STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Salisbury	1505 Bringle Ferry Road Salisbury, NC 28146

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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 observations and staff interviews, the facility failed to store, label and date food in 1 of 1 freezer reviewed for safe food handling. During an observation conducted with the Dietary Manager, multiple food items were observed removed from their original packaging, placed in resealable plastic bags without labeling, and lacked open and/or expiration dates. Additionally, food items in original packaging were observed without opening or expiration dates. These findings had the potential to affect the safety and quality of food served to residents. The findings included:During an initial kitchen tour of the walk-in freezer, conducted with the Dietary Manager on 03/30/2026 at 9:55 AM, the following concerns were identified:- One bag of french fries had been removed from the original packaging and placed in an unlabeled resealable plastic bag exposed to air, with no open date or expiration date.- Three sausages had been removed from the original packaging and placed in an unlabeled resealable plastic bag, with no open date or expiration date, and visible ice crystals present.- One bag of hush puppies was stored in its original packaging with no open date or expiration date.- One bag of 30 baguettes was stored in its original packaging with no open date or expiration date.- Two packages of gluten-free bread were stored in its original packaging labeled with an open date of 12/04/2025, with missing expiration date.- One chocolate cream pie remained in its original packaging with no expiration date.- One package of 25 chicken breasts had been removed from their original packaging and placed in an unlabeled resealable plastic bag and not dated.On 03/30/2026 at 3:00 PM, an interview was conducted with the Dietary Manager. The Dietary Manager stated all food items stored in the freezer should have been labeled and dated when opened, labeled and dated when removed from the original packaging, and discarded once expired. She reported staff had previously been educated on these requirements during an in-service.On 04/01/2026 at 11:39 AM, an interview was conducted with the Cook's Assistant. She reported she completed weekly checks of the freezer, which included entering the freezer, checking for expired food items, and ensuring items were labeled and dated. The Cook's Assistant stated that weekly kitchen audits were not documented and that if concerns arose, they were addressed immediately. She further stated that during the previous week, a freezer audit had been completed by the [NAME] on second shift.On 04/01/2026 at 11:50 AM, an interview was conducted with the Cook. The [NAME] stated she conducted freezer audits with the Cook's Assistant and that they rotated responsibility for completing the audits weekly. The [NAME] stated she was responsible for completing the freezer audit during the previous week. She further reported she checked expired food items but did not check for improperly labeled food items. The [NAME] stated she had received education regarding proper food storage and labeling and reported that all items in the freezer were labeled appropriately after the concerns were identified.On 04/02/2026 at 2:00 PM, an interview was conducted with the Administrator. The Administrator revealed she was not aware of open food items not being labeled with the appropriate date. The Administrator reported she conducted weekly audits with the Dietary Manager, which included overall kitchen cleanliness, as well as review of the freezer, refrigerator, and dry storage areas. The Administrator stated that an audit conducted on 03/18/2026 revealed food items in the freezer that were not labeled or covered. The Administrator reported corrective action was taken at that time and (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the items were removed. The Administrator stated the expectation was that all food items should be properly labeled, dated, covered, and monitored for compliance.