DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Myrtle Grove	**5725 Carolina Beach Road , Wilmington, North Carolina, 28412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation was conducted from 12/2/25 through 12/3/25. Event # 1DD091-H1. The following intakes were investigated: 2671348 and 2678600. 2 of the 2 complaint allegations resulted in a deficiency.	F0000		12/23/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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:	F0600	Corrective Action 1. During an interview with the DHHS surveyor on 12/3/25, Nurse #1 reported that resident #1 verbalized complaints of pain on 12/13/25. Tramadol was removed from the medication cart but subsequently wasted with a witnessing nurse. Medication was not administered due to resident behaviors. There were no evidence that the resident's pain was followed up on, reassessed, or otherwise addressed by Nurse #1. The resident was assessed on 11/14/25 by Director of Nursing (DON), with no obvious signs of pain. The resident was resting quietly in bed. On 12/3/25, the Director of Nursing notified the provider that the resident's pain was not addressed by the nurse on 11/13/2025. The nurse was terminated on 11/20/25, and her actions were reported to the board of nursing on 11/19/25. Others having the potential to be affected 2. All residents with behaviors have the potential to be affected. The attending provider was notified for review of ongoing pain management needs and medication orders. The Director of Nursing (DON) and/or designee initiated a 24-hour lookback audit of all residents with PRN and scheduled pain medications to identify any missed pain follow-up or unresolved pain documentation. Completed on 12/5/25.	12/23/2025

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 reverse for further 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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F0600 SS = D	Continued from page 1 Resident #1 was admitted to the facility on 8/9/17 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 10/24/25 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.	F0600	Continued from page 1 All other identified residents were noted to have appropriate measures and/or responses in place. The Director of Nursing and/or designee assessed and did not appear to be a contributing factor of their behaviors. What measures will be put in place or what systemic changes 3. Education will be provided by the Administrator and/or designee for all facility staff, to include FT, PT, PRN and Agency staffing on the Facility Policy: NC Abuse and Neglect, with emphasis on neglect related to withholding resident pain treatment. Additional education was provided by the Director of Nursing and/or designee for all clinical staff on: Saber Pain Management Protocol Required documentation of pain assessment, interventions, reassessments, and provider notification. Handling residents who exhibit behaviors and pain management Immediate provider notification when pain medication cannot be administered due to resident behaviors and/or safety concerns. After 12/7/25, no staff shall be permitted to work until education has been received. Monitoring of Corrective Action 4. The DON and/or designee(s) will conduct a medical record review for all residents with documented pain 5x week for 12 weeks to ensure all documented pain was addressed appropriately by the nurse. In addition, the DON and/or designee will conduct 5 care observations weekly for 12 weeks, on residents with a history of behaviors, to ensure the behaviors are handled appropriately, and pain is being addressed when necessary. Any issues will be addressed immediately, staff will receive re-education or progressive disciplinary action, and the provider will be notified.	

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F0600 SS = D	Continued from page 2 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 expressed pain and	F0600	Continued from page 2 The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. Audits begin week of 12/8/25. The Director of Nursing (DON) is responsible for the implementation of this plan. Date of compliance: 12/23/25	

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F0600 SS = D	Continued from page 3 requested medication. The DON stated that Nurse #1 should have used better judgment when she withheld the as needed medication from Resident #1 and that she should have attempted to administer the medication again later. The DON agreed that this incident was neglect. An interview was conducted with the Nurse Practitioner (NP) on 12/3/25 at 2:10 PM. The NP indicated that pain should be addressed by the staff and the as needed medication for pain should be administered. The NP stated that it was not appropriate for the nurse to withhold medication from a resident that expressed pain and requested pain medication. The NP further indicated that pain could contribute to agitated behaviors in a cognitively impaired resident.	F0600		
F0604 SS = G	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F0604	Corrective action The resident was assessed on 11/14/2025 by the Assistant Director of Nursing and Charge Nurse and found to have discoloration and a small scratch noted to the right wrist. The provider assessed the resident on 11/17/2025 and an x-ray of both wrists was obtained with no abnormal findings. The nurse was terminated on 11/19/2025. NA 1 and NA 2 received one on one education and disciplinary action on (date) for not immediately ensuring resident safety and notifying the Abuse Coordinator. Others having the potential to be affected All residents with behaviors have the potential to be affected. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or designee(s) completed a skin assessment on all cognitively impaired residents on 12/19/2025 to ensure there was no evidence that any of the residents may have been restrained previously during care. There were no new injuries identified on the skin assessments. Social Worker and/or designee conducted a Resident Abuse Questionnaire on 100% of cognitively intact residents that includes questions as it relates to abuse, neglect and restraints on 12/18/2025 with no additional reports of abuse or neglect. What measures will be put in place or what systemic changes	12/23/2025

