

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Drexel		STREET ADDRESS, CITY, STATE, ZIP CODE 307 Oakland Avenue Morganton, NC 28655	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop an individualized comprehensive care plan in the area of anticoagulant (blood thinner) medication use for 1 of 5 residents whose comprehensive care plans were reviewed (Resident #8). The findings included: Resident #8 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (severe or complete paralysis of one side of the body) following a cerebral infarction (a blocked or narrowed blood vessel that cuts off blood flow to a part of the brain) and chronic atrial fibrillation (a sustained irregular heart rhythm). A review of the active medication orders for Resident #8 revealed an order for rivaroxaban (an anticoagulant medication) 20 milligrams (mg) by mouth; take daily with evening meal for history of cerebral infarction. The medication had a start date of 12/30/2025. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #8 dated 04/21/2026 indicated Resident #8 was receiving an anticoagulant. A review of Resident #8's Medication Administration Record from 12/30/2025 through 05/13/2026 revealed Resident #8 received rivaroxaban 20 mg daily with her evening meal. A review of Resident #8's comprehensive care plan dated 12/30/2025 and updated on 04/27/2026 did not include any care plan focus area or interventions related to Resident #8 receiving an anticoagulant medication. On 05/13/2026 at 12:25 PM an interview was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident #8's care plans and stated it did not address the anticoagulant medication. The MDS Coordinator explained that care plans were reviewed following completion of the MDS assessment. The MDS Coordinator further explained the care plan should include the use of an anticoagulant medication and she must have overlooked the anticoagulant medication when she updated the care plan on 04/27/2026. An interview was conducted with the Administrator on 05/14/2026 at 11:04 AM. The Administrator stated she expected all resident care plans to be reflective of high-risk medications including the use of anticoagulant medications.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record reviews, and staff interviews, the facility failed to implement their Infection Control policies and procedures for Enhanced Barrier Precautions (EBP) when the Wound Nurse and Nurse Aide (NA) #1 failed to wear a gown while providing wound care to Resident #12. Resident #12 was admitted to the facility with a chronic heel wound with drainage. This deficient practice occurred for 2 of 8 staff observed for infection control practices (Wound Nurse and NA #1). The findings included: Review of the Enhanced Barrier Precautions policy and procedure which is part of the Infection Control policies and procedures last revised on 04/15/26 revealed the following: Policy: Enhanced Barrier Precautions (EBP) are intended to prevent transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk resident during high contact activities. High risk residents are those with chronic wounds and indwelling devices (such as central lines, urinary catheters, and traches) and for all those colonized or infected with a MDRO currently targeted by the Centers for Disease Control and Prevention (CDC). High contact care activities are activities that may result in transfer of MDROs to hands and clothing of healthcare personnel, even when blood and body fluid exposure is not anticipated. These include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use and wound care. Procedure: Standard precautions such as hand hygiene always apply. Staff engaging in high-contact activities will don both gloves and gown before initiating the activity and remove personal protective equipment (PPE) before exiting the room or area where the activity occurred. Residents placed on EBP should remain on EBP for the duration of their stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. An observation of wound care on 05/12/26 at 12:33 PM on Resident #12 revealed the Wound Nurse and NA #1 went into the room with mask and gloves but no gown. There was no sign on the door indicating the resident was on EBP and there were no supplies in a caddie on the door or cabinet in the hallway outside the door. Resident #12 was sitting up in his wheelchair beside his bed and the door to his room was open. The Wound Nurse began with Resident #12's right leg and foot. He washed his hands with soap and water and donned gloves but did not don a gown and proceeded to paint the wound on the resident's right leg with betadine. NA #1 washed her hands with soap and water and donned clean gloves but no gown to hold Resident #12's right leg up for the Wound Nurse. The Wound Nurse doffed his gloves, washed his hands with soap and water and donned clean gloves and removed the old dressing from Resident #12's right heel while NA #1 held his leg up. The old dressing had a moderate amount of serosanguinous drainage (thin watery fluid with pale pink, light red, or blood-tinged drainage from wound). The Wound Nurse doffed his gloves, washed his hands and donned clean gloves and cleaned the wound with wound cleanser-soaked gauze. He doffed his gloves, washed his hands and donned clean gloves and applied calcium alginate (highly absorbent wound dressing frequently utilized in wound care to manage heavy drainage) and covered with a bordered gauze dressing. The Wound Nurse and NA #1 doffed their gloves, washed their hands and donned clean gloves but no gown and the Wound Nurse removed the old dressing on Resident #12's 3rd toe on the left foot. He proceeded to doff his gloves, sanitize his hands and donned clean gloves and cleansed the 3rd toe with wound cleanser-soaked gauze. The Wound Nurse doffed his gloves, sanitized his hands and donned clean gloves and applied calcium alginate and bandage to the toe. He then doffed his gloves, sanitized his hands and donned clean gloves but no gown and while NA #1 held his left leg up removed the dressing on the left heel. The Wound Nurse doffed his gloves, sanitized his hands and donned clean gloves and applied calcium alginate to the heel and covered with bordered gauze dressing. He doffed his gloves, washed his hands with soap and water and donned clean gloves and gathered his supplies and barrier off the overbed table and took them out of the room. NA #1 doffed her gloves, washed her hands and took the trash out of Resident #12's room. An interview on (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>05/12/26 at 12:53 PM with the Wound Nurse revealed that since there was no sign on the door he thought he didn't have to wear a gown into Resident #12's room to do his wound care. The Wound Nurse stated he had talked with the Infection Preventionist (IP) and learned that he should have worn a gown into Resident #12's room to provide wound care. An interview on 05/12/26 at 2:33 PM with NA #1 revealed she didn't wear a gown in the room to assist the Wound Nurse with wound care because there was no sign on the door and the Wound Nurse had not worn a gown. NA #1 stated she had since learned that she and the Wound Nurse should have worn a gown in the room. An interview on 05/14/26 at 10:26 AM with the IP revealed Resident #12 should have had a sign on his door for EBP with a caddie on the door or cabinet in the hall with personal protective equipment (PPE) available. She stated the resident had just moved from a different hall and his sign had probably been left on his previous room door along with the supplies. The IP stated she would have expected the Wound Nurse and NA #1 to have worn a gown into Resident #12's room to provide wound care. An interview on 05/14/26 at 10:43 AM with the Director of Nursing (DON) revealed she would have expected the Wound Nurse and NA #1 to have worn a gown while providing wound care to Resident #12. She further stated wound care was a high contact activity and the Wound Nurse and NA #1 should have worn a gown.</p>		

