STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with Resident #101, the resident's Power of Attorney (POA), and staff, the facility failed to follow professional standards of practice for medication administration for 1 of 1 resident reviewed (Resident #101) when Nurse #3 crushed and administered Atorvastatin 40 mg (milligrams), a medication used to lower cholesterol and reduce the risk of cardiovascular events such as heart attack and stroke.The findings included:Resident #101 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, epilepsy, slurred speech, and dysphagia.Review of physician orders dated 02/07/2026 revealed Atorvastatin 40 mg was ordered to be administered orally once daily. The order specified the medication was to be administered whole and was not to be crushed.Review of the manufacturer's Prescribing Information for Atorvastatin dated February 2023, revealed the tablets are to be swallowed whole and should not be crushed, chewed, or broken.Review of the Medication Administration Record (MAR) revealed on 02/09/2026 at 9:00 PM Nurse #3 administered Atorvastatin 40 mg to Resident #101. The MAR did not specify the form in which the medication was administered however, The MAR included instructions indicating the Atorvastatin 40 mg was not to be crushed. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact.An interview conducted with Resident #101's Power of Attorney (POA) on 02/10/2026 at 10:00 AM revealed she stayed overnight on 02/09/2026 and observed Nurse #3 crush and administer Resident #101's nighttime medications, including Atorvastatin 40 mg. The POA stated she informed Nurse #3 that the physician's order specified the medication was to be administered whole and not crushed and reported she had a copy of the order available at that time. The POA stated Nurse #3 responded that the medications had already been crushed and informed her that if Resident #101 refused to take the medication in crushed form, she would not receive her medication until the next scheduled dose.An interview conducted with Resident #101 on 02/10/2026 at 10:15 AM revealed Nurse #3 administered her nighttime medication, including Atorvastatin 40 milligrams (mg), in crushed form on 02/09/2026. Resident #101 stated Nurse #3 informed her the medication would not harm her and told her that if she refused to take it, she would not receive it again until the next scheduled dose. Resident #101 stated she took the medication as instructed.An interview conducted with Nurse #3 on 02/10/2026 at 6:17 PM revealed she crushed and administered Resident #101's nighttime medications, including Atorvastatin 40 mg, on 02/09/2026. Nurse #3 stated it was her first shift at the facility as an agency nurse and her first time caring for Resident #101. Nurse #3 stated she believed the medications needed to be crushed due to the Resident #101's history of stroke and information reportedly received from the previous shift nurse. Nurse #3 acknowledged she did not verify the physician's order prior to crushing the medication and did not contact the provider or pharmacy to clarify the order.An interview conducted with the Director of Nursing (DON) on 02/12/2026 at 12:48 PM revealed Nurse #3 was working as an agency nurse on 02/09/2026. The DON stated nursing staff are expected to review physician orders prior to medication administration and administer medications as prescribed. The DON stated she was notified of the incident on 02/10/2026 by Resident #101's POA. The DON reported she initiated an internal investigation upon learning of the incident. The DON stated Nurse #3 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged crushing the medication without verifying the physician's order. The DON indicated Nurse #3 was removed from the schedule pending investigation.An interview conducted with the Administrator on 02/12/2026 at 1:57 PM revealed he was made aware of the medication administration incident involving Resident #101 by the DON. The Administrator stated nursing staff are expected to follow physician orders and facility policy regarding medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	311 W Phifer Street Marshville, NC 28103

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Physician and staff interviews, the facility failed to have effective systems in place for shift change narcotic reconciliation and failed to keep discontinued narcotic medications under two locks for return to the pharmacy. This failure resulted in 30 missing oxycodone/acetaminophen 10/325 milligrams (mg) and 50 missing oxycodone 5 mg for a total of 80 missing tablets. This occurred for 2 of 2 residents reviewed for misappropriation of medications (Resident #98 and Resident #103).The findings included:Review of the medical record for Resident #98 revealed a physician order dated [DATE] for oxycodone/acetaminophen (a narcotic pain medication) 10/325 mg one (1) tablet by mouth twice per day as needed for moderate pain.Review of the medication administration record revealed on [DATE] Resident #98 received oxycodone/acetaminophen 10/325 mg at 9:21 AM for pain he rated 9 (1-10 scale with 1 being no or minimal pain and 10 being intense