STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345165	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marion	**1264 Airport Road , Marion, North Carolina, 28752**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/23/2026 through 2/26/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1E493F-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/23/2026 02/26/2026. Event ID# 1E493F-H1. The following intakes were investigated: 744383, 2709950, and 744382. 3 of 3 complaint allegations did not result in deficiency.	F0000		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the	F0607		

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 reverse for further 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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F0607 SS = D	Continued from page 1 following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and law enforcement, the facility failed to follow their Abuse, Neglect and Exploitation policy when the Administrator was not immediately notified of an allegation of misappropriation of narcotic medications which resulted in delayed protection of other residents and reporting for 1 of 3 residents reviewed for misappropriation of property (Resident #134). The findings included: The facility's "Resident Abuse Policy: Abuse, Neglect and Exploitation" indicated it was the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown origin. The facility staff were to immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator would immediately begin an investigation and notify the applicable local and state agencies. Once the Administrator and Department of Health and Human Services were notified, an investigation of the allegation or suspicion would be conducted. The Initial Allegation Report completed by the Director of Nursing (DON) dated 4/15/2025 revealed the facility became aware of an allegation of missing Oxycodone (narcotic pain medication) for Resident #134 from the sealed Controlled Medication Return Bag on 4/11/2025. Resident #134 had been discharged from the facility at the time the medication went missing. The report indicated Police Officer #1 was called on 4/15/2025 at 9:30am. During a telephone interview on 2/25/2026 at 4:40 PM Assistant Director of Nursing (ADON) #1 stated she was told on 4/10/2025 by a floor nurse, she could not remember which floor nurse, that pharmacy staff was on	F0607		

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F0607 SS = D	Continued from page 2 the phone related to an issue with narcotic medication sent back to the pharmacy. ADON #1 stated no one from the pharmacy was on the line when she got to the phone on 4/10/2025 and she did not attempt to call the pharmacy back. ADON #1 stated the pharmacy called again on 4/11/2025 and she was informed of the missing Oxycodone for Resident #134. ADON #1 stated she did not inform the DON of the missing Oxycodone until 4/12/2025 because the pharmacy was going to check to see if the medication could be found. ADON #1 stated at that time, she did not know she was supposed to report missing narcotics immediately and since the DON was not at the facility, she thought it could wait to see if the medications were found at the pharmacy before she notified the DON. ADON #1 stated she did not think the missing oxycodone was ever found. She indicated the DON and Administrator conducted the investigation. The Facility Investigation Report completed by the Administrator dated 4/18/2025 was submitted to the State Agency with an investigation summary. The report and summary revealed the facility became aware of possible drug diversion on 4/11/2025 when the pharmacy reported a missing medication card that contained seven tablets of Oxycodone 5 milligrams (mg) that were intended to be returned for Resident #134 from the sealed Controlled Medication Return Bag. The report indicated Nurse #1 and Nurse #2 were suspended pending investigation, and that Nurse #2 was given a do not return notice through the agency. The report indicated Police Officer #1 was notified on 4/15/2025 at 9:30 AM and the case number was listed as pending. During a phone interview on 2/25/2026 at 10:36 AM Police Officer #1 stated he did not recall the facility notifying him of missing Oxycodone in April 2025. Officer #1 stated he had “communications”, which was the phone number that was listed on the facility’s initial report, conduct a search for any calls that came in regarding the facility in April 2025 and there were no calls found. Officer #1 explained that “communications” tracked every call that was received and kept a record of who the call was assigned to. Police Officer #1 added that the facility emailed him at times for other issues, so he reviewed his emails and did not find any emails related to missing narcotics. He stated that missing narcotics would be considered a crime that would need to be reported. Review of Nurse #1’s timecard for April 2025 revealed Nurse #1 worked on the following dates and times after ADON #1 was notified by the pharmacy of the missing Oxycodone for Resident #134 (4/11/2025) and prior to initiation of the facility’s investigation:4/12/2025 at	F0607		

