| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345507 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Care of Myrtle Grove | 5725 Carolina Beach Road<br>Wilmington, NC 28412 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews, the facility failed to 1.) develop a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include a plan of care for a resident (Resident #9) admitted with a feeding tube. 2.) implement the use of bilateral fall mats as care planned to prevent injury in the event of a fall from bed (Resident #5) for 2 of 21 residents reviewed for care plan development and implementation. Findings Included:<br><br>1.) Resident #9 was admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding) tube.<br><br>The Minimum Data Set (MDS) admission assessment and care areas assessment dated [DATE] revealed Resident #9 was cognitively impaired and received tube feedings. The care area assessment indicated to initiate a care plan for Resident #9’s feeding tube.<br><br>Review of Resident #9’s medical record from 9/18/24 through 8/21/25 revealed no care plan was developed to care for Resident #9’s feeding tube.<br><br>During an observation on 8/18/25 at 1:00 PM Resident #9 was observed with a feeding tube in place.<br><br>During an interview on 8/21/25 at 1:00 PM the MDS Nurse stated she was not aware Resident #9 did not have a care plan in place for care of the feeding tube. She stated she began working as the MDS Nurse a few months ago and the previous MDS Nurse would have been the person responsible for initiating a care plan for the feeding tube after the MDS admission assessment was completed.<br><br>During an interview on 8/21/25 at 2:00 PM the Director of Nursing (DON) stated the previous MDS nurse was no longer employed with the facility. She indicated care plans should be developed and implemented according to the required guidelines.<br><br>2. Resident #5 was admitted to the facility 07/01/25.<br><br>Review of Resident #5’s physician order dated 07/30/25 listed: Bilateral fall mats - left and right side of bed, while resident is in bed.<br><br>Review of Resident #5’s admission Minimum Data Set assessment dated [DATE] revealed Resident #5 was severely cognitively impaired, required total assistance for bed mobility and transfers, extensive assistance for locomotion, personal hygiene, and dressing.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nursing note dated 07/23/25 at 3:53 PM for Resident #5 revealed resident experienced a witnessed fall in their room at 1:30 PM with no complaints of pain or discomfort reported at the time of the fall. The resident slid out of bed to a sitting/upright position and no visible injuries, bleeding, swelling, or deformities noted. The resident returned to bed via mechanical lift with two nursing staff assisted. Fall prevention measures were reinforced, and resident’s Responsible Party (RP) and provider were notified of the incident.<br><br>An Interdisciplinary Team (IDT) Meeting note dated 07/30/25 at 1:29 PM for Resident #5 revealed the resident was admitted on [DATE] after stroke. Fall on 07/23/25. Resident lowered himself from bed to floor. Fall mat was added to left side of his bed, as previously a fall mat was added to the right side of the bed, with bed kept in low position to reduce injury.<br><br>Resident #5’s revised care plan dated 07/30/25 revealed he had self-care and mobility deficits and was at risk for falls related to recent falls, weakness, right-side hemiplegia, and poor safety awareness. An updated care plan intervention included: Bilateral fall mats (right and left side of bed) while resident was in bed.<br><br>A nursing note dated 08/02/25 at 6:05 AM for Resident #5 revealed the resident slid out of bed onto his buttocks on the fall mat on the left side of his bed. No injuries noted. Resident at his baseline for responsiveness and was sitting up smiling and giving us a thumbs up that he was okay. Resident representative (RP) and Nurse Practitioner (NP) notified.<br><br>A nursing note dated 08/14/25 at 4:37 PM for Resident #5 revealed the resident was relocated to a room on the 700-hall, per family and Resident #5 request, with housekeeping staff placing all personal belongings in his 700-hall room.<br><br>An observation was conducted on 08/20/25 at 11:10 AM for Resident #5 revealed resident resting in bed, fully dressed, with one fall mat located on the floor next to the left side of his bed, and no fall mat on the right side of his bed. The resident motioned with his hands that he did not know where his second fall mat was, and that he only had one mat in his current room but had bilateral fall mats in his previous room.