STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345165	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marion	1264 Airport Road Marion, NC 28752

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with Guardian, witnesses, resident, Psychiatric Provider, Nurse Practitioner (NP), and staff, the facility failed to provide the necessary supervision to prevent Resident #1 from exiting the facility unsupervised and without staff's knowledge through one of two doors that did not alarm when opened. Resident #1 was at risk for falls, her diagnoses included dementia, and she had been identified with a decline in cognition with signs of increased confusion and disorientation in the months prior to March 2026. Staff reported these signs included getting lost in the hallways, not being able to figure out how to get back to her room and forgetting that she required supervision to smoke. On 3/2/26 around 10:00 AM an unknown individual found Resident #1 outside of the facility in her wheelchair on the opposite side of the road as the facility, in the roadway, trying to self-propel up the road. Staff were unaware the resident had left the facility without supervision. In addition, not all staff were aware Resident #1 had exited the facility to understand the need for heightened awareness for her safety and whereabouts. Resident #1 was not injured; however, there was a high likelihood of serious harm, injury, or death with risks that included getting lost, falling with an inability to get out of harm's way, and/or getting hit by a car. Additionally, the facility failed to ensure staff were aware of Resident #1's unsupervised exit. The deficient practice affected 1 of 3 reviewed for accidents.Immediate Jeopardy began on 3/2/2026 when Resident #1 exited the facility unsupervised and without staff's knowledge. Immediate Jeopardy was removed on 3/5/2026 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure all staff and providers are aware of the elopement, education is completed and monitoring systems put into place are effective.The findings included:Resident #1 was admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) following cerebral infarction, anxiety and depression.The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 was [AGE] years old and cognitively intact. She had age related nuclear cataracts (a slow-developing, common eye condition where the center [nucleus] of the eye's lens gradually hardens and yellows, causing blurry vision) and her vision was assessed as adequate with corrective lenses. Resident #1 had no functional limitations with range of motion and she utilized a wheelchair. She required partial/moderate assistance with upper body dressing and substantial/maximum assistance with lower body dressing, putting on/taking off footwear, and transfers. She was independent with self-propelling her wheelchair.The active care plan as of 3/1/26 revealed Resident #1 was care planned for requiring supervised leave of absences and her mental function varied over the course of the day related to medical conditions. Resident #1's care plan also included the risk for decreased/ impaired vision and the risk for falls secondary to decreased mobility, abnormal gait, muscle weakness. There were no interventions documented for the for care planned problem areas.Resident #1's active physician orders as of 3/1/26 included Namenda (used to treat moderate to severe (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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He reported that he felt that it was important for all staff to know that Resident #1 had actually left the building and went down the road and not that she just attempted to elope because an attempt to elope is a lot less dangerous than an actual elopement. The DON spoke about how Resident #1 exited the facility on 3/2/26. He indicated it was determined that Resident #1 exited out the side door of the facility. He explained that the side door of the facility and the front door of the facility were the only two exterior doors that did not alarm when opened. He further explained that the side door had a wanderguard alarm on it only prior to Resident #1's unsupervised exit on 3/2/26 and Resident #1 did not have a wanderguard in place until after the unsupervised exit. The DON indicated the side door was the only door that could not be easily visualized by the receptionist. An observation of the facility was conducted on 3/24/26 at 4:30 PM. The facility was a one-story construction that visitors could enter via the paved or the gravel parking lot. Immediately outside of the side door of the facility was an approximately 50-foot wheelchair ramp that led by the side of the front porch to the front of the facility and into the main paved parking lot of the facility. At the end of the wheelchair ramp to the right led to a paved hill that was used to enter and exit the paved parking lot. The entrance/exit to the paved parking lot had ditches filled with six-to-eight-inch jagged rocks and led out into a well-traveled main road that had a posted speed