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	06/04/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to discard food past its use-by date in 1 of 1 walk-in cooler. This practice had the potential to affect food served to residents.The findings included:An observation of the walk-in cooler with the Food Services Director on 5/31/26 at 9:48 AM revealed a box of four 5-pound bags of shredded coleslaw with a use-by date of 5/28/26 stamped on the bags.An interview on 5/31/26 at 9:57 AM with the Food Services Director revealed she and the other dietary staff were responsible for checking the cooler daily for food that needed to be discarded. She indicated the shredded coleslaw bags should have been discarded according to their use-by date. The Food Services Director reported she had checked the cooler that morning. An interview on 6/04/26 at 11:23 AM with the Administrator revealed the Food Services Director was responsible for ensuring expired foods were discarded. She indicated the bags of shredded coleslaw should have been discarded according to their use-by date and expected dietary staff would follow policy to determine when food needed to be discarded.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a person-centered individualized care plan for 1 of 3 residents reviewed for urinary catheters (Resident #6).The findings included:Resident #6 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was moderately cognitively impaired, was dependent on staff for toileting hygiene and was always incontinent of both urine and bowel.Resident #6's care plan which was last reviewed and revised on 3/11/26 indicated no information about care for an indwelling catheter.A review of a physician's order dated 3/12/26 indicated catheter care: change indwelling urinary catheter as needed. An interview with MDS Nurse #1 on 6/4/26 at 12:41 PM revealed she last updated Resident #6's care plan on 3/11/26. During the interview, MDS Nurse #1 looked through Resident #6's medical record and noted that Resident #6's catheter was initiated on 3/12/26, and this was why she did not know that Resident #6 had an indwelling urinary catheter because she had just updated her care plan the day before. MDS Nurse #1 stated that she checked the orders whenever she updated the care plans. She also stated that she updated the care plans whenever she was made aware of any changes with the residents and if she was told during the morning meetings about any new information. MDS Nurse #1 stated nursing should be trained to update the care plans when needed, and if she had known about Resident #6's urinary catheter, she would have updated her care plan.An interview with the Director of Nursing (DON) on 6/4/26 at 2:25 PM revealed MDS should be keeping up with a list of residents with indwelling urinary catheters. The DON stated the MDS nurses were supposed to check the daily orders, and that Resident #6's care plan should have been updated if there was a new order for a urinary catheter.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, staff, and Physician Assistant (PA) interviews, the facility failed to follow a physician order to float Resident #47's heels while in bed as tolerated during three observations. Additionally, the facility failed to implement a bowel protocol for Resident #43 who had not had a bowel movement documented in 6 days. This deficient practice occurred for 2 of 4 residents (Resident #47 and Resident #43) reviewed for quality of care. The findings included: 1. Resident #47 was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease (progressive circulation disorder that narrows or blocks blood vessels). On 4/16/26 there was a physician order stating to float heels when in bed as tolerated every shift. On 4/22/26 the admission Minimum Data Set (MDS) assessment indicated Resident #47 was cognitively intact. She needed substantial/maximal assistance to roll left and right. The admission MDS also indicated that she had no wounds and had a pressure reducing device for her bed. The 5/11/26 care plan had a focus area regarding skin integrity and one of the approaches was to offload heels in bed as tolerated. On 5/31/26 at 12:54 PM an interview was held with Resident #47. She stated that she had a sore on her left heel. She stated that it was causing her pain having the heel on her mattress. On 5/31/26 at 12:54 PM an observation was made of Resident #47 heels. Both heels laid on a pressure reducing mattress with no socks. The left heel had a round 1 inch in diameter scab. On 6/2/26 Resident #47 had a bilateral lower extremity arterial duplex ultrasound and the Medical