<br><br>An interview and observation were conducted on 08/20/25 at 11:15 AM with the Director of Nursing (DON). She observed Resident #5’s room on the 700-hall and stated the resident should have had bilateral fall mats, one placed on each side of his bed as stated in resident’s care plan and it did not. She stated the resident was recently transferred to a new room from the 400-hall within last few days and that facility staff must have left resident’s second fall mat in his old room on. The DON stated per resident’s care plan she would immediately ask housekeeping to make sure Resident #5 had another fall mat placed on the right side of his bed to help prevent him from a possible injury from another fall due to his history of falls.<br><br>An interview was conducted on 08/20/25 at 11:20 AM with the Administrator. She stated the resident should have had bilateral fall mats, one placed on each side of his bed as stated in resident’s care plan and it did not. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to maintain an environment that was free from accident hazards when a mechanical lift that was not in use was left in the hallway (600 hall) by a staff member (Nurse Aide #3) which resulted in a cognitively impaired resident with poor safety awareness and a history of falls with injury to trip over the lift while ambulating in the hallway causing a fall with minor injury of blood on her left nostril. This occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #11). Findings included: Resident #11 was admitted to the facility on [DATE] with diagnoses including Alzheimer's with dementia and agitation, and a history of falls. A care plan revised 3/14/25 revealed Resident #11 was at risk for falls due to a history of falls with injury, other risk factors included weakness, use of psychotropic medications, impaired memory, confusion and incontinence. The goal of care was to minimize the risk of falls and minimize injuries. Interventions included in part; provide staff education regarding fall hazards and implement preventative fall interventions. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 was severely cognitively impaired and independent with ambulation. She had two or more falls with injury. A post fall report dated 6/25/25 at 2:30 PM revealed Resident #11 had a fall in the hallway while ambulating. The current interventions that were not in place was the mechanical lift was in the hallway. The root cause was that a staff member left the lift in the hallway. Resident #11 tripped on the lift due to poor vision, inattention, and poor safety awareness. The immediate intervention was one-to-one education with the staff member (Nurse Aide #3). Education included the importance of always taking the mechanical lift back to the clean utility room when not in use.Attempts were made to contact Nurse Aide #3 on 8/21/25 at 1:30 PM with no response. A progress note dated 6/25/25 at 2:30 PM written by Nurse #1 revealed Resident #11 was found sitting on the floor on her buttocks having tripped on the mechanical lift while ambulating. A small trickle of blood was coming from her left nostril but subsided after being cleaned. There were no other injuries noted. Her vital signs were stable, and neurological checks were within normal limits. Resident #11 was able to move all extremities without difficulty or discomfort. She was wearing shoes at the time and was able to stand from the floor with two-person assistance as she was unsafe using the mechanical lift as evidenced by being unable to follow simple directions and grabs at the moving components of the lift. Resident #11 had been quickly ambulating throughout the facility with a slight lean to the left. She was taken to her room to rest throughout the day, but she gets out of the bed and continues to ambulate within minutes. During an interview on 8/21/25 at 10:15 AM Nurse #1 stated she routinely provided care to Resident #11 who had severe dementia with agitation and ambulated independently in the hallway and needed constant redirection. Nurse #1 stated Resident #11 had a fall in June 2025 when she tripped on the mechanical lift that was in the hallway outside of her room. She stated Resident #11 had some blood coming from her nose from the fall but had no other injuries, and her vital signs and neurological checks remained stable. Nurse #1 indicated Resident #11 continued to ambulate unassisted and due to severe dementia and poor safety awareness she would not be able to call for staff assistance before ambulating in and out of her room. Nurse #1 stated the mechanical lifts were to be kept in the utility room when not in use. An interdisciplinary note dated 7/2/25 at 12:15 PM revealed Resident #11 had a fall on 6/25/25. Resident #11 tripped over the mechanical lift that was in the hallway. Intervention was one to one staff education in regard to maintaining egress (a continuous unobstructed pathway) of the hallway. Resident #11 remained at baseline and continued to wander ad lib through the facility. Resident #11 has occasional periods of agitation and continues with poor