

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Care of Cornelius		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Mount Zion Parkway Cornelius, NC 28031	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews, staff and resident interview, the facility failed to reassess for the ability to self-administer medications for a resident who was self-administering a medication for 1 of 1 resident reviewed for self-administering medications (Resident #10).The findings included:Resident #10 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD).Review of Resident #10's physician orders dated 08/06/24 for calcium carbonate chewable tablets 500 milligrams, take two tablets every eight hours as needed for GERD.Review of Resident #10's Self-Administration assessment dated [DATE] indicated the Resident did not want to self-administer medications.Review of Resident #10's annual Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident was cognitively intact.On 07/22/25 at 1:05 PM during an interview and observation of Resident #10 it was noted that there was a bottle of antacid tablets approximately 1/4 full of tablets of various colors sitting on her over bed table in her room. When Resident #10 was asked about the medication the Resident explained that a family member brought the medication to her because she had gastric reflux and heart burn mostly at night and she took the medication when she needed them. The Resident stated she did not have heartburn every night, but she wanted them close by when she needed them. Subsequent observations were made on 07/23/25 at 2:23 PM, 07/24/25 at 8:42 AM and 07/25/25 at 8:51 AM and the bottle of antacid tablets remained at Resident #10's bedside.An interview was conducted with Nurse #4 on 07/25/25 from 11:25 AM. The Nurse explained that Resident #10 did not have an order to self-medicate and she did not think she would be able to administer her own medications. The Nurse was notified of the bottle of antacids on the Resident's over bed table and the Nurse retrieved the medication and stated she would address it with the Director of Nursing. The Nurse stated she had not noticed the medication in the Resident's room.During an interview with the Director of Nursing (DON) on 07/25/25 at 11:54 AM, the DON explained that residents had to be assessed to be able to keep their medications at bedside and had to be assessed to be able to medicate themselves according to the physician orders. She indicated that Resident #10 could possibly self-administer her antacid medication but first she would have to be assessed in order to do so.</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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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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and Law Enforcement Detective and staff interviews, the facility failed to assure residents' property was safeguarded and staff did not misappropriate the residents' property for personal gain. Nurse Aide #1 used Resident #118's credit card to make unauthorized purchases totaling \$757.73 without Resident #118's permission or knowledge and Housekeeper #1 used Resident #119's credit card to make an unauthorized purchase totaling \$152.13 without Resident #119's permission or knowledge for 2 of 3 residents reviewed for misappropriation of resident property (Resident #118 and Resident #119). Findings included: The facility's Resident Abuse policy, last revised on 08/30/23, revealed in part, the facility would ensure all residents were free from misappropriation of property. 1. Resident #118 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #118 with intact cognition. Review of the facility's investigation revealed on 12/12/24 at 3:30 PM the facility became aware of an allegation of misappropriation of property when Resident #118 reported her credit card was missing and an investigation was initiated. Resident #118 was notified by a family member that there were charges made using her credit card and when Resident #118 looked, she was unable to locate the credit card. Resident #118's credit card was frozen by the bank, the charges were disputed and law enforcement was notified. Continued review of the facility's investigation included an undated statement signed by the Administrator that revealed in part, the Law Enforcement Detective contacted the Administrator on 12/23/24 at 1:00 PM stating they had identified Nurse Aide (NA) #1 through video surveillance as the person who made the unauthorized purchases using Resident #118's credit card. NA #1 was working at the facility on 12/23/24 and was on break until 2:00 PM. Immediately upon returning from break, NA #1 was escorted to the Director