Director deemed the left heel wound an arterial wound with arterial insufficiency (narrowed or blocked arteries slowing blood flow) as the main contributing factor to wound development. On 6/3/26 at 9:15 AM a second observation was made of Resident #47 and both of her heels laid on her mattress with no socks. On 6/3/26 at 10:26 AM an interview was held with a Physician Assistant (PA). She stated that she had just learned of the heel wound on 6/1/26. The PA stated that Resident #47 was on Hospice and spent a lot of time in her bed, but she recently decided to end Hospice care. When the PA saw her today, she also observed that her heels were not being floated. On 6/3/26 at 12:50 PM an interview was held with Nurse Aide (NA) #1 who was assigned to Resident #47. The NA stated that she was not aware that Resident #47's heels were to be floated. NA #1 went and spoke to Resident #47 about floating her heels and got a pillow to float them. On 6/3/26 at 12:55 PM an interview was held with NA #2. NA #2 also did not know that Resident #47's heels were to be floated as tolerated. On 6/3/26 at 2:38 PM an interview was held with Unit Manager #2. She stated that each NA had a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet to pull down the care plan for each resident and it showed that Resident #47 heels were to be floated as tolerated and that Resident #47 could decline having them floated. On 6/4/26 at 11:39 AM a third observation was made of Resident #47 and neither of her heels were being floated. They were observed laying on her mattress and the Resident had socks on. Resident #47 was sleeping so was unable to be interviewed. On 6/4/26 at 3:00 PM an interview was held with the Director of Nursing (DON). She stated the staff should be following the physician orders and be offering Resident #47's heels to be floated if she wanted. On 6/4/26 at 3:30 PM multiple telephone calls were made to the Medical Director. He did not return any of the calls. On 6/4/26 at 3:46 PM an interview was held with the Administrator. She stated that she would expect the staff to be following the plan of care, and she would be reviewing the care plans and making sure each approach was entered into the tablets that the NAs use. 2. Review of a facility bowel protocol policy reviewed last on 1/31/26 read in part, If 48 hours without a bowel movement (BM): -Give Miralax (polyethylene glycol) (laxative) 17 grams (gm) in 4-8 ounces (oz) liquid -If no BM by 10 AM the following day, repeat Miralax 17 gm in 4-8 oz liquid -If no BM by the next morning, administer enemeez micro enema 5 milliliters (ml) rectally. If no BM within an hour, contact provider. Resident #43 was admitted to the facility on [DATE]. His diagnoses included dementia. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented he had severe cognitive impairment. The MDS indicated he did not have behaviors or rejection of care. The MDS reported he required substantial/ maximal assistance with his activity of daily living (ADL) tasks, toileting hygiene, and transfers. The MDS documented he was frequently incontinent of bowel. Resident #43 did not have a care plan for constipation. Resident #43's physician orders did not include any medication that could cause constipation. His physician orders did not include any medications to move his bowels prior to 5/7/26. A nursing note on 5/1/26 documented Resident #43 was transferred to the hospital for evaluation due to a change in mental status. A hospital emergency room (ER) report dated 5/1/26 documented Resident #43 had a scan of his abdomen during an ER visit showing chronic constipation. The ER report did not include any information that indicated he received any treatment or medication for his bowels during his ER visit. The report did not include any discharge orders for bowel medications. The ER report included he was being discharged back to the facility and included orders for an antibiotic for treatment of possible (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pneumonia. A hospital abdominal scan dated 5/1/26 read, large colonic stool burden with features of chronic constipation. A nursing note dated 5/2/26 by Nurse #3 documented Resident #43 returned to the facility on 5/2/26 at 12:30 AM. The note did not mention the abdominal scan showing constipation or any orders for bowel medications. An interview was conducted with Nurse #3 on 6/4/26 at 2:50 PM. Nurse #3 worked night shift (10:30 PM- 6:30 AM) and was Resident #43's assigned nurse on 5/1/26, 5/2/26, 5/3/26, 5/4/26, 5/5/26, and 5/6/26. She thought she recalled Resident #43 returning with paperwork from his ER