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F0607 SS = D	Continued from page 3 6:33 PM to 4/13/2025 at 6:55 AM4/13/2025 at 6:31 PM to 4/14/2025 at 7:31 AM4/14/2025 at 6:29 PM to 4/15/2025 at 6:57 AMDuring a telephone interview on 2/25/2026 at 2:39 PM Nurse #1 stated he did not recall the exact date he was suspended related to the allegation of drug diversion for Resident #134's Oxycodone in April 2025. The facility provided a copy of an email received from Nurse #2's agency that included the following dates and times that Nurse #2 worked at the facility after ADON #1 was notified by the pharmacy of the missing Oxycodone for Resident #134 (4/11/2025) and prior to the initiation of the facility's investigation:4/10/2025 at 2:30 PM to 4/11/2025 at 7:00 AM4/11/2025 at 2:30 PM to 4/12/2025 at 7:00 AMDuring an interview on 2/26/2026 at 11:41 AM the DON stated he was familiar with the alleged incident of missing narcotic medications for Resident #134 from April 2025. The DON stated the pharmacy called the facility on 4/10/2025 to report issues with narcotic medication that was supposed to be returned, but when ADON #1 answered the phone the pharmacy was no longer on the line. The DON indicated ADON #1 should have called the pharmacy back on 4/10/2025. The DON stated ADON #1 spoke to the pharmacy on 4/11/2025 and was notified of the missing narcotics for Resident #134. The DON stated on 4/12/2025 he was notified by ADON #1 of the missing narcotics for Resident #134 that were supposed to be sent back to the pharmacy. The DON revealed that he did not notify the Administrator of the missing narcotics until 4/14/2025 because at the time incident he did not know missing narcotics was a reportable event. He reported that he was now aware that he should have notified the Administrator of the missing Oxycodone as soon as he was notified on 4/12/2025 because missing narcotics was a reportable incident that needed to be investigated. The DON stated the initial allegation report should have been completed within 24 hours of the facility being made aware of the possible diversion. The DON spoke about law enforcement notification. He reported that he believed he contacted Officer #1 on 4/15/2025, but there was no evidence on his (the DON's) call logs. He indicated he called Police Officer #1 on a direct phone number on 4/18/2025 and left a voice mail, but there was not a police report available. The DON's call log showed a call made Police Officer #1's direct number on 4/18/2025. The DON stated the facility was unable to locate the missing medication or determine how they went missing and the allegation of diversion was unsubstantiated due to lack of evidence. During an interview on 2/26/2026 at 12:00 PM the Administrator stated she was familiar with the alleged	F0607		

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F0607 SS = D	Continued from page 4 incident of missing narcotic medications for Resident #134 from April 2025. The Administrator revealed she was first notified of the missing narcotics by the DON on 4/14/2025. The Administrator indicated that the DON reported that ADON #1 spoke to the pharmacy on 4/11/2025 and was informed of the 7 tablets of Oxycodone missing from the sealed narcotic return bag. ADON #1 then notified the DON of the missing Oxycodone on 4/12/2025. The Administrator stated that when the DON informed her of the missing narcotics on 4/14/2025, an investigation was started. The Administrator stated she should have been notified of the missing narcotics immediately. The Administrator stated she believed law enforcement was verbally notified on 4/15/2025, possibly from her cell phone as she was out of the facility at the time. She verified there was no record of law enforcement notification. The Administrator stated she expected protocol to be followed for reporting missing narcotics, and she should have been notified immediately by ADON #1 on 4/11/2025 and by the DON on 4/12/2025. The Administrator stated the facility was unable to locate the missing medication or determine how they went missing, and the allegation of diversion was unsubstantiated due to lack of evidence. The facility presented a corrective action plan to the State Agency that was not accepted.	F0607		
F0644 SS = E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by:	F0644		