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on record review, observations, and staff interviews, the facility failed to secure cords from wall-mounted televisions which could cause a tripping hazard for 7 of 27 rooms (603,604, 605, 606, 607, 608, and 609) on 1 of 4 halls (600 hall).The findings included:The facility grievances were reviewed, and a grievance filed on 4/30/25 indicated that television cords from the wall-mounted televisions poised a tripping hazard.A purchase order form dated 5/5/25 indicated that ten (10) cord securement kits were approved on 5/5/25 by the former Administrator. An education in-service form dated 5/5/25 and presented by the former Administrator to the Maintenance Director indicated that while the television cords were not a safety concern, the cords should be kept close to the wall by cord securement system or by tying up cords.An audit conducted by the Maintenance Director on 5/7/25 indicated that 38 rooms required television cord securement. Included in the audit identified as needing TV cord securement were 27 rooms on the 600-hall including rooms 603,604, 605, 606, 607, 608, and 609.Observations were conducted on 3/30/26 at 9:58 AM to 10:30 AM. The following rooms had television cords hanging loose from the wall-mounted televisions: 603, 604, 605, 606, 607, 608, and 609. The televisions were hung from the walls approximately 6 feet high and two cords hung down from the televisions to hang freely roughly 2 to 3 feet off the ground. One cord was the power cord plugged into the wall at about 2 feet off the ground, and the second cord was an auxiliary cord that dangled freely. These auxiliary cords appeared to be connected to the televisions and a cable box, and several feet of slack wire were noted to hang in the air. While passing through the space between the end of the bed and the hanging cords, the cords needed to be pushed to the side to pass through the area.Observations were conducted on 4/2/26 at 9:46 AM to 10:00 AM with the Maintenance Director. The following rooms had television cords hanging loose from the wall-mounted televisions: 603, 604, 605, 606, 607, 608, and 609. The Maintenance Director reported he could recall that he placed an order for the cord securement kits, but he did not recall installing the cord securement kits and he was not certain if the kits were backordered or if the facility received the kits. The Maintenance Director explained that he did not have a completed work order for the installation of the cord securement kits, and he did not recall why the kits were not installed in the rooms with loose television cords. The Maintenance Director reported he became aware of the television cords when the grievance was filed on 4/30/25, and he completed an audit of all rooms on 5/7/25 and discovered 38 rooms required cord securement. The Maintenance Director explained he did not have the cord securement kits in the facility, and he had to order them but did not recall what happened after the order was placed. The former Administrator was not available for interview.The Administrator was interviewed on 4/2/26 at 11:40 AM. The Administrator reported she started her position in June 2025, and she was informed by the former Administrator that all investigations were completed, and the corrections had been made. The Administrator explained she was not aware the television cords had not been secured. The Administrator reported she expected repairs to be completed and documented to provide a safe environment for residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Power of Attorney (POA), staff, and the Nurse Practitioner (NP), the facility failed to ensure a resident's advance directive information was accurate and consistent throughout the medical record for 1 of 3 residents reviewed for advance directives (Resident #3). Resident #3 was admitted to the facility on [DATE]. Resident #3's electronic health record (EHR) revealed the resident's code status was listed as full code in the EHR banner. Resident #3's care plan dated 1/9/2026 revealed Resident #3 was a full code. A discharge return anticipated [NAME] Data Set (MDS) dated [DATE] indicated Resident #3 was discharged to the hospital. An entry MDS dated [DATE] indicated Resident #3 was readmitted to the facility. A review of the Advance Directive dated 01/17/2026, initiated by the hospital physician, revealed the resident's code status was Do Not Resuscitate (DNR). An active physician's order initiated on 01/17/2026 indicated Resident #3's code status was Do Not Resuscitate (DNR). A Care Conference Summary dated 01/23/2026, completed by the Social Worker, indicated Resident #3 was a full code. Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had severely impaired cognition. On 03/30/2026 at 2:00 PM, an interview was conducted with Resident #3's POA. The POA stated that a few months ago, the resident became ill and was admitted to the hospital. He reported that he could not recall the exact timeframe of the hospitalization. The POA stated that during that hospitalization, Resident #3 wished for his code status to be DNR. ^Resident #3's POA further stated that once back at the facility, Resident #3 had expressed a desire to be a full code. The POA stated he notified staff at the facility that Resident #3 would be a full code. He could not recall who specifically was notified or the timeframe of the notification. The POA stated he believed that Resident #3's code status had remained full code while a resident at the facility and that he was unaware the resident's code status was DNR following his readmission from the hospital.