STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Saluda	501 Esseola Circle Saluda, NC 28773

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff and Nurse Practitioner (NP) interviews, the facility failed to effectively supervise a cognitively impaired resident when the resident was able to exit the facility unsupervised and without staff knowledge for 1 of 3 residents reviewed for supervisions to prevent accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with diagnosis that included dementia, bipolar disorder, panic disorder, and anxiety disorder.Review of the annual minimum data set (MDS) dated [DATE] revealed that Resident #1 was severely cognitively impaired. He displayed no wandering behavior during the look back period and needed supervision with mobility and transfers. Resident #1 had no falls and needed supervision with ambulation. Review of the care plan started on 12/9/24 and last updated on 12/16/25 revealed that Resident #1 waws at risk of elopement- wandering in facility I'm gonna walk out the door - may stand by exit doors, may try to follow behind staff as they exit facility. Goals included Resident #1 will wander safely within specified boundaries. Interventions included approach: 1:1 for elopement attempt. Redirect Resident #1 from front door area as needed- offer coffee, snack, walk in courtyard, offer redirect to room. Provide visual and verbal cues as needed. redirect to snack, coffee, activity as desired. Approach from the front. Walk in step with Resident #1 first before redirecting. Maintain a calm environment and approach to Resident #1.Review of the elopement assessment form dated 12/10/25 revealed that Resident #1 was independent for ambulation. Resident #1 displayed risk factors which included that he exhibited exit seeking behaviors. Resident #1 also verbalized wanting to go home, going on a trip, or going to meet someone. Resident #1 did not accept present residency situation or location. The immediate interventions included continuing his current plan of care. The assessment identified Resident #1 as being at risk for elopement. Review of nursing progress note from Nurse #1 dated 12/16/2025 revealed Resident #1 was noted to be in driveway at 10:42 AM today. Resident #1 was redirected by staff back into facility. A skin assessment was completed immediately on Resident #1. Resident #1 was placed on 1:1 (One-to-one supervision by a staff member). The NP and Resident #1's guardian were made aware of the incident and the need for possible placement in a locked unit and currently being placed on 1:1 for safety. Resident #1's guardian voiced understanding. No injury was noted on Resident #1.An interview on 1/8/26 at 11:10 AM with Nurse #1 revealed that she was the assigned nurse for Resident #1 on 12/16/25. She stated that Resident #1 was dressed in a sweatshirt, pants, socks, and shoes when he eloped from the building. Nurse #1 stated that around 10:10 AM on 12/16/25 Resident #1 was inquiring about leaving the facility and she told Resident #1 he needed to talk to the physician and that it was almost time to go smoke. She stated that Resident #1 left the nurse's station and returned to his room where he lay down in his bed. She stated that Resident #1 had been discussed in the morning meeting regarding an increase in exit-seeking behavior. Nurse #1 further indicated that there were a lot of staff and plumbing vendors going in and out of the building that day. She stated (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #1 probably got out of the building by following one of the plumbing vendors. Nurse #1 stated that at 10:42 AM on 12/16/25 she was on side one (the section of the building where Resident #1's room was located) in the common area and she looked out the window and saw Resident #1 standing midway down the driveway that was on the right side of the parking lot. Nurse #1 stated that she immediately ran outside and called out to Resident #1 brought him back into the building and placed him in a wheelchair. She stated that she then completed a head-to-toe assessment with no injuries noted to Resident #1. Nurse #1 then placed Resident #1 on one-to-one with a staff member. She stated that after he was returned to the building Resident #1 had not displayed any further exit seeking behaviors. Nurse #1 stated that when she inquired why Resident #1 had left the building Resident #1 stated that he was going home. An interview with Nurse Aide (NA) #1 on 1/8/26 at 11:31 AM revealed that she saw Resident #1 display exit-seeking behavior one time at 10:30 AM on 12/16/25 before he eloped. She stated that Resident #1 was inquiring about how he could get home. NA #1 indicated she redirected Resident #1 by letting him know she would bring him some coffee, and he walked independently to his room where he sat on his bed. NA #1 revealed that she then brought Resident #1 some coffee while he was sitting on his bed. NA #1 further revealed that Resident #1 had not displayed exit seeking behavior prior to this incident for a very long time. She stated that she could not recall how long it had been exactly, but it had been at least a few months. NA #1 stated that she was aware she needed to keep an eye on Resident #1 because he had been displaying exit seeking behavior, but she still had other residents to care for and was unable to continuously watch him. She stated that she identified a resident who was exit seeking by them wandering around, going to the doors, asking about leaving, or them stating that they want to