visit on 5/2/26. She recalled his chest scan had shown there was fluid in his lungs and that he had returned with a new order for an antibiotic. Nurse #3 stated she did not recall a scan that showed anything bad about his bowels and thought there was an abdominal scan that said small or moderate stool in his colon. Nurse #3 then said she was not sure and might be mixing up the abdominal scans from his 5/1/26 and 5/8/26 ER visits. She said she could not remember for sure what his 5/1/26 ER visit abdominal scan showed or that she had seen it. Nurse #3 stated if there was a scan that had shown something significant, she would have notified the on-call provider about what it said. Nurse #3 stated she did not recall anything abnormal occurring with Resident #43 during the night shifts she worked from 5/1/26-5/6/26 after he returned from the hospital. She stated Resident #43 had not had any episodes of emesis. She reported she had not assessed his abdomen because he had not had any acute issues to indicate she needed to do so. She did not recall receiving in report Resident #43 had not had a BM. Resident #43's electronic medical record documented he had not had a bowel movement from 5/1/26 through 5/8/26. Review of the May 2026 Medication Administration Report (MAR) revealed he had not received any medications to move his bowels from 5/1/26 through 5/6/26. A progress note documented by PA #1 dated 5/6/26 stated Resident #43 was being seen for follow up after his ER visit on 5/1/26. The note indicated Resident #43 had returned from the ER on [DATE] with a diagnosis of possible aspiration pneumonia and was started on an antibiotic. PA #1's note under physical exam stated abdomen, soft, nontender, with no rebound or guarding. Under assessment and plan the note stated constipation: chronic constipation was noted as an incidental finding on imaging obtained during recent ER visit. Add Miralax (polyethylene glycol) once daily to the current medication regimen. An order dated 5/7/26 was entered by PA #1 at 6:24 AM and read, polyethylene glycol 17 gm once a day, mix with 8 ounces of water. Review of the May 2026 MAR indicated Resident #43 received polyethylene glycol as ordered on 5/7/26 and 5/8/26. A nursing note dated 5/7/26 at 9:32 AM by Nurse #1 documented a Nurse Aide (NA) reported Resident #43 was vomiting. The note additionally documented Nurse #1 notified the provider and received orders for Zofran (antinausea medication) 4 milligrams every 8 hours as needed and to give Resident #43 an enema (laxative) for constipation. The nursing note indicated to contact the provider if (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vomiting gets worse or doesn't stop, or if the enema does not work. An order dated 5/7/26 read, administer, 1 enema per rectum once a day as needed. The MAR documented the enema was administered as ordered on 5/7/26. An order dated 5/7/26 read, ondansetron (Zofran) 4 mg, take 4 mg as needed every 8 hours for nausea/ vomiting (N/V). The MAR documented Zofran was administered as ordered. An interview was conducted with NA #3 on 6/4/26 at 11:10 AM. NA #3 reported she was Resident #43's assigned NA on day shift on 5/1/26, 5/4/26, 5/5/26, 5/6/26, 5/7/26 and 5/8/26, She recalled Resident #43 vomiting on 5/7/26. She said the vomit was dark brown in color and that she notified the nurse. She could not recall which nurse she had notified. She said Resident #43 was incontinent of bowel and was unable to take himself to the bathroom. NA #3 explained she sometimes got swamped with performing resident care and missed charting. She could not remember for sure if Resident #43 had a BM or not when she had worked from 5/1/26 to 5/8/26 but did not think he had. An interview was conducted with Nurse #1 on 6/4/26 at 12:37 PM. She stated she was Resident #43's assigned nurse on 5/7/26 day shift (6:30 AM-2:30 PM). Nurse #1 reported a NA notified her on 5/7/26 sometime after breakfast Resident #43 was vomiting, she could not remember who the NA was that notified her. She reported she went and assessed Resident #43. Nurse #1 stated the vomit was a dark brown color. She recalled he had bowel sounds present in all four abdominal quadrants and did not have any abdominal tenderness. She did not recall his abdomen being distended. She reported Resident #43 was incontinent of bowel and was unable to toilet himself without assistance. She stated she contacted PA #1 and notified her about what was going on with Resident #43. Nurse #1 stated she checked Resident #43's BM record and let PA #1 know his record did not show he had had a BM in several days. Nurse # could not