^ Additionally, Resident #3's POA reported that a care plan meeting had occurred within the current year (2026), but he could not recall if Resident #3's code status was reviewed or discussed during the meeting. On 03/30/2026 at 3:00 PM, a phone interview was conducted with the Social Worker regarding Resident #3's code status. The Social Worker stated that upon admission to the facility on [DATE], Resident #3 was a full code. The Social Worker reported that Resident #3 was hospitalized in January 2026 and returned to the facility as a DNR. The Social Worker stated that Resident #3's last care plan meeting was held on 01/23/2026 and included the resident's POA, herself, and the Minimum Data Set (MDS) Nurse. The Social Worker reported that during the meeting, Resident #3's code status was discussed and remained DNR per the POA. When asked about the discrepancy between the physician's order that indicated DNR and the care plan, Care Conference Summary, and the Demographic tab in the EHR that all reflected full code, the Social Worker stated the discrepancy occurred because she did not update the code status at the time of the care plan meeting. She explained that she typically completed updates a few days after the care plan meeting. The Social Worker stated she was also responsible for updating the code status on the Demographic tab of the EHR. The Social Worker further stated she was responsible for conducting code status audits and completed one three months ago, with no concerns identified. On 03/31/2026 at 12:39 PM, an interview was conducted with the MDS Nurse regarding Resident #3's code status. The MDS Nurse reported that during the care plan meeting on 01/23/2026 Resident #3's POA requested that Resident #3's code status remain DNR. The MDS Nurse stated she made the NP aware of this information. The MDS Nurse further stated the Social Worker was responsible for updating the code status on the care plan. On 03/31/2026 at 1:00 PM, a phone interview was conducted with the NP regarding Resident #3's code status. The NP stated he spoke with Resident #3's POA during the resident's most recent hospitalization; however, he could not recall the exact date of the conversation. The NP reported that (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the POA wished for Resident #3's code status to remain DNR. An interview was conducted on 04/02/2026 at 10:30 AM with the Regional Nurse Consultant, who was serving as the acting Director of Nursing (DON). The Regional Nurse Consultant revealed she was not aware of the discrepancy with Resident #3's code status in the medical record. The Regional Nurse Consultant stated that when a family requested to initiate, change, or maintain an advance directive, the expectation was that the care plan and EHR be updated at that time without delay. She further stated that a resident or family member may change an advance directive at any time and should inform nursing staff or social services of the requested change. The Regional Nurse Consultant acknowledged that the care plan and EHR should have been updated to reflect the resident's current code status. An interview was conducted with the Administrator on 04/02/2026 at 11:00 AM. The Administrator revealed she was not aware of the code status discrepancy with the physician's order for DNR and the care plan/demographic tab information in the EHR that both indicated full code for Resident #3. The Administrator stated that the expectation was that the code status documented in the EHR, physician orders, and care plan be consistent and reflect the same information. The Administrator further stated that Resident #3's care plan and EHR should have been updated immediately upon notification of the change in code status.

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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 and staff, resident, and Urologist interviews, the facility failed to ensure a follow-up urology appointment was scheduled and completed as ordered for 1 of 3 residents reviewed for urinary catheter (Resident #39).Resident #39 was admitted to the facility on [DATE].Resident #39's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact.A review of the hospital urology consult after-visit summary dated 01/13/2026 revealed Resident #39's suprapubic catheter was changed, with instructions to follow up on 02/10/2026 for routine catheter replacement.A review of Nurse #1's progress note dated 01/13/2026 revealed the suprapubic catheter was changed, and Resident #39 was to return for a urology follow up appointment on 02/10/2026.A phone interview was attempted with Nurse #1 on 03/30/2026 at 2:00 PM; however, no response was received.A physician's order dated 03/27/2026 indicated Resident #39 had an order to change the catheter as needed (PRN) if it