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F0644 SS = E	Continued from page 5 Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for residents with new mental health diagnoses for 5 of 7 residents reviewed for PASRR (Resident #5, Resident #12, Resident #51, Resident #71 and Resident #100). The findings include: a. Review of Resident #5's medical record revealed PASRR level I was completed 2/01/22 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #5 was admitted to the facility on 9/19/23 with diagnosis that included hypertension, diabetes, and readmitted on 12/15/25 with diagnosis of post-traumatic stress disorder (PTSD) (diagnosed on 12/10/23), and major depressive disorder (diagnosed on 5/19/25). The annual Minimum Data Set (MDS) dated 1/13/26 revealed Resident #5's current active diagnoses included post-traumatic stress disorder and major depressive disorder. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. b. Review of Resident #12's medical record revealed PASRR level I was completed on 1/24/25 prior to admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Review of hospital discharge summary dated 1/29/25 revealed Resident #12 had a history of Parkinson's disease, heart failure, coronary artery disease, anxiety disorder, major depressive disorder, and psychotic disorder with delusions due to known physiological condition. Resident #12 was admitted to the facility on 1/29/25 with diagnosis that included Parkinson's disease, heart failure, anxiety disorder, major depressive disorder, and psychotic disorder with hallucinations.	F0644		

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F0644 SS = E	Continued from page 6 The quarterly Minimum Data Set (MDS) dated 12/27/25 revealed Resident #12's current active diagnoses included anxiety disorder, major depressive disorder, and psychotic disorder with hallucinations and had received antidepressant and antipsychotic medications within past 7 days. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. c. Review of Resident #51's medical record revealed PASRR level I was completed on 2/04/22 prior to admission to the facility with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #51 was admitted to the facility on 2/07/22 with diagnosis that included heart failure, diabetes, seizure disorder and readmitted on 9/24/25 with diagnosis that included heart failure, diabetes, seizure disorder, anxiety disorder (diagnosed on 4/21/22), major depressive disorder (diagnosed on 4/21/22), and psychotic disorder with delusions (diagnosed on 8/20/24). The quarterly Minimum Data Set (MDS) dated 1/01/26 revealed Resident #51's current active diagnoses included anxiety disorder, major depressive disorder, and psychotic disorder with delusions. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. d. Review of Resident #71's medical record revealed PASRR level I was completed 2/06/17 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #71 was admitted to the facility on 6/23/17 with diagnosis that included hypertension, heart disease, and readmitted on 1/30/24 with diagnosis to include stroke, heart disease, hypertension, and major	F0644		

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F0644 SS = E	Continued from page 7 depressive disorder (diagnosed on 4/14/25). The quarterly Minimum Data Set (MDS) dated 12/18/25 revealed Resident #71's current active diagnosis to include major depressive disorder. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. e. Review of Resident #100's medical record revealed PASRR level I was completed 8/29/14 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #100 was admitted to the facility on 5/01/23 with dementia, hypertension and readmission on 10/23/25 with diagnosis to include dementia, anemia, hypertension, major depressive disorder (diagnosed on 10/30/23), PTSD (diagnosed on 10/30/23) and anxiety disorder (diagnosed on 12/17/24). The quarterly Minimum Data Set (MDS) dated 10/29/25 revealed Resident #100's current active diagnoses included major depressive disorder, PTSD, and anxiety disorder. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. An interview on 2/26/26 at 3:55 PM with the Social Worker (SW) revealed she had started her position as the Social Worker in October 2025. She stated as the facility Social Worker she would be responsible for completing PASRR level II paperwork for residents and had just recently received Social Work training from the corporate office to include when and how to complete and submit PASRR level II paperwork. The Social Worker stated it was her understanding that residents were admitted to the facility with a PASRR level I or level II that had been completed prior to their admission and believed she would be responsible for completing and submitting PASRR paperwork when the resident received a temporary level II that required paperwork be resubmitted after 30, 60, or 90 days or if the resident had received a new mental health diagnosis	F0644		

