STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Waynesville	360 Old Balsam Road Waynesville, NC 28786

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, and staff and family interviews, the facility failed to determine if a resident with cognitive impairment had a Resident Representative before allowing the resident to sign admission paperwork for 1 of 1 resident (Resident #91) reviewed for resident rights. Findings included: Resident #91was admitted to the facility on [DATE] with diagnosis that included dementia. Resident #91was discharged from the facility to another skilled nursing facility on 4/18/25. A hospital discharge summary dated 3/6/25 stated Resident #1 had advanced dementia. Resident #91's face sheet was reviewed and revealed Resident #91 was listed as the first primary contact as the primary financial contact receive account receivable (A/R) statement. Resident #91's [Family Member] was listed as the second contact as the emergency contact. An additional family member was listed as the third contact as the Resident Representative. Resident #91's Spouse was not listed on her contact list. Review of Resident #91's facility admission agreement paperwork revealed the paperwork had been signed by Resident #91 on 3/11/25 and was witnessed by the former Admission Coordinator. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 had severe cognitive impairment. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #91's Family Member, who was her legal representative on 5/21/25 at 12:10 PM. She reported it was not until Resident #91 left the facility and the Family Member had signed admission paperwork for Resident #91 at the new facility that she became concerned about the admission paperwork because she had not signed any of it when Resident #91 was admitted to the facility on [DATE]. The Family Member stated she called the facility after Resident #91 had moved to ask about who had signed the admission paperwork for Resident #91 and was told by the former Admission Coordinator Resident #91 had signed the paperwork. The Family Member explained Resident #91 had dementia and would not understand anything she signed. She verbalized the facility had told her, Resident #91's Spouse had been present in the room when Resident #91 had signed the admission paperwork. The Family Member stated the facility did not say why they did not have Resident #91's spouse sign the paperwork instead of Resident #91. She recalled the former Admission Coordinator was very quick to say Resident #91 had signed but her Spouse was present. The Family Member stated the Spouse was present and they could have had him sign the paperwork, but they had Resident #91 sign it. The Family Member stated Resident #91 was not competent to sign the paperwork. The Family Member explained Resident #91 knew who she was but was not aware of her surroundings. She felt the facility should have known from Resident #91's medical history that she could not sign paperwork. The Family Member explained Resident #91's Spouse was overwhelmed and would not have known what he was signing. She said he would not have understood the paperwork either and that he would have just signed it. The Family Member stated she had been at the facility a lot and if she was not there the facility could have called her, and she would have come to sign the paperwork. The Family Member reported she felt the admission paperwork for Resident #91 should have been signed by someone who understood what the paperwork was, and that the admission paperwork would have been a foreign language to her parents. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the former Admission Coordinator on 5/21/25 at 2:33 PM. She stated the admission paperwork was completed and signed electronically using a tablet device. She recalled Resident #91, and stated she was aware Resident #91 had a diagnosis of dementia from her hospital admission paperwork but that she was not aware of the extent of her dementia. She recalled completing the admission paperwork with Resident #91 and her Spouse. The former Admission Coordinator said she had talked with Resident #91 and her Spouse about the paperwork and that Resident #91's cognition seemed perfectly fine. The former Admission Coordinator stated she had asked if Resident #91 had a power of attorney (POA) and the Spouse and Resident #91 had said no. She reported that both Resident #91 and her Spouse participated in the conversation. The former Admission Coordinator reported she felt they understood what was being discussed. The former Admission Coordinator stated she was unsure if Resident #91 or her Spouse were able to retain the information discussed. The former Admission Coordinator stated she was aware of what dementia was and agreed memory impairment and short-term memory loss were features of dementia. The former Admission Coordinator reported the Spouse had said to let Resident #91 sign the admission paperwork and that was why she had let Resident #91 sign the documents. She explained if a resident was cognitive enough to sign or there was a family member in the room who said the resident was coherent enough to sign she let the resident sign. She stated if a resident was able to sit up, talk, tell her where they were, and was very aware then the resident was okay to sign the admission paperwork. She reported if a resident was