recall how many days his record indicated it had been since his last BM. She recalled PA #1 provided orders for Zofran and an enema to be administered. Nurse #1 reported she gave the Zofran and administered the enema to Resident #43 before lunch. She stated the Zofran was effective and Resident #43 stopped vomiting for a few hours after he took the Zofran. She stated around lunch time Resident #43 vomited again, and he had not had BM results from the enema. Nurse #1 recalled she contacted PA #1 again and PA #1 ordered a Kidney Ureter Bladder (KUB) x-ray. Nurse #1 stated she was assigned to work on a different hall for the evening shift (2:30 PM-10:30 PM) and gave report to the oncoming evening shift nurse, Nurse #4. Nurse #1 explained the process of how residents were identified when they had not had a BM. She stated nurse management printed a BM report every day. She said the BM report was left at the nursing desk by management, and the nurses were told to check the list. Nurse #1 explained if a resident had not had a BM in 3 days or greater, the bowel protocol was started. She explained the bowel protocol included to administer Miralax (laxative), then if still no BM by the next day to administer Miralax again, and then if still no BM the next day to administer an enemeez (mini enema (laxative)). Nurse #1 explained she typically checked the BM report log but did not recall if Resident #43 was flagged on the BM report log for not having a BM. She did not recall if she went back and checked the log to see when Resident #43's last BM was but said she had checked Resident #43's BM record in his electronic medical chart to see when he had last had a BM documented. She did not recall the date of his last BM but said it had been several days. A nursing note dated 5/7/26 at 10:30 PM by Nurse #4 read, results received from KUB and indicated the on-call provider was notified of the results and that there were no new orders. The note stated to notify the provider of any further vomiting. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #4 on 6/4/26 at 1:43 PM. She was Resident #43's assigned evening shift nurse on 5/7/26. She recalled the portable x-ray company came to the facility and completed the KUB x-ray for Resident #43 on the evening shift. She did not recall what time they came. She remembered the KUB results came back on her shift and showed some constipation. Nurse #4 stated she notified the on-call provider of the KUB results. Nurse #4 stated Resident #43 had one small episode of vomiting on her shift and she gave him Zofran. She recalled the vomit was a dark brown color. She reported the Zofran was effective and he did not have any more vomiting on her shift. Nurse #4 stated she notified the on-call provider of the KUB results and vomiting episode. She recalled the on-call provider did not give any additional orders except to notify them if he had any additional vomiting and said she reported that to the oncoming night shift nurse, Nurse #5. A KUB report dated 5/7/26 read; no obstruction or ileus. Moderate stool burden, suggesting constipation. Nurse #5 was the assigned night shift nurse for Resident #43 on 5/7/26. Nurse #5 was unavailable for interview. An interview was conducted with Nurse #6 on 6/3/26 at 4:35 PM. She was the assigned day shift nurse for Resident #43 on 5/4/26, 5/5/26, and 5/8/26. She did not recall Resident #43 being flagged on the BM log for not having a BM. She explained there was a bowel protocol that was supposed to be followed if a resident had not had a BM in 3 days. She was unable to recall what the bowel protocol was. She recalled Resident #43 vomited on 5/8/26 and said that she contacted the on-call provider and obtained an order to send him to the ER. She stated on 5/8/26 when he went to the ER his abdomen was distended but was not tender and that he had normal bowel sounds present. She reported Resident #43 was incontinent of bowel and was unable to take himself to the bathroom. Prior to 5/8/26 she did not recall Resident #43's abdomen being distended, tender, or him having any issues with his bowels. An interview was conducted with Nurse #7 on 6/4/26 at 4:29 PM. He was the assigned nurse for Resident #43 for evening shift on 5/3/26 and 5/8/26. He stated when he arrived for his shift on 5/8/26 the day shift nurse was in the process of sending Resident #43 to the hospital. He did not recall who the day shift nurse was. He did not recall Resident #43 having any issues during his shift on 5/3/26. A nursing note dated 5/9/26 at 3:02 AM by Nurse #3 documented Resident #43 was admitted to the hospital. A hospital Discharge