safety awareness and impulsivity. During an interview on 08/19/25 at 2:47 PM Unit Manager #1 stated the mechanical lifts were to be kept in the utility room when not in use and not left in the hallway. She stated Resident #11 had a fall in June 2025 due to tripping on the mechanical lift that was left unattended in the hallway by a staff member (Nurse Aide #3). She provided one-to-one education to Nurse Aide #3 regarding properly storing the lifts and not leaving the lift in the hallway when not in use due to it being a fall hazard. During an interview on 8/21/25 at 2:00 PM the Director of Nursing (DON) indicated Resident #11 had severe dementia, a history of falls, and ambulated independently on the 600-hall. The DON stated the mechanical lifts were to be stored when not being used and not left in the hallway to prevent accidents. She indicated staff had received training on fall hazards including where to properly store the mechanical lifts. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observations, record review, and staff interviews, the facility failed to discard four expired insulin pens according to the manufacturer's guidelines and record an opened date on an insulin pen on 1 of 4 medication carts (700 hall medication cart) that were reviewed for medication storage. Findings Included. Review of the manufacturer's guidelines for Insulin Lispro (Humalog) pens and Insulin Glargine (Lantus) pens instructed to discard 28 days after opening. An observation of the 700-hall medication cart on 8/20/25 at 11:00 AM revealed the following:Insulin Lispro (Humalog) pen with an opened date of 6/12/25 and expiration date of 7/10/25. Insulin Lispro (Humalog) pen with an opened date of 7/7/25 and expiration date of 8/5/25. Insulin Lispro (Humalog) pen with an opened date of 6/18/25 and expiration date of 7/16/25. Insulin Glargine (Lantus) pen with an opened date of 7/1/25 and expiration date of 7/29/25. Insulin Glargine (Lantus) pen with no opened date and 60 of 300 units had been administered. During an interview on 08/18/25 at 11:01 AM Medication Aide #1 stated she was assigned to the 700-hall medication cart today. She stated she was not allowed to administer insulin and only nurses administered insulin therefore she did not check the cart for expired insulin. During an interview on 08/18/25 at 11:30 AM Unit Manager #1 stated the nurses were required to check the carts for expired medications. Unit Manager #1 indicated the nurses were required to check insulin pens for expiration dates before administering and record the date on the pen when opened. She stated she thought all of the medication carts had been checked today but unfortunately the insulin on the 700-hall cart was missed. During an interview on 08/19/25 at 4:00 PM the Director of Nursing (DON) stated all nurses were responsible for checking medication carts at least weekly for expired medications and insulin pens should be checked daily and prior to use. She stated the expired insulin on the 700-hall cart should have been discarded and an open date labeled on the Lantus pen. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, record review, and staff interviews, the facility failed to follow the infection control policy and procedures when 1.) Medication Aide #1 entered a resident's room (Resident #73) who was on Contact Precautions due to a wound infection without donning personal protective equipment (PPE) to include gloves and a gown. 2.) Nurse Aide #1 did not don PPE for Enhanced Barrier Precautions (EPB) to include a gown when providing high-contact resident care activities for Resident #26 who had a surgical wound dressing and a lower leg dressing. This occurred for 2 of 4 staff members reviewed for infection control practices. Findings Included.<br><br>1.The facility’s Infection Control Policy revised 5/19/25 revealed Contact Precautions were intended to prevent the transmission of infectious agents which were spread by direct or indirect contact with the resident or resident’s environment. Contact Precautions were indicated in the presence of excessive wound drainage, urine or fecal incontinence or other discharges that could not be contained and suggest an increased potential for environmental contamination and risk of transmission. Personal Protective equipment included to wear gloves and a gown.<br><br>During observations on 8/20/25 at 10:30 AM Medication Aide #1 was observed entering Resident #73’s room who was on contact precautions without wearing gloves or a gown. A sign was posted on the outside of the resident's doorway that read to don gloves and a gown prior to entering the room and remove before exiting. A PPE supply cart was outside of the room by the doorway and stocked with gloves and gowns. Medication Aide #1 was observed at Resident #73’s bedside using a stethoscope and blood pressure cuff to obtain Resident#73’s blood pressure. Medication Aide #1 left the room after obtaining the blood pressure.