not alert/ oriented enough to sign their admission paperwork she would reach out to the POA or family to complete the paperwork. She said if the Spouse or legal representative was in the room then they should be the person who signed the paperwork. The former Admission Coordinator explained she had not been aware Resident #91 had a POA until Resident #91 was getting ready to discharge from the facility. She stated Resident #91's [Family Member] had called and asked about who had signed Resident #91's admission paperwork and the daughter had told her at that time she was Resident #91's POA. The former Admission Coordinator said the facility did not have a copy of Resident #91's POA paperwork. She reported that Resident #91's daughter emailed the POA (Health Care) paperwork to the facility close to the day of the resident's discharge, but did not give an exact date. After the former Admission Coordinator received the POA paperwork she added it to Resident #91's medical record. An interview was conducted on 5/21/25 at 3:10 PM with the Director of Nursing (DON). The DON reported that the admission paperwork should be signed by the Resident Representative (RR) or POA if a resident had cognitive impairments. The DON said even if a spouse or POA was in the room and said to let them sign, they could not because they would be signing a legal document they did not understand. The DON recalled Resident #91 and said she did not think Resident #91 was competent to sign her own admission paperwork. An interview was conducted with the Administrator on 5/22/25 at 2:04 PM. The Administrator stated he remembered Resident #91 and was aware she had dementia. He reported Resident #91 should not have signed her admission paperwork because they were legal documents and she had dementia. The Administrator stated Resident #91's authorized legal representative should have signed the papers. He said he had not been aware of the situation previously and was not sure what had happened.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record review and staff interviews, the facility failed to protect a severely cognitively impaired resident (Resident #65) from the right to be free of physical abuse. On 3/07/27 around 10:30 PM, when Nursing Assistant (NA) #1, and NA #2 were providing care for Resident #65, the resident became agitated and combative. NA #2 struck the resident with an open hand on her lower left arm. The deficient practice occurred for 1 of 4 residents reviewed for abuse. Findings included: Resident #65 was admitted to the facility on [DATE] with diagnoses which included dementia and hypertension. Resident #65's care plan revised 4/02/25 revealed a problem area of cognitive loss/dementia due to progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to a diagnosis of dementia. The goal was for the resident to maintain her highest level of cognition. Approaches included: to be patient with resident; break tasks and activities into manageable subtasks; give one instruction at a time; and gently redirect the resident when she made inappropriate actions. Resident #65's significant change Minimum Data Set, dated dated dated [DATE] revealed she was severely cognitively impaired and was dependent or required substantial assistance for activities of daily living. She was not assessed to have behavioral problems during the lookback period. Nurse Aide (NA) #2's handwritten statement was undated and read I changed (Resident #65's) bed while NA #3 and NA #1 gave her a shower. Got her in bed and she likes to hit. I blocked her with my arm and grabbed her hands so she wouldn't hit. NA #1 and NA #3 were in the room, and I never hit her she hit me! A telephone interview with NA #2 was attempted but unsuccessful. A typed statement from NA #1 dated 3/09/25 read, Around [9:50 PM] [NA #1, NA #2, and NA #3] went to [Resident #65's] room who was in bed and agitated. (NA #2 and NA #1) transferred [Resident #65] on the lift while [NA #3] handled the lift. [NA #3 and NA #1] gave [Resident #65] the shower in the shower room while [NA #2] stayed in the room and changed the linen. [Resident #65] finished her shower and was brought back to her room and placed back in bed with the lift. [NA #2 and NA #1] rolled [Resident #65] to get the lift pad and towels from under her. [Resident #65] was rolled towards [NA #2], while [NA #1] was drying her back [Resident #65] was hit [NA #2] several times. When [Resident #65] was placed on her back, [NA #2] struck [Resident #65] on the left forearm. She went down [Resident #65's] face and said, Get you're a-s over. Afterwards [NA #2] stated to [NA #1 and NA #3] she has no sympathy for (resident). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/21/25 at 12:55 PM with NA #1 revealed she was present in the room at the time of the incident between Resident #65 and NA #2 which occurred on 3/07/25 around 10:30PM. She stated she and NA #2 were settling Resident #65 in bed after her shower. She stated NA #3 was in the room and she did not know what he had heard or seen. As NA #1 and NA #2 were turning Resident #65 to remove the lift pad and wet linens from under her, NA #1 observed the resident hit NA #2. NA #1 stated she observed NA #2 hit Resident #65 with her open hand on the resident's left lower arm. The resident did not say or do anything in response to being hit on the arm. NA #2 stated to NA #1 that she did not care anymore and had no sympathy for the resident. NA #1 stated she did not say anything to NA #2 about seeing NA #2 hit the resident. NA #1 stated she just froze and didn't know what to say or do. NA #1 stated she and NA #2 and NA #3 exited the room. NA #1 stated she was in shock and did not know what to do. NA #1 stated she got off work at 10:30 PM, so she clocked out and left the facility right after the incident. She stated she was afraid to report the incident to the on-duty nurse, Nurse #1, because she was afraid of a confrontation with NA #2. NA #1 indicated she did not report it until after she got home, which was about a 15-minute drive. NA #1 further stated she contacted the Director of Nursing and reported the incident, but did not remember the time of the call. NA #3's emailed statement dated 3/08/25 at 12:24 AM read, Hello [Administrator], The following is my report on the events of the period of time (roughly 10:00-10:25 PM) in which the incident discussed allegedly occurred: [NA #1] and myself had just finished giving [Resident #65] a shower. We used the full mechanical lift to transport [Resident #65] from the shower chair to her bed, where she was then laid down on her side. I left the room for about 10 seconds while I moved the lift out of the room and retrieved washcloths to finish cleaning [Resident #65]. During this period, [Resident #65] exclaimed pain/discomfort several times, which is not at all unusual for any of us, seeing as she has experienced this discomfort with most forms of movement for the entirety of my employment. [NA #1 and NA #2] finished cleaning and preparing [Resident #65] for bed while I mostly either stood by for occasional help or worked on cleaning the floor ([Resident #65] had also defecated while being transferred), so I can't say I observed the entire interaction. In regard to the matter at hand, I did hear [NA #2] exclaim some frustration with [Resident #65] for hitting her while we finished cleaning her, but at no point did I hear or see anything that indicated to me that [NA #2] hit [Resident #65]. Please let me know if there are any further details that you would like me to clarify. An interview on 5/21/25 at 9:29 AM with NA #3 revealed he was present in the room on 3/07/25 at the time of the incident. He stated he was cleaning the floor and heard NA #2 tell Resident #65 not to hit her. He was unaware of the incident until he was driving home and received a call from the Administrator. NA #3 indicated he did not have any further conversations with NA #1 or NA #2 that evening. Nurse #1's progress note dated 3/07/25 11:58 PM (recorded as late entry on 3/08/25 at 8:34 AM) read in part that Resident #65 was assessed from head to toe. No new discoloration, swelling, bruising, injury noted. Patient appears to have no pain or discomfort noted. On-call physician was notified. Law Enforcement Officer escorted NA #2 out of the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/21/25 at 3:34 PM with Nurse #1 revealed she was on duty on 3/07/25 when the physical abuse incident occurred between NA #2 and Resident #65. She stated she was unaware of the incident until the Director of Nursing (DON) called her after 11:00 PM. She did not remember the exact time but she took the telephone to NA #2 so she could talk with the DON. She stated a Law Enforcement Officer arrived at the facility, talked with NA #2 and escorted her out of the facility. Nurse #1 assessed Resident #65 who had no bruises, welts, discoloration or other injuries noted and no discomfort was observed. An interview on 5/21/25 at 2:36 PM with the Director of Nursing (DON) revealed that NA #1 had called her after 11:00 PM on 3/07/25 to report the incident. NA #1 stated that she had observed Resident #65 hit NA #2 and NA #2 hit the resident. NA #1 also stated she felt uncomfortable reporting the incident to Nurse #1, so she waited until she got home to call the DON to report the incident. The DON indicated she had called the facility, talked to Nurse #1 and NA #2 was asked to leave the building. She stated she personally talked to NA #2 on the telephone, told her she was being suspended and asked her to leave the building. NA #2 was still in the facility working her shift when the DON called the facility and talked with Nurse #1 and NA #2. As NA #2 was leaving the facility, a Law Enforcement Officer arrived at the facility and escorted her out of the building. The DON instructed Nurse #1 to complete a full skin assessment on Resident #65 and notify the on-call physician. An interview on 5/22/25 at 9:31 AM with the Administrator revealed he had been notified by the DON that NA #1 had observed NA #2 hit Resident #65 on her left lower arm immediately after she was notified by NA #1 which was after 11:00 PM on 3/0725. The Administrator stated he contacted Law Enforcement. During the investigation, he talked with NA #2 who stated that NA #1 perceived the incident incorrectly. The allegation was investigated, and the facility did not substantiate it. The Administrator stated NA #2 was terminated for poor customer service. The police did not press charges against NA #2. The facility provided a corrective action plan which was not acceptable to the State Agency due to not including observations of nurse aides providing care in their audits to ensure the deficient practice will not recur.