STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Nash	1210 Eastern Avenue Nashville, NC 27856

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to treat a resident in a dignified and respectful manner when Resident #86 requested toileting assistance from Nurse Aide (NA) #1 to use the bed pan for a bowel movement and the NA told the resident to have a bowel movement in his brief. A reasonable person expects to be assisted with toileting needs by their caregiver and would have experienced embarrassment when told to have a bowel movement in their brief rather than be assisted with toileting needs as requested. This deficient practice affected 1 of 3 residents reviewed for dignity (Resident #86). Findings included:Resident #86 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 was cognitively intact. He had no behaviors and was dependent on staff for toileting and transfers. Resident #86 was coded as continent of bowel and bladder. Review of the facility's investigation documentation completed by the Administrator revealed on [DATE] Resident #86 and a family member filed a grievance about him being told to make a bowel movement in his brief when he asked Nurse Aide (NA) #1 for incontinence assistance on [DATE] at approximately 9:30 PM. NA #1 confessed this statement to the Administrator via telephone on [DATE]. It was determined that NA #1 was unsure of her resources to be able to care for the residents appropriately, and she did not know who she could ask for assistance at the time of the incident. She told Resident #86 once he had the bowel movement to turn on his call light prior to the end of her shift at 11:00 PM. At 11:00 PM, NA #2 completed her first round on Resident #86 and asked if he needed to go to the bathroom or if he needed his brief changed. He stated that he did not. NA #2 asked if she could check, and he said that it would be fine. She found Resident #86 to be clean and dry. The facility interviewed alert and oriented residents regarding dignity, and skin checks were performed on all non-interviewable residents. No concerns were found. Corrective actions included mandatory inservice for all staff on resident rights (dignity/respect). In addition, NA #1 was immediately suspended and when she returned to work the following week, she received a one-on-one education on dignity/respect. During a phone interview with Resident #86's family member on [DATE] at 2:49 PM they indicated that the resident was discharged from the facility on [DATE] and has since expired. During a phone interview on [DATE] at 1:44 PM, NA #1 recalled on the evening of [DATE] that it was her first day on the floor by herself. It was around 9:30 PM when final rounds were performed, and Resident #86 wanted to use the bedpan. She stated she felt overwhelmed because multiple residents rang the call bell at the same time, and she had never worked with Resident #86 before. All other nursing staff were busy. NA #1 stated she asked Resident #86 politely if he could have a bowel movement in his brief, and she would return to change him. However, she got busy with other residents and forgot to go back to his room before her shift was over at 11:00 PM. She indicated that she now knew what she said to Resident #86 was wrong, and she was suspended for 1.5 weeks during the investigation. Upon return, she received one on one education related to dignity/respect. An interview was conducted with NA #2. She revealed that she worked during the overnight shift on [DATE], and she was interviewed by the Administrator on [DATE] due to Resident #86's complaint on [DATE]. She reported that on [DATE] at 11:00 PM, she performed her first rounds and Resident #86 was dry/clean. The Director of Nursing (DON) was interviewed on [DATE] at 10:28 AM. She revealed that NA #1 was of a small body frame, and Resident #86 was a larger man, and NA #1 informed her she felt she could not put the resident on the bed pan. The DON stated that NA #1 could have retrieved the nurse on duty to help her with the bed pan. She (the DON) indicated NA #1 should have said, let me find someone else to assist and will return as soon as I can. NA #1 was suspended, educated, and re-initiated in NA training. An interview was conducted with the Administrator on [DATE] at 11:14 AM. He revealed that NA #1 should have told Resident #86 when he rang his call bell on [DATE] that she would get help and be right back. She was re-educated on dignity and why what she said was not appropriate. The facility provided the following corrective action plan with a completion date of [DATE]:- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:Resident #86 was told that he should go to the bathroom in his brief by his assigned nursing assistant at approximately 9:30 pm on [DATE]. Resident #86 was checked on during the overnight shift that began on [DATE] by the nursing assistant at 11:00 PM, 1:30 AM, 3:00 AM, and 5:30 AM. Per the nurse and nursing assistant assigned to the resident, the resident did not voice any issues or care needs until 5:30 AM at which point the resident had a bowel movement and activities of daily living care was provided. The resident was interviewed by the Director of