limit of 35 miles per hour and had blind curves on each side of the facility's driveway, which made it difficult to see any oncoming traffic. To the left of the wheelchair ramp led back to the front of the facility. Straight ahead of the wheelchair ramp led across the paved parking lot and into a gravel parking lot of the facility. Resident #1 was found on the opposite side of the road from the facility on the two-lane roadReview of weather data from Weather Underground for 3/2/26 at 10:00 AM revealed the recorded temperature was 56 degrees Fahrenheit with light winds and no precipitation. Review of google earth revealed that there was 47 feet from the side door of the facility to the end of the wheelchair ramp, 157 feet from the end of the wheelchair ramp to the main road and 258 feet from facility parking lot to where Resident #1 was found. The slope out of the parking lot was 8.9 degrees. An interview with Assistant Director of Nursing (ADON) #1 revealed that on the morning of 3/2/26 management staff were in the conference room for morning meeting when Witness #2 came into the room and reported that a resident was out on the road. ADON #1 reported that everyone in the room went out to find the resident. She indicated that when they found Resident #1 she was just past the gravel parking lot and was on the opposite side of the road from the facility, in her wheelchair, in the road. ADON #1 stated Resident #1 was upset, not easy to console, and was adamant that she must continue down the road and not go back to the facility when staff got to her. She reported Resident #1 was stating she wanted to go home to see her son. ADON #1 reported they wheeled Resident #1 back into the building, assessed her and she began to calm down. ADON #1 recalled that Resident #1 did not have any injuries. ADON #1 reported Resident #1 had not indicated in the past that she wanted to leave the facility. ADON #1 stated Resident #1 had experienced a decline over the last several months prior to 3/2/26 and was not safe to be outside without supervision. A telephone interview with Witness #1 on 3/24/26 at 2:00 PM revealed that on the morning of 3/2/26 she was on the front porch of the facility and remembered seeing Resident #1 coming down the ramp beside the front porch of the facility and observed her go out into the paved parking lot in front of the facility. Witness #1 reported she assumed the resident was going outside to enjoy the morning. Witness #1 reported she (Witness #1) continued into the facility to get her family member who she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	12:54 pm she reported that she had been off for several days prior to 3/2/26 and upon returning to work she was reading thru the recent progress notes of the residents in her care and found the progress note completed by the DON alerting her to Resident #1's attempted elopement. Nurse #3 revealed that to present date (3/24/26) no one had told her that Resident #1 had actually left the facility. An interview with the Administrator on 3/24/26 at 3:20 PM revealed that on 3/2/26 the morning meeting was being held in the conference room, and the meeting was about over when Witness #2 came into the room to let staff know that a resident was in the road. The Administrator reported that she and the staff were able to catch up to Resident #1 and that she was across the road from the facility, just past the gravel parking lot, sitting in her wheelchair in the road. The Administrator stated the staff were able to get Resident #1 back into the building. She reported that Resident #1 had never indicated that she wanted to leave the facility prior to 3/2/26 and the staff were surprised by this event. The Administrator explained that Resident #1 did worry about her blind son a lot and she (the Administrator) had discussed with Resident #1's guardian that the adult son lived right down the road with other family members. The Administrator indicated she was aware that Resident #1 had started having some increased confusion a few months ago and a lot of diagnostics were completed, such as labs and scans, as well as medication changes, but she was unsure what medications had been changed. The Administrator revealed that the Psychiatric Provider and the NP both were able to assess Resident #1 on 3/2/26. The Administrator reported that Resident #1 went out the side door of the facility and that prior to 3/2/26 the side door did not alarm unless there was a wanderguard close by. The Administrator further stated the Maintenance Director put an alarm on the side door that sounded anytime the door was opened on 3/2/26 after Resident #1 was returned to the facility and management also put signs out at the nurses' station to make the nursing staff aware of the alarm. The Administrator reported that a wanderguard was placed on Resident #1's ankle for safety. The Administrator stated she was not sure why all staff did not know that Resident #1 had actually got out of the building and she would need to speak to the DON about his progress note on 3/2/26 that indicated the