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F0644 SS = E	Continued from page 8 or had a significant change. She revealed she believed she would be notified during their morning meetings and from the nursing staff of any residents who had received a new mental health diagnosis or had a significant change so the level II paperwork could be completed. The Social Worker stated she was not aware and did not know why the sampled residents did not have an evaluation for a Level II PASRR completed but after reviewing their mental health diagnoses, she believed Level II PASRR evaluations should have been completed. During an interview on 2/26/26 at 4:30 PM with the Administrator, she revealed the Social Worker would be responsible for completing and submitting PASRR paperwork. She stated the new Social Worker had only been in the position for a few months and to her knowledge had just received the training from corporate office on completing and submitting PASRR paperwork. The Administrator revealed she was not aware of the sampled resident's diagnosis or that they did not have a PASRR level II evaluation paperwork completed and did not know why a PASRR level II evaluation request had not been submitted. She stated that her understanding was that a PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis and that according to the sampled resident's diagnoses a PASRR level II should have been completed.	F0644		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must	F0755		

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F0755 SS = D	Continued from page 9 employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Pharmacist in Charge and staff, the facility failed to have effective systems in place for the return, disposition, and accurate accounting of controlled medications to the pharmacy for 1 of 3 residents reviewed for misappropriation of property (Resident #134). The findings included: Resident #134 was admitted to the facility on 3/29/2025. The physicians order dated 3/29/2025 revealed Resident #134 was to receive oxycodone (a narcotic opioid analgesic prescribed to treat moderate to severe pain by acting on the central nervous system) 5 milligrams (mg) every 6 hours as needed (PRN) for pain. The March 2025 medication administration record (MAR) revealed starting on 3/29/2025 Resident #134 received a total of 4 tablets of oxycodone 5mg. The medication was documented as administered per physician order on 3/29/2025 at 8:25 PM, on 3/30/2025 at 6:33 PM, on 3/31/2025 at 5:51 AM and 8:46 PM. No further doses were documented as administered for the remainder of the month. The April 2025 MAR revealed Resident #134 received a total of one (1) tablet of oxycodone 5mg. The medication was documented as administered on 4/1/2025 at 5:15 PM. No further doses were documented as administered for the remainer of the month.	F0755		

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F0755 SS = D	Continued from page 10 The controlled substance count record dated 3/29/2025 revealed Resident #134 had 7 tablets remaining after the last dose was administered to Resident #134 on 04/01/2025. Resident #134 was discharged from the facility on 04/02/2025. The pharmacy Controlled Substance Prescription Returned to Pharmacy form dated 4/7/2025 and signed by Nurse #1 and Nurse #2 revealed Resident #134's oxycodone 5mg with 7 tablets remaining was being returned to the pharmacy in the Controlled Medication Return Bag #1109772, due to the medication being discontinued. The form was signed as received by the pharmacy on 4/9/2025 and a note was written that read "medication was not in the bag have called the facility 2 times since yesterday waiting to hear back from someone at the facility about this issue". The pharmacy Pick-Up Slip dated 4/8/2025 signed by Nurse #3 and the pharmacy driver revealed Controlled Medication Return Bag #1109772 was picked up at the facility on 4/8/2025 and was dated and initialed by the pharmacy on 4/9/2025. The pharmacy return technician who processed the Controlled Substance Prescription Returned to Pharmacy form on 4/9/2025 was unable to be reached due to no longer working for the pharmacy. During a telephone interview on 2/25/2026 at 2:39 PM Nurse #1 verified he had worked on 300 hall on the night of 4/7/2025. Nurse #1 verified he had prepared Resident #134's oxycodone for return to the pharmacy. Nurse #1 stated he took the Controlled Substance Prescription Returned to Pharmacy form to Nurse #2 and had her sign it without having the narcotic cards for Resident #134 and another resident on hand for verification. Nurse #1 stated that leaving the medication in the medication room unattended while he obtained Nurse #2's signature was not proper protocol, and it was a mistake to complete the form that way. Nurse #1 stated he should have had the medications that were being returned with him when he had the second nurse to sign the form so the medications could be verified by the 2nd nurse that signed the form and he should not have sealed the bag by himself. Nurse #1 stated Nurse #2 was not involved with the verification or return of Resident #134's oxycodone except for signing the form. Nurse #1 stated he placed Resident #134's card of narcotics that contained the 7 oxycodone along with another resident's card that contained one tablet of oxycodone and the Controlled Substance	F0755		