pain). This was administered by Medication Aide (MA) #1 and it was documented as effective for his pain.Review of the schedule for [DATE] revealed MA #1 was scheduled to work on the day shift (7:00 AM to 3:00 PM) and Nurse #1 was scheduled to work afternoon and night shift (3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM).Review of the schedule for [DATE] revealed MA #1 was scheduled to work the day shift. A facility initial allegation report completed by the former Administrator dated [DATE] reported that oxycodone/acetaminophen 10/325 mg belonging to Resident #98 was not located in the medication cart. The report indicated that the pharmacy was notified, the police were notified, and an investigation of Change of Custody and delivery was initiated.The facility investigation report completed by the former Assistant Director of Nursing dated [DATE] described the investigation that was initiated on [DATE] that included suspension of MA #1 and Nurse #1. Alert and oriented residents were interviewed regarding administration of their pain medications and pain assessments were conducted on moderately cognitively impaired residents. No issues were identified during the assessments. The facility conducted a 30-day look back audit on all narcotics received and the facility identified one other resident (Resident #103) with missing narcotics. The facility reviewed 7 employee files and licenses, and conducted urine drug screening on 7 staff, including MA #1 and Nurse #1 and all urine drug screens were negative for narcotic medications. The facility notified Adult Protective Services on [DATE] as well as the local police and Drug Enforcement Administration. The facility concluded that they were unable to substantiate the misappropriation of the medications. A statement given by MA #1 dated [DATE] documented, (MA#1) worked 100, 300, and 600 units on [DATE]. The narcotics count was 36 for the AM and the PM shifts (number of cards of narcotics matched the number of narcotic sheets). My relief for the afternoon on [DATE] was (Nurse #1). On [DATE] (MA #1) received the cart from (Nurse #1). She assured me the count was still 36 like the previous day and we counted the cart. I gave return meds to (Unit Manager (UM) #1) .I continued my med pass on 300 unit. (Resident #98) asked for pain meds while being transported to therapy. I assured him I would bring it to him. As I looked in narcotics book and cart, I didn't see a blister pack for him (of oxycodone/acetaminophen 5/325 mg tablets). I know that I didn't give the last pill the previous day, so I was unsure of why he didn't have any more (narcotic medication). I notified (UM #1) .A clarifying statement given by MA #1 dated [DATE] documented Tuesday morning ([DATE]) Nurse #1 and I were counting narcotics on 600 hall . and the count was accurate. We went to the 100/300 hall medication cart to count narcotics, we started counting, she said, ?we still have 36 items in the cart' and I did not count to confirm.An interview was conducted with MA #1 on [DATE] at 2:21 PM. MA #1 reported she had worked several shifts before and after Nurse #1 prior to [DATE] and the morning of [DATE], she and Nurse #1 had counted the narcotics in the medication cart for the 600 hall, but when MA #1 went to count the 300 hall cart and Nurse #1 told her, Oh, we don't need to do that, it's the same as it was yesterday afternoon. MA #1 reported she knew she should not skip the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	311 W Phifer Street Marshville, NC 28103

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotic count, but she believed Nurse #1 and signed the narcotic count sheet without counting the narcotics in the 300-hall cart. MA #1 reported later that morning, Resident #98 requested oxycodone/acetaminophen pain medication and when she opened the locked narcotic drawer, she discovered Resident #98 did not have pain medications in the drawer. MA #1 reported she had administered one tablet to Resident #98 on [DATE] and knew he had a full card of medications in the locked narcotic drawer. MA #1 explained she immediately alerted Unit Manager (UM) #1. MA #1 explained that on [DATE] during the narcotic count at 3:00 PM, she recalled seeing a full card with 30 tablets of oxycodone/acetaminophen for Resident #98 in the narcotic drawer. MA #1 reported she was suspended from work during the investigation and submitted urine for drug screening.An email statement written by Nurse #1 dated [DATE] documented that Nurse #1 worked from 2:45 PM on [DATE] until 7:15 AM on [DATE]. The statement indicated that Nurse #1 had given report at the end of her shift to MA #1 and the two of them counted narcotics on the first cart (the hall was not specified) and all narcotics were accounted for, and Nurse #1 gave MA #1 the keys for that cart. The note documented that MA #1 and Nurse #1 proceeded to count the second cart (the hall was not specified). The note documented that all narcotic counts were correct and there were no concerns or issues.A statement dated [DATE] from Nurse #1 was reviewed. The statement reported Nurse #1 was scheduled to work [DATE] on the 100, 300, and 600 halls from 3:00 PM