<br><br>During an interview on 8/20/25 at 10:35 AM Medication Aide #1 stated she was not aware that Resident #73 was on contact precautions due to not being assigned to her care since contact precautions were implemented. She stated she went in the room to check Resident #73’s blood pressure before administering her medications and she did not notice the sign by the doorway. Medication Aide #1 stated she had received infection control training including providing care to residents on contact precautions and knew if contact precautions were in place that she was supposed to wear a gown and gloves. She indicated that not wearing the required PPE prior to entering the room was done in error.<br><br>During an interview on 8/20/25 at 11:30 AM the Infection Preventionist Nurse stated Resident #73 was on contact precautions due to a wound infection and remained on antibiotics. A gown and gloves were required prior to entering Resident #73’s room. She indicated staff had received infection control training to include contact precautions.<br><br>During an interview on 8/20/25 at 4:30 PM the Director of Nursing (DON) stated Resident #73 remained on contact precautions due to a wound infection with wound drainage. Medication Aide #1 should have followed their policy for contact precautions and put on a gown and gloves before going into Resident #73’s room. She stated staff had been trained on the infection control policy.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of facility’s Enhance Barrier Precautions (EBP) Policy dated 05/19/25 revealed in part: “EBP are intended to prevent transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents during high contact. High-risk residents: those with chronic wounds and indwelling devices (such as central lines, urinary catheters, and tracheotomy) and for all those colonized or infected with MDRO currently targeted by Centers for Disease Control (CDC). High contact care activities: activities that may result in transfer of MDRO to hands and clothing of healthcare personnel, even when blood and body fluid exposure is not anticipated. These include dressing, bathing/showering, transferring, providing hygiene, changing linen, changing briefs, assisting with toileting, device care or use, and wound care. Residents placed on EBP should remain on EBP for the duration of their stay or until resolution of the wound.”<br><br>Review of Resident #26’s August/2025 Medication Administration Record (MAR) revealed to cleanse right chest surgical incision with normal saline, apply petroleum ointment to wound bed and cover with dry dressing daily, and apply foam dressing to left shin wound every 3 days, with order dates for both orders of 07/24/25.<br><br>During an observation on 08/18/25 at 2:00 PM an EBP sign was posted on Resident #26's room door that read in part: Enhanced Barrier precautions, and providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a central line, urinary catheters, feeding tubes, and wound care: any skin opening requiring a dressing.<br><br>A follow-up observation was conducted on 08/18/25 at 2:01 PM, after knocking and opening Resident #26’s door, revealed Nurse Aide (NA) #1 in Resident #26's room removing bed linen, helping the resident with activities of daily living, emptying resident’s urinal, and was assisting resident from bed to wheelchair without a gown on. Resident #26 was lying in bed dressed, with sheets and blanket pulled off resident. NA #1 had on gloves when providing care activities for Resident #26 but was not wearing a gown. A bin with PPE (personal protective equipment) supplies was by the door, including one time use disposable gowns.<br><br>An interview was conducted on 08/18/25 at 2:06 PM with NA #1. She stated she did not put on a gown when providing care for Resident #26. She stated she was trained on EPB and knew Resident #26 was on EPB (due to having wound dressings) and did not need to wear a gown because she was not doing wound care, just ADL care and transferring the resident. After reading the EPB sign on resident’s door, NA #1 said she should have donned a gown during Resident #26’s ADL care and transfer but had not read the whole EBP sign.<br><br>An interview was conducted on 08/20/25 at 2:45 PM with the Director of Nursing (DON). She revealed on 08/18/25 at 2:01 PM the NA #1 should have donned a disposable gown during Resident #26’s ADL care, linen change, and transfer, while being on Enhanced Barrier Precautions.<br><br>An interview was conducted on 08/21/25 at 3:00 PM with the Administrator. She stated staff should wear the appropriate personal protective equipment PPE when providing direct care to residents on enhanced barrier precautions. She also stated that all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned personal protective equipment (PPE). |