STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Biscoe	401 Lambert Road Biscoe, NC 27209

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49295 Based on record review, and staff and resident interviews, the facility failed to report to the Administrator/Abuse Coordinator and Adult Protective Services the theft of residents' money and personal property for 3 of 4 residents reviewed for misappropriation of resident property (Resident #16, Resident #64 and Resident #60). The facility failed to submit a 5-day investigation report to the state survey agency for 1 of 4 residents (Resident #16). Findings included: Facility Resident Abuse Policy: Abuse, Neglect and Exploitation policy, revised 7/11/24 was reviewed. Policy stated It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown origin. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. Once the Administrator and Department of health are notified, an investigation of the allegation or suspicion will be conducted. The investigation must be completed within five working days from the alleged occurrence. Final Report will be submitted to applicable State agency, after the investigation is completed, but no later than five working days from the alleged occurrence. 1. Resident #16 was admitted to facility on 9/27/16. Resident #16 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #16 was cognitively intact and with no behaviors. An interview was conducted with Resident #16 on 3/3/25 at 11:45 am. Resident #16 stated that on 2/8/25 someone took her lock box that contained money, and a personal ring from her room. Resident #16 indicated that she last seen her lock box on 2/7/25 and on 2/8/25 she realized that both the lock box and the lock box keys were missing. Resident #16 revealed that that the lock box contained 30 dollars, and a ring valued at 500 dollars. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted with Nurse Aide (NA) #3 on 3/5/25 at 1:46 pm. NA #3 confirmed that she worked on 2/8/25 from 7:00 am to 7:00 pm. NA #3 revealed that she went into Resident #16's room to check on her at 4:00 pm. NA #3 stated that Resident #16 indicated that she wanted NA #3 to get her (Resident #16) a drink from the vending machine. NA #3 revealed that Resident #16 had a lock box that was always kept by the window and the keys hung on the wall. NA #3 indicated that when she went to get the lock box for Resident #16 it was not there to be found. NA #3 indicated that Resident #16 did not know where the lock box was. NA #3 further revealed that even the lock box keys were missing. NA #3 indicated that she immediately notified Unit Manager #1 about the missing lock box and lock box keys. NA #3 stated that together with Unit Manager #1 they looked everywhere in Resident #16's room and could not find the lock box or the lock box keys. A phone interview was conducted with Unit Manager #1 on 3/6/25 at 10:51 am. Unit Manager #1 confirmed that she worked on 2/8/25 from 7:00 am to 7:00 pm. Unit Manager #1 revealed that at 4:10 pm, NA #3 notified her that Resident #16 was missing both her lock box and lock box keys. Unit Manager #1 indicated that together with NA #3 they looked everywhere in Resident #16's room and could not find the lock box or the lock box keys. Unit Manager #1 indicated that Resident #16 kept her money in the lock box and used the money to get drinks from the vending machine or anything that she needed staff to assist and get for her. Unit Manager indicated that Resident #16 had reported that she had 30 dollars in the lock box and a personal ring. Unit Manager indicated that she notified Director of Nursing (DON) at 4:30 pm. Unit Manager #1 further revealed that DON informed her to fill out a grievance concern form and place it in the Administrators box in the front office. Unit Manager #1 indicated that she did not notify anyone else about the missing lock box and lock box keys. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 11:35 am. DON indicated that she received notification from Unit Manager #1 on 2/8/25 at 4:35 pm, indicating that Resident #16 was missing her lock box and lock box keys. The DON indicated that she told Unit Manager #1 to notify the Administrator. The DON stated that as far as she knew the Administrator was notified of the missing money that was in the lock box and lock box keys on 2/8/25. An interview was conducted with the Administrator on 3/6/25 at 1:21pm. The Administrator indicated that she was notified on 2/10/25 via phone by Unit Manager #1 about Resident #16 missing 30 dollars. The Administrator also confirmed that adult protective services was not notified. The Administrator confirmed that Resident #16 did not have a 5-day working investigation report submitted to NC DHHS. 2. Resident Number #64 was admitted to facility on 1/31/24. Resident #64 annual Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #64 was cognitively impaired but was able to make himself understood (ability to express ideas and wants) and had no behaviors. An interview was conducted with Resident #64 on 3/3/25 at 12:49 pm. Resident #64 indicated that he had 240 dollars stolen from him. Resident #64 indicated that the money was inside his wallet that was inside the top drawer of his bedside dresser, and it went missing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted with NA #4 on 3/5/25 at 1:57 pm. NA #4 confirmed that she worked on 2/8/25 from 7:00 am to 7:00 pm. NA #4 revealed that Resident #64 reported to her that he was missing money. NA #4 confirmed that Resident #64 did have money in a wallet that he would use to get drinks from the vending machine. NA #4 stated that she notified Unit Manager #1 on the morning of 2/8/25 at 8:00 am. NA #4 indicated that she looked everywhere in Resident #64's room and could not find the missing wallet that had money in it. A phone interview was conducted with Unit Manager #1 on 3/6/25 at 10:51 am. Unit Manager #1 confirmed that she worked on 2/8/25 from 7:00 am to 7:00 pm. Unit Manager #1 indicated that she was notified about Resident #64 missing 200 dollars from his wallet on 2/8/25. Unit Manager #1 indicated that she was notified by Nurse #3 via phone, because she (Unit Manager #1) had already left work. Unit Manager #1 indicated she was notified while at home by Nurse #3. Unit Manager #1 further revealed that she told Nurse #3 to fill out a grievance form, and place it in the administrators box by the front office and notify DON. Unit Manager #1 indicated that she followed up and called the DON as well and notified her of Resident #64's missing money. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 11:35 am. The DON indicated that she received notification from Unit Manager #1 on 2/8/25 at 4:35 pm, indicating that Resident #64 was missing his wallet. The DON indicated that she told Unit Manager #1 to notify the Administrator. The DON further stated that as far as she knew the Administrator was notified of the missing money that was in the wallet on 2/8/25. Review of the 5-day working day investigation report for Resident #64 was submitted on 2/17/25 at 4:59 pm and adult protective services were not notified. An interview was conducted with the Administrator on 3/6/25 at 1:21pm. The Administrator indicated that she was notified on 2/10/25 via phone by Unit Manager #1 about Resident #64's missing money. The Administrator also confirmed that adult protective services were not notified. 3. Resident #60 was admitted to facility on 3/8/19. Resident #60 significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #60 was cognitively intact and had no behaviors. An interview was conducted with Resident #60 on 3/3/25 at 12:03 pm. Resident #60 indicated that his money had been stolen. Resident #60 revealed that his money was inside a lock box that was placed inside the top drawer of his bedside dresser. Resident #60 indicated that the whole lock box was missing, which had 600 dollars. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 11:35 am. DON indicated that she did not receive notification from any staff about Resident #60 missing money. The DON indicated that she was notified of Resident #60 missing money on 2/10/25 by Unit Manager #2 while in the facility. The DON indicated that the Administrator was also notified. Review of the 5-day working day investigation report for Resident #60 was submitted on 2/17/25 at 5:02 pm and adult protective services were not notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 3/6/25 at 1:21pm. The Administrator indicated that she was notified on 2/10/25 via phone by Unit Manager #1 that Resident #60 was missing money. The Administrator also confirmed that adult protective services were not notified.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on staff interviews, resident interview, and record reviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications and dental status for 2 of 22 (Residents #2 and # 29) residents reviewed for MDS accuracy. The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus. Review of Resident #2's January 2025 physician orders included an order for insulin lispro 100 unit/ml (milliliter); administer per sliding scale before meals and at bedtime. Review of Resident #2's January 2025 medication administration record revealed insulin lispro was received on 7 days during the look back period. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the medications section was coded as 0 out of 7 days that injections of any type were received, and 0 out of 7 days insulin injections were received during the lookback period. An interview was conducted on 03/05/25 at 3:59 PM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that she did not code the insulin injections that were received for 7 days during the lookback period. An interview was conducted on 03/06/25 at 10:50 AM with the Administrator. She stated she expected the MDS assessments to be coded accurately. 49295 2. Resident #29 was admitted to facility 4/9/24, with diagnosis that included diabetes, chronic obstructive pulmonary disease, depression, heart failure and hypertension. Resident #29 Significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #29 had no oral or dental problems. An observation was made on 3/3/25 with Resident #29 at 11:53 am. Resident #29 was observed to have missing upper and lower teeth, with only 4 remaining upper teeth, and at least 5 remaining lower broken teeth. The 4 remaining upper teeth were noted to have decay and discoloration. On 3/6/25, at 9:36 am, an observation was made with MDS Nurse #1 while she (MDS Nurse #1) was examining Resident #29's mouth, doing an oral assessment. MDS Nurse #1 indicated that Resident #1 was noted to have five lower bottom teeth that were broken, and 4 upper teeth that had visible decay. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with MDS Nurse #1 on 3/6/25, at 9:36 am. MDS Nurse #1 indicated that she did not accurately reflect Resident #29 dental status on the significant change assessment dated [DATE]. MDS Nurse #1 further indicated that Resident #29's should have been coded as having obvious or likely cavity on the assessment. MDS Nurse #1 stated she would complete a modification to ensure that the assessment accurately reflected Resident #29's dental status. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 11:35 am. The DON indicated that she required assessments accurately reflected a resident's dental status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review, observations and staff interviews, the facility failed to develop an individualized person-centered care plan in the area of nutrition for 1 of 2 residents reviewed for nutrition (Resident #2). The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA) and cognitive communication deficit. Resident #2's active orders included an order dated 12/26/24 for adaptive equipment: Divided Plate. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2's cognition was severely impaired. She required setup/cleanup assistance with meals. Review of Resident #2's active care plan, last reviewed on 02/06/25, revealed a care plan focus for nutritional status that read Resident #2 was at an increased nutritional risk due to dysphagia, congestive heart failure, age-related physiological decline, impaired mobility, diabetes mellitus, and weight loss. The care plan focus did not include an intervention for a divided plate during meals. Observation made in the dining room on 03/04/25 at 8:20 AM of Resident #2 eating breakfast from a divided plate. Observation made in the dining room on 03/05/25 at 12:05 PM of Resident #2 eating lunch from a divided plate. An interview was conducted on 03/05/25 at 3:59 PM with the Minimum Data Set (MDS) Nurse #1. She verified there were no areas on Resident #2's care plan for a divided plate during meals and there should have been an intervention added to the nutrition focus area. She explained dietary completed the focus care area for nutrition and should have added the intervention for the divided plate, but it was a group effort. A phone interview was conducted on 03/05/25 at 5:22 PM with the Registered Dietitian (RD). She stated Resident #2 did have an order for a divided plate with meals and that it should have been included in the care plan. She indicated she should have added the divided plate to the care plan focus for nutrition. An interview was conducted on 03/06/25 at 10:50 AM with the Administrator. She stated she expected Resident #2's care plan should have included the divided plate during meals.