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, resident, and Medical Director interviews, the facility failed to notify the physician of a significant change when the resident's feeding tube site was identified by staff as visibly irritated, leaking, and caused the resident pain when touched for 1 of 1 sampled resident reviewed for feeding tube care (Resident #64). Findings included: Resident #64 was readmitted to the facility on [DATE] with diagnoses that included gastrostomy status (an artificial opening into the stomach through the abdomen wall to provide nutritional support). Review of Resident #64's physician orders revealed that on 4/5/25 a new order was initiated for nurses to clean the gastronomy tube (g-tube) site with normal saline and then apply a calcium alginate cover with split gauze twice daily until healed. Resident #64's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #64 was moderately cognitively impaired and she had a feeding tube. Review of the treatment administration record (TAR) for Resident #64 during the month of July 2025 revealed that Nurse #1 signed off on the order for g-tube site care on 7/23/25. During an interview with Nurse Aide (NA) #3 on 7/24/25 at 8:35 AM, she revealed that during care this morning, Resident #64's g-tube site had a smell and gurgling sounds/movements. The site looked very red, the gauze was saturated, and it needed to be removed during Resident #64's bath that morning. NA #3 stated she told Nurse #1 about her concerns when she observed Resident #64's g-tube site this morning. An observation of Resident #64's g-tube site was conducted in conjunction with an interview on 7/24/25 at 8:40 AM. Resident #64 gave permission to observe her g-tube site. There was a large area of redness (excoriation) indicating irritation on the outer area of the skin fold holding the g-tube. The surgical site could not be seen entirely due to Resident #64's positioning causing a large skin fold holding the g-tube in between. A white discharge was observed leaking causing buildup inside the skin fold. When asked, Resident #64 stated she felt pain when the skin fold was opened, or the red area was touched. There was no gauze surrounding the site. Nurse #1 was interviewed on 7/24/25 at 8:55 AM. She stated that when she cleaned Resident #64's g-tube site on 7/23/25 during the day, she observed an odor like curdled milk from the feeding that leaked. The leaking and odor were new observations. She also noticed redness around the site, which was a daily occurrence for Resident #64, and she did not complain of pain on 7/23/25. Nurse #1 stated she had not had a chance to clean it yet this morning. An interview and observation of Resident #64 were conducted with the ADON on 7/24/25 at 8:59 AM. She revealed that Nurse #1 was the unit manager for the 300-hall, but Nurse #1 would cover the cart if there was a call out. The ADON confirmed the presence of leakage and an excoriated area around the g-tube site. She further confirmed Resident #64 stated the area was painful to the touch. She stated that Nurse #1 should have addressed this concern yesterday and notified the provider on 7/23/25 because the pain, leaking, and discomfort was a significant change. During the interview and observation of the resident with the ADON, Nurse #1 entered Resident #64's room at 9:04 AM. She observed the g-tube site and stated it looked about the same, just not as red as yesterday. Nurse #1 indicated that NA #3 told her earlier that morning the gauze was wet and removed during the bath this morning due to being soiled. She said if she thought there was an issue, she would have notified the provider on 7/23/25. Nurse #2, who worked overnight on 7/23/25 beginning at 11:00 PM, was interviewed on 7/25/2025 at 8:59 AM. She confirmed that the area was red (excoriated) around Resident #64's g-tube site where the gauze was placed and when she administered medications via the tube, the flow machine (a medical device used to allow a controlled liquid flow through a tube) said that it was clogged. However, that did not seem to be the case because she was able to administer the medications and flushes. Nurse #2 stated that she did not look at the actual g-tube surgical opening to assess. Resident #64 had been in and out to the Emergency Department (ED) several times during July due to g-tube site complications, and they sent her back saying it was fine. She stated when she had concerns with the g-tube site in the past, she called the on-call provider, and they suggested for the Medical Director to look at it the next morning. Nurse #2 stated she would have sent Resident #64 out to the ED to be evaluated and ensure the tube feed infusion was sufficient. However, due to her experience with notifying the provider, she stated she notified Nurse #1 (the oncoming day shift nurse on 7/24/25) instead. Nurse #1 told her that she had the same problem with Resident #64's tube feeding site this past week. During an interview with the Director of Nursing (DON) on 7/25/25 at 10:11 AM, she revealed the red skin around the g-tube site had been a chronic issue, and the resident was seen by the wound provider last year. She indicated if Nurse #2 reported an issue to Nurse #1 about Resident #64's g-tube site