elopement was attempted as she was unsure why the DON would have written that. The Administrator reported she felt that it was important for all staff to know that Resident #1 had actually left the building and went down the road and not that she just attempted to elope. She explained that an actual elopement presented much more danger than just an attempted elopement. The Administrator indicated that it was not safe for Resident #1 to be out of the facility unsupervised. The Administrator was notified of immediate jeopardy on 03/24/26 at 6:00 PM.The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; On 3/2/2026, Resident #1 experienced an unsupervised exit from the facility through a side exit door and was observed off facility property by a family member, which alerted staff. The resident was immediately returned to the facility without injury by the Administrator, Director of Nursing, and Assistant Director of Nursing. The Administrator and Director of Nursing (DON) conducted an immediate review of the incident on 03/02/2026. The Administrator and DON determined the root cause to be that the side exit door did not have an alarm system installed that alerted staff to any opening of the door at the time of the incident, which allowed Resident #1 to exit the facility without staff awareness.Immediately upon the resident's return to the facility on 3/2/2026, the following actions were taken:The Administrator and DON contacted Resident #1's guardian, primary care provider, and Medical Director on 3/2/2026.Resident #1's nurse completed a head-to-toe nursing assessment on 3/2/2026, and no injuries were noted.The Administrator and Director of Nursing (DON) interviewed Resident #1. During the interview, Resident #1 verbalized a desire to go home to care for her son. The Administrator reassured Resident #1 that her son is cared for by a full-time caregiver.The Director of Rehabilitation Services completed a Brief Interview for Mental Status (BIMS) assessment on 3/2/2026, with a score of 8/15 (a score of 8 indicates moderate cognitive impairment). Resident #1's nurse completed an elopement risk assessment on 3/2/2026, and Resident #1 was identified as high risk for elopement. At the time of[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345165	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marion	1264 Airport Road Marion, NC 28752

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff and resident interview the facility failed to maintain a complete and accurate medical record when staff documented a resident attempted elopement and was intercepted by staff. This occurred for 1 of 3 residents (Resident #1) reviewed for accurate medical recordThe findings included:A review of a progress note dated 3/2/26 written at 10:30 AM by the Director of Nursing (DON) indicated that Resident #1 attempted elopement and was intercepted. The DON indicated in the note that reorientation was attempted to her situation without success.An interview with the DON on 3/24/2026 at 2:58 PM revealed on the morning of 3/2/2026 management staff were in the morning meeting a visitor came into the conference room telling them a resident was outside. He reported that the staff in the morning meeting immediately left the conference room to locate the resident. He reported that when they found Resident #1 she was on the road just past the gravel parking lot. He stated Resident #1's mentation was altered, she was what I would describe as manic. He reported that it was difficult to make the resident understand the danger she was in on the road and why she needed to return to the facility. The DON reported Resident #1 was difficult to convince to come back to the facility, as she kept attempting to propel herself via wheelchair further up the hill on the road stating she needed to go take care of her son. He indicated they were able to get Resident #1 back to the facility. The DON was unable to explain why he wrote in the progress note that Resident #1 attempted elopement and was intercepted by staff. The DON reported that Resident #1 did elope and was found down the road below the gravel parking lot.An interview with the Administrator on 3/24/26 at 3:20 PM revealed that on 3/2/26 the morning meeting was being held in the conference room and the meeting was about over when a visitor came into the room to let staff know that a resident was in the road. The Administrator reported that she and the staff were able to catch up to Resident #1 and that she was across the road from the facility, just past the gravel parking lot, sitting in her wheelchair in the road. The Administrator reported that Resident #1 went out the side door of the facility. The Administrator reported she was not sure why all staff did not know that Resident #1 had actually got out of the building and she would need to speak to the DON about his progress note on 3/2/26 that indicated the elopement was attempted as she was unsure why the DON would have written that. The Administrator stated she expected all information entered into a resident's medical record to be accurate.