of Nursing's (DON) office by the Administrator and interviewed. At first, NA #1 denied the accusation but when NA #1 was informed that law enforcement had video evidence of her making the purchases using Resident #118's credit card, NA #1 admitted to the Administrator and DON that she had taken Resident #118's credit card without authorization. NA #1 was terminated from employment and escorted out of the facility. A review of Resident #118's bank account records from 12/07/24 to 12/12/24 revealed four separate purchases were made to restaurants on 12/07/24 totaling \$92.92; five separate purchases were made to restaurants and department stores on 12/10/24 totaling \$489.38; and three separate purchases were made to restaurants and a grocery store on 12/12/24 totaling \$175.43. Resident #118 discharged from the facility on 12/20/24 and was unable to be interviewed during this investigation. During a phone interview on 07/23/25 at 2:55 PM, NA #1 stated she did not take Resident #118's credit card and did not make the unauthorized credit card purchases. NA #1 expressed she never provided care to Resident #118 and was not working the day the credit card was allegedly lost. When asked if she was informed that law enforcement was able to positively identify her through video surveillance as the person making the unauthorized purchases, she replied no. NA #1 restated she did not do what she was being accused of and voiced she felt the facility administration singled her out for one reason or another. Review of the time clock report and corresponding staff schedule for 12/06/24 revealed NA #1 worked 7:00 PM to 7:00 AM and was assigned to Resident #118's hall. During a phone interview on 07/25/25 at 9:40 AM, the Law Enforcement Detective revealed he went to the grocery store and one of the department stores where purchases were made, told store employees what he was looking for and they were able to provide him with video security footage. He explained he was able to get still shots (photographs) from the video security footage, ran the images through facial recognition software and NA #1 was positively identified when a match was made to her driver's license photo. In addition, the loss prevention employee at the department store was able to confirm NA #1 used her membership number when making the purchase. The Law Enforcement Detective stated he never interviewed NA #1 as he had all the information needed and charges were filed. During an interview on 07/24/25 at 1:55 PM, the DON confirmed she was present on 12/23/24 when the Administrator interviewed NA #1 about Resident #118's credit card. The DON stated once the Administrator informed NA #1 that law enforcement had video evidence, NA #1 admitted that she took Resident #118's credit card without her knowledge and made the purchases. The DON stated NA #1 never provided any explanation as to why she took Resident #118's credit card. During interviews on 07/23/25 at 10:21 AM and 07/25/25 at 7:50 AM, the Administrator revealed at the time of Resident #118's admission to the facility (12/06/24), her family was managing her finances, noticed the charges made on her credit card and when they called Resident #118</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and staff interviews the facility failed to ensure Nurse #7 suctioned a resident's tracheostomy (a surgical opening in the neck to allow breathing) using sterile technique (a way of providing care that attempts to eliminate germs to prevent infection) for 1 of 1 resident reviewed for tracheostomy care (Resident #1). Findings included: Resident #1 was admitted to the facility 07/07/25 with diagnoses including pneumonia and respiratory failure (when the lungs can't properly exchange oxygen and carbon dioxide). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact and received tracheostomy care and suctioning. Review of a respiratory care plan initiated 07/07/25 revealed Resident #1 had a tracheostomy and interventions included providing oxygen as ordered and suctioning her tracheostomy as needed. A continuous observation of Nurse #7 on 07/25/25 from 10:50 AM to 11:20 AM revealed she was providing tracheostomy care for Resident #1. During tracheostomy care, Resident #1 indicated she needed to be suctioned. Nurse #7 immediately discontinued tracheostomy care, removed her gloves, washed her hands, applied clean gloves, opened the package containing the sterile suction catheter (tube), connected the suction catheter to the suction machine, turned on the suction machine, and inserted the suction catheter into Resident #1's tracheostomy, applied suction for approximately 15 seconds, removed the suction catheter from the tracheostomy, waited approximately 30 