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F0604 SS = G	Continued from page 4 restraints. This REQUIREMENT is NOT MET as evidenced by: 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 8/9/17 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 10/24/25 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	F0604	Continued from page 4 Education was provided for all facility staff on the North Carolina Resident Abuse/Neglect Policy (with emphasis that restraints are not permitted during care by 11/18/2025). In addition, all nursing staff were educated by the Director of Nursing or designee on How to provide care to residents with refusals and/or behavioral concerns by 11/18/2025 with emphasis on addressing unmet needs that may be contributing to the behaviors. All newly hired staff will be educated by the Director of Nursing or designee before orientation is concluded. Education was completed on 11/18/2025. Moving forward the Administrator will review the Abuse policy, types of abuse, signs of abuse and abuse reporting requirements monthly in the Facility Town Hall meetings. Monitoring of corrective action The Director of Nursing and/or designee(s) will conduct 5 care observations weekly for 12 weeks for residents with documented behaviors to ensure staff are not restraining residents in order to provide care and that staff have attempted to address any unmet needs that may contribute to the behaviors prior to performing care. Issues will be addressed immediately, re-education and/or progressive disciplinary action will be done with the staff involved and the provider will be notified. The results of the audits will be reviewed by the Quality Assurance and Process Improvement Committee, which consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Minimum Data Set Nurse, Unit Manager 1 and Unit Manager 2, monthly for 3 months. Audits began on 12/8/2025. The Licensed Nursing Home Administrator (LNHA) is responsible for the implementation of this plan. Date of compliance: 12/23/2025	

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F0604 SS = G	Continued from page 5 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 #1and 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	F0604		

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F0604 SS = G	Continued from page 6 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 way before, and it was very upsetting to her. NA #1 stated that she had 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 but due to being in shock at the time, she did not report it until the following day when she returned to work. An interview was conducted with Nurse #1 on 12/2/25 at 1:38 PM. Nurse #1 stated that she began employment at the facility in October 2025. Nurse #1 stated that she had never worked in a nursing facility before and was unaware of the policies and procedures. Nurse #1 indicated that she did not think that holding a resident’s arms was abuse, as this was a technique used in the emergency department with patients with combative behavior. Nurse #1 stated that on 11/13/25 she was assigned to Resident #1 from 7:00 PM to 7:00 AM and the resident was scheduled for a weekly skin assessment. Nurse #1 indicated that she administered Resident #1’s scheduled medications that evening and then a few minutes later went back into the room while the NAs were providing incontinence care so she could complete the scheduled weekly skin assessment. Nurse #1 indicated that she observed Resident #1 on her side with NA #2 assisting to position her and NA #1 provided the incontinence care. Resident #1 was agitated and was attempting to bite and scratch the NAs. Nurse #1 stated she observed Resident #1’s skin including the buttock and perineal area and then went to the other side of the bed positioning herself by the resident’s face and upper body. Nurse #1 stated that Resident #1 scratched her on the face, so she held the resident by her wrists and held her arms against her body. Nurse #1 indicated that she crossed the resident’s arms across her body and held them there, using a technique that she had used in the emergency department to control a combative patient. Resident #1 was cursing at her so Nurse #1 stated she cursed back at her, and she revealed that she did not think that this was abuse. Nurse #1 stated that the NAs completed the incontinence care and rolled the resident onto her back. Nurse #1 indicated that she observed a pillow on the nightstand and she threw it on the resident because she did not want to get close enough to the resident to place it under her head. The pillow landed on the resident’s chest. Nurse #1 stated that she did not hold the pillow over Resident #1’s	F0604		