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F0755 SS = D	Continued from page 11 Prescription Returned to Pharmacy form in the Controlled Medication Return Bag on his own and sealed the bag and placed it in the locked narcotic drawer of the medication cart. Nurse #1 stated he did not know what happened to Resident #134's oxycodone and did not think the tablets were ever found. During a telephone interview on 2/25/2026 at 3:06 PM Nurse #2 stated Nurse #1 had asked her to sign some paperwork on 04/07/2025 but she was not involved with packaging Resident #134's medications and did not verify the medications that were being returned to the pharmacy. Nurse #2 stated she did not have access to Resident #134's medication and had no idea what happened to them. Nurse #2 stated she did not realize what she had signed with Nurse #1. Nurse #2 stated that when she was called in for the interview about the missing medication, she requested to see the form she had signed, and she was shown the Controlled Medication Return form dated 4/7/2025 that she had signed with Nurse #1. Nurse #2 verified her signature on the paper and stated she should not have signed it without making sure the medications being sent back were present in the return bag. Nurse #2 stated she knew she was supposed to verify the amount of narcotic medications that were being returned if she signed a return form and should have verified, they were in the return bag when it was sealed. During an interview on 2/25/2026 at 10:24 AM Nurse #3 verified her signature on the pharmacy pick up slip dated 4/8/2025. Nurse #3 stated when the pharmacy driver arrived at the facility for pick up 4/8/2025, Nurse #3 verified the serial number on the Controlled Medication Returned Bag matched the serial number on the pharmacy pick up ticket. Nurse #3 and the pharmacy driver signed the pharmacy pick up slip and the Controlled Medication Returned Bag was given to the pharmacy driver. Nurse #3 stated she did not recall the specific bag from 4/8/2025, but the bag would have been sealed properly for the pharmacy driver to accept it, and she would not have handed over an unsealed bag. Nurse #3 stated she did not verify the contents of the bag when it was handed to the pharmacy driver. Nurse #3 revealed the following process when pharmacy picked up controlled medications for return the nurse retrieved the sealed Controlled Medication Returned Bag from the locked narcotic drawer in the medication cart. The nurse and pharmacy driver would verify the serial number on the Controlled Medication Returned Bag matched the serial number on the pharmacy pick up ticket. The nurse and driver would sign the pickup ticket and the pharmacy driver would take possession of the Controlled Medication Returned bag. Nurse #3 stated	F0755		

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F0755 SS = D	Continued from page 12 verifying the contents of the sealed bag was not required, but after the incident in April 2025 she tried to verify the contents when she returned narcotic medication. During an interview on 2/25/2026 at 2:07 PM the Pharmacist in Charge explained when the facility had narcotics to return to the pharmacy, the Controlled Substance Prescription Returned to Pharmacy form was completed which contained the serial number of the Controlled Medication Return Bag, the pharmacy then generated a pick up ticket that contained the serial number that was on the Controlled Substance Prescription Returned to Pharmacy form. When the pharmacy driver arrived at the facility the driver and a nurse at the facility would verify the serial number on the Controlled Medication Return Bag matched the pickup ticket, the pharmacy did not require verification of the return bag contents by the driver. The Pharmacist in charge stated the driver would not accept a bag if the serial number did not match and if the seal of that bag appeared to be tampered with or was not properly sealed. The Pharmacist in Charge retrieved the pharmacy copy of the Controlled Substance Prescription Returned to Pharmacy form dated 4/7/2025 that was signed by Nurse #1 and Nurse #2 and verified the name and initials of the pharmacy return technician and the handwritten note that read “medication was not in the bag have called the facility 2 times since yesterday waiting to hear back from someone at the facility about this issue” matched the copy provided by the facility. The Pharmacist in Charge added that the 7 oxycodone pills never arrived at the pharmacy so the facility would still be responsible for following up on the missing medications. The Pharmacist in Charge was unable to provide a contact number for the pharmacy return technician. During a telephone interview on 2/25/2026 at 4:40 PM Assistant Director of Nursing (ADON) #1 stated she had spoken to someone from the pharmacy 4/11/2025, but did not recall the person’s name or what time the call occurred, regarding Resident #134’s missing oxycodone. The ADON #1 recalled Nurse #1 had packaged up narcotics to be returned and had Nurse #2 sign the paperwork. The ADON #1 stated Nurse #2 should have verified the medication since she signed the Controlled Substance Prescription Returned to Pharmacy form. The ADON #1 stated she did not notify the Director of Nursing (DON) or Administrator right away because she was waiting to hear back from the pharmacy to see if the medications had been found. The ADON #1 stated she reported the missing oxycodone to the DON on 4/12/2025. The ADON #1 stated she now knew she was supposed to report missing	F0755		