became clogged or dislodged.An interview on 03/30/2026 at 1:26PM with Resident #39 revealed his suprapubic catheter was last changed on 01/13/2026 by a urologist. Resident #39 stated the suprapubic catheter was to be changed monthly by a urologist. Resident #39 further stated he made a nurse aware of the urology appointment in February of 2026 and could not recall who he spoke to. Resident #39 reported he had lower abdominal soreness and believed it was related to the suprapubic catheter not being changed in over a month.A review of Nurse #2's progress note dated 03/22/2026 revealed Resident #39 voiced concerns about the suprapubic catheter not being changed and requested a urology appointment. The progress note also revealed Nurse #2 left a message for the facility Transportation Coordinator to arrange the appointment.An interview with Nurse #2 on 03/31/2026 at 10:24 AM revealed Resident #39 stated he had not been to the urologist in over a month and wanted to have his suprapubic catheter changed. Nurse #2 stated she contacted the facility's Transportation Coordinator to schedule a urology appointment. Nurse #2 further stated Resident #39 had a PRN (as needed) order for the suprapubic catheter to be changed, and she offered to change it; however, Resident #39 refused, stating he preferred for the urologist to perform the suprapubic catheter change. Nurse #2 stated she was not aware of the urology appointment that occurred on 01/13/2026 or of the follow up appointment scheduled for 2/10/2026. Nurse #2 stated that Resident #39 did not report abdominal soreness and she assessed him regularly for pain and cleaned the suprapubic catheter site during care.An interview with the facility's Transportation Coordinator on 03/31/2026 at 10:37 AM revealed she was responsible for scheduling all outside appointments. She stated that once a resident returned from an appointment, the after-visit summary was reviewed by the nurse, who then identified any follow-up appointments. The nurse was then responsible for making a copy of the after-visit summary, highlighting the next appointment, and placing it in a box outside of her office labeled appointments. The Transportation Coordinator stated she then enters the upcoming appointment on a physical calendar and in the electronic health record (EHR) under the resident calendar tab. When asked about Resident #39's urology appointment, she stated the last documented appointment was on 01/13/2026. She reported she did not have an appointment scheduled for February 2026 and stated she was not aware of a follow-up appointment on 2/10/2026. The Transportation Coordinator further stated she scheduled the urology appointment for 03/31/2026 after Nurse #2 informed her of Resident #39 concerns on 03/22/2026.A review of Nurse #2's progress note dated 03/31/2026 revealed Resident #39 was seen by urology, and the suprapubic catheter was changed on 03/31/2026.A phone interview was conducted with the hospital Urologist via telephone on 03/31/2026 at 3:58 PM. The Urologist reported she evaluated Resident #39 on 03/31/2026 and observed discharge and a small amount of blood at the suprapubic urinary catheter insertion site. The Urologist indicated she found no skin breakdown or infection at that time of the evaluation. The Urologist revealed Resident #39 had been (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled for a suprapubic urinary catheter replacement on 02/10/2026 but did not attend the appointment. The Urologist stated the suprapubic urinary catheter required monthly replacement to prevent infection and tissue breakdown. The Urologist indicated that missing the 02/10/2026 appointment placed Resident #39 at high risk for harm and could have resulted in infection and tissue breakdown.An interview was conducted on 04/02/2026 at 10:30 AM with the Regional Nurse Consultant, who was serving as the acting Director of Nursing (DON). The Regional Nurse Consultant revealed she was not aware of the missed urology appointment on 02/10/2026 for Resident #39. The Regional Nurse Consultant stated her expectation was that nurses were to communicate with the Transportation Coordinator regarding appointments so residents could attend appointments as scheduled.An interview was conducted with the Administrator on 04/02/2026 at 11:00 AM, which revealed she was not aware of the missed urology appointment on 02/10/2026 for Resident #39. The Administrator stated Nurse #1 was an agency nurse and may not have been aware of the process for notifying the Transportation Coordinator. The Administrator stated the expectation was for nursing to notify the Transportation Coordinator of upcoming appointments for residents to ensure appointments were arranged timely so residents could attend appointments as scheduled.