to 11:00 PM and the 100, 300, 600 and 200-210 halls from 11:00 PM to 7:00 AM on [DATE]. The statement read that when MA #1 arrived on [DATE] they counted the narcotics on the 600-hall cart. The statement did not include information regarding the 300-hall cart. Multiple efforts were made to contact Nurse #1 for interviews and those attempts were unsuccessful.UM #1 was interviewed on [DATE] at 10:16 AM. UM #1 explained that she was working on [DATE] and MA #1 approached her to report that Resident #98 was missing narcotic pain medications. UM #1 reported she asked MA #1 if she had counted the narcotics at shift change and MA #1 reported she and Nurse #1 had not counted the narcotics on the 300-hall cart. UM #1 described searching all narcotic drawers in each of the medication carts and she was unable to locate the missing oxycodone/acetaminophen for Resident #98. UM #1 reported she called Nurse #1 to inquire about the missing medications and Nurse #1 was evasive with her answers and told her she would be in to work at 3:00 PM [DATE].The former Director of Nursing (DON) was interviewed by phone on [DATE] at 12:56 PM. The former DON reported she was not working on [DATE] but was notified of the missing oxycodone/acetaminophen by UM #1. The former DON explained that MA #1 and Nurse #1 had not counted the narcotics at shift change on [DATE], but the facility was not able to determine who took the oxycodone/acetaminophen. The former DON reported all nurses and medication aides were trained to complete narcotic counts at the change of any shift, including MA #1 and Nurse #1.The Director of Nursing was interviewed on [DATE] at 3:12 PM and she reported she had started her position after the incidents, but she expected all narcotics to be counted at the end of one shift and the beginning of the next shift by the oncoming and leaving nursing staff and if the narcotic counts had discrepancies, the nursing staff should report those issues immediately.The Physician was interviewed on [DATE] at 1:37 PM. The physician reported he was notified of the medications for Resident #98 and Resident #103 were missing and he was part of the Quality Assurance Performance Improvement (QAPI) meeting on [DATE]. The Physician reported that Resident #98 had replacement medications provided by the facility and Resident #98 was not harmed.Review of the medical record for Resident #103 revealed a physician order dated [DATE] for oxycodone 5 mg with instructions to administer one (1) tablet by gastric tube every 4 hours as needed for pain.An interview was conducted with MA #1 on [DATE] at 2:21 PM. MA #1 reported when she received report on [DATE] from Nurse #1, she was told there were medications that needed to be returned to the pharmacy that belonged to Resident #103. MA #1 reported the medications were in a bag and sitting unlocked in the medication room, and she took the medications to UM #1 to be returned to the pharmacy. MA #1 reported she was aware that Resident #103 had died a few days before and knew that the medications would need to go back to the pharmacy, but she did not have (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorization to do that, so she took the medications to UM #1. MA #1 explained she did not look at the medications or know what medications were in the bag.A statement by Nurse #1 dated [DATE] documented that (unspecified time and date) that Resident #103's medications were separated in the locked narcotic drawer and Nurse #1 took the medications out of the locked narcotic drawer and put in a clear pharmacy return back and put the bag into the medication room. The statement documented that Nurse #1 told MA #1 there were narcotics that needed to be returned (to pharmacy). Multiple attempts were made to contact Nurse #1 for interviews and those attempts were unsuccessful.The facility investigation report dated [DATE] described the investigation that was initiated on [DATE] that included suspension of MA #1 and Nurse #1. Alert and oriented residents were interviewed regarding administration of their pain medications and pain assessments were conducted on moderately cognitively impaired residents. No issues were identified during the assessments. The facility conducted a 30-day look back audit on all narcotics received and the facility identified one other resident (Resident #103) with missing narcotics. The facility reviewed 7 employee files and licenses, and conducted urine drug screening on 7 staff, including MA #1 and Nurse #1 and all urine drug screens were negative for narcotic medications. The facility notified Adult Protective Services on [DATE] as well as the local police and Drug Enforcement Administration. The facility concluded that they were unable to substantiate the misappropriation of the medications. UM #1 was interviewed on [DATE] at 10:16 AM. UM #1 explained that she was working on [DATE] and MA #1 approached her with medications for Resident #103 that needed to be returned to the pharmacy. UM #1 explained she was in the middle of investigating the missing narcotic medications for Resident #98 and she placed the medications for Resident #103 into an unlocked cabinet in the nurses' station. UM #1 explained that she should have locked the medications in a locked cabinet in the medication room, but she was preoccupied with the investigation for Resident #98's missing narcotic medications. UM #1 reported that later that day, she and Nurse #2 were preparing to return the medications to the pharmacy and that was when they discovered that the oxycodone prescribed for Resident #103 was missing. UM #1 explained that two nurses were required to count medications before returning them to the pharmacy and that's when they discovered the missing oxycodone prescribed to Resident #103 was not in the bag. Nurse #2 was interviewed on [DATE] at 10:50 AM. Nurse #2 reported that to return narcotic medications to the pharmacy, two nurses must count the medications and scan the medication for return. Nurse #2 explained that medications should not have been removed from the cart by one nurse and should not have been left unlocked. The former Director of Nursing (DON) was interviewed by phone on [DATE] at 12:56 PM. The former DON stated UM #1 was aware that the narcotic medications needed to be locked up. The former DON did not know why Nurse #1 removed the medications from the locked medication cart.During the interview with the DON on [DATE] at 3:12 PM, the Regional Director of Clinical Services reported that discontinued narcotics were kept under two locks until the pharmacy returns for them and there are two nurses to sign them out.The Administrator was interviewed on [DATE] at 3:16 PM. The Administrator explained he started his position after the incident happened and he expected all narcotic hand-offs were completed per policy. The facility submitted the following corrective action plan: Nurse #1 and Med Aide #1 failed to properly complete the shift change controlled substance inventory log. Staff relied on verbal confirmation rather than physically verifying and documenting the count together. Additionally, a nurse manager failed to secure medications intended for return to pharmacy by leaving them in an unlocked cabinet behind nurses' station. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.On [DATE], Med Aide #1 identified missing oxycodone/acetaminophen 10/325mg tabs for Resident #98 based on availability from previous day. A thorough search was conducted in the facility to locate the medication without success.On [DATE] Medication Aide (MA) #1 received 300 med cart from Nurse #1, they did not complete a proper narcotic count. During med pass Resident #98 requested pain med from MA #1. When MA #1 looked inside med cart she did not see the medication. The MA #1 remembered that the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous day the medication was there. The medication aide immediately notified the Unit Manager, who confirmed with the pharmacy that 60 tablets had been delivered on [DATE]. A search of the medication cart did not locate the missing medication. Resident #98 was found to be missing #50 oxycodone/acetaminophen 10/325mg tablets. The Nurse Manager informed the Administrator and Director of Nursing. The Administrator subsequently notified the Regional [NAME] President of Operations, Regional Director of Clinical Services, Marshville Police, the pharmacy representative, medical director, responsible party, and the resident. All nurses who had worked the medication cart, including the DON, submitted to urine drug screening. MA #1 and Nurse #1 (assigned during the timeframe the medication went missing) were suspended pending investigation. The Staff Development Coordinator conducted a full narcotic count on all medication carts. Additionally, the SDC initiated education for licensed nurses and medication aides on Chain of Custody for Controlled Substances and Abuse to include misappropriation. Director of Nursing and Nurse Managers completed pain audits on all residents receiving narcotics. Interviews completed on alert and oriented residents with a BIMS of 12 or above. No issues identified. A new script was obtained for Resident #98's pain medication by NP #1 and pharmacy sent pain medication which was billed to the facility on [DATE]. Resident #98 did not have any negative outcomes due to missing pain medication.The morning of [DATE] Nurse #1 informed MA #1 about medications on the counter in the medication room that needed to be returned. MA #1 took the medications from the medication room to the main nurse's station to give to the Unit Manager. The Unit Manager placed the medications in an unlocked cabinet behind the nurses' station where she was working to return later. Later in the day, Unit Manager and Nurse #2 scanned and returned all medications to pharmacy. During the investigation for missing narcotics, it was discovered that Resident #103 was missing 30 tablets of oxycodone 5mg. Resident #103 expired [DATE]. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.All residents receiving controlled pain medication have the potential of being affected.Director of Nursing/Designee completed pain audits on all residents receiving narcotics. Interviews completed on all alert and oriented residents with a Brief Interview for Mental Status of 12 or above. No negative findings noted. These audits were completed on [DATE]. Residents with a BIMS of 12 or above were asked the following questions: 1) Do you receive medication for pain? 2) If yes, are you having any problems receiving your pain medication? 