seconds, reinserted the suction catheter, applied suction for approximately 15 seconds, removed the suction catheter from Resident #1's tracheostomy, removed the suction catheter from the suction machine, discarded the suction catheter in the trash, removed her clean gloves, discarded the gloves in the trash, and washed her hands. Nurse #7 did not don sterile gloves or use sterile technique while suctioning Resident #1. In an interview with Nurse #7 on 07/25/25 at 11:24 AM she confirmed she did not use sterile gloves or sterile technique to suction Resident #1's tracheostomy. She stated she was aware there were tracheostomy suction kits which contained sterile gloves and sterile water that she was supposed to use, but she was nervous and forgot. An interview with the Director of Nursing (DON) on 07/25/25 at 11:48 AM revealed she expected sterile technique to be used when suctioning a tracheostomy tube. An interview with the Administrator on 07/25/25 at 12:55 PM revealed he expected nursing staff to follow facility policy for suctioning a tracheostomy.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure accurate accounting for the receipt of nine (9) tablets of controlled medications. This was for 1 of 1 facility emergency-controlled medication storage areas. The findings included: Review of a pharmacy order sheet for scheduled I and II controlled medications revealed one (1) oxycodone immediate release (IR) 5 milligrams (mg) was ordered on 08/07/24. Review of a pharmacy order sheet for scheduled IV controlled medications revealed four (4) lorazepam 0.5 mg tablets and four (4) tramadol 50 mg tablets were ordered on 08/07/24. Review of a pharmacy delivery sheet for controlled medications revealed the following controlled medications were delivered to the facility on [DATE]: (1) oxycodone IR 5 mg tablet, (4) tramadol 50 mg tablets and (4) lorazepam 0.5 mg tablets. The delivery sheet was signed by the delivery driver and Nurse #5. On 07/22/2025 at 3:03 PM an interview was conducted with the Director of Nursing (DON) who explained that on 08/09/24 she reviewed the pharmacy delivery sheet for the controlled medications and found that the controlled medications were signed for by Nurse #5. The DON went to the medication cart that Nurse #5 worked on 08/08/24 to obtain the controlled medications but the medications were not on the medication cart. Nurse #6 who was assigned to the medication cart on 08/09/24, reported that she did not count controlled medications from the pharmacy with Nurse #5 during shift change that morning on 08/09/24. The DON continued to explain that she and Nurse #6 completed a review of all medication carts and could not find the controlled medications. The DON called Nurse #5 to inquire about the controlled medications and Nurse #5 reported that she received controlled medications for a resident but not for the facility's emergency controlled medication storage. Nurse #5 explained to the DON that she signed the delivery sheet but admitted by she did not count the controlled medications in the package with the delivery driver before she signed the delivery sheet. The DON explained that she notified the Administrator who called the pharmacy to report the missing controlled medications and inquire about the delivery driver. An interview was conducted with Nurse #5 on 07/22/25 at 7:46 PM who confirmed that she worked on the night of 08/08/24. The Nurse explained that she received the pharmacy delivery of controlled medications for a resident but did not receive the controlled medications for the emergency controlled storage. Nurse #5 reported she did not count the controlled medications with the delivery driver but did sign the delivery sheet. The Nurse was insistent that there were no other medications in the package except for the resident's controlled medications. The Nurse continued to explain that she was asked to come to the facility on [DATE] to provide a statement and adhere to a drug test for reasonable suspicion which she complied, and the result was negative on 08/09/24. Nurse #5 reported that she was suspended on 08/09/24 pending investigation of the missing controlled medications which lasted ten (10) days. The Nurse stated she was reported to the Board of Nursing (BON) and the BON informed the Nurse that there would be no formal disciplinary action. The Nurse explained that she was called to the facility on [DATE] and was given a written warning on not following the proper procedure of obtaining controlled medications and was educated on the proper procedure of obtaining controlled medications. The Nurse reported that now the new procedure was for two (2) nurses to verify the controlled medication count when delivered from the