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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record reviews and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, Lorazepam, prescribed for anxiety/restlessness had a stop date of 14 days for 1 or 6 residents (Resident #80) reviewed for unnecessary medications. The findings included: Resident #80 was admitted to the facility on [DATE] with diagnoses which included restlessness and agitation. Resident #80's quarterly Minimum Data Set, dated dated dated [DATE] revealed she was severely cognitively impaired and was coded for hospice care. A physician's order dated 12/03/24 at 1:07 PM read for Lorazepam (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for anxiety/restlessness. There was no stop date. Review of the monthly drug regimen review consultation report dated 12/14/24 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The physician's response signed by the Physician and undated read to accept the recommendation above and implement as written. No stop date or discontinuation date was written on the recommendation. A review of Resident #80's December 2024 and January 2025 Medication Administration Records (MARs) revealed the Lorazepam 0.5 mg every 4 hours PRN for anxiety and restlessness remained an active order. Review of Resident #80's February 2025 and March 2025 MARs revealed per staff documentation, Resident #80 had received Lorazepam the following doses: 4 doses in February 2025, 14 doses in March 2025, 7 doses in April, and 7 doses between May 1st and 19th, 2025. Review of the monthly drug regimen review consultation report dated 3/23/25 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The physician's response signed by the Physician's Assistant dated 4/02/25 read to add a stop date of 4/15/25 to the Lorazepam order. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #80's April 2025, and May (1st through the 19th) 2025 Medication Administration records revealed through staff documentation, Resident #80 received 7 doses of Lorazepam in April, and 7 doses between May 1st and 19th, 2025. Review of the monthly drug regimen review consultation report dated 4/19/25 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The Physician's response signed by the Physician's Assistant dated 4/28/25 was to decline the recommendation with the rationale it was a hospice patient order. An interview on 5/21/25 at 9:44 AM with Nurse #2 revealed she received the monthly drug regimen review consultation reports, distributed them to the physicians, and ensured the recommendations were completed. She stated that since Resident #80 was on hospice, their Lorazepam PRN order did not require a stop date. Nurse #2 indicated she noted the resident was on hospice on the pharmacy consultation report and had not entered a stop date for the December 2024, March 2025 or April 2025 monthly drug regiment review consultation reports. An interview on 5/21/25 at 10:08 AM with Nurse #3 revealed she also received the pharmacy medication reviews, distributed them to the physicians, and ensured the recommendations were completed. She stated that since Resident #80 was on hospice, their Lorazepam PRN order did not require a stop date. Nurse #3 stated it was her understanding that hospice resident PRN psychotropic medications did not require a stop date. An interview on 5/21/25 at 10:13 AM with the Director of Nursing (DON) revealed the staff thought that hospice residents did not require a stop date for their psychotropic medications. The DON indicated she was aware of the regulation which required a stop date for psychotropic medications and was unaware that Nurse #2 and Nurse #3 thought that hospice residents were an exception. She was unaware that Resident #65's Lorazepam did not have a stop date and said the facility should follow regulations. An interview on 5/22/25 at 9:35 AM with the Administrator revealed he believed hospice wanted their residents to have their psychotropic medications to be continued but was aware of the requirement for PRN psychotropic medications to have a stop date.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record review, staff, and Adult Protective Services (APS) Social Worker (SW) interviews, the facility failed to follow and implement their abuse policy and procedures in the areas of protecting, investigating, and reporting to the Administrator, the State Agency, and/or law enforcement for 2 of 4 residents (Resident #51 and Resident #65) reviewed for abuse. Nursing Assistant (NA) #1 observed NA #2 strike Resident #65 with an open hand during care and did not immediately intervene, did not report the incident immediately to the Administrator, and NA #2 continued to work on the floor with other residents. This failure resulted in a lack of protection for other residents. The findings included: Review of the facility policy titled North Carolina Resident Abuse Policy, revised 7/11/24 indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. 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 procedure in this policy. If a staff member is accused or suspected of abuse, the facility will immediately remove the staff member from resident care area. The accused staff member will be removed from the facility pending the outcome of the investigation. 1. Resident #65 was admitted to the facility on [DATE] with diagnoses which included dementia. Resident #65's significant change Minimum Data Set, dated dated dated [DATE] revealed she was severely cognitively impaired. The initial allegation report was completed by the Administrator and dated 3/07/25. The incident date was 3/07/25. The date the facility became aware of the incident was 3/07/25 at 10:00 PM. Allegation details reported that staff alleged witnessing NA #2 strike Resident #65 while providing care. 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 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. NA #1 stated she observed NA #2 hit Resident #65 with her open hand on the resident's left lower arm. NA #2 stated to NA #1 that she did not care anymore and had no sympathy for the resident. NA #1 stated she and NA #2 and NA #3 exited the room. NA #1 stated after the incident, she observed NA #2 walk down the hall where she was assigned and she was available to provide care for the facility residents. NA #1 stated she was in shock and did not know what to do. NA #1 stated she got off work on 3/07/25 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. She did not report it until after she got home, which was about a 15-minute drive. NA #1 stated she contacted the Director of Nursing and reported the incident, but did not remember the time of the call. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 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. 