STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Statesville	2001 Vanhaven Drive Statesville, NC 28625

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews with residents, Pharmacist and Nurse Practitioner, the facility failed to have effective systems in place to prevent misappropriation of two resident's controlled opioid pain medications. Resident #41's had 28 tablets of Oxycodone/Acetaminophen 10/325 milligrams (mg) and Resident #34 had 30 tablets that were discovered missing from the medication cart and were never located. This deficient practice affected 2 of 2 residents reviewed for misappropriation of resident property.The findings included:1. Resident #41 was admitted to the facility on [DATE] with diagnoses that included polyneuropathy (a neurological condition characterized by the simultaneous damage of multiple peripheral nerves throughout the body).Review of Resident #41's medical record revealed an order dated 01/21/26 for Oxycodone/Acetaminophen 10/325 mg one tablet every six hours as needed for pain. The medication was discontinued on 01/22/26.Review of Resident #41's Medication Administration Record for January 2026 indicated Resident #41 was given Oxycodone/Acetaminophen 10/325 mg tablet at 12:03 AM on 01/22/26.Review of the pharmacy delivery sheet revealed Resident #41's Oxycodone/Acetaminophen 10/325, 30 tablets were delivered to the facility on [DATE] at 11:16 PM and was received by Nurse #5.During a telephone interview with Nurse #5 on 07/01/26 at 4:20 PM the Nurse explained that she remembered she received Resident #41's Oxycodone/Acetaminophen 10/325 mg 30 tablets in on 01/22/26 but could not remember the time.Review of Resident #41's medical record revealed an order dated 01/22/26 for Oxycodone/Acetaminophen 5/325 mg one tablet by mouth every eight hours as needed for pain and was written by Nurse Practitioner #1.Review of Resident #41's medical record revealed an order dated 01/23/26 for Oxycodone/Acetaminophen 5/325 mg give two tablets by mouth every six hours.Review of Resident #41's admission Minimum Data Set assessment dated [DATE] revealed her cognition was moderately impaired and revealed she received scheduled pain medication and pain medication as needed.Review of a Progress Note written 01/27/26 at 11:21 AM written by Nurse #4 revealed Resident #41 was out of the Percocet (Oxycodone) 5/325 mg but did have Percocet 10/325 mg that were previously discontinued. Verbal order given by Nurse Practitioner #1 to give one Oxycodone/Acetaminophen 10/325 mg with an Acetaminophen 325 mg tablet to equal the ordered dose of two 5/325 mg until the medication came in from the pharmacy.Review of a Facility Reported Incident (FRI) Investigation Report dated 02/01/26 submitted by the Administrator revealed in part: an allegation of Diversion of Resident of Drugs discovered on 01/28/26 at 11:00 AM. The facility identified a card of Oxycodone 10/325 mg missing from the 500-hall medication cart (belonging to Resident #41). The facility has audited all narcotic cards and (declining) count sheets to verify no other cards were missing and the (shift change controlled substance inventory) count sheets were correct. The agency Nurse in question, Nurse #3, was gone when the card was noticed missing. The agency was notified and made aware Nurse #3 could not return to work pending the investigation. Summary of Investigation: The facility concluded an assumption of diversion due to the Oxycodone 10/325 card and declining count sheet not being found however, the facility could not definitively determine by whom. Following extensive search, the card and declining count sheet were not found. Nurse #3 denied seeing the card in the medication cart. The facility staff stated the card was in the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart when the medications were counted. Narcotic count sheet appeared to be altered. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse #4 and Medication Aide (MA) #1 were drug tested and the results were negative. Nurse #3 did not show up for the drug test. The agency was notified of the facility's expectations and Nurse #3 was marked as do not return. The allegation was substantiated.Review of a Drug Enforcement Administration form dated 01/29/26 revealed the facility reported the loss or theft of 28, Oxycodone/Acetaminophen 10/325 mg tablets.On 06/28/26 at 11:26 AM an interview was conducted with Resident #41 who explained that she had back problems and had endured pain for years which caused her to have to take pain medication to control her pain. The Resident continued to explain that she had never had a problem getting her pain medication when she requested it.An interview was conducted with MA #1 on 06/30/26 at 9:35 AM. The MA explained that on 01/28/26 Resident #41 asked her when she last had her pain medication and the MA looked for the declining count sheet for Resident #41's Oxycodone/Acetaminophen 10/325 mg to determine what time the Resident had her last dose that the MA had taken from that specific card on 01/27/26. The MA explained that the order for Oxycodone/Acetaminophen 10 mg had been discontinued but the supply remained on the medication cart. The MA stated she had to use one of the pills (Oxycodone 10 mg) to give to Resident #41 the day prior on 01/27/26 at 12:00 PM which left the remaining count of 28 pills so she knew there should have been 28 pills left in the card and the declining count sheet recorded 28 remaining the last time she saw the sheet 01/27/26. The MA could not find both the card of the Oxycodone/Hydrocodone 10/325 mg tablets or the declining count sheet for that medication. While looking at the narcotic notebook, MA #1discovered that the shift inventory count sheet had been altered because the signature was not her signature as she signed her name nor was it the same inventory count sheet that she initiated the day prior on 01/27/26. The