3) Do you have any unrelieved pain that we need to address at this time? Confused residents received the Pain Assessment in Advanced Dementia (PAINAD) Scale.Upon discovery on [DATE] the facility, in accordance with our Quality Assurance Performance Improvement program, leadership implemented the following corrective action measures:[DATE] Facility staff notified unit manager of the discrepancies on the narcotic count sheet. Unit manager notified Director of Nursing and Nursing Home AdministratorXXX[DATE] Administrator and Staff Development Coordinator interviewed Med Aide #1 and Nurse #1 and urine drug tests completed. MA #1 and Nurse #1 denied taking the medications. MA #1 and Nurse #1's urine drug tests were negative for oxycodoneXXX[DATE] Administrator notified Med Aide #1 and Nurse #1 of being suspended pending investigationXXX[DATE] Director of Nursing and Nursing Home Administrator notified Regional [NAME] President of Operations, Regional Director of Clinical Services, Marshville police department, pharmacy representative, medical director, nurse practitioner, Resident #98, and Responsible PartyXXX[DATE] Staff Development Coordinator completed full narcotic counts on all medication carts. No other missing narcotics were identifiedXXX[DATE] Staff Development Coordinator initiated education on the Chain of Custody Controlled Substances Process and abuse to include misappropriation with licensed nurses and medication aidesXXX[DATE] Director of Nursing/Designee completed a complete pain assessment audit on all residentsXXX[DATE] Director of Nursing and Staff Development Coordinator completed a 30-day lookback audit of all narcotics received and identified Resident #103 (deceased on [DATE]) had #30 oxycodone 5mg tabs that were received on [DATE] from pharmacy cannot be accounted for. No other discrepancies identifiedXXX[DATE] Ad (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	311 W Phifer Street Marshville, NC 28103

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hoc Quality Assurance Performance Improvement meeting was completed.Audits completed on all narcotic sheets on [DATE]/600/800 med carts to determine if there was any diversion. One area was identified for Resident #98 and Resident #103. Director of Nursing/designee completed audits with all licensed nurses/medication aides of the count process during shift change from [DATE]-[DATE]. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.The Director of Nursing/Designee re-educated all licensed nurses/medication aides including agency nurses on Chain of Custody Controlled Substances, securing medications, and misappropriation on [DATE]. The education included that both outgoing and incoming staff are required to physically visualize each controlled substance and reconcile the count against the log before signing. Reinforced that verbal confirmation alone is not acceptable practice. All newly hired licensed nurses and agency staff will be educated on said process during orientation. Nurse #1 and MA#1 that failed to complete the narcotic count received disciplinary action. The nurse manager who failed to secure medications received disciplinary action as well. The Director of Nursing placed a lock on cabinet in medication room to store medications that need to be returned to pharmacy. Director of Nursing/Designee is conducting unannounced spot checks during shift change. Indicate how the facility plans to monitor its performance and make sure that solutions are sustained.The Director of Nursing/Designee will audit five random narcotic counts with licensed nurses/medication aides weekly, to ensure accuracy and proper reconciliation of narcotics.The Director of Nursing/Designee will audit medication carts, medication rooms, and nurses' station weekly to ensure narcotics are secured properly. This audit will be completed weekly for 8 weeks.The Director of Nursing/Designee will audit five random residents to ensure that they have no issues with care and services weekly for 8 weeks.The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.The facility completed and accepted the plan of correction at an ad hoc QAPI meeting on [DATE].Root cause analysis: The facility completed a thorough investigation to determine the root cause of the missing medications. All investigative steps were taken in accordance with internal protocols and applicable regulatory standards. Nevertheless, the missing narcotics were not recovered, and no evidence was found to clarify the nature of the loss. The facility investigation did reveal that nurses/medication aides were not completing the Shift Change Controlled Substances Inventory Log properly during shift change/narcotic counts. Some staff were relying on verbal confirmation and taking each other's word that the count was correct. Additionally, the investigation revealed a nurse manager left medications in unlocked cabinet. Nurse Manager failed to follow facility policy which requires