pharmacy. During an interview with Nurse #6 on 07/22/25 at 8:00 PM the Nurse explained that she was approached by the DON on 08/09/24 and asked if she counted the emergency controlled medications during shift change with Nurse #5 and the Nurse reported that she had not counted any emergency storage medications with Nurse #5. Nurse #6 continued to explain that she helped the DON search for missing controlled medications and could not find them and she helped count all the controlled medications on all the medication carts in the facility and the counts were all reconciled. On 07/22/25 at 4:50 PM an interview was conducted with the Administrator who reported that he was notified on 08/09/24 of the missing emergency controlled medications ordered by the DON on 08/07/24. The Administrator explained that all the medication carts and medication rooms were searched but the missing controlled medications were not found. The Administrator stated that they brought Nurse #5 in on 08/09/24 for a written statement and a drug test which was negative and suspended her pending the completion of the investigation. He continued to explain that he reported the missing controlled medications to the local law enforcement who investigated the situation and there were no charges related to the investigation. He stated he reported the missing controlled medications to Adult Protective Services (APS) and there was no report taken by APS citing there was no resident involved in the missing controlled medications therefore there was no abuse, neglect or exploitation. The Administrator</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12% for 3 of 5 residents observed during the medication administration (Resident #79, Resident #84 and Resident #26).The findings included:The manufacturer's instructions for a prefilled insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary.1. Resident #79 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus.Review of Resident #79's physician orders dated 04/29/25 for Lantus insulin give 10 units subcutaneously every day.On 07/23/25 at 8:55 AM an observation was made of Nurse #3 preparing to administer insulin to Resident #79 via an insulin pen. The Nurse removed the Lantus insulin pen from the medication cart and set the counter to 10 units. Nurse #3 administered the 10 units of insulin without priming the insulin pen as advised by the manufacturer's instructions.An interview was conducted with Nurse #3 on 07/23/25 at 2:51 PM. The Nurse was asked to review the steps of giving insulin via an insulin pen. Nurse #3 repeated the steps she had taken when administering insulin to Resident #79 but did not include priming the insulin pen. The Nurse was asked if she knew about priming the insulin and she indicated she knew but thought it was only for the first time the insulin pen was used.During an interview with the Pharmacist on 07/24/25 at 2:30 PM the Pharmacist explained it was important to prime the insulin every time it was used in order to remove any air bubbles that may be present in order to inject the full amount of insulin prescribed for the Resident. During an interview with the Director of Nursing (DON) on 07/24/25/25 at 2:30 PM the DON indicated that she expected Nurse #3 to follow the manufacture's recommendations when given insulin using an insulin pen.2. Resident #84 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus.Review of Resident #84's physician orders revealed an order dated 01/18/25 for Lispro insulin 2 units subcutaneously before meals.On 07/22/25 at 4:10 PM an observation was made of Nurse #2 preparing to administer insulin to Resident #84 via an insulin pen. The Nurse removed the Lispro insulin pen from the medication cart and set the counter to 2 units. Nurse #2 administered the 2 units of insulin without priming the insulin pen as advised by the manufacturer's instructions.An interview was conducted with Nurse #2 on 07/23/25 at 2:35 PM. The Nurse was asked to review the steps when giving insulin using an insulin pen and Nurse #2 repeated how he administered the insulin the day before. When the Nurse was asked about priming the insulin pen the Nurse reported that he was not aware that the insulin pen needed to be primed before giving the insulin and stated he would remember to do that going forward.During an interview with the Pharmacist on 07/24/25 at 2:30 PM the Pharmacist explained it was important to prime the insulin every time it was used in order to remove any air bubbles that may be present in order to inject the full amount of insulin prescribed for the Resident. During an interview with the Director of Nursing (DON) on 07/24/25/25 at 2:30 PM the DON indicated that she expected Nurse #2 to follow the manufacture's