leave. NA #1 stated that they have a Kardex in the resident's closets which included if the resident had exit seeking behaviors. NA #1 stated that Resident #1's Kardex indicated he had exit seeking behaviors. She stated that when she saw residents with exit seeking behaviors she told her Nurse immediately and they communicate with staff about keeping an eye on those behaviors and resident. Review of the facility investigation completed by the DON revealed that on 12/16/25 at 10:10 AM, Resident #1 was observed in the hall near the Unit Manager's and Scheduler's office doors. At 10:30 AM, Resident #1 was noted to be lying on his bed in his room by Nurse Aide #1. At 10:42 AM, Resident #1 was discovered in the middle of the facility driveway, having had an unsupervised exit from the building. Nurse #1 visualized Resident #1 in the driveway at 10:42 AM and immediately redirected him back into the facility. A skin assessment was completed, and no injuries were noted. Resident #1 was then placed on one-to-one supervision for safety. The Nurse Practitioner (NP) was notified of the incident, along with the guardian. The guardian was informed of the need for possible placement in a locked unit and of the immediate one-to-one supervision put in place; the guardian expressed understanding. In conclusion, because several vendors and staff were entering and exiting the facility that day Resident #1 was able to walk out with a vendor leading to his unsupervised exit of the facility. Referrals were sent out for a memory care unit placement and Resident #1 remained on one-to-one monitoring. On 12/17/25, Resident #1 was accepted to a facility with a locked unit and was transferred there on the same day.An online website named Wunderground was used to obtain the outside weather in the Saluda area on 12/16/25 and noted at 10:54 AM the temperature was 41 degrees with the highest temperature reaching 52 degrees from 10:54 AM to 2:54 PM.An interview with NP on 1/7/26 at 11:48 AM revealed that she was notified about Resident #1's elopement on 12/16/25. She stated that she had not seen him after the elopement because Resident #1 was transferred to a facility with a locked unit the next day on 12/17/25. The NP further revealed that any time she had seen Resident #1 he was always sitting on his bed. She stated that Resident #1 had displayed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no signs or symptoms of exit seeking behavior during her previous visits. An interview with the DON on 1/8/26 at 10:55 AM revealed that Resident #1 had been showing increased signs of exit seeking behavior on the morning of 12/16/25. The DON explained that Resident #1 had been asking about leaving and had been standing on side one near the common area doors which were locked with a keypad. She stated that she had discussed Resident #1 had increased exit seeking behavior during the morning interdisciplinary team meeting. After that meeting, she informed staff that they needed to increase their observations of Resident #1 and increased redirection attempts because his exit seeking behaviors had escalated. The DON reported that on 12/16/25, the day Resident #1 eloped from the building, a scrub supply van had been available outside for staff to purchase scrubs, and plumbing services were also entering and exiting through the side one common area door. She stated that she believed the plumbing company may have let Resident #1 out or that he might have left when the plumber entered or exited the building, since the staff were aware of who Resident #1 was. The DON explained that before this incident, staff were typically stationed in the common area when vendors entered or exited through that side door. She further explained that after the incident, vendors and staff were required to use only the front door, which was always locked and required staff to let individuals in and out. An interview with the Administrator on 1/8/26 at 10:59 AM revealed that Resident #1 had exit seeking behavior the morning of 12/16/25 and it was discussed in the morning meeting. He stated that the staff were informed to observe Resident #1 more closely because he had increased exit seeking behavior. The Administrator stated there were vendors going in and out of the doors on the side one common area along with staff and he felt Resident #1 just left with the vendors. He stated that to speak with Resident #1 he gave the impression he was just a visitor. He further revealed that the staff were letting the plumbers in and out of the locked building and/or they were following the staff as they went in and out of the building to the scrub truck. He stated that Resident #1 was spotted in the parking lot at 10:42 AM and was last seen by staff in the building at 10:30 AM. Resident #1 had no injuries and was placed on one-to-one until his transfer to a facility with a locked memory care unit the next day 12/17/25. The Administrator stated that the side one common area doors had since been locked with a code change only he, the DON, and the Maintenance Director had. He stated that all deliveries and staff were to use the main entrance which is locked and have to have a staff member let vendors in and out of the main door. The Administrator stated the door that Resident #1 exited the facility through had an alarm installed after the incident that goes off anytime the door is opened even when the code was used.An observation conducted on 1/8/26 at 11:05 AM with the Administrator and Director of Nursing (DON) revealed that