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, manufacturer's instructions, and interviews with staff, Medical Director, and the Nurse Practitioner, the facility failed to dispose of singleˆuse feeding tube declogging devices contrary to manufacturer instructions, which increased the risk of contamination and infection (Resident #5) and failed to ensure a resident was administered the tube feeding formula specified in the physician order (Resident #37) for 2 of 2 residents reviewed for tube feeding (Resident #5 and Resident #37).The findings included: 1. Resident #5 was admitted to the facility on [DATE] with diagnosis of a history of gastrostomy tube (a flexible, hollow tube surgically placed through the abdomen into the stomach) for feeding and medication administration. She was readmitted to the facility on [DATE] with orders to continue the use of her gastrostomy tube for feeding and medication administration. A quarterly Minimum Data Set assessment dated [DATE] indicated severe cognitive impairment, presence of feeding tube, use of a feeding tube for nutrition, received 3-51% or more of her daily total calories from enteral feeding, and received 2-501 milliliters of fluid each day. On 3/30/2026 at 11:55 AM Resident #5 was observed lying in bed with a tube feeding infusing at 40 milliliters per hour. A soiled clear plastic bag containing dried tan feeding residue hung on the wall behind the head of the bed. Inside were two long, thin plastic stylets (declogging devices) with dried residue on them. A manufacturer's package inside the bag displayed the product name Enteral Feeding Tube Declogger and stated under Precautions that the declogger was intended for single use only. During an observation and interview on 3/30/2026 at 11:55 AM, Nurse #8 entered Resident #5's room and offered to answer any questions about the feeding set-up or the resident's care. She reported that nightˆshift staff were responsible for maintaining the declogging devices and stated the decloggers were used for one week. She did not remove used soiled decloggers observed at that time. During an observation of Resident #5's room and interview with Nurse #8 on 3/31/2026 at 9:30 AM, the observation revealed the two used soiled decloggers that had been inside the soiled bag behind the head of the bed were no longer present. Nurse #8 reported she removed the 2 soiled decloggers and discarded the packaging on 3/30/2026. She stated she hung new supplies on the morning of 3/31/2026 and indicated she had not used the decloggers herself. She stated the devices were intended for single use only and should be discarded after each use. On 3/31/2026 and 4/1/2026 attempts to reach Nurse #5 by telephone for an interview were unsuccessful. Nurse #5 was assigned to Resident #5's during night shift on 3/28/2026 and 3/29/2026. On 4/1/2026 at 6:09 AM Nurse #1 reported she was an agency nurse who had worked at the facility for three months and had completed training in feedingˆtube care. She stated she used a new feeding tube declogger each time and threw it away immediately after use. She confirmed she had not worked night shift on 3/28/2026 or 3/29/2026. On 4/1/2026 at 6:22 AM Nurse #10 reported she completed training in medication administration and feeding tubes. She stated the feeding tube decloggers were not reusable and should be discarded after use. She reported a new declogger could be obtained from the central supply closet. On 4/2/2026 at 1:00 PM, a telephone interview was conducted with Nurse #11. She reported she had worked the 7:00 PM to 7:00 AM shift for several years and previously worked every other weekend and had previously cared for Resident #5. She reported she had not used a declogger herself in a very long time but had assisted another staff in the use. She reported that she understood them to be reusable but would have to ask her supervisor or coworker how many times they could be reused because she had not used one in a very long time. Nurse #11 further stated she had not worked the previous weekend. On 3/31/2026 at 10:00 AM the Central Supply Manager explained that the facility stocked two different sizes of singleˆuse feeding tube decloggers. She confirmed the facility only had single-use decloggers and staff were supposed to throw them away after one use. She pointed out the manufacturer's warning label that read the device should be discarded after a (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	single use and showed that ten packages of decloggers were available in the supply room. On 4/1/2026 at 11:40 AM the Longˆ Term Care Unit Manager stated she served as the Unit Manager for all the longˆterm care halls and participated in infection control and environment of care rounds. She reported she had not been at work on 3/30/2026 or 3/31/2026 and stated she was unaware that singleˆuse feedingˆtube decloggers had been reused. She reported that staff received clear instruction