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F0604 SS = G	Continued from page 7 face. Nurse #1 stated that she was informed the following day that she was suspended due to the incident with Resident #1. 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. Nurse #1 was making Resident #1 more agitated. Nurse #1 put a pillow over Resident #1's face but was not holding it down. 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 indicated that she was in shock that Nurse #1 engaged in this abusive behavior toward a resident. NA #2 stated that Resident #1 did not complain of pain at the time of the incident, and she did not recall if resident had pain the following day when she was assigned to her. NA #2 recalled that Resident #1 had bruising to her hands and wrists following the incident. NA #2 stated that she did not recall any changes in Resident #1's behavior on 11/14/25. Review of a skin observation completed by the Assistant Director of Nursing (ADON) dated 11/14/25 at 4:37 PM revealed that Resident #1 had bruising and a scratch on her right forearm and wrist. A nursing progress note written by the ADON dated 11/14/25 at 4:39 PM indicated that Resident #1 had new bruising and a small scratch to the right forearm and wrist. Full range of motion to the bilateral upper extremities was noted. The note indicated that Resident #1 was not complaining of any pain at this time where the bruise was. The provider was notified. An interview was conducted with the Assistant Director of Nursing (ADON) on 12/3/25 at 12:20 PM. The ADON stated that she was responsible for staff education and orientation of new staff members. The ADON stated that	F0604		

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F0604 SS = G	Continued from page 8 she discussed abuse and the forms of abuse with all newly hired staff and that Nurse #1 received this training as part of her orientation. The ADON indicated that she interviewed Nurse #1 after the incident and Nurse #1 stated that she held Resident #1's arms but that the nurse did not think her action was abuse or a form of restraint. A review of a facility event report dated 11/14/25 at 5:12 PM revealed that Resident #1 was involved in an alleged episode of verbal and physical abuse. Resident #1 sustained discoloration to the right forearm and wrist. The report indicated that at approximately 10:00 PM on 11/13/25 Nurse #1 spit on Resident #1, cursed at her, placed a pillow over the resident's face and held the resident's arms during care. An interview was conducted with NA #3 on 12/2/25 at 2:05 PM. NA #3 stated that Resident #1 was combative with care spitting, kicking and biting. NA #3 stated that she tried to redirect the resident, explain all tasks and procedures, remain calm, and talk to the resident during care. NA #3 indicated that these interventions usually worked but if Resident #1 remained agitated, she would ensure the resident's safety and reapproach after a few minutes. NA #3 stated that she was assigned to Resident #1 on 11/14/25 from 3:00 PM to 11:00 PM but she worked on the 7:00 AM to 3:00 PM shift that day also and assisted with Resident #1's care that morning. NA #3 stated that on the morning of 11/14/25, Resident #1 kept saying that her thumb and hand were broken and hurt. NA #3 stated that Resident #1 seemed scared and upset during the day on 11/14/25 but was unable to state how the resident's behavior was different. A review of Resident #1's physician orders indicated an order dated 11/14/25 for lorazepam 0.25 mg twice per day as needed for severe anxiety or agitation due to a diagnosis of vascular dementia with psychotic disturbance. Review of Resident #1's MAR revealed that the pain monitoring on the day shift and night shift from 11/14/25 through 11/16/25 was documented as 0 out of 10 pain level. Review of Resident #1's electronic Medication Administration Record (MAR) revealed that as needed lorazepam was administered on 11/16/25 at 12:08 AM and 10:09 AM due to behavioral issues and was documented as effective. Review of Resident #1's MAR revealed that tramadol 50	F0604		