Resident #1's room was located 22 feet from the nursing station and 60 feet from the doors on side one of the common area. When Nurse #1 saw Resident #1 outside of the building he was approximately 150 feet away from the facility, positioned halfway down the driveway and about 50 feet from the road. Traffic at the facility had been low over the previous two days, and Resident #1 was observed walking independently prior to the elopement and when he was spotted in the driveway of the facility. During the observation it was noted that the side one common area exit consisted of double doors equipped with a keypad. These doors faced the parking lot, with a driveway on both the left and right sides. The door from which Resident #1 had exited through was confirmed to have been locked by a keypad, and only the Administrator, DON, and Maintenance Director had access to the code. The facility provided the following Corrective Action Plan with a completion date of 12/20/25:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.On 12/16/25 Resident #1 had an unsupervised departure from the facility. He walked down to the middle of the facility driveway. Resident was visualized at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the driveway and staff immediately brought resident back into the facility. During the investigation on 12/16/25, the Director of Nursing determined that the resident potentially followed a person out the door after they entered or exited. The Provider was notified on 12/16/2025 of the incident by the Director of Nursing. The Guardian was notified on 12/16/2025 of the incident by the Social Worker. Resident was placed on one-on-one supervision immediately on 12/16/2025 and was implemented by the Director of Nursing.Elopement drill completed by Maintenance Director on both shifts on 12/16/2025. Head to toe skin assessment was completed by Nurse #1 of Resident #1 on 12/16/2025. No injuries or adverse effects was noted. Resident #1 was discharged to a secured facility on 12/17/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On 12/16/25 when the facility was made aware that Resident #1 had departed the building unsupervised the Director of Nursing completed an immediate head count of other residents in the facility, all other residents were accounted for. The Maintenance Director immediately checked door alarms on 12/16/2025. Doors were found to be in working order. No issues were identified. The Director of Nursing or designee reviewed progress notes for the last 30 days for all residents in the facility for changes in behaviors and reviewed all elopement assessments to ensure they were accurate on 12/16/2025. There were no other residents newly identified at risk for elopement. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 12/16/25 the Director of Nursing or designee educated all staff in the facility on the facility elopement policy. 1. Upon discovery that a resident cannot be located a head count will be conducted. If the resident is still missing a code green is to be announced on the facility paging system to alert all staff to assist in locating the missing resident. 2. The clinical supervisor will notify the Administrator, the Director of nursing and the attending physician. 3. The highest-ranking staff member will become the team leader and coordinate the search. 4. The team leader will maintain documentation during the search process. 5. The floor plan will be used to ensure a thorough search of the interior. 6. If the resident is not located on the premises the team lead will direct staff to conduct an external search. The team leader will notify the family/legal representative and inquire as the potential whereabouts of the resident. 7. If the resident is not located on the premises the Administrator will notify the local emergency response agencies. The elopement policy also states that an elopement assessment is to be completed on admission, quarterly and as needed. Staff were also educated to report new or increased behaviors or exit seeking behaviors to nursing staff. If a resident is designated as at risk for elopement that should be added to the elopement books at the receptionist desk and at each nurses' station. The facility social worker is responsible for updating and maintaining accuracy of the elopement book. No staff will work until they have received this education provided by Director of Nursing or designee. On 12/16/25 the Administrator informed the Scheduler to ensure all agency staff receive the education prior to working. The Director of Nursing or Designee monitors that any new agency staff signs this education prior to starting their first shift at facility. Verbal education is provided to ensure understanding. The Administrator informed the Payroll Coordinator they are to ensure all newly hired staff receive the education during new hire orientation.On 12/16/25 Director of Nursing and Unit Managers were educated by the Regional Director of Clinical Services to review progress notes for new and increased behaviors to include wandering for the need to complete a new elopement assessment during clinical morning meeting Monday through Friday. Nurse management was also educated to review during clinical morning meeting Monday through Friday, the resident diagnosis for dementia and other cognitive impairment and review with the interdisciplinary team to include the Administrator, Director of Nursing, Medical Records, Nurse (continued on next page)

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