summary dated [DATE] indicated Resident #43 arrived at the ER from the facility on 5/8/26 due to concerns of gastrointestinal (GI) bleed. The note stated per Emergency Medical Services (EMS) the facility reported constipation since 4/30/26 and coffee ground emesis (vomit). The discharge summary documented, EMS saw coffee-ground emesis in the emesis basin. The hospital course indicated scans were completed of the abdomen and pelvis. The discharge summary stated the abdominal scan was consistent with acute cholecystitis (inflammation of the gall bladder) with suspected choledocholithiasis (presence of gallstones in the bile duct), but no active gastrointestinal (GI) bleeding was identified. There was noted to be a large colonic stool burden. The note stated he underwent endoscopic retrograde cholangiopancreatography (ERCP) (procedure to remove gallstones) on 5/13/26 with stone removal and that he had significant clinical improvement almost immediately after GI intervention. The discharge summary said his hemoglobin (blood cells that carry oxygen) had been trended and was fairly stable, doubt any significant GI bleeding however (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he may have esophagitis for which protonix (medication to treat gastric reflux) was started. The note additionally stated he was started on Dulcolax (laxative) suppository daily as needed for constipation. The discharge diagnosis included Choledocholithiasis (the presence of a gallstone in the bile duct) and that he was status post ERCP. A nursing noted dated 5/15/26 documented Resident #43 was readmitted to the facility on [DATE]. Resident #43's electronic medical record documented bowel movements and indicated Resident #43 had no further bowel issues since being readmitted to the facility on [DATE]. An interview was conducted with PA #1 on 6/3/26 at 9:22 AM. The PA recalled Resident #43 was sent to the ER on [DATE] and returned over the weekend on 5/2/26. She reported she returned to the facility on Monday 5/4/26 and had her office request the notes and diagnostics from his 5/1/26 ER visit. PA #1 reported she reviewed the ER notes on 5/6/26 and had seen Resident #43. She recalled an abdominal scan from his 5/1/26 ER visit showed constipation and stated she had ordered Miralax to treat his constipation. She stated the facility had a no BM list staff were supposed review a bowel protocol they were supposed to follow if a resident was flagged for not having a BM. She stated she thought the bowel protocol was supposed to start if a resident had not had a BM in over 2 days, but she was not certain. She did not know how it was missed that Resident #43 had not had a BM. PA #1 reported Resident #43's constipation could have caused his vomiting. She additionally explained Resident #43 was diagnosed with cholelithiasis during his 5/8/26 hospitalization and said it could have caused the vomiting too. She stated she could not say for sure his vomiting was not from his acute gall bladder. An interview and observation were conducted with the Regional Director of Nursing on 6/4/26 at 12:19 PM. She provided a BM report log from 4/20/26 through 5/10/26. Resident #43 was not flagged on the report for not having a BM. The Regional DON stated Resident #43 should have flagged on the report but didn't. She stated the information technology (IT) department for the electronic computer system had been contacted to determine why Resident #43 had not been flagged on the report. She stated she was told there had been an updated to the electronic computer system around the beginning of May and that a glitch may have occurred in the system. She stated Resident #43 should have flagged on the BM report for not having a BM but did not and that was why it had been missed. An interview was conducted with the Director of Nursing (DON) on 6/4/26 at 2:25 PM. She stated the bowel protocol was supposed to start when a resident was flagged on the BM report log for not having a BM in 48 hours. The DON explained Resident #43 not having a BM was missed because he had not pulled to the BM report log. An interview was conducted with the Administrator on 6/4/26 at 3:46 PM The Administrator stated Resident #43 not having a BM was missed because there was an error in the electronic computer system and Resident #43 was not flagged on the BM report log for not having a BM.