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F0604 SS = G	Continued from page 9 mg as needed was administered on 11/17/25 at 11:08 AM for a pain level of 6 due to hand pain. The MAR indicated that the medication was effective. A nursing progress note dated 11/17/25 at 1:44 PM written by Unit Manager #1 revealed that Resident #1 complained of bilateral hand pain and reported the left-hand pain was worse than the right. The note indicated that Resident #1 had no swelling to the right hand and was able to move her fingers as she normally did. Resident #1 was unwilling to allow the Unit Manager to assess her left hand due to pain. The provider was notified and an order was received for x rays of resident's bilateral hands. Review of Resident #1's physician order revealed an order dated 11/17/25 to obtain x-rays of the right and left wrists. A nursing progress note dated 11/17/25 at 2:20 PM written by Unit Manager #1 revealed that Resident #1 had mild bruising to her bilateral forearms. The note indicated that Resident #1 had a history of pain to the left hand. Resident #1 complained of bilateral hand pain earlier in the day but no complaint of pain at this time. No mental anguish or changes in behavior were noted. Review of a Physician progress note dated 11/17/25 indicated that Resident #1 complained of bilateral hand pain with pain greater in the left hand than the right. Two Nurse Aides reported that they observed a nurse grab Resident #1 roughly by her hands. Resident #1 reported that someone grabbed her and hurt her. Resident #1 did not report any other trauma. An order was written for lorazepam as needed for anxiety due to trauma following the incident. Resident #1 was observed using her right hand but not using the left hand and did not want anyone to touch it. The assessment and plan indicated that Resident #1 had left greater than right hand pain and bruising after being grabbed by a nurse. X rays were ordered. The progress note indicated that staff were to provide supportive care and administer lorazepam as needed for anxiety due to the trauma. No evidence of injury to other areas of the body was observed. Review of an x ray report dated 11/17/25 indicated that x rays of the bilateral wrists were completed on 11/17/25. The results indicated no gross abnormality however it was a limited study and a fracture was not excluded due to a non-diagnostic lateral view. A recommendation was made to repeat the x rays and obtain a multiple view study.	F0604		

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F0604 SS = G	Continued from page 10 A review of a weekly skin observation dated 11/18/25 indicated that Resident #1 had bruising to her right forearm. A Nurse Practitioner (NP) note dated 11/18/25 indicated that Resident #1 was evaluated for a scheduled follow up regarding x rays that were obtained of the bilateral hands after the resident complained of hand pain to the nursing staff. Resident #1 was noted with bruising of the bilateral hands and wrists. The note further indicated that the NP was notified about an incident in which a staff member grabbed the resident's hands and held them down firmly. X-rays were negative for a fracture. Review of a psychiatric follow-up note dated 11/18/25 indicated that Resident #1 was followed for depression and anxiety. Staff reported that Resident #1 was abused by a staff member. Staff reported that the nurse grabbed Resident #1's hands and arms restraining the resident so she couldn't move. The note indicated that Resident #1 stated she was scared about the lady coming back and endorsed she was abused. A recommendation was made to continue with the low dosage of lorazepam, that was added to Resident #1's medications on 11/14/25 as needed for anxiety. A review of Resident #1's MAR revealed that pain monitoring on the day shift and night shift from 11/18/25 through 11/23/25 was documented as a 0 out of 10 pain level. Review of Resident #1's physician orders revealed an order dated 11/24/25 to obtain complete multiple views of the right and left wrists. An x-ray report dated 11/24/25 indicated that complete multi view x rays of the bilateral wrists were completed on 11/24/25 with no fracture or dislocation noted with mild osteoarthritis and no acute abnormality of the wrists. A review of Resident #1's MAR revealed that pain monitoring on the day shift on 11/24/25 was documented at a 5 out of 10 pain level. A physician note dated 11/24/25 at 8:28 PM indicated that x ray results were reviewed. Resident #1 continued with bruising and pain to the left hand after she was grabbed by a nurse. A review of Resident #1's MAR revealed that the resident received tramadol 50 mg for a pain level of 4	F0604		

