body. Resident #1 was trying to get the nurse to stop and was screaming. Nurse #1 continued to hold Resident #1's wrists. Resident #1 spit and cursed at Nurse #1 and the nurse spit back at the resident and cursed at her. Nurse #1 then put a pillow up to Resident #1's face. NA #1 stated that she was behind the resident on the other side of the bed, so she was unable to tell if the pillow was touching the resident's face. NA #1 stated that during this incident, NA #2 told Nurse #1 several times that she needed to leave the resident alone and walk away. Nurse #1 eventually left the room, and NA #1 stated that she and NA #2 finished the incontinence care and were able to calm Resident #1 down. NA #1 stated that she had never witnessed a staff member treat a resident this</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Myrtle Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 5725 Carolina Beach Road Wilmington, NC 28412	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to follow its abuse policies and procedures in the area of immediately reporting an allegation of staff to resident abuse to the Administrator and in the area of protection. This occurred for 1 of 1 resident who was investigated for a staff to resident allegation of abuse (Resident #1). Findings included: Review of the facility resident abuse policy titled North Carolina Abuse Policy last reviewed on 7/2/2025 revealed in part; staff must report all allegations, suspicions and incidents of abuse and neglect to the Administrator/Abuse Coordinator immediately, but no later than 2 hours. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies. The investigation must be completed within five (5) working days of the alleged occurrence. The policy indicated that if a staff member was accused or suspected of abuse, the staff member will immediately be removed from the facility and removed from the schedule pending the outcome of the investigation. Resident #1 was admitted on [DATE] with diagnosis which included severe vascular dementia with psychotic disturbance, cognitive communication deficit, anxiety, delusional disorder and depression, chronic pain with peripheral neuropathy. An interview was conducted with Nurse Aide (NA) #1 on 12/2/25 at 1:09 PM. NA #1 stated on the evening of 11/13/25, she was not assigned to Resident #1, but at approximately 10:00 PM NA #2 who was the assigned Nurse Aide, asked her to assist with providing incontinent care. NA #1 stated that Resident #1 required 2-person assistance with incontinence care due to her combative behaviors. NA #1 stated that while she and NA #2 were providing incontinence care to Resident #1, Nurse #1 entered the room to administer medication. NA #1 stated she did not know why, but after administering the medication, Nurse #1 stayed in the room while she and NA #2 were completing incontinence care. Nurse #1 went to the side of the bed where NA #2 was holding Resident #1 on her side while NA #1 was cleaning the resident's buttock and peri area. Nurse #1 was at the upper part of Resident #1's body and grabbed Resident #1's arms and held them against her body. Resident #1 was trying to get the nurse to stop and was screaming. Nurse #1 continued to hold Resident #1's wrists. Resident #1 spit and cursed at Nurse #1 and the nurse spit back at the resident and cursed at her. Nurse #1 then put a pillow up to Resident #1's face. NA #1 stated that she was behind the resident on the other side of the bed and was unable to tell if the pillow was touching the resident's face. NA #1 stated that during this incident NA #2 told Nurse #1 several times that she needed to leave the resident alone and walk away. Nurse #1 eventually left the room, and NA #1 stated that she and NA #2 finished the incontinence care and were able to calm Resident #1 down. NA #1 stated she tried to collect herself and complete the rest of her work for the shift and left at the end of her shift. NA #1 stated that she did not report the incident until the next day on 11/14/25 when she returned for her 3:00 PM to 11:00 PM shift. NA #1 stated that she received training on abuse, and she knew that what Nurse #1 did was not right. NA #1 stated that she knew that restraining a resident, holding them down and providing care against their will, cursing and spitting at a resident were all forms of abuse and acknowledged awareness of the facility's abuse reporting policy. NA #1 stated that she was so upset by the incident that she needed time to process what happened, so she did not report it until the following day when she returned to work. An interview was conducted with NA #2 on 12/3/25 at 3:15 PM. NA #2 stated that she and NA #1 went into Resident #1's room to provide incontinence care on 11/13/25 at approximately 10:00 PM. Nurse #1 was in the room and had just administered medication to Resident #1. The nurse remained in the room as NA #2 and NA #1 rolled Resident #1 over and provided incontinence care. Resident #1 became more agitated seeing that Nurse #1 was still in the room. Resident #1 started spitting and Nurse #1 spit back at the resident. Resident #1 was cursing and Nurse #1 cursed back at the resident. Nurse #1 held the resident's arms tightly across her chest to prevent the resident from hitting or moving. NA #2 stated that Nurse #1 was making Resident #1 more agitated. Nurse #1 laid the pillow over the resident's face. NA #2 stated she and NA #1 removed the pillow from the resident's face. NA #2 indicated that several times, she told Nurse #1 to leave the room and let them provide Resident #1's care but the nurse did not listen and did not leave. NA #2 stated that she and NA #1 were finishing Resident #1's care and Nurse #1 eventually left the room. NA #2 stated that she was in shock that the nurse engaged in this behavior and treated the resident like that. Following the incident, NA #2 stated that she needed time to process what happened, so she did not report it to administration until the next day, 11/14/25 when she returned to work for her 3:00 PM to 11:00 PM shift. NA #2 stated that she was aware of the abuse policy and</p>		