

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/29/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Care of Raeford		STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N Fulton Street Raeford, NC 28376	

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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews with staff, Responsible Party (RP), Emergency Medical Services (EMS) personnel, and the Medical Director, the facility failed to accurately transcribe necessary information from the FL2 (a medical form completed by a physician to document a patient's medical condition, necessary care, and recommended level of care) to ensure staff monitored a resident's blood glucose (sugar) and administered insulin or sought clarification from a medical provider for a resident with diabetes. Resident #1 was admitted to the facility from home on Friday 8/29/25 for respite care (short-term care that provides relief for caregivers) with an FL2 that indicated 5 units of Lantus (long-acting insulin used to manage blood glucose levels) at bedtime and continuous glucose monitoring. Lantus was not administered on 8/29/25 and 8/30/25 at bedtime and Resident #1's blood glucose was not monitored throughout his stay at the facility from 8/29/25 at approximately 1:45 PM through Sunday 8/31/25 at approximately 1:45 PM when he was discharged home with his RP. On 8/31/25 at approximately 2:06 PM after leaving the facility, the resident's continuous blood glucose monitoring device indicated HI (reading above 500) (normal blood glucose reference range is 70 -110 milligram [mg] per deciliter [dl]). A blood sugar of 500 is considered a medical emergency. The RP administered 5 units of Lantus to the resident. At 5:40 PM that same day (8/31/25), the RP contacted EMS who arrived at the resident's home at 6:09 PM and when they obtained Resident #1's blood glucose level it was 403. Resident #1 was transferred to the Emergency Department (ED) where he presented with an elevated blood glucose of 428 (7:17 PM), elevated heart rate and diarrhea. Resident #1 was monitored overnight at the ED and given intravenous (IV) fluids for persistent tachycardia (elevated heart rate above 100 beats per minute) and hyperglycemia (high blood glucose). This deficient practice affected 1 of 3 residents reviewed for diabetes care (Resident #1). The findings included:Resident #1's Long Term Care FL2 form signed by Resident #1's primary care provider on 8/11/25 included the following orders related to diabetes management: 1. Metformin (diabetes medication) 750 milligrams (mg) oral tablet twice a day with food 2. Empagliflozin (diabetes medication) 12.5 mg tablet by mouth daily 3. Lantus (long-acting insulin) 5 units subcutaneously at bedtime 4. Continuous glucose monitoring During an interview with the Admissions Director on 9/25/25 at 9:56 AM she indicated that a representative from the Veteran's Affairs (VA) had reached out to her to set up the respite care at the facility with a referral date of 8/27/25 for respite services from 8/29/25 through 8/31/25. She indicated that the VA sent her the required paperwork to include the FL2 form which she reviewed to ensure the facility was in a position to care for the resident. The Admissions Director stated that she called Resident #1's RP on 8/28/25 and informed her to bring his medicine when she brought the resident to the facility for admission on [DATE]. The Admissions Director stated that she took a hard copy of the FL2 form to the B-hall nurses' station because the nurse would need the FL2 form for admission orders and she gave it to a nurse, but she could not recall who the nurse was. She explained that she also scanned a copy into Resident #1's electronic record. During an interview with the Director of Nursing (DON) on 9/24/25 at 11:15 AM she indicated that Nurse #2 was initially supposed to admit Resident #1 and they thought that he was supposed to come to the facility on Thursday 8/28/25. The following orders were transcribed into Resident #1's electronic health record (EHR) by Nurse #2 on 8/28/25: 1. Albuterol sulfate 90 micrograms (mcg)/actuation hydrofluoroalkane (HFA) aerosol inhaler, administer two puffs every 6 hours as needed for shortness of breath/wheezing.2. Amlodipine 5 mg tablet, administer one tablet daily for hypertension.3. Cholecalciferol (vitamin D3) 50 mcg (2,000 unit) capsule, administer one tablet daily for vitamin D deficiency.4. Donepezil 5 milligram mg tablet, administer one tablet daily for dementia.5. Empagliflozin 25 mg tablet, administer half tablet orally daily for diabetes mellitus.6. Losartan 50 mg tablet, administer one tablet daily for hypertension.7. Metformin 750 mg tablet, administer one tablet twice a day with food.8. Pantoprazole 40 mg tablet, delayed release, administer one tablet daily for gastroesophageal reflux disease (GERD). There were no orders entered for 5 units Lantus at bedtime and/or continuous blood glucose monitoring. During an interview with Nurse #2 on 9/24/25 at 12:57 PM she indicated that she was initially supposed to admit Resident #1 to a room in her hallway (B-Hall) on 8/28/25, but he ended up in a different room and Nurse #1 completed the admission. Nurse #2 stated that she had transcribed Resident #1's orders from the FL2 form into the EHR on 8/28/25, but she was not sure why she did not enter the orders for blood glucose monitoring and 5 units of Lantus. Nurse #2 stated that the admitting nurse normally would transcribe the orders into the EHR and verify with the written orders to</p>		