all narcotics to be secured under a double-lock system at all times. Include dates when the corrective action will be completed. Date of Compliance: [DATE]The plan of correction was validated on [DATE]. Initial audits of the narcotic drawers were reviewed, resident interviews and pain assessments were reviewed, and education provided to staff was reviewed. Nursing staff were interviewed, and they were able to correctly describe the process for narcotic medication counts and when to perform those counts. A change of shift narcotic count was observed and no issues were identified. Narcotic drawers and sheets were reviewed and no issues were identified. The facility's date of compliance of [DATE] was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with Resident #101's Power of Attorney (POA), Facility Physician, Pharmacist, Nurse Practitioner #1 (NP), and staff, the facility failed to ensure Resident #101 was free from a significant medication error when Nurse #3 crushed and administered Brivaracetam (anticonvulsant medication used to control partial -onset seizures) 100 milligram (mg) extended-release, Eslicarbazepine 800 mg (anticonvulsant used to treat seizure disorders), Lamotrigine 200 mg (anticonvulsant medication used to control various types of seizures), and Xcopri 150 mg (anticonvulsant used to treat partial-onset seizures), despite physician orders indicating the medications were to be administered whole and not crushed. This deficient practice occurred 1 of 1 resident reviewed for significant medication errors (Resident #101).The findings included:Resident #101 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, epilepsy, slurred speech, and dysphagia.Resident #101's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and revealed no physical or verbal behavioral symptoms and no rejection of care.Review of the Medication Administration Record (MAR) revealed on 02/09/2026 at 9:00 PM Nurse #3 initialed the MAR indicating she had administered Brivaracetam 100 mg, Eslicarbazepine 800 mg, Lamotrigine 200 mg, and Xcopri 150 mg to Resident #101. The MAR did not specify whether the medications were to be administered whole or crushed.Review of physician orders revealed Brivaracetam 100mg was ordered on 02/09/2026 to be administered orally twice daily, with special instructions stating DO NOT CRUSH; Eslicarbazepine 800 mg was ordered on 02/07/2026 to be administered orally once daily and not crushed; Lamotrigine 200 mg was ordered on 02/07/2026 to be administered orally five times daily and not crushed; and Xcopri 150 mg was ordered on 02/08/2026 to be administered orally twice daily and not crushed.Review of the manufacturer's Prescribing Information revealed that Brivaracetam Prescribing Information dated January 2021 states that tablets should be swallowed whole and should not be chewed or crushed. The Lamotrigine (extended-release) Prescribing Information dated July 2023 states that tablets should be swallowed whole and must not be chewed, crushed, or divided. The Eslicarbazepine Prescribing Information dated March 2024 states that tablets may be administered whole. The Xcopri Prescribing Information dated April 2023 states that tablets may be taken whole. Failure to administer these anti-seizure medications as recommended by the manufacturer and as ordered by the physician may alter drug effectiveness and can increase the risk for breakthrough seizures, increased adverse reactions, or other complications.An interview conducted with Resident #101's Power of Attorney (POA) on 02/10/2026 at 10:00 AM revealed she stayed the night on 02/09/2026 and was present when Nurse #3 crushed and administered Resident #101's nighttime medications. The medications included Brivaracetam, Eslicarbazepine, Lamotrigine and Xcopri. Resident #101's Power of Attorney stated she informed Nurse #3 that the medications should not be crushed according to the physician's orders, which she had a copy of. Resident #101's Power of Attorney stated Nurse #3 informed her that she had already crushed the medications and that if Resident #101 did not take the crushed medications, she would not receive them again until the next night. Resident #101's Power of Attorney stated that within 40 minutes of taking the medication, side effects occurred. She stated Resident #101 felt extremely nauseated, experienced slurred speech beyond baseline, sweating, feeling extremely hot, and weakness. Resident #101's Power of Attorney stated she informed Nurse #3 of the symptoms. Nurse #3 stated she would check on Resident #101; however, the Power of Attorney stated Nurse #3 only checked on Resident #101 once during the night to obtain vital signs.Interview with Resident #101 on 02/10/2026 at 10:15AM revealed Nurse #3 told her to take the crushed medication on 02/09/2026 because it would not hurt her. Resident #101 stated she took the medication because it was important for her seizures, and Nurse #3 stated she would not receive the medication again until the next night if she refused to take it. Resident #101 stated she felt (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Autumn Care of Marshville		STREET ADDRESS, CITY, STATE, ZIP