MA stated she immediately reported what she discovered to the DON. The MA stated she was drug tested and the result was negative.On 06/29/26 at 1:25 PM and 07/01/26 at 2:13 PM interviews were conducted with the Director of Nursing who explained that on the morning of 01/28/26 Medication Aide #1 informed her that Resident #41 asked the MA what time she had her pain medication (Oxycodone/Acetaminophen 10/325) the previous day (01/27/26). The MA looked for the declining count sheet for the Oxycodone/Acetaminophen 10/325 mg tablets because the MA had used one of the discontinued 10/325 mg pills that were stored on the medication cart to equal the new dose of 5/325 mg 2 tablets that was ordered for a one-time dose on 01/27/26. The declining count sheet would have the documented time that the MA gave Resident #41 the pain medication on 01/27/26 but the MA could not find the declining count sheet, nor could she find the card of the medication for the 10/325 mg Oxycodone/Hydrocodone. The MA also noticed that the shift change controlled substance inventory count sheet (a form that indicated how many narcotic cards and declining count sheets were on the medication cart) had been altered. MA #1's signature and Nurse #4's signature had been altered. Nurse #4 worked 01/27/26 until 01/28/26 shortly after midnight and gave report to Nurse #3 who was an agency Nurse that had never worked at the facility. The DON continued to explain that they called Nurse #4 into the facility and the Nurse explained that there should have been 28 Oxycodone/Acetaminophen 10/325 mg tablets left in the card and the declining count sheet had a balance of 28 when the Nurse reported off to Nurse #3 shortly after midnight on 01/28/26. Nurse #4 also reviewed the shift change controlled substance inventory count sheet and noticed her signature had been altered as well. The DON continued to explain that four staff, MA #1, Nurse #4, the Assistant Director of Nursing (ADON) and the DON submitted to a drug test and all results were negative. The ADON and DON were drug tested because they had keys to the medication cart. The facility made numerous attempts to call Nurse #3, and the Nurse returned their call on 01/29/26. Nurse #3 reported that she had no knowledge of Resident #41's missing narcotic card and declining count sheet nor did she know anything about an altered inventory count sheet. Nurse #3 agreed to come to the facility for a drug test but did not return to the facility. The DON stated they continued to call Nurse #3, but the Nurse would not answer their calls. The DON explained that she determined that Nurse #3 must have (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they felt their needs were being met.On 2/26/26 pain assessments were conducted for all non-alert and oriented residents by the Director of Nursing or designee.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:The Facility Human Resources/Payroll Coordinator conducts criminal background checks, license checks, pre-employment drug tests, and completes reference checks from previous employers for all newly hired employees. Any contracted agency is responsible to conduct pre-employment drug screening, license, reference and background checks and provide documentation at the Administrator or designee's request.Beginning on 2/26/26, the Director of Nursing or designee educated all licensed nurses and certified medication aides on the requirement of two people signing the narcotic descending sheets and delivery sheets when receiving narcotics from the pharmacy. Education also included listing the number of cards and sheets received from the pharmacy, how to properly fill out the shift change controlled substance inventory count sheet, including to start a new sheet the sheet must be filled out by two people and the number of cards and sheets must be listed in the indicated spot. Empty narcotic blister packs and the corresponding narcotic descending sheets must stay on the cart until the Director of Nursing or designee can remove the cards and initial the removal on the shift change controlled substance inventory sheet daily. In addition, the Director of Nursing or designee removes all discontinued medications from the medication carts daily including weekends. Staff were required to take a test to ensure understanding and competence of the process. The Director of Nursing or designee reviewed the test to ensure that the staff understood the education. Any nurse or medication aide who had not been educated by 3/5/26 will not be permitted to work until education and test are completed by the Director of Nursing or designee. The Regional Nurse Consultant educated the clinical nurse management team on 3/2/26 of pharmacy services: receiving controlled substances inventory shift sheets, how to audit system, how to perform staff observations.All newly hired licensed nurses will be educated on said process during orientation by the Director of Nursing or designee. The Administrator contacted the Drug Enforcement Agency on 3/1/26 and NCDHHS Drug Control Unit on 3/4/26 to schedule an onsite inspection to occur at the earliest convenience.On 3/31/26 the Regional Director of Clinical Services contacted [NAME] Healthcare Corporate Compliance to conduct training for all licensed nurses and certified medication aides on penalties and consequences of drug diversion, which took place on 4/1/26.Indicate how the facility plans to monitor its performance and make sure that solutions are sustained:Beginning the week of 3/1/26 the Director of Nursing or Designee will interview 3 nurse/medication aides at random times for the element of surprise to ensure they can verbalize the narcotics process x 12 weeks. Any nurse/medication aide who cannot verbalize the process will be re-educated and made to retake and pass a test.Interviews were conducted with 5 alert and oriented residents to identify issues with medication