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F0604 SS = G	Continued from page 11 on 11/27/25 at 9:42 PM and the medication was effective. On 12/2/25 at 12:30 PM Resident #1 was observed in her bed with the head of the bed elevated feeding herself lunch using her right hand. Resident #1 was calm and able to answer simple questions. Resident #1 was observed with bruising to the left hand around the thumb, on top of the hand and the wrist. Resident #1 stated "that girl was squeezing my hand and my thumb is broken. It hurts." An interview with the Regional Nursing Consultant on 12/2/25 at 4:04 PM revealed that she, the Administrator and Director of Nursing developed the plan of correction and determined that the root cause was poor decision making by Nurse #1. The Regional Nursing Consultant stated that a specific plan of correction for restraints was not written but restraints were discussed in the staff education that was provided and staff were informed that residents had the right to be free from restraints. The Regional Nursing Consultant confirmed that Nurse #1 holding Resident #1's arms during care was a form of physical restraint and was not allowed. An interview was conducted with the Director of Nursing (DON) on 12/3/25 at 1:40 PM. The DON stated that it was not appropriate for Nurse #1 to physically restrain Resident #1 during care. The DON stated that Nurse #1 should have used better judgment in the situation and that physically restraining a resident during care was not allowed. The DON indicated that Nurse #1 was reported to the Board of Nursing due to this incident. An interview was conducted with the Nurse Practitioner (NP) on 12/3/25 at 2:10 PM. The NP indicated that she evaluated Resident #1 a few days after the incident occurred and noted that the resident had bruises on both hands and wrists and complained of pain in both hands with pain greater in the left than the right. The NP stated that she ordered x rays to rule out an injury to her hands or wrists. The NP stated that the x rays were negative. The NP indicated that she did not observe any changes in Resident #1's behavior following the incident. An interview with the Administrator on 12/3/25 at 4:30 PM revealed that she was out of the facility on 11/13/25 and 11/14/25 but was informed by the DON of the alleged abuse incident. The Administrator stated that after the investigation was completed, the allegation of abuse was substantiated. The Administrator indicated that physically restraining a	F0604		

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F0604 SS = G	Continued from page 12 resident during care was not appropriate and Nurse #1 was terminated and reported to the Board of Nursing due to her actions.	F0604		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: 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).	F0607	Corrective action Nursing Assistant #1 and Nursing Assistant #2 alleged that nurse #1 restrained and cursed at resident #1 during care on 11/13/2025. NA #1 and NA #2 failed to immediately report the allegation and were re-educated on Abuse Reporting and received disciplinary action on 11/14/2025. The resident was assessed on 11/14/2025 by Assistant Director of Nursing and Charge Nurse and found to have discoloration and a small scratch noted to the right wrist. The provider assessed the resident on 11/17/2025 and an x-ray of both wrists was obtained with no abnormal findings. Nurse #1 was suspended pending facility investigation on 11/14/2025 and terminated on 11/19/2025. Others that having the potential to be affected All residents have the potential to be affected. The Director of Nursing, Assistant Director of Nursing, and/or designee(s) interviewed all staff on abuse to ensure all allegations had been reported to the Abuse Coordinator. There were no unreported allegations. Staff interviews were completed by 11/18/2025. In addition, on 12/19/2025 the Administrator reviewed all facility reported incidents since September 1, 2025 to ensure the allegation was reported to the Abuse Coordinator immediately. There was one additional reporting issue identified that is currently being investigated by the facility Administrator. The employee that reported the incident late was provided re-education and competency validation using an Abuse and Neglect Quiz. What measures will be put in place or what systemic changes All facility staff will be educated on the NC Abuse Policy with emphasis on reporting requirements and the education will be validated using an Abuse and Neglect Quiz. The education will be completed by the Administrator or designee by 12/21/2025. All newly	12/23/2025

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F0607 SS = D	Continued from page 13 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 8/9/17 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	F0607	Continued from page 13 hired staff will be educated by the Administrator or designee on the NC Resident Abuse policy with emphasis on reporting requirements prior to concluding their orientation and their education will be validated using an Abuse and Neglect Quiz. Moving forward the Administrator will review the Abuse policy, types of abuse, signs of abuse and abuse reporting requirements monthly in the Facility Town Hall meetings. Monitoring of corrective action The Administrator or designee(s) will conduct Staff Abuse Interviews on 5 random staff weekly x12 weeks to ensure all allegations of resident abuse have been reported to the Abuse Coordinator according the NC abuse reporting requirements. In addition the Administrator will audit all Facility Reported Incidents for 3 months to ensure staff reported the incident immediately to the appropriate person. Any issues identified will result in immediate re-education of staff and progressive disciplinary action. The results of the audits will be reviewed by the Quality Assurance and Process Improvement Committee, which consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Minimum Data Set Nurse, Unit Manager 1 and Unit Manager 2, monthly for 3 months. The Licensed Nursing Home Administrator (LNHA) is responsible for the implementation of this plan. Date of compliance: 12/23/2025	