CODE 311 W Phifer Street Marshville, NC 28103	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nauseated, experienced slurred speech, sweating, feeling hot, and weakness. Resident #101 stated she could not recall exactly how long the symptoms lasted but reported they began an hour after taking the medication. Resident #101 stated she was unable to participate in physical therapy on 02/10/2026 because her symptom of weakness was present. Review of Resident #101's vital signs taken by Nurse #3 revealed on 02/10/2026 at 12:51 AM, Resident #101's temperature was 98 degrees Fahrenheit, pulse 80 beats per minute, respirations 18 per minute, blood pressure 118/69 mmHg, and oxygen saturation 98%. On 02/10/2026 at 9:41 AM, Resident #101's temperature was 98 degrees Fahrenheit, pulse 72 beats per minute, respirations 18 per minute, blood pressure 126/60 mmHg, oxygen saturation 95%.An interview conducted with Nurse Aide (NA) #2 on 02/10/2026 at 11:35 AM revealed she cared for Resident #101 on 02/09/2026. NA #2 stated Resident #101 informed her that she was scared when Nurse #3 crushed her medications instead of administering them whole. NA #2 stated that around 9:00 PM, Resident #101 was sweating more than usual. NA #2 reported assisting Resident #101 by washing her up, changing her into a gown, and removing her blanket. The NA #2 indicated that Resident #101 did not express complaints of nausea or weakness at that time. NA #2 further stated she did not obtain Resident #101's vital signs.An interview conducted with Nurse #3 on 02/10/2026 at 6:17 PM revealed 02/09/2026 from 11:00 PM to 7:00 AM on 2/10/2026 was her first day working for the facility and first time working with Resident #101, as she was an agency nurse. Nurse #3 stated she crushed Resident #101's medications on 02/09/2026 because the facility had not specified otherwise and the nurse from the morning shift of 02/09/2026 stated Resident #101's medications needed to be crushed. Nurse #3 stated she assumed Resident #101's night medications should have been crushed because the resident had a history of stroke. Nurse #3 stated stroke patients often receive crushed medication, and she thought Resident #101 needed her medications crushed. Nurse #3 stated Resident #101's family did not express concerns about the crushed medications until after they were administered. Nurse #3 stated she got vital signs on Resident #101 at 4:00 AM on 02/10/2026, and the resident appeared to be fine.An interview conducted with the Pharmacist on 02/10/2026 at 6:01 PM revealed that crushing Brivaracetam, Eslicarbazepine, Lamotrigine, and Xcopri could decrease the effectiveness of the active ingredients needed to control seizures and other diagnoses. The Pharmacist stated that the symptoms may have resulted from the medications being administered in crushed form and administered all at once. The Pharmacist further stated she did not believe the crushed medications would be a significant concern, as Resident #101 would have already had the medications in her system from previous doses.An interview conducted with the Nurse Practitioner #1 (NP) on 02/10/2026 at 6:52 PM revealed she assessed Resident #101 on 02/10/2026 at 5:00 PM and reported that Resident #101 was stable with no observed side effects or complications. The NP#1 reported that nursing staff did not contact her at the time of the medication error. NP #1 stated she was made aware of the medication error by the Director of Nursing on 02/10/2026. NP #1 indicated that if a medication error occurs, the dose may be wasted and re-administered as appropriate. NP #1stated the Brivaracetam was designed to be extended-release over time. NP #1 stated administering the Eslicarbazepine, Lamotrigine, and Xcopri crushed and all at once, rather than allowing it to release gradually, could contribute to potential side effects. The NP #1stated the side effects the resident experienced were a direct result of the medications being crushed.An interview conducted with the facility's Physician on 02/12/2026 at 11:00 AM revealed he was unaware of the medication error involving Resident #101. The facility's Physician stated that Eslicarbazepine, Lamotrigine, and Xcopri could be crushed if necessary. The Facility's Physician stated Brivaracetam should not be crushed because it is an extended-release medication that absorbs into the bloodstream more quickly when crushed. The Facility's Physician stated the symptoms occurred as a side effect of the medications being crushed and administered all at once.An interview conducted with the Director of Nursing (DON) on 02/12/2026 at 12:48 PM revealed Nurse #3 was hired as an agency nurse. The DON stated Nurse #3 obtained vital signs at midnight for Resident #101, and no abnormal vital signs were found. The DON further stated she was made aware of the medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	311 W Phifer Street Marshville, NC 28103

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	error on 02/10/2026 by Resident #101's POA.An interview conducted with the Administrator on 02/12/2026 at 1:57 PM revealed he was made aware of the medication error involving Resident #101 by the DON.