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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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, Pharmacy Manager and Medical Director interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication for 2 of 3 residents reviewed for misappropriation of property (Resident #96 and Resident #18). The findings included:The facility's Abuse, Neglect, and Exploitation policy last revised on 7/11/24 revealed it was the facility's policy to report all allegations to the Administrator/Abuse Coordinator. The policy further read that the Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. The policy defined misappropriation as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without consent. a. Resident #96 was admitted to the facility on [DATE] with diagnoses which included joint replacement surgery. Resident #96 discharged from the facility on 3/03/25.Resident #96 had a physician order dated 2/04/25 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet; give one tablet by mouth every 4 hours as needed for pain for up to 7 days. The order was discontinued on 2/11/25. The Medication Administration Record (MAR) for February 2025 revealed Resident #96 was administered the oxycodone 5 mg tablet on 2/06/25 at 10:25 am for pain by Nurse #3 and was noted as effective. No other doses were documented as administered.A review of Resident #96's prescriptions for schedule II-IV controlled medication revealed hand-written prescriptions for oxycodone 5 mg tablet x 30 tablets were sent to the pharmacy and received at the facility on the following dates in February 2025:2/06/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff.2/13/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff.2/18/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff. 2/24/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff.b. Resident #18 was admitted to the facility on [DATE] with diagnoses which included osteoarthritis, fracture of right ulna (forearm bone), and gout.Resident #18 had a physician order dated 4/30/24 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet, administer 1 tablet every 4 hours as needed for pain.A review of Resident #18's prescriptions for schedule II-IV controlled medication revealed hand-written prescriptions for oxycodone 5 mg tablet x 30 tablets were received at the facility on the following dates in February 2025:1/31/25 oxycodone 5 mg tablet x 30 tablets were ordered and were delivered to the facility on 2/04/25.2/12/25 oxycodone 5 mg tablet x 30 tablets were ordered and were delivered to the facility on 2/18/25.2/18/25 oxycodone 5 mg tablet x 30 tablets were ordered and delivered to the facility on 2/24/25.The Medication Administration Record (MAR) for February 2025 revealed Resident #18 was administered the oxycodone 5 mg tablet on the following dates and times:2/04/25 at 9:41 pm by Nurse #4 and the medication was noted as effective.2/05/25 at 7:40 pm by Nurse #4 and the medication was noted as effective.2/11/25 at 8:25 pm by Nurse #4 and the medication was noted as effective.2/12/25 at 8:24 pm by Nurse #4 and the medication was noted as effective. 2/17/25 at 9:04 pm by Nurse #4 and the medication was noted as effective.2/24/25 at 7:32 pm by Nurse #4 and the medication was noted as effective.2/26/25 at 10: 25 am by Nurse #5 and the medication was noted as effective.2/28/25 at 7:42 pm by Nurse #4 and the medication was noted as effective.An interview was conducted with Resident #18 on 7/25/25 at 1:10 pm. Resident #18 revealed her pain was controlled and she had no issues getting pain medication when needed. Resident #18 stated she did not often have pain and she did not recall a time when she could not get the medication.A review of the initial allegation report revealed the facility became aware of the misappropriation of facility property on 2/28/25 at 12:00 pm when the Director of Nursing (DON) determined narcotic medications were delivered for a resident that no longer had an active physician order. An allegation of diversion of facility drugs was submitted for Resident #96 and Nurse #3 was suspended pending the outcome of the investigation. The Administrator submitted the initial allegation report on 2/28/25 at 2:48 pm.A review of the 5-day investigation report dated 3/06/25 revealed the allegation of diversion of facility drugs was substantiated by the facility and identified two residents (Resident #96 and Resident #18) who were affected. The DON noted the number of narcotic count down sheets (used to record the administration of the medication) and the number of narcotic medication cards that were unaccounted for was 7 in total. Resident #96 was found to be missing 4 medication cards and declining count sheets for oxycodone 5 mg tablets and Resident #18 was found to be missing 3 medication cards and declining count sheets for oxycodone 5 mg tablets. Each medication card contained 30 tablets. Nurse #3 was terminated and reported to the North Carolina Board of Nursing.An attempt to conduct a telephone

