STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Fayetteville	1401 71st School Road Fayetteville, NC 28314

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to ensure a dependent resident's toenails were trimmed and podiatry services were arranged for 1 of 3 residents reviewed for foot care (Resident #8).The findings included:Resident #8 was admitted to the facility on [DATE] with diagnoses that included hypertension, dementia, age-related physical debility and need for assistance with personal care.Resident #8's care plan had a care focus area initiated 3/17/26 that indicated that Resident #8 had an activity of daily living self-care deficit related to decreased functional mobility with the goal for her needs to be met with staff assistance. Interventions included assist with activities of daily living, dressing, grooming, toileting, feeding, and oral care.A bath/shower sheet dated 3/18/26 completed by Nurse Aide (NA) #1 indicated Resident #8 had received a bed bath and needed podiatry services. This sheet was signed off by Nurse #2.A bath/shower sheet dated 3/21/26 completed by NA #1 indicated Resident #8 had refused a shower, received a bed bath and needed podiatry services. This sheet was signed off by Nurse #2.An admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #8 as severely cognitively impaired. She required substantial to maximal assistance with oral and personal hygiene, showers/bathing and transfers. She was not coded for rejection of care during the assessment period.A bath/shower sheet dated 4/15/26 completed by NA #1 indicated Resident #8 had received a bed bath and needed podiatry services. This sheet was signed off by Nurse #2.A review of the facility's podiatry clinic schedule dated 4/20/26 revealed Resident #8 was not seen by the podiatrist and was not on the list to be seen on that day.A review of Resident #8's electronic medical records (EMR) on 4/21/26 revealed no consultation reports or notations in Resident #8's EMR that she was scheduled to see a podiatrist or that she had been seen by a podiatrist since admission to the facility.During an interview with NA #1 on 4/23/26 at 8:30 AM she revealed that she frequently cared for Resident #8 during the first shift (7:00 AM to 3:00 PM). NA #1 stated that she had noticed that Resident #8's toenails were long and thick from when she was admitted to the facility in March 2026 and that she had attempted to trim them without success. NA #1 stated that she had documented in the shower sheets a couple of times that Resident #8 required podiatry services which were supposed to be signed off by the primary nurse. She stated that she had mentioned it to Nurse #2 on more than one occasion and she could remember the last day she had mentioned it was on 4/15/26 and that if she had not mentioned it, Nurse #2 would still be aware because she had signed off on the shower sheets where she (NA #2) had documented on 3/18/26, 3/21/26 and 4/15/26 that Resident #8 needed podiatry services.An interview was conducted with Nurse #2 on 4/23/26 at 10:55 AM. She stated that she could not remember if NA #1 or anyone else had mentioned to her that Resident #8 needed podiatry services. She indicated that she had not seen it on the shower sheets when she signed off on them and that she should have read the shower sheets more carefully to ensure Resident #8 received footcare. Nurse #2 further stated that she should have put Resident #8 on the podiatry list and obtained consent from Resident #8's Responsible Party (RP) or asked the physician for a podiatry consult for Resident #8. An observation and interview was conducted on 4/22/26 at 10:40 AM in the company of Unit 1 and Unit 2 Managers. All of Resident #8's toenails on both feet were observed to be thick, long and curved (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	downward past her toenail bed. When Resident #8 was asked if her toes hurt or if she wanted her toenails trimmed, she stated, I don't know. The two Unit Mangers stated that they were not aware of Resident #8's toenails condition prior to this observation and that normally the nurse aides would notify the primary nurses if a resident required podiatry services and the nurses would ask the physician for a podiatry consult.During a follow up interview on 4/23/26 at 8:58 AM with Unit 2 Manager she stated that Nurse #2 should have reached out to the physician for a podiatry consult when she signed off on Resident #8's shower sheet on 3/18/26.An interview was conducted with the Director of Nursing (DON) on 4/23/26 at 11:46 AM. The DON stated that when Nurse #2 signed off on the shower sheet on 3/18/26 she should have obtained consent from Resident #8's RP and put her on the podiatry list to be seen at the facility during the podiatry clinic on 4/20/26 or she could have requested a podiatry consult from the physician to ensure Resident #8 received appropriate foot care. The DON stated that she was not aware that Resident #8's toenails were long and that after she was made aware on 4/22/26, Resident #8 has been scheduled to be seen at an offsite podiatry clinic on 5/2/26. An interview was conducted with the Administrator on 4/23/26 at 12:55 PM. The Administrator stated nobody had mentioned to her that Resident #8's toenails were long and that if she had been made aware she would have ensured Resident #8 was seen during the 4/20/26 podiatry clinic at the facility. She stated that Nurse #2 should have reached out to the physician for a podiatry consult or put her on the podiatry list and obtained RP consent for Resident #8 to be seen in house on 4/20/26. The Administrator indicated she expected all residents to receive podiatry services when needed.