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F0607 SS = D	Continued from page 14 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 that all staff were required to report abuse or suspected abuse immediately. A review of a facility event report dated 11/14/25 at 5:12 PM revealed that Resident #1 was involved in an alleged episode of verbal and physical abuse. Resident #1 sustained discoloration to the right forearm and wrist. The report indicated on 11/13/25 at	F0607		

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F0607 SS = D	Continued from page 15 approximately 10:00 PM Nurse #1 spit on Resident #1, cursed at her, placed a pillow over the resident's face and held her arms. A facility summary report of the incident stated that on 11/14/25 at approximately 4:10 PM, Nurse Aide (NA) #1 and NA #2 alleged that Nurse #1 physically restrained Resident #1 by holding her against her will during care and cursed at the resident on 11/13/25. Resident #1 was assessed on 11/14/25 by the Assistant Director of Nursing (ADON) and found to have discoloration and a small scratch to her right wrist. The provider, responsible party, Wilmington Police Department and Adult Protective Services were notified of the allegation on 11/14/25. Nurse #1 was suspended pending facility investigation on 11/14/25. The report indicated that an interview was conducted on 11/14/25 with NA #1 which revealed that NA#2 requested that she assist her with providing incontinence care to Resident #1. When Nurse #1 entered the room to administer Resident #1's medication, NA #1 and NA #2 were providing incontinence care. Upon seeing Nurse #1 enter the room, Resident #1 started screaming. Resident #1 was turned on her side. Nurse #1 approached Resident #1 and held the resident's arms against her body. Resident #1 spit in Nurse #1's face and scratched her. Resident #1 cursed at Nurse #1 and the nurse cursed back at the resident. Resident #1 started spitting at Nurse #1 and the nurse spit back at Resident #1. Nurse #1 placed a pillow in front of Resident #1's face. NA #2 was telling Nurse #1 to walk away, and Nurse #1 did not initially but finally walked out of the room. An interview was conducted with the Assistant Director of Nursing (ADON) on 12/3/25 at 12:20 PM. The ADON stated that she and the Director of Nursing (DON) were informed on 11/14/25 by NA #1 and NA #2 of the staff to resident abuse allegation that occurred on 11/13/25 by Nurse #1 to Resident #1. The ADON stated she immediately notified the Administrator. An interview was conducted with the DON on 12/3/25 at 1:40 PM. The DON stated that it was not appropriate for Nurse #1 to physically restrain Resident #1 during care or to curse or spit at her. The DON stated that Nurse #1 should have used better judgment in the situation and that this incident constituted abuse. The DON stated that NA #1 and NA #2 should have reported the incident immediately and that Nurse #1 should have been removed from the assignment for the remainder of the 7:00 PM to 7:00 AM shift on 11/13/25 to protect Resident #1 and the other residents. The DON stated an investigation should have been immediately initiated after the alleged incident occurred. The DON indicated	F0607		

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F0607 SS = D	Continued from page 16 that when the incident of abuse was reported by NA #1 and NA #2 on 11/14/25, Nurse #1 was informed that she was suspended pending the investigation, was not to report for her scheduled shift on 11/14/25 from 7:00 PM to 7:00 AM or any other shifts. The DON stated that the investigation concluded that abuse occurred, Nurse #1 was terminated and a complaint was filed with the Board of Nursing regarding Nurse #1's actions. An interview was conducted with the Administrator on 12/3/25 at 3:25 p.m. The Administrator explained that she was out of the facility on 11/14/25 when she received a phone call from the ADON who informed her of the abuse allegation. The Administrator further explained that NA #1 and NA #2 did not report the allegation of staff to resident abuse within the required 2-hour timeframe and that disciplinary action forms were completed on 11/14/25 for the employees regarding their failure to report staff to resident abuse immediately. The Administrator indicated that due to NA #1 and NA #2 not immediately reporting the incident, Nurse #1 finished out her 7:00 PM to 7:00 AM shift on 11/13/25 which included being assigned to Resident #1. The Administrator stated that Nurse #1 was scheduled to work from 7:00 PM to 7:00 AM on 11/14/25 but was suspended prior to the start of that shift and did not return to work due to the conclusion of the investigation which substantiated the allegation of abuse.	F0607		