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to notify the Ombudsman in writing of an unplanned discharge to home for 1 of 3 residents reviewed for discharge (Resident #68). In addition, the facility failed to notify the Resident Representative in writing of the reason for the transfer/discharge to the hospital and failed to provide a copy of the bed hold policy to the resident and Resident Representative for 3 of 4 residents reviewed for hospitalization (Resident #5, Resident #36, and Resident #54).The findings included: 1. Resident #68 was admitted to the facility on [DATE]. The Discharge Against Medical Advice (AMA) form dated 6/16/25 revealed Resident #68 was signed out from the facility by the Responsible Party (RP) against medical advice. The Discharge Against Medical Advice form was signed by the Director of Social Services. The Ombudsman Notification for June 2025 (a list residents that was provided to the Ombudsman to notify of resident transfers/discharges that occurred from 6/1/25 through 6/30/25) revealed Resident #68’s AMA discharge from the facility on 6/16/25 was not included in the notification information sent to the Ombudsman. During an interview on 7/24/25 at 8:53 am the Director of Social Services revealed she did not notify the Ombudsman of Resident #68’s AMA discharge to home. The Director of Social Services stated that she notified the Ombudsman of transfers to the hospital only and not any residents that discharged home. An interview was conducted with the Administrator on 7/24/25 at 2:59 pm who revealed the Director of Social Service was responsible to notify the Ombudsman of transfers from the facility but he was not sure if that included residents that discharged home. 2. Resident #5 was admitted to the facility on [DATE]. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was independent with daily decision making. A review of Resident #5’s progress notes revealed he was discharged to the hospital on 7/10/2025 and had not readmitted to the facility. Review of Resident #5’s medical record revealed no documentation Resident #5, or his Resident Representative received written notification of the reason for his transfer/discharge to the hospital or received a copy of the bed hold policy. Multiple attempts made to contact Resident #5’s Representative were unsuccessful. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was completed on 7/24/2025 at 3:24 pm with Nurse #4. The Nurse stated she completed Resident #5’s hospital discharge paperwork on 7/10/2025. Nurse #4 revealed she completed the written notification of the reason for transfer/discharge form and the bed hold policy, made a copy of both, sent the original with Resident #5 to the hospital and placed the copies in the medical records bin at the nurse’s station for the Medical Records staff member to pick up. The Medical Records staff member was unavailable for interview. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident’s representative to review the option to pay to hold a resident’s bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents’ electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident’s medical record. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provided the option of paying the fee to hold the resident’s bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident’s electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy. 3. Resident #36 was admitted to the facility on [DATE]. The quarterly MDS assessment dated [DATE] revealed Resident #36 was independent with daily decision making. A review of Resident #36’s progress notes revealed she was discharged to the hospital on 6/19/2025 and was readmitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #36’s medical record revealed no documentation Resident #36, or her Resident Representative received written notification of the reason for her transfer/discharge to the hospital or received a copy of the bed hold policy. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident’s representative to review the option to pay to hold a resident’s bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents’ electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident’s medical record. The Medical Records staff member was unavailable for interview. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provide the option of paying the fee to hold the resident’s bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident’s electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy. 4. Resident #54 was admitted to the facility on [DATE]. The MDS assessment dated [DATE] revealed Resident #54 was cognitively intact. A review of Resident #54’s progress notes revealed she was discharged to the hospital on 7/9/2025 and was readmitted to the facility on [DATE]. Review of Resident #54’s medical record revealed no documentation Resident #54, or her Resident Representative received written notification of the reason for her transfer/discharge to the hospital or received a copy of the bed hold policy. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was completed on 7/24/2025 at 1:45 pm with Resident #54. Resident #54 stated she was unable to recall if she received a copy of the bed hold policy when she discharged to the hospital on 7/9/2025. An interview was completed on 7/24/2025 at 4:05 pm with Nurse #10. The Nurse was unable to recall if she completed Resident #54’s transfer paperwork on 7/9/2025. Nurse #10 revealed she sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital when a resident transferred to the hospital. Nurse #10 stated she placed copies of those forms in the medical records bin at the nursing station. The Medical Records staff member was unavailable for interview. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident’s representative to review the option to pay to hold a resident’s bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents’ electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident’s medical record. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provide the option of paying the fee to hold the resident’s bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident’s electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Nash	1210 Eastern Avenue Nashville, NC 27856

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a care plan for 1 of 5 residents reviewed for psychotropic medications (Resident #2).The findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses that included vascular dementia.Review of a physician's order dated 7/9/25 revealed an order for Olanzapine 2.5 milligrams (MG), take 1 tablet by mouth at bedtime. (Olanzapine is an antipsychotic medication used to treat mental health conditions and regulate your mood, behaviors and thoughts)The Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 had severe cognitive impairment and received antipsychotic medication on a routine basis.Review of Resident #2 ‘s Comprehensive Care Plan dated 10/29/24 and revised 7/11/25 contained no information or interventions regarding antipsychotic medications.An interview conducted with the MDS nurse on 7/24/25 at 10:00 AM. The nurse was observed to review Resident #2's care plan and stated it must have been an oversight that Resident #2 was not care planned for the antipsychotic medication.On 7/25/25 at 3:55 PM an interview was conducted with the Administrator who stated he expected that antipsychotics would be included in the resident's care plan.

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Pharmacy Manager, and Medical Director interviews, the facility failed to have effective systems in place for the inventory of controlled substances which resulted in a narcotic medication being ordered for a resident that did not have a physician order and the medication being diverted from the facility for 1 of 3 residents reviewed for misappropriation of resident's property (Resident #96). The findings included:Review of the Inventory Control of Controlled Substances Policy last revised 8/01/24, read in part a facility representative should regularly check the inventory records to reconcile inventory. The policy further noted this process should include current and discontinued inventory of controlled substances to the log used in the facility's-controlled medication inventory system.Resident #96 was admitted to the facility on [DATE] with diagnoses which included joint replacement surgery. Resident #96 discharged from the facility on 3/03/25.Resident #96 had a physician order dated 2/04/25 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet; give one tablet by mouth every 4 hours as needed for pain for up to 7 days. The order was discontinued on 2/11/25.A review of Resident #96's hand-written prescriptions for schedule II-IV controlled medication and the prescription manifest (log of medications received at the facility) confirmed prescriptions for oxycodone 5 mg tablet x 30 tablets per medication card were received at the facility after the physician order was discontinued on 2/13/25, 2/18/24, and 2/24/25.A telephone interview was conducted on 7/25/25 at 12:33 pm with the Pharmacy Manager who revealed when the facility submitted the hand written prescriptions for Resident #96's oxycodone 5 mg tablet the order was processed and delivered to the facility. The Pharmacy Manager stated the written prescriptions received from the facility were considered a physician order and she stated the pharmacy staff were not responsible to confirm that there was an active order in the facility electronic health record prior to processing the order for Resident #96. The Pharmacy Manager stated the facility was responsible for the management the medication once it was delivered to the facility. During an interview on 7/25/25 at 3:07 pm the Medical Director revealed that in the past he had left a few signed blank prescription slips at the facility with the DON or ADON for emergency use only when he was unable to be reached or unable to provide a prescription for resident medication. The Medical Director stated Nurse #3 was previously employed by the facility as ADON before she returned as a staff nurse recently, but he was unable to confirm when Nurse #3 obtained the signed blank prescription slips to order narcotics from the pharmacy for Resident #96 without his knowledge.During an interview on 7/25/25 at 11:47 am with the Director of Nursing she revealed the facility did not have a process in place to make sure that narcotic medication that was delivered to the facility was put in the medication cart and