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. The DON had called the facility, talked to Nurse #1 and NA #2 was asked to leave the building. NA #1 reported to the DON 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 (2:30 PM - 6:30 AM) 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 and the resident representative. The facility notified the Department of Social Services of the incident. An interview on 5/22/25 at 9:31 AM with the Administrator revealed he had been notified about the incident and an investigation had been completed. He stated that NA #1 should have reported the incident immediately, but she had been afraid to report the incident with NA #2 present. 50046 2. Resident #51 was admitted to the facility on [DATE] with a diagnosis of dementia. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #51 had short-term and long-term memory problems. The MDS noted her cognitive skills for daily decision making were moderately impaired. Resident # 89 was admitted to facility on 1/7/25 with diagnoses that included bipolar disorder (psychiatric disorder). The admission 5-day MDS dated [DATE] revealed Resident #89 was cognitively intact. During a phone interview with an Adult Protective Services (APS) Social Worker (SW) on 5/21/25 at 12:25 PM she revealed she came to the facility on [DATE] to investigate a staff to resident abuse allegation. The APS SW stated she had talked with the facility SW and explained she was investigating an alleged staff to resident abuse allegation for Resident #51 that had been reported by the resident's roommate, Resident #89. The APS SW recalled the facility SW stating she did not know anything about it and that Unit Manager (UM) #1 would be better to talk to about it. The APS SW stated the facility SW took her to UM #1's office. The APS SW recalled herself, UM #1, and the facility SW sitting in UM #1's office and talking about the allegation. The APS SW reported she told UM #1 she was at the facility to investigate a staff to resident abuse allegation involving Resident #51 that had been reported by Resident #89. The APS SW stated the abuse allegation was not substantiated. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility SW was unavailable for interview. An interview was conducted with UM #1 on 5/21/25 at 2:09 PM. UM #1 reported she remembered an APS SW coming to the facility to visit Resident #89 and Resident #51. She recalled talking with the APS SW but did not remember the details of the conversation. UM #1 reported she did not recall the APS SW saying she was investigating a staff to resident abuse allegation for Resident #51 that was reported by Resident #89. Review of the Facility Reportable Incidents revealed there was no record of the alleged staff to resident abuse incident reported to APS by Resident #89 for Resident #51. An interview was conducted with the Administrator on 5/20/25 at 11:00 AM. The Administrator was not aware of an abuse allegation involving Resident #51 from February 2025 or March 2025. The Administrator explained he would continue to look for information. On 5/20/25 at 2:45 PM the Administrator provided a letter dated 3/14/25 addressed to the Administrator titled North Carolina Department of Health and Human Services Division of Aging and Adult Services Notice to Administrator: Completion of Evaluation. The letter revealed the following information: APS received a phone call from Resident #51's roommate, Resident #89, reporting that Resident #51 had gotten beat up last night. The timeline told to APS from Resident #89 was a bit scattered and it was unclear if this happened last night or a couple of days or weeks ago. Resident #89 was unable to state who the perpetrator was, but she indicated it was not a resident and alluded to it being a staff person. When telling APS the information, Resident #89 seemed scared, like someone was listening. The APS SW's investigation on 3/14/25 did not confirm/substantiate abuse or the need for protection as the APS SW did not know who the alleged perpetrator was, what time of day it happened, or what day it happened. An additional interview was conducted with the Administrator on 5/20/25 at 2:45 PM. The Administrator stated the facility SW was unavailable due medical leave. He reported he had found the letter APS regarding the abuse allegation and investigation involving Resident #51 in a file located in the SW's desk. The Administrator stated the SW had not mentioned the letter to him. The Administrator explained he had not been aware of the letter or allegation before he found the letter today (5/20/25). The Administrator said if he had been aware of the staff to resident abuse allegation he would have followed the facility's abuse investigation and reporting process, which would have included reporting the allegation to the state agency and law enforcement. An interview was conducted with the Director of Nursing (DON) on 5/21/25 at 3:02 PM. The DON stated she had not been aware of the staff to resident abuse allegation involving Resident #51 or that APS had come to the facility and completed an investigation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000 Based on observation and staff interviews, the facility failed to remove four containers of fortified nutritional shake nectar consistency that had a used by date of [DATE]. The four expired containers were found in 1 of 2 nourishment rooms. These practices had the potential to affect any residents that used nectar thickened consistency. The findings included: On [DATE] at 8:25 AM the east side nourishment room was observed and in one of the cupboards there were four containers of fortified nutritional shake with nectar consistency that had a used by date of [DATE]. On [DATE] at 9:13 AM an interview was conducted with the Dietary Manager. The Dietary Manager stated she had no idea how the 4 containers of nutritional shake were missed. The Dietary Manager stated that she inspects both nourishment rooms daily and somehow it got missed. The Dietary Manager stated after hearing about the expired nutritional shakes she inspected both nourishment rooms and all the nutritional shake products she had in the kitchen to ensure there were no other expired containers. The only explanation for the product being missed could possibly be the Dietary Manager's newer staff stocking the nourishment room and placing new products in front of the older product. On [DATE] at 10:37 AM an interview was conducted with the Administrator. He stated that he had been made aware of the expired nutritional shake, and he can't explain how it was missed, but would expect the product to be removed. All food products should be inspected and removed if they are expired.