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews with the resident, staff and the Hospice Nurse, the facility failed to provide a physician's order and an indication for use of an indwelling catheter for 1 of 3 residents reviewed for urinary catheters (Resident #6).The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses that included severe protein-calorie malnutrition, anemia, hypertension and diabetes. Review of Resident #6's medical record indicated no urinary diagnosis listed. She was most recently re-admitted from the hospital on 1/23/26 for left brachial deep vein thrombosis (blood clot in a deep vein in the left arm) and was re-admitted to the facility with hospice care on 1/23/26. There was no mention of the indwelling urinary catheter in the hospital discharge summary.Further review of Resident #6's medical record indicated no physician's order or progress notes related to the indwelling urinary catheter.A hospice note dated 1/23/26 in Resident #6's medical record indicated the presence of an indwelling urinary catheter which was patent, intact and connected to bedside drainage. The note did not include a physician's order or indication for the use of the catheter.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was moderately cognitively impaired, was dependent on staff for toileting hygiene and was always incontinent of both urine and bowel. Resident #6 received hospice care.Resident #6's care plan which was last reviewed and revised on 3/11/26 indicated no information about care for an indwelling catheter.A phone interview with the Hospice Nurse on 6/4/26 at 1:08 PM revealed Resident #6 was re-admitted from the hospital with the indwelling urinary catheter in place. The Hospice Nurse stated that she had offered Resident #6 to have the urinary catheter removed, but Resident #6 was adamant that she wanted to keep it. The Hospice Nurse stated that she did not know the official diagnosis to support the use of the indwelling urinary catheter. She further stated that she knew Resident #6 complained of urinary symptoms a lot and had frequent urinary tract infections, but Resident #6 did not want to have the urinary catheter removed. The Hospice Nurse stated that the urinary catheter could be used for comfort reasons, and she did not think there had been any issues with Resident #6 having the catheter in place.A review of a physician's order dated 3/12/26 indicated catheter care: change indwelling urinary catheter as needed. This order was entered into Resident #6's medical record by Nurse #1. An interview with Nurse #1 on 6/4/26 at 2:02 PM revealed the Hospice Nurse asked her to place an order for the care of Resident #6's indwelling urinary catheter on 3/12/26. Nurse #1 stated that Resident #6 already had a catheter in place at that time. Nurse #1 stated that she was not sure how Resident #6 obtained the indwelling urinary catheter, but that Resident #6 might have been re-admitted from the hospital with it in place. Nurse #6 further stated that she normally would look for the diagnosis that would support the catheter use and if there was none, she would reach out to the medical provider, but in Resident #6's case, she did not question the order to change the urinary catheter because Resident #6 was a hospice resident and hospice usually had different reasonings for the use of indwelling urinary catheters.An observation and interview with Resident #6 were conducted on 6/1/26 at 8:56 AM. Resident #6 was lying in bed, and she was observed to have an indwelling urinary catheter which was hooked to the bedframe on the right side of her bed. Resident #6 stated that she requested to have the catheter placed for convenience because she was having to wait long for incontinence care to be provided to her. Resident #6 could not recall when the catheter was inserted.An interview with Unit Manager #1 on 6/4/26 at 3:07 PM revealed she did not know that Resident #6 did not have a diagnosis to support the use of her indwelling urinary catheter. Unit Manager #1 stated that she started working at the facility in March and might have been in orientation when an order was started for Resident #6's indwelling catheter. Unit Manager #1 stated that she checked all the new orders daily, but she did not note that Resident #6 had an order for an indwelling urinary catheter. Unit Manager #1 stated that she was not aware of (continued on next page)

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	345110	A. Building B. Wing	06/04/2026