during orientation and on their skills checklists on how to administer tube feedings and label supplies. She added nurses were expected to follow physician orders when administering and managing feeding tubes. She stated the reuse of single-use medical devices can cause infections and staff should follow the manufacturer's instructions. On 4/2/2026 at 1:11 PM Nurse Practitioner #2 was made aware of the 3/30/2026 surveyor observation of a soiled bag containing two used decloggers with dried residue in Resident #5's room. She stated she was unaware that staff had been retaining or reusing singleˆuse decloggers. She reported that items labeled for single use should be used once and discarded. She stated she was not aware of harm resulting from reuse but identified increased infection risk for residents with gastrostomy tubes because of the high sugar content and the feeding tube sites often get infected easily. On 3/31/2026 at 11:38 AM, an interview was conducted with the Interim Director of Nursing (DON). She reported she was not aware that any staff had reused singleˆuse feedingˆtube decloggers. The Interim DON stated that nursing staff were expected to follow physician orders and follow any manufacturer's instructions for the use of tube feeding supplies.2. Resident #37 was admitted to the facility on [DATE] with diagnoses of gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding).Review of Resident #37's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was independent with most activities of daily living (ADL). Resident #37 received all nutrition and hydration through the feeding tube. Review of Resident #37's care plan dated 1/19/2026 revealed she was at risk for complications related to the need for a feeding tube. Interventions included: administer tube feedings and flushes per order, head of bed elevated during feedings per order, NPO status (nothing by mouth), if tube becomes dislodged notify the MD (Medical Doctor).Review of a physician order dated 6/19/25 revealed an order for Resident #37 to receive Diabetasource 1.2 at 80 milliliters (ml) per hour (hr.) administered continuously over 20 hours (disconnect at 8:00 PM reconnect at 12:00 AM) with all shifts required to document in the medication administration record (MAR). Record total amount every shift.Review of March 2026 MAR revealed Nurse #3 signed off Resident #37's enteral tube feeding of Diabetasource 1.2 at 80 ml/hr. was started at 12:00 AM on 3/30/2026.An observation of Resident #37's tube feeding formula container was conducted on 3/30/2026 at 12:34 PM. Resident #37 was sitting on her bed in her room while being administered her tube feeding. The tube feeding formula container was labeled, IsoSource 1.5 at 80 ml hourly and dated 3/30/26 at 10:52 AM. Additional observation of Resident #37's tube feeding on 3/30/2026 at 3:39 PM revealed she continued to receive IsoSource 1.5 at 80 ml hourly.An observation and interview with Nurse #1 were conducted on 3/30/2026 at 3:41 PM. During the interview, Nurse #1 stated she hung Resident #37's tube-feeding formula container at 10:52 AM and labeled it as IsoSource 1.5. She reported that she believed IsoSource and Diabetasource were equivalent formulas because they are produced by the same manufacturer. Based on this assumption, Nurse #1 confirmed she hung an IsoSource 1.5 formula container for Resident #37.Nurse #1 stated on 3/30/2026 at 3:45 PM she verified the physician orders, and the proper tube feeding was infusing for Resident #37.An interview with the Registered Dietitian was conducted on 3/31/2026 at 10:35 AM. She stated there was difference with Diabetasource tube feeding formula and IsoSource tube feeding formula. The Registered Dietitian stated Diabetasource 1.2 formula provides less carbohydrates and is used for those who have a diagnosis of diabetes as such with Resident #37. She stated IsoSource 1.5 formula was used for short term use and provides extra nutrition but if Resident #37 received it on a short-term basis this would not have adversely affected her. She further revealed Resident #37 would have had a significant weight gain if she was receiving IsoSource 1.5 instead of physician (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Salisbury	1505 Bringle Ferry Road Salisbury, NC 28146

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered Diabetasource 1.2 tube feeding formula. The Registered Dietitian confirmed Resident #37 had not had a weight gain.An interview was conducted with the Medical Director on 4/1/2026 at 11:00 AM. He revealed that if Resident #37 received IsoSource 1.5 formula there would not be an adverse outcome if this was administered on a short-term basis. He further revealed he would not order the IsoSource 1.5 tube feeding formula because of Resident #37's diagnosis of diabetes and Diabetasource 1.2 was the proper tube feeding formula.