administration or unrelieved pain. Five non-alert and oriented residents were assessed by the Director of Nursing or designee for any indicators of pain. These audits were started the week of 3/1/26 and conducted x 8 weeks.Likewise, the Regional Nurse Consultant will conduct random weekly audits on varying days of the week with nurse/medication aides to ensure they can verbalize the narcotics process x 4 weeks, then monthly x 2 months.Director of Nursing or designee will randomly defined as different shifts, days for the element of surprise, audit narcotic count sheets and shift inventory sheets. Likewise, the Director of Nursing or designee will check all medication carts daily for zeroed out descending count sheets and medication cards for removal.The pharmacist will conduct monthly audits to ensure compliance.The facility completed and accepted an ad hoc QAPI meeting on 3/1/26. The QAPI team implemented the above plan to ensure compliance. The QAPI team consists of the Director of Nursing, Administrator, Medical Director, Social Worker, Business Office Manager, Life Enrichment Director, Admissions Director, MDS nurse, Dietary Manager, Human Resources Manager, and Assistant Director of Nursing. The QAPI committee will continue to review the audit findings for 3 months to ensure compliance is met. The QAPI committee determined the new date of compliance will be 04/02/26.The facility's corrective action plan with a correction date of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Statesville	2001 Vanhaven Drive Statesville, NC 28625

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/02/26 was validated onsite on 7/1/26 by observations and interviews.Multiple observations were conducted of nurses removing controlled medications from the locked box and comparing the count to the declining sheet and documenting on the declining sheet during the medication administration. All four medication carts were reviewed for correct controlled medication counts and matching declining sheets. Correct shift change inv

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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 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 reviews and interviews with staff and the Pharmacist, the facility failed to have effective systems in place for the return of discontinued controlled medications to the pharmacy for 1 of 2 residents reviewed for pharmacy services (Resident #41). The findings included:Review of Resident #41's medical record revealed an order dated 01/21/26 for Oxycodone/Acetaminophen 10/325 milligrams (mg) every six hours as needed for pain. The medication was discontinued on 01/22/26.Review of Resident #41's medical record revealed an order dated 01/22/26 for Oxycodone/Acetaminophen 5/325 mg one tablet by mouth every eight hours as needed for pain and was written by Nurse Practitioner #1.Review of the pharmacy delivery sheet revealed Resident #41's Oxycodone/Acetaminophen 10/325, 30 tablets were delivered to the facility on [DATE] at 11:16 PM and was received by Nurse #5.An interview was conducted with Nurse #5 on 07/01/2026 at 4:20 PM. The Nurse confirmed that she remembered receiving Resident #41's Oxycodone/Acetaminophen 10/325 mg, 30 tablets on 01/22/26.Interviews were conducted with Nurse #1 on 06/30/26 at 1:40 PM and 07/01/26 at 3:15 PM. The Nurse explained that before the drug diversion happened the discontinued controlled medications were left on the medication cart until the nurse managers removed the medications from the medication cart.An interview was conducted with Medication Aide (MA) #1 on 06/30/26 at 9:35 AM. The MA explained the discontinued controlled medications were left on the medication cart until the nurse managers removed them from the cart, but she was not sure how often it was that they were removed from the medication cart.An interview was conducted with Nurse #4 on 06/30/26 at 10:23 AM. The Nurse stated she worked as a nurse manager, and the facility recently had issues with drug diversion. Nurse #4 explained that before the diversions, the discontinued controlled medications remained on the medication carts until they were removed by the nurse managers.Interviews were conducted with the Director of Nursing (DON) on 06/29/26 at 1:15 PM and 06/30/26 at 4:50 PM. The DON explained Resident #41's Oxycodone/Acetaminophen 10/325 mg was ordered on 01/21/26 and delivered on 01/22/26 and although it was discontinued on 01/22/26 the medication remained in the medication cart. The DON continued to explain that on the morning of 01/28/26, Medication Aide (MA) #1 looked to see what time she administered Resident #41 her pain medication the day before and the MA could not find the declining count sheet for that controlled medication. The MA notified the DON, and the DON conducted an investigation of the missing controlled pain medication and discovered the last count was on 01/28/26 shortly after midnight between Nurse #4 and Nurse #3 and there were 28 tablets left on the medication card. She stated the system for returning controlled medications during that time was for the discontinued controlled medications to remain in the medication carts until the nurse managers, including myself, the administrative nurses, removed the medications which was about twice a week.On 07/01/26 at 3:10 PM an interview was conducted with the Administrator who explained that after the facility investigated the drug diversion, they discovered that the nurses and medication aides were not required to have two nurses' signatures on shift change control inventory sheets, the pharmacy delivery sheets or the declining count sheet for that specific controlled medication. The Administrator indicated that because stricter systems were not in place, she could see that the potential was there to divert narcotics.The facility did not present a plan of correction to the survey team before the exit.