verified as current order. She stated the nurses would sign for the medication and then put the pharmacy manifest (delivery sheet) in a bin in the medication storage room but there was not a process in place for reviewing to make sure the medications were correct, that the order was confirmed, and that the medication was in the cart. The DON stated Nurse #3 was interviewed when she identified that the handwriting on the oxycodone prescriptions for Resident #96 belonged to Nurse #3. The DON stated Nurse #3 was suspended until the investigation could be completed and that Nurse #3 later contacted her and admitted that she wrote the prescriptions for Resident #96's oxycodone and took the medications from the facility. The DON stated Nurse #3 was terminated and she was reported to the North Carolina Board of Nursing (NCBON) for diversion of narcotics.The Administrator was interviewed on 7/25/25 at 3:43 pm who revealed the facility was unable to confirm how Nurse #3 obtained the signed blank prescriptions to order the medication for Resident #96. The Administrator stated the DON was responsible for the investigation and determined that Nurse #3 had written the oxycodone prescriptions for Resident #96 after the order was discontinued and that Nurse #3 had taken the medication from the facility. Upon discovery of the occurrence, the facility implemented the following quality assurance measures: On 2/28/25 it was determined that there were narcotics delivered to a resident that no longer had an order for the medications. The medications were not in the facility and had not been returned to the pharmacy. On 2/28/25 the DON contacted the pharmacy and obtained copies of the written prescriptions that had been faxed from the facility fax machine and the investigation conducted. A root cause analysis was completed and it was determined that there was no system in place to ensure medications were actually received on delivery and the facility had no system to ensure medications and declining count sheets were removed from the cart appropriately. The decision to monitor the system for receipt of narcotics, confirmation of active orders, and the removal of the medication and count down sheets

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain an accurate medication administration record for 1 of 5 residents reviewed for medication administration (Resident #36).The findings included:Resident #36 was admitted to the facility on [DATE] with diagnoses that included seizures.1a. Review of a physician order dated 5/1/24 revealed Lamotrigine 200 milligrams (mg) was to be administered two times a day for seizures. (Lamotrigine is an anticonvulsant medication used to treat and prevent seizures)Review of Resident #36's June Medication Administration Record (MAR) revealed no documentation of Resident #36's receiving her 8:00 PM dose of Lamotrigine on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, and 6/18/25. 1b. Review of a physician order dated 5/1/24 revealed Phenobarbital 60 mg was to be given at bedtime for seizures. (Phenobarbital is a barbiturate derivative medication used to treat seizures)Review of Resident #36's June MAR revealed no documentation of Resident #36's receiving her 8:00 PM dose of Phenobarbital on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, and 6/18/25.During an interview with Nurse #10 on 7/24/25 at 3:29 PM she stated she was familiar with Resident #36 and worked with her often. Nurse #10 reported Resident #36 usually came to the medication cart to request her evening medications after dinner. Nurse #10 stated there were no issues with Resident #36 refusing her medications. Nurse #10 stated she had administered Resident #36's seizure medications in the evening on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, 6/18/25. Nurse #10 stated medication administration documentation should have been completed when the medication was given. Nurse #10 stated she had missed the documentation because her assignment was heavy and busy. Nurse #10 further indicated she had met the Director of Nursing (DON) (6/19/25) and the missing documentation was brought to her attention. Nurse #10 further stated she was educated by the DON on how to go back into the MAR to complete the missing documentation. Nurse #10 stated she thought she had fixed the missing documentation.An interview was conducted with the DON 7/24/25 at 4:25 PM. The DON stated she went to Nurse #10 on 6/19/25 when she reviewed Resident #36's MAR and saw the missing documentation. The DON stated she educated Nurse #10 on how to edit the MAR to complete the missing documentation. The DON stated she expected that all medications administered would be documented in the MAR. She further stated if the medication was administered and the documentation was missed, she expected the employee would amend the MAR to reflect the administration of the medication.An interview was conducted with the Administrator on 7/25/25 at 3:53 PM. The Administrator stated he expected that all medication doses given would be documented. The Administrator further stated he expected that when missing documentation was brought to staff's attention the missing documentation would have been corrected.