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's concerns about not being provided incontinence care and requesting to have an indwelling catheter placed. Unit Manager #1 further stated that there should have been a reason to place an indwelling urinary catheter, and it should have been included in the physician's order.An interview with MDS Nurse #1 on 6/4/26 at 12:41 PM revealed she did not know that Resident #6 had an indwelling urinary catheter. During the interview, MDS Nurse #1 looked through Resident #6's medical record and noted an order to change Resident #6's urinary catheter as needed on 3/12/26, but there was no order for the use of the indwelling urinary catheter. She stated she could not determine when Resident #6's catheter was started and it might have been when Resident #6 went into hospice care. MDS Nurse #1 scanned through the hospice notes and did not find any information about Resident #6's indwelling urinary catheter. MDS Nurse #1 stated she could not find any diagnosis for Resident #6 that supported the use of the indwelling urinary catheter. She also stated that although Resident #6 had a right to request for a catheter, the doctor had to document justification for its use and MDS Nurse #1 did not see any reason for the urinary catheter.An interview with the Director of Nursing (DON) on 6/4/26 at 2:25 PM revealed she had just started working at the facility when Resident #6 was re-admitted to the facility from the hospital in January. The DON stated Resident #6 might have been re-admitted to the facility with an indwelling urinary catheter. The DON stated that the administrative nurses usually checked the orders and if the resident did not have a qualifying diagnosis for the catheter, then they needed to either get an appropriate diagnosis or have the catheter discontinued. The DON stated Resident #6 not having a diagnosis for her indwelling catheter was an oversight. The DON stated they reviewed orders in the morning meetings, but she did not remember talking about Resident #6's indwelling urinary catheter.An interview with the Administrator on 6/4/26 at 4:10 PM revealed Resident #6 should have an appropriate diagnosis for the urinary catheter, and the clinical team who reviewed the orders in the morning meeting should have caught this concern.Attempts were made to interview the Medical Director, but they were not successful.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, the facility failed to ensure [NAME] Wing Medication Cart #1 was secured while unattended for 1 of 4 medication carts observed for medication storage (West Wing Medication Cart #1).The findings include:On 6/3/26 a continuous observation was made on of the [NAME] Wing Medication Cart #1 from 2:40 PM till 2:55 PM. The cart was observed with the lock button not pushed in to secure the cart. [NAME] Wing Medication Cart #1 was sitting at the nurses' station for approximately 15 minutes when Resident #87 wheeled himself next to the medication cart opened the 3rd drawer down from the top and looked in and took his hand and swept the top of the medication blister packs and then closed the drawer. He then opened the 4th drawer and looked inside and then closed the drawer and continued on his way. Nurse #2 was sitting at the desk using the computer. Nurse #2 was informed of the situation at 2:55 PM and quickly got up and pushed the lock button in to secure the medication cart.On 6/3/26 at 2:55 PM an interview was conducted with Nurse #2. She stated that she had just finished counting medications with the Unit Manager #2 and she thought the Unit Manager #2 had secured the medication cart. Nurse #2 stated the cart should have been locked since it was not being used.On 6/3/26 at 3:15 PM an interview was held with the Unit Manager #2. She stated that she was informed that one of the medication carts had been left unlocked. She thought Nurse #2 had locked the [NAME] Wing Medication Cart #1 after counting medications with her. She stated that the medication cart should have been locked and it was a mistake. On 6/4/26 at 2:50 PM an interview was held with the Director of Nursing (DON) who stated that all medication carts should be locked and secured when unattended.On 6/4/26 at 3:49 PM an interview was held with the Administrator who stated she would expect the medication cart to be locked and secured.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interviews, the facility failed to follow their infection control policies and procedures for clean dressing change and hand hygiene when Wound Nurse Aide (NA) #1 failed to change her gloves and perform hand hygiene while performing wound care for Resident #5. This deficient practice occurred for 1 of 5 staff members observed for infection control practices (Wound NA #1). Findings included:Review of the facility's policy and procedure last approved 12/12/25 entitled Clean Dressing Change Policy read in part Where sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.