recommendations when given insulin using an insulin pen.3. Resident #26 was admitted to the facility on [DATE] with diagnoses that included neuralgia (nerve pain caused by damage or irritation).Review of Resident #26's physician orders dated 03/22/25 revealed Vitamin B-12, 2,500 micrograms (mcg) by mouth once a day for neuralgia.An observation was made of Nurse #3 on 07/23/25 at 9:00 AM during a medication administration of Resident #26. The Nurse prepared Resident #26's medications which included Vitamin B-12. The Vitamin B-12 was supplied in a bottle of 1,000 mcg per tablet. The Nurse picked up the bottle of B-12 and stated she would have to cut one of the tablets in half in order to give the correct dose then proceeded to cut one tablet in half and put the half tablet in the medicine cup along with a whole tablet and administered 1,500 mcgs to Resident #26 instead of 2.5 tablets which would equal 2,500 micrograms.An interview was conducted with Nurse #3 at 2:51 PM on 07/23/25. The Nurse was asked to review the calculation of Resident #26's Vitamin B-12 tablets. The Nurse stated the total dose to be given was 2,500 and she cut one tablet in half and thought she gave the Resident 2.5 tablets. The Nurse was informed that she only gave 1.5 pills which was not enough to equal the 2,500 dose of Vitamin B-12 and the Nurse stated she should have gotten the 500-microgram stock bottle from the medication room and used it instead of cutting one of the pills in half</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and staff interviews, the facility failed to secure 3 bottles of medicated powder observed in a resident's room for 1 of 1 resident reviewed for medication storage (Resident #19). Findings included: Resident #19 was admitted to the facility 08/13/24 with diagnoses including obstructive uropathy (a condition that occurs when urine cannot drain out of the body) and macular degeneration (an eye disease that causes vision loss). The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was severely cognitively impaired and required partial/moderate assistance with bed to chair transfers. An observation of Resident #19's dresser on 07/21/25 at 3:10 PM revealed two 15 gram (gm) and one 60 gm bottles of Nystatin powder (antifungal medication) 100,000 units/gm sitting on top. Additional observations Of Resident #19's dresser on 07/22/25 at 1:55 PM, on 07/23/25 at 8:22 AM, on 07/24/25 at 8:42 AM, and on 07/25/25 at 10:32 AM revealed two 15 gm and one 60 gm bottles of Nystatin powder 100,000 units/gm sitting on top. An observation of Resident #19's dresser with Nurse #4 on 07/25/25 at 11:35 AM revealed two 15 gm and one 60 gm bottles of Nystatin powder 100,000 units/gm sitting on top. An interview with Nurse #7 on 07/25/25 at 11:35 AM revealed medicated powders should be stored in the treatment cart unless there was a physician's order to leave the medication in the resident's room. She stated she had not been all the way in Resident #19's room since beginning her shift at 7:00 AM on 07/25/25 and had not seen the bottles of medicated powder or she would have removed them. An interview with the Director of Nursing (DON) on 07/25/25 at 11:40 AM revealed Resident #19's medicated powder should have been stored in the treatment cart unless there was a physician's order to store the medication in the resident's room. The DON confirmed there was no physician order to leave Nystatin powder in Resident #19's room. An interview with the Administrator on 07/25/25 at 12:55 PM revealed he expected staff to follow the facility's policy for medication stored at the bedside.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observations, record review, and dietary staff, Registered Dietitian (RD), and Regional Registered Dietitian interviews, the facility failed to provide food items as specified by the approved menu. This practice had the potential to affect 11 residents receiving a regular diet and 2 residents receiving a puree diet (consisting of foods with a pudding-like texture) on 1 of 4 units (700/800 hall). Findings included: A review of the approved menu for residents receiving a regular diet on 07/23/25 revealed the following foods were on the menu: chili and beans, garden salad with dressing, cornbread, and carrot cake. Alternate food items for the lunch meal included mixed vegetables and noodles. A review of the approved menu for residents receiving a puree diet revealed the following foods were on the menu: chili and beans, steamed squash, puree bread, and carrot cake. a. An observation of Dietary Aide #1 on the 700/800 hall on 07/23/25 from 12:10 PM through 12:19 PM revealed he checked the temperature of the garden salad, and the temperature was 43 degrees Fahrenheit. Dietary Aide #1 placed the pan of salad on ice and re-checked the temperature, which was 46.8 degrees Fahrenheit. Dietary Aide #1 was instructed by the Regional Registered Dietitian to serve mixed vegetables instead of garden salad to residents receiving a regular diet since the garden salad did not reach the correct temperature. An observation of Dietary Aide #1 revealed he began plating food on 07/23/25 at 12:20 PM. Residents receiving a regular diet received chili and beans, mixed vegetables, cornbread, and carrot cake. On 07/23/25 at 12:50 PM Dietary Aide #1 ran out of mixed vegetables and began serving chili and beans, noodles, cornbread, and carrot cake to residents receiving a regular diet. Dietary Aide #1 did not ask the Registered Dietitian (RD) or the Regional Registered Dietitian before substituting noodles for mixed vegetables. An interview with Dietary Aide #1 on 07/23/25 at 1:05 PM revealed he frequently ran out of food on the tray line, and he would plate whatever food he had left on the serving line. He stated he did not notify his supervisor when he ran out of food and did not ask for guidance to provide a nutritionally equivalent substitute. An interview with the Regional Registered Dietitian on 07/24/25 at 1:21 PM revealed Dietary Aide #1 should have stopped the meal tray line for the lunch meal on 07/23/25 when he ran out of mixed vegetables, notified his supervisor, and waited until a nutritionally equivalent substitute was available before sending regular trays to residents. She stated noodles were not an appropriate substitution for mixed vegetables. An interview with the Administrator on 07/24/25 at 3:22 PM revealed Dietary Aide #1 should have waited until an appropriate substitute was available for the lunch meal on 07/23/25 instead of substituting noodles for mixed vegetables. b. An observation of the meal tray line on 07/23/25 at 12:20 PM revealed Dietary Aide #1 began plating the food. Residents on a puree diet did not receive puree bread or a substitute for bread. In an interview with the RD on 07/23/25 at 12:30 PM she confirmed no puree bread was available for the lunch meal on 07/23/25. She stated residents receiving a puree diet should receive the same food or an appropriate substitution as residents receiving any other diet texture. An interview with Dietary Aide #1 on 07/23/25 at 1:05 PM revealed he did not have puree bread or a substitute to serve residents receiving a puree diet on 07/23/25 and he did not notify his supervisor that the puree bread was unavailable. An interview with [NAME] #1 on 07/24/25 at 1:21 PM revealed she did make puree bread for the lunch meal on 07/23/25, but it did not get sent to the 700/800 hall. An interview with the Administrator on 07/24/25 at 3:22 PM revealed puree bread did not get sent to the 700/800 hall for the lunch meal on 07/23/25. He stated residents receiving a puree diet on 07/23/25 did not receive bread and they should have received bread per the menu.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Care of Cornelius		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Mount Zion Parkway Cornelius, NC 28031	
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, resident and staff interviews, the facility failed to honor a resident's food preferences for 1 of 1 resident reviewed for food preferences (Resident #88). Findings included: Resident #88 was admitted to the facility 03/08/23. Review of Resident #88's physician orders revealed an order dated 05/31/24 for a low concentrated sugar diet (a diet that reduces or eliminates foods with high amounts of sugar). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was cognitively intact, was able to make herself understood, and was able to understand others. Resident #88's nutrition care plan, last edited 06/23/25, revealed she had increased nutrition/hydration risks related in part to diabetes and interventions included monitoring her dietary intake and respecting/honoring resident dietary choices. The Dietary Manager (DM) was observed to interview Resident #88 on 07/21/25 at 1:04 PM. During the interview Resident #88 informed the DM that she was taught not to waste food and it was upsetting to her when she received food like oatmeal or grits that she knew she would not eat. The DM stated she understood that Resident #88 did not want to receive oatmeal or grits on her meal trays. An observation of Resident #88's meal tray ticket on 07/22/25 at 8:30 AM revealed she was documented to receive scrambled eggs, sausage patties, toast, cereal of choice, and a banana. Resident #88's meal tray ticket documented she was to receive double portions. There was no documentation on her meal tray ticket reflecting her dislikes. An observation of Resident #88's breakfast meal tray at the same date and time revealed she received a bowl of grits, a scoop of eggs, 2 pieces of sausage patties, 2 pieces of toast, and no banana. An interview with Resident #88 on 07/22/25 at 8:32 AM revealed she would like to have her banana as requested. She stated having fresh fruit for breakfast was important to her and receiving the grits on her tray was frustrating to her because she had informed the dietary department numerous times she did not like grits. An interview with the Dietary Manager (DM) on 07/24/25 at 10:41 AM revealed residents should receive all items listed on their tray ticket, and she expected resident preferences to be honored. She stated residents should not receive items they had asked not to receive. An interview with the Administrator on 07/24/25 at 3:30 PM revealed he expected residents to receive the food preferences they communicated to staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Care of Cornelius		STREET ADDRESS, CITY, STATE, ZIP CODE  19530 Mount Zion Parkway Cornelius, NC 28031	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record review, and staff interviews, the facility failed to ensure staff implemented their infection control policy for hand hygiene when a nurse aide failed to remove dirty gloves and perform hand hygiene during incontinence care for Resident #1. This deficient practice was identified for 1 of 7 staff members observed for infection control practices (Nurse Aide #4). Findings included: Review of the facility's policy titled Hand Hygiene/Handwashing Policy last revised 02/28/25 read in part as follows: Hand hygiene is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by handwashing. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: before moving from work on a soiled body site to a clean body site on the same patient, after contact with bodily fluids, and immediately after glove removal. A continuous observation of Nurse Aide (NA) #3 on 07/23/25 from 8:41 AM through 9:05 AM revealed NA #3 provided incontinence care to Resident #1. With gloved hands NA #3 cleaned urine with resident care wipes, placed the wipe in the trash can, assisted Resident #1 with rolling onto her left side, cleaned urine with resident care wipes, placed the wipe in the trash can, applied skin barrier ointment to Resident #1's right buttock, rolled a clean brief and bed pad under Resident #1, assisted Resident #1 with rolling onto her right side, cleaned urine with resident care wipe, placed the wipe in the trash can, pulled the clean brief and bed pad under resident, applied skin barrier ointment to Resident #1's left buttock, assisted Resident #1 with rolling onto her back, pulled up the brief and fastened it, pulled Resident #1's gown down, removed the pillow under Resident #1's head and pulled her up in the bed using the bed pad, assisted Resident #1 with rolling on her left side, placed a pillow under her left side, assisted Resident #1 with rolling onto her right side, placed a pillow under her right side, placed a pillow under Resident #1's head, pulled up her bed sheet and cover, used the bed control to raise Resident #1's head, placed the call light on Resident #1's bed and within her reach, pulled her overbed table across her bed and lowered the table, removed his gloves and placed them in a trash bag, picked up the trash bag, and exited the room. NA #3 did not remove his gloves and perform hand hygiene after removing urine, after applying ointment to Resident #1's buttocks, and before touching other items in Resident #1's environment. NA #3 did not perform hand hygiene after removing his gloves at the completion of care and before exiting Resident #1's room. An interview with NA #3 on 07/23/25 at 9:08 AM revealed he usually changed his gloves during incontinence care only if they were visibly soiled and he performed hand hygiene when he was ready to exit the resident's room. He stated he was nervous and that was why he did not perform hand hygiene after removing his gloves when he finished providing care and before exiting Resident #1's room. An interview with the Director of Nursing (DON) on 07/23/25 at 10:40 AM revealed she expected staff to remove gloves and perform hand hygiene when moving from dirty to clean tasks. An interview with the Administrator on 07/24/25 at 4:20 PM revealed he expected staff to remove their gloves and perform hand hygiene after performing incontinence care and before performing the next task. An interview with the Infection Preventionist on 07/25/25 at 10:11 AM revealed when staff performed incontinence care they should remove their gloves after cleaning the resident, perform hand hygiene, and then continue care.</p>		