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<p>F 0565</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on record reviews, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns voiced by residents during Resident Council meetings for twelve of thirteen months reviewed (May 2025, June 2025, July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, January 2026, March 2026, April 2026, and May 2026).The findings included:Review of the Resident Council Meeting minutes for the period May 2025 through May 2026 revealed the following:The Resident Council Meeting minutes dated 05/06/25 revealed the Old Business section noted no concerns. Under the New Business section there were noted concerns from residents regarding staff being slow answering call lights on the 3:00 PM to 11:00 PM shift on the 200 hall. A grievance form was not attached to the minutes. There were 15 residents in attendance including Resident #4 who was the president of the resident council and Residents #39, #46, #80 and #89.The Resident Council Meeting minutes dated 06/04/25 revealed the Old Business section noted no concerns. Under the New Business section there were noted concerns of call lights not being answered in a timely manner, staff turning off call lights and not meeting the needs of residents and not returning for a long time and when the residents turned the call light back on, staff questioned residents as to why they turned their call light back on. The residents also voiced concerns of ice was not being passed on 2nd and 3rd shift on all halls. A grievance form was completed on 06/04/25 regarding call lights not being answered in a timely manner and turning off call lights, not returning for long periods of time and ice not being passed on 2nd and 3rd shift. The grievance form was assigned to the Director of Nursing (DON) on 06/04/26 for completion. There were 15 residents in attendance including Residents #39, #46, #80 and #89.The Resident Council Meeting minutes dated 07/01/25 revealed the Old Business section noted call lights not being answered in a timely manner, ice not being passed daily on all shifts. The resolution on the grievance form completed on 06/04/26 was that inservice education was provided to staff regarding when answering call lights, they were to address the resident's needs at the time of entering the room and not just tell the resident they would be back, cut off the call light and not return. A sporadic call bell audit was completed for four weeks but only one room was checked per day. The grievance was documented as resolved on 06/18/25. Under the New Business section there were complaints that call lights were still not being answered in a timely manner especially on the 200 hall and ice was not being passed routinely. A grievance form was completed on 07/01/25 regarding call lights not being answered in a timely manner especially on the 200 hall and ice not being passed routinely. The grievance form completed on 07/01/25 was assigned to the DON. There were 12 residents in attendance including Residents #4, #46, and #80.The Resident Council Meeting minutes dated 08/04/25 revealed the Old Business section noted call lights were not being answered timely on 200 hall and ice was not being passed routinely. The resolution on the grievance form completed on 07/01/25 was that staff were educated on answering call light in a timely manner and not turning lights off until the resident's needs were met and that ice was to be passed to residents each shift. The resolution was effective 07/15/26. Under New Business there were no complaints. There were 12 residents in attendance including Residents #4, #46 and #80.The Resident Council Meeting minutes dated 09/02/25 Under the Old Business section there were no complaints or follow-up. Under the New Business section there were complaints of issue still with call lights being answered and ice not being passed. A grievance form was completed on 09/02/25 regarding issue still with call lights being answered and ice not being passed. The grievance form dated 09/02/25 was assigned to the DON. There were 12 residents in attendance including Residents #4, #46 and #80.The Resident Council Meeting minutes dated 10/07/25 revealed the Old Business section noted an issue with call lights and ice not being passed. A grievance form completed on 09/02/26 revealed all staff were inserviced on answering call lights and clinical staff were educated on passing ice on all 3 shifts. The resolution date was 09/16/25. Under the New Business section there were complaints about call lights being (continued on next page)</p>		

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