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F0755 SS = D	Continued from page 13 narcotics immediately to the DON or Administrator so it could be investigated. During an interview on 2/26/2026 at 11:41 AM the DON stated the pharmacy called the facility on 4/10/2025 and when ADON #1 went to answer the phone no one was there. The Pharmacy called back on 4/11/2025 and reported the missing medication to ADON #1. The DON indicated he was not notified until 4/12/2025. The DON stated when he was notified on 4/12/2025 the ADON #1 was waiting to hear back from the pharmacy to see if the pharmacy had found the missing medication. The DON stated on 4/14/2025 when the pharmacy had not found the medication the DON notified the Administrator. The DON stated when Nurse #1 took the form to Nurse #2 to sign, Nurse #1 should also have had the medication for verification and not left the medication unattended while he obtained Nurse #2's signature. The DON stated that when the pharmacy driver picked up controlled medications from the facility the nurse and driver only verified the serial number on the bag and the pickup ticket. The DON stated the missing oxycodone had not been found. During an interview on 2/26/2026 at 12:00 PM the Administrator stated she was notified of the missing narcotics on 4/14/2025, and the medications had not been found. The Administrator stated she expected nurses that signed Controlled Medication Return form to verify the medication that they signed for matched the medication that was placed in the return bag and no staff should sign a Controlled Medication return form without verification of the medications being returned. The Facility presented a corrective action plan that was not accepted by the state agency due to lack of new interventions.	F0755		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 14 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with the resident and staff, the facility failed to secure medications left unattended in a resident's room for 1 of 1 resident reviewed medication storage (Resident #59). Findings included: Resident #59 was admitted to the facility on 11/27/23. Review of Resident #59's physician orders revealed no active orders for 2% miconazole (antifungal) powder or 10% zinc oxide (topical) protective cream. During an observation of Resident #59's room on 02/23/2026 at 11:29 AM, in clear view on the nightstand beside the bed was a 3 ounce bottle of 2% miconazole antifungal powder and a 2.75-ounce tube of 10% zinc oxide protective cream. During an interview on 02/23/2026 at 11:29 AM, Resident #59 stated that Nurse Aide (NA) staff applied the miconazole powder and zinc oxide cream when incontinence care was done and she did not want to self administer either medication. During an interview and observation on 02/23/2026 at 11:34 AM, NA #1 entered Resident #59's room and stated she was assigned to the hall. She observed the zinc oxide cream and miconazole powder on the nightstand and stated those were from the facility's house stock. NA #1 explained the miconazole powder and zinc oxide cream were applied by NA staff when incontinence care was done but should not have been left in Resident #59's room, and she removed both items.	F0761		

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F0761 SS = D	Continued from page 15 An interview was conducted on 02/25/2026 at 12:17 PM with the Director of Nursing (DON) in the presence of the Administrator. The DON explained that the 2% miconazole powder and zinc oxide cream were stored on the treatment cart and should not have been left in Resident #59's room. The DON added that if Resident #59 needed the miconazole powder or zinc protective cream, a physician's order was required.	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880		

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F0880 SS = D	Continued from page 16 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow their Enhanced Barrier Precautions Policy which included the use of personal protective equipment (PPE) during high contact activities for residents with wounds when the Wound Care Nurse failed to don a gown prior to providing incontinence care and prior to providing wound care on a chronic wound to Resident #74. The deficient practice occurred for 1 of 10 staff observed for infection control practices (Wound Care Nurse). The findings included: Review of the facility's policy last revised on 05/19/2025, titled "Enhanced Barrier Precautions Policy" read in part:	F0880		

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F0880 SS = D	Continued from page 17 “Policy: Enhanced Barrier Precautions (EBP) are intended to prevent transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents during high contact activities.” Definitions: “High risk residents: those with chronic wounds and indwelling devices (such as central lines, urinary catheters, and traches) and for all those colonized or infected with a MDRO currently targeted by the CDC.” High contact activities: activities that may result in transfer of MDROs to hands and clothing of healthcare personnel, even when blood and body fluid exposure is not anticipated. These include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, and wound care. Procedure:Standard precautions such as hand hygiene always apply. Staff engaging in high-contact activities will don both gloves and gown before initiating the activity and remove the PPE before exiting the room or area where the activity occurred. Residents placed on EBP should remain on EBP for the duration of their stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.Signage indicating the appropriate type(s) of precautions and indicating that visitors should stop at Nurses Station before entering, will be placed on the resident’s door.”An observation and interview on 02/23/26 at 11:29 AM with Resident #74 revealed her resting in bed dressed for the day. Resident #74 stated she had a sore on her bottom that was dressed daily. Upon exiting her room, it was noted there was no sign on the door indicating the resident was on Enhanced Barrier Precautions (EBP) and there was no personal protective equipment (PPE) outside her room or on her door. A second observation on 02/24/26 at 9:57 AM revealed no signage on Resident #74’s door and no PPE outside her room or on her door. An observation was conducted on 02/24/26 at 10:38 AM of wound care being provided to Resident #74 for her coccyx pressure wound. The Wound Care Nurse walked into Resident #74’s room with her wound care supplies in her gloved hands and placed them on the head of the bed on the resident’s bed sheet. Without donning a gown, she proceeded to do incontinence care on Resident #74 by cleaning her and putting a clean brief on her. The	F0880		

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F0880 SS = D	Continued from page 18 Wound Care Nurse doffed her gloves, sanitized her hands, and donned clean gloves and without donning a gown proceeded to clean the wound on Resident #74's coccyx area with normal saline. She doffed her gloves, sanitized her hands, donned clean gloves and without donning a gown placed the collagen to Resident #74's wound bed and covered the wound with an absorbent dry dressing. The Wound Care Nurse doffed her gloves sanitized her hands and gathered her trash and left the room. An interview on 02/25/26 at 10:51 AM with the Wound Care Nurse revealed Resident #74 had not been on the list of residents devised by the Infection Preventionist (IP) as needing EBP so her EBP sign was not on her door and PPE not on her door or outside her room. The Wound Care Nurse stated she thought it was odd that Resident #74 was not on precautions but said she wasn't on the list devised by the IP as needing precautions so she had not questioned it. She also stated they had gotten clarification from the IP on the evening of 02/24/26 and learned that it was not only chronic wounds (more than 6 months in duration) but all wounds that required EBP. The Wound Care Nurse stated that once she found out on the evening of 02/24/26 she placed a sign on Resident #74's door and placed a bin outside her door with PPE in it. A telephone interview on 02/25/26 at 4:50 PM with the IP revealed that she kept a list of residents with devices and wounds that required EBP and PPE when providing care to them. The IP stated Resident #74 had not been on the list because she was not aware that Resident #74 had a pressure wound to her coccyx. The IP further stated that the Wound Care Nurse thought the IP was aware of Resident #74's wound but the IP had told the Wound Care Nurse and the Director of Nursing (DON) that she was not aware that Resident #74 had a wound. The IP indicated she would have expected the Wound Care Nurse to have worn a gown when she was providing incontinence care and wound care to Resident #74. An interview with the Director of Nursing (DON) revealed he would have expected Resident #74 to have been on EBP and the Wound Care Nurse to have worn gloves and a gown while providing incontinence care and wound care to the resident.	F0880		