-Check for any dressing present, remove and wrap in gloves as you take gloves off, discard in trash bag.-Perform hand hygiene-Don clean gloves-Cleanse with ordered solution or normal saline soaked gauze pads.-Remove gloves and discard-Perform hand hygiene and don clean gloves.-Apply new dressing as ordered Review of the facility's policy and procedure last approved 4/3/26 entitled Hand Hygiene Policy read in part: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:-before moving from work on a soiled body site to a clean body site on the same patient.-After touching a patient or the patient's immediate environment.-After contact with blood, body fluids, or contaminated surfaces.-Immediately after glove removal An observation was completed on 6/3/26 from 7:59 AM to 8:24 AM of Wound NA #1 performing wound care for Resident #5. Wound NA #1 performed hand hygiene when she entered Resident #5's room and put on clean gloves and a gown. She removed the soiled dressing from Resident #5's left ischium (lower back part of the hip bone) pressure ulcer wound and discarded it in the trash; she did not change her gloves or perform hand hygiene after removing the dressing. Using the same gloves Wound NA #1 proceeded to clean the wound; she did not change her gloves after cleaning the wound. Wound NA #1 then applied gauze moistened with 0.25 % Dakin's (medical grade bleach solution used to treat wounds) solution to the wound bed and covered the wound with an absorbent dressing. Wound NA #1 removed her gloves and washed her hands at the sink located in Resident #5's room and put on clean gloves. She then removed the soiled dressing from Resident #5's right ischium pressure ulcer wound and discarded it in the trash; she did not change her gloves after removing the dressing. Using the same gloves Wound NA #1 cleaned the wound; she did not change her gloves after cleaning the wound. Wound NA #1 then applied calcium alginate (specialized highly absorbent wound dressing) to the wound bed and covered the wound with an absorbent dressing. She removed her gloves and washed her hands at the sink located in the room and put on clean gloves. Wound NA #1 then removed the offloading boat from Resident #5's right foot and removed the dressing from her right heel pressure ulcer and discarded it in the trash. Using the same pair of gloves, Wound NA #1 cleaned the wound, applied calcium alginate to the wound bed, covered the wound with a bordered dressing, and reapplied the offloading boot to her right foot. Wound NA #1 removed her gown and gloves, discarded them into the trash, washed her hands at the sink in the room, and exited the room. An interview was conducted with Wound NA #1 on 6/3/26 at 8:25 AM. Wound NA #1 stated she was supposed to remove her gloves, perform hand hygiene, and put on new clean gloves after she removed the dirty dressing and after cleaning the wound. She said she should have performed hand hygiene and put on clean gloves before she applied the new dressings. Wound NA #1 stated she normally changed her gloves during wound care but had forgotten to change them during Resident #5's wound care today. She reported she had received training on infection control practices for wound care. An interview was conducted with the Infection Preventionist (IP) on 6/3/26 at 10:33 AM. The IP stated Wound NA #1 should have removed her gloves, performed hand hygiene and put on new clean gloves after removing Resident #5's old dressings. She stated Wound NA #1 should have also performed hand hygiene and put on a new pair of gloves after cleaning the wounds before she applied the new dressings. The IP stated Wound NA #1 should follow the facility's infection control policies and clean dressing change policy. She reported Wound NA #1 had received infection control training (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and training for wound care. The IP indicated she was surprised that Wound NA #1 had not changed her gloves. An interview was conducted with the Director of Nursing (DON) on 6/3/26 at 1:56 PM. The DON stated Wound NA #1 should follow the facility's infection control and clean dressing change policies. The DON said Wound NA #1 should have changed her gloves and performed hand hygiene after she removed Resident #5's dirty dressings before she applied the new clean dressings. She was not sure why Wound NA #1 had not changed her gloves. An interview was conducted with the Administrator on 6/4/26 at 3:46 PM. The Administrator said Wound NA #1 should have changed her gloves during Resident #5's wound care and should have followed the facility's infection control and dressing change policies.