STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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 2/9/26 through 2/12/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1E34E9-H1.	E0000		02/26/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/9/26 through 2/12/26. Event ID# 1E34E9-H1. The following intakes were investigated: 2735172, 2687876, 2635041, 2624951, 2598418, 864341, 864340, 864339, and 864338 6 of the 21 complaint allegations resulted in deficiency.	F0000		02/26/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with Resident #101, the resident's Power of Attorney (POA), and staff, the facility failed to follow professional standards of practice for medication administration for 1 of 1 resident reviewed (Resident #101) when Nurse #3 crushed and administered Atorvastatin 40 mg (milligrams), a medication used to lower cholesterol and reduce the risk of cardiovascular events such as heart attack and stroke. The findings included: Resident #101 was admitted to the facility on	F0658	F658 Services Provided Meet Professional Standards/ F760 Sign Med Error 1) Resident #101 was assessed for adverse reactions; no negative outcomes noted. The attending physician and pharmacy were notified immediately upon discovery of the medication error. Nurse #3 was immediately suspended pending facility investigation. 2) On 3/5/26 the Director of Nursing and Assistant Director of Nursing audited all current resident receiving medications with "Do Not Crush" designations was conducted to ensure orders included "Do Not Crush" in special instructions. Additionally, residents who receive their medications crushed were reviewed to identify any medications that cannot be crushed, so that liquid formulations could be requested for administration. The DON/designee reviewed MARS and medication administration practices for the past 30 days to ensure no additional occurrences. Any identified concerns were addressed immediately with physician notification and staff counseling/ reeducation. 3) The Assistant Director of Nursing provided education	03/10/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0658 SS = D	Continued from page 1 02/07/2026 with diagnoses that included cerebral infarction, epilepsy, slurred speech, and dysphagia. Review of physician orders dated 02/07/2026 revealed Atorvastatin 40 mg was ordered to be administered orally once daily. The order specified the medication was to be administered whole and was not to be crushed. Review of the manufacturer's Prescribing Information for Atorvastatin dated February 2023, revealed the tablets are to be swallowed whole and should not be crushed, chewed, or broken. Review of the Medication Administration Record (MAR) revealed on 02/09/2026 at 9:00 PM Nurse #3 administered Atorvastatin 40 mg to Resident #101. The MAR did not specify the form in which the medication was administered however, The MAR included instructions indicating the Atorvastatin 40 mg was not to be crushed. Review of the comprehensive Minimum Data Set (MDS) assessment dated 02/11/2026 revealed she was cognitively intact. An interview conducted with Resident #101's Power of Attorney (POA) on 02/10/2026 at 10:00 AM revealed she stayed overnight on 02/09/2026 and observed Nurse #3 crush and administer Resident #101's nighttime medications, including Atorvastatin 40 mg. The POA stated she informed Nurse #3 that the physician's order specified the medication was to be administered whole and not crushed and reported she had a copy of the order available at that time. The POA stated Nurse #3 responded that the medications had already been crushed and informed her that if Resident #101 refused to take the medication in crushed form, she would not receive her medication until the next scheduled dose. An interview conducted with Resident #101 on 02/10/2026 at 10:15 AM revealed Nurse #3 administered her nighttime medication, including Atorvastatin 40 milligrams (mg), in crushed form on 02/09/2026. Resident #101 stated Nurse #3 informed her the medication would not harm her and told her that if she refused to take it, she would not receive it again until the next scheduled dose. Resident #101 stated she took the medication as instructed. An interview conducted with Nurse #3 on 02/10/2026 at 6:17 PM revealed she crushed and administered Resident #101's nighttime medications, including Atorvastatin 40 mg, on 02/09/2026. Nurse #3 stated it was her first shift at the facility as an agency nurse and her first	F0658	Continued from page 1 on Medication Administration/ Do Not Crush Medication to licensed nurse and medication aides to include agency staff on: Reviewing pharmacy-provided "Do Not Crush" lists Following facility medication administration policy Verification of crushability prior to crushing any medication Physician order clarification if an alternate formulation is required Updated "Do Not Crush" reference lists were placed on all medication carts for easy access. A medication administration competency validation will be completed for all licensed nurses to include agency nurses and medication aides by 3/6/2026. New staff and agency nurses will receive competency validation during orientation. This education will be completed by 3/6/2026 and will be included in new hire orientation. 4) Beginning on 3/5/2026 DON /designee will conduct weekly random medication pass observations for 8 weeks to monitor compliance. Audit findings will be reviewed in the Quality Assurances and Performance Improvement Meeting monthly x 3 months. Any identified concerns will result in immediate corrective action and reeducation as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0658 SS = D	Continued from page 2 time caring for Resident #101. Nurse #3 stated she believed the medications needed to be crushed due to the Resident #101's history of stroke and information reportedly received from the previous shift nurse. Nurse #3 acknowledged she did not verify the physician's order prior to crushing the medication and did not contact the provider or pharmacy to clarify the order. An interview conducted with the Director of Nursing (DON) on 02/12/2026 at 12:48 PM revealed Nurse #3 was working as an agency nurse on 02/09/2026. The DON stated nursing staff are expected to review physician orders prior to medication administration and administer medications as prescribed. The DON stated she was notified of the incident on 02/10/2026 by Resident #101's POA. The DON reported she initiated an internal investigation upon learning of the incident. The DON stated Nurse #3 acknowledged crushing the medication without verifying the physician's order. The DON indicated Nurse #3 was removed from the schedule pending investigation. An interview conducted with the Administrator on 02/12/2026 at 1:57 PM revealed he was made aware of the medication administration incident involving Resident #101 by the DON. The Administrator stated nursing staff are expected to follow physician orders and facility policy regarding medication administration.	F0658		
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 employ or obtain the services of a licensed pharmacist who-	F0755	"Past Noncompliance - no plan of correction required"	03/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 3 §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, Physician and staff interviews, the facility failed to have effective systems in place for shift change narcotic reconciliation and failed to keep discontinued narcotic medications under two locks for return to the pharmacy. This failure resulted in 30 missing oxycodone/acetaminophen 10/325 milligrams (mg) and 50 missing oxycodone 5 mg for a total of 80 missing tablets. This occurred for 2 of 2 residents reviewed for misappropriation of medications (Resident #98 and Resident #103). The findings included:Review of the medical record for Resident #98 revealed a physician order dated 8/20/25 for oxycodone/acetaminophen (a narcotic pain medication) 10/325 mg one (1) tablet by mouth twice per day as needed for moderate pain.Review of the medication administration record revealed on 9/15/25 Resident #98 received oxycodone/acetaminophen 10/325 mg at 9:21 AM for pain he rated “9” (1-10 scale with 1 being no or minimal pain and 10 being intense pain). This was administered by Medication Aide (MA) #1 and it was documented as effective for his pain. Review of the schedule for 9/15/25 revealed MA #1 was scheduled to work on the day shift (7:00 AM to 3:00 PM) and Nurse #1 was scheduled to work afternoon and night shift (3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM). Review of the schedule for 9/16/25 revealed MA #1 was scheduled to work the day shift. A facility initial allegation report completed by the former Administrator dated 9/16/25 reported that oxycodone/acetaminophen 10/325 mg belonging to Resident #98 was not located in the medication cart. The report indicated that the pharmacy was notified, the police	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 4 were notified, and an investigation of Change of Custody and delivery was initiated. The facility investigation report completed by the former Assistant Director of Nursing dated 9/22/25 described the investigation that was initiated on 9/16/25 that included suspension of MA #1 and Nurse #1. Alert and oriented residents were interviewed regarding administration of their pain medications and pain assessments were conducted on moderately cognitively impaired residents. No issues were identified during the assessments. The facility conducted a 30-day look back audit on all narcotics received and the facility identified one other resident (Resident #103) with missing narcotics. The facility reviewed 7 employee files and licenses, and conducted urine drug screening on 7 staff, including MA #1 and Nurse #1 and all urine drug screens were negative for narcotic medications. The facility notified Adult Protective Services on 9/16/25 as well as the local police and Drug Enforcement Administration. The facility concluded that they were unable to substantiate the misappropriation of the medications. A statement given by MA #1 dated 9/16/25 documented, “(MA#1) worked 100, 300, and 600 units on 9/15/25. The narcotics count was 36 for the AM and the PM shifts (number of cards of narcotics matched the number of narcotic sheets). My relief for the afternoon on 9/15/25 was (Nurse #1). On 9/16/25 (MA #1) received the cart from (Nurse #1). She assured me the count was still 36 like the previous day and we counted the cart. I gave return meds to (Unit Manager (UM) #1) …I continued my med pass on 300 unit. (Resident #98) asked for pain meds while being transported to therapy. I assured him I would bring it to him. As I looked in narcotics book and cart, I didn’t see a blister pack for him (of oxycodone/acetaminophen 5/325 mg tablets). I know that I didn’t give the last pill the previous day, so I was unsure of why he didn’t have any more (narcotic medication). I notified (UM #1) …” A clarifying statement given by MA #1 dated 9/18/25 documented “Tuesday morning (9/16/25) Nurse #1 and I were counting narcotics on 600 hall … and the count was accurate. We went to the 100/300 hall medication cart to count narcotics, we started counting, she said, ‘we still have 36 items in the cart’ and I did not count to confirm.” An interview was conducted with MA #1 on 2/11/26 at 2:21 PM. MA #1 reported she had worked several shifts before and after Nurse #1 prior to 9/16/25 and the morning of 9/16/25, she and Nurse #1 had counted the	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 5 narcotics in the medication cart for the 600 hall, but when MA #1 went to count the 300 hall cart and Nurse #1 told her, “Oh, we don’t need to do that, it’s the same as it was yesterday afternoon.” MA #1 reported she knew she should not skip the narcotic count, but she believed Nurse #1 and signed the narcotic count sheet without counting the narcotics in the 300-hall cart. MA #1 reported later that morning, Resident #98 requested oxycodone/acetaminophen pain medication and when she opened the locked narcotic drawer, she discovered Resident #98 did not have pain medications in the drawer. MA #1 reported she had administered one tablet to Resident #98 on 9/15/25 and knew he had a full card of medications in the locked narcotic drawer. MA #1 explained she immediately alerted Unit Manager (UM) #1. MA #1 explained that on 9/15/25 during the narcotic count at 3:00 PM, she recalled seeing a full card with 30 tablets of oxycodone/acetaminophen for Resident #98 in the narcotic drawer. MA #1 reported she was suspended from work during the investigation and submitted urine for drug screening. An email statement written by Nurse #1 dated 9/18/25 documented that Nurse #1 worked from 2:45 PM on 9/15/25 until 7:15 AM on 9/16/25. The statement indicated that Nurse #1 had given report at the end of her shift to MA #1 and the two of them counted narcotics on the first cart (the hall was not specified) and all narcotics were accounted for, and Nurse #1 gave MA #1 the keys for that cart. The note documented that MA #1 and Nurse #1 proceeded to count the second cart (the hall was not specified). The note documented that all narcotic counts were correct and there were no concerns or issues. A statement dated 9/18/25 from Nurse #1 was reviewed. The statement reported Nurse #1 was scheduled to work 9/15/25 on the 100, 300, and 600 halls from 3:00 PM to 11:00 PM and the 100, 300, 600 and 200-210 halls from 11:00 PM to 7:00 AM on 9/16/25. The statement read that when MA #1 arrived on 9/16/25 they counted the narcotics on the 600-hall cart. The statement did not include information regarding the 300-hall cart. Multiple efforts were made to contact Nurse #1 for interviews and those attempts were unsuccessful. UM #1 was interviewed on 2/12/26 at 10:16 AM. UM #1 explained that she was working on 9/16/25 and MA #1 approached her to report that Resident #98 was missing narcotic pain medications. UM #1 reported she asked MA #1 if she had counted the narcotics at shift change and MA #1 reported she and Nurse #1 had not counted the narcotics on the 300-hall cart. UM #1 described	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 6 searching all narcotic drawers in each of the medication carts and she was unable to locate the missing oxycodone/acetaminophen for Resident #98. UM #1 reported she called Nurse #1 to inquire about the missing medications and Nurse #1 was “evasive” with her answers and told her she would be in to work at 3:00 PM 9/16/25. The former Director of Nursing (DON) was interviewed by phone on 2/11/26 at 12:56 PM. The former DON reported she was not working on 9/16/25 but was notified of the missing oxycodone/acetaminophen by UM #1. The former DON explained that MA #1 and Nurse #1 had not counted the narcotics at shift change on 9/16/25, but the facility was not able to determine who took the oxycodone/acetaminophen. The former DON reported all nurses and medication aides were trained to complete narcotic counts at the change of any shift, including MA #1 and Nurse #1. The Director of Nursing was interviewed on 2/12/26 at 3:12 PM and she reported she had started her position after the incidents, but she expected all narcotics to be counted at the end of one shift and the beginning of the next shift by the oncoming and leaving nursing staff and if the narcotic counts had discrepancies, the nursing staff should report those issues immediately. The Physician was interviewed on 2/12/26 at 1:37 PM. The physician reported he was notified of the medications for Resident #98 and Resident #103 were missing and he was part of the Quality Assurance Performance Improvement (QAPI) meeting on 9/17/25. The Physician reported that Resident #98 had replacement medications provided by the facility and Resident #98 was not harmed.Review of the medical record for Resident #103 revealed a physician order dated 9/10/25 for oxycodone 5 mg with instructions to administer one (1) tablet by gastric tube every 4 hours as needed for pain.An interview was conducted with MA #1 on 2/11/26 at 2:21 PM. MA #1 reported when she received report on 9/16/25 from Nurse #1, she was told there were medications that needed to be returned to the pharmacy that belonged to Resident #103. MA #1 reported the medications were in a bag and sitting unlocked in the medication room, and she took the medications to UM #1 to be returned to the pharmacy. MA #1 reported she was aware that Resident #103 had died a few days before and knew that the medications would need to go back to the pharmacy, but she did not have authorization to do that, so she took the medications to UM #1. MA #1 explained she did not look at the medications or know what medications were in the bag.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 7 A statement by Nurse #1 dated 9/18/25 documented that (unspecified time and date) that Resident #103's medications were separated in the locked narcotic drawer and Nurse #1 took the medications out of the locked narcotic drawer and put in a clear pharmacy return back and put the bag into the medication room. The statement documented that Nurse #1 told MA #1 there were narcotics that needed to be returned (to pharmacy). Multiple attempts were made to contact Nurse #1 for interviews and those attempts were unsuccessful. The facility investigation report dated 9/22/25 described the investigation that was initiated on 9/16/25 that included suspension of MA #1 and Nurse #1. Alert and oriented residents were interviewed regarding administration of their pain medications and pain assessments were conducted on moderately cognitively impaired residents. No issues were identified during the assessments. The facility conducted a 30-day look back audit on all narcotics received and the facility identified one other resident (Resident #103) with missing narcotics. The facility reviewed 7 employee files and licenses, and conducted urine drug screening on 7 staff, including MA #1 and Nurse #1 and all urine drug screens were negative for narcotic medications. The facility notified Adult Protective Services on 9/16/25 as well as the local police and Drug Enforcement Administration. The facility concluded that they were unable to substantiate the misappropriation of the medications. UM #1 was interviewed on 2/12/26 at 10:16 AM. UM #1 explained that she was working on 9/16/25 and MA #1 approached her with medications for Resident #103 that needed to be returned to the pharmacy. UM #1 explained she was in the middle of investigating the missing narcotic medications for Resident #98 and she placed the medications for Resident #103 into an unlocked cabinet in the nurses' station. UM #1 explained that she should have locked the medications in a locked cabinet in the medication room, but she was preoccupied with the investigation for Resident #98's missing narcotic medications. UM #1 reported that later that day, she and Nurse #2 were preparing to return the medications to the pharmacy and that was when they discovered that the oxycodone prescribed for Resident #103 was missing. UM #1 explained that two nurses were required to count medications before returning them to the pharmacy and that's when they discovered the missing oxycodone prescribed to Resident #103 was not in the bag.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 8 Nurse #2 was interviewed on 2/12/26 at 10:50 AM. Nurse #2 reported that to return narcotic medications to the pharmacy, two nurses must count the medications and scan the medication for return. Nurse #2 explained that medications should not have been removed from the cart by one nurse and should not have been left unlocked. The former Director of Nursing (DON) was interviewed by phone on 2/11/26 at 12:56 PM. The former DON stated UM #1 was aware that the narcotic medications needed to be locked up. The former DON did not know why Nurse #1 removed the medications from the locked medication cart. During the interview with the DON on 2/12/26 at 3:12 PM, the Regional Director of Clinical Services reported that discontinued narcotics were kept under two locks until the pharmacy returns for them and there are two nurses to sign them out. The Administrator was interviewed on 2/12/26 at 3:16 PM. The Administrator explained he started his position after the incident happened and he expected all narcotic hand-offs were completed per policy. The facility submitted the following corrective action plan: Nurse #1 and Med Aide #1 failed to properly complete the shift change controlled substance inventory log. Staff relied on verbal confirmation rather than physically verifying and documenting the count together. Additionally, a nurse manager failed to secure medications intended for return to pharmacy by leaving them in an unlocked cabinet behind nurses' station. • Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/16/2025, Med Aide #1 identified missing oxycodone/acetaminophen 10/325mg tabs for Resident #98 based on availability from previous day. A thorough search was conducted in the facility to locate the medication without success. On 9/16/25 Medication Aide (MA) #1 received 300 med cart from Nurse #1, they did not complete a proper narcotic count. During med pass Resident #98 requested pain med from MA #1. When MA #1 looked inside med cart she did not see the medication. The MA #1 remembered that the previous day the medication was there. The medication aide immediately notified the Unit Manager,	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 9 who confirmed with the pharmacy that 60 tablets had been delivered on 9/3/25. A search of the medication cart did not locate the missing medication. Resident #98 was found to be missing #50 oxycodone/acetaminophen 10/325mg tablets. The Nurse Manager informed the Administrator and Director of Nursing. The Administrator subsequently notified the Regional Vice President of Operations, Regional Director of Clinical Services, Marshville Police, the pharmacy representative, medical director, responsible party, and the resident. All nurses who had worked the medication cart, including the DON, submitted to urine drug screening. MA #1 and Nurse #1 (assigned during the timeframe the medication went missing) were suspended pending investigation. The Staff Development Coordinator conducted a full narcotic count on all medication carts. Additionally, the SDC initiated education for licensed nurses and medication aides on Chain of Custody for Controlled Substances and Abuse to include misappropriation. Director of Nursing and Nurse Managers completed pain audits on all residents receiving narcotics. Interviews completed on alert and oriented residents with a BIMS of 12 or above. No issues identified. A new script was obtained for Resident #98's pain medication by NP #1 and pharmacy sent pain medication which was billed to the facility on 9/18/2025. Resident #98 did not have any negative outcomes due to missing pain medication. The morning of 9/16/25 Nurse #1 informed MA #1 about medications on the counter in the medication room that needed to be returned. MA #1 took the medications from the medication room to the main nurse's station to give to the Unit Manager. The Unit Manager placed the medications in an unlocked cabinet behind the nurses' station where she was working to return later. Later in the day, Unit Manager and Nurse #2 scanned and returned all medications to pharmacy. During the investigation for missing narcotics, it was discovered that Resident #103 was missing 30 tablets of oxycodone 5mg. Resident #103 expired 9/12/25. • Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving controlled pain medication have the potential of being affected. Director of Nursing/Designee completed pain audits on all residents receiving narcotics. Interviews completed on all alert and oriented residents with a Brief Interview for Mental Status of 12 or above. No negative findings noted. These audits were completed on	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 10 9/17/2025. Residents with a BIMS of 12 or above were asked the following questions: 1) Do you receive medication for pain? 2) If yes, are you having any problems receiving your pain medication? 3) Do you have any unrelieved pain that we need to address at this time? Confused residents received the Pain Assessment in Advanced Dementia (PAINAD) Scale. Upon discovery on 9/16/2025 the facility, in accordance with our Quality Assurance Performance Improvement program, leadership implemented the following corrective action measures: 9/16/2025 Facility staff notified unit manager of the discrepancies on the narcotic count sheet. Unit manager notified Director of Nursing and Nursing Home Administrator. 9/16/2025 Administrator and Staff Development Coordinator interviewed Med Aide #1 and Nurse #1 and urine drug tests completed. MA #1 and Nurse #1 denied taking the medications. MA #1 and Nurse #1's urine drug tests were negative for oxycodone. 9/16/2025 Administrator notified Med Aide #1 and Nurse #1 of being suspended pending investigation. 9/16/2025 Director of Nursing and Nursing Home Administrator notified Regional Vice President of Operations, Regional Director of Clinical Services, Marshville police department, pharmacy representative, medical director, nurse practitioner, Resident #98, and Responsible Party. 9/16/2025 Staff Development Coordinator completed full narcotic counts on all medication carts. No other missing narcotics were identified. 9/16/2025 Staff Development Coordinator initiated education on the Chain of Custody Controlled Substances Process and abuse to include misappropriation with licensed nurses and medication aides. 9/17/2025 Director of Nursing/Designee completed a complete pain assessment audit on all residents. 9/17/2025 Director of Nursing and Staff Development Coordinator completed a 30-day lookback audit of all narcotics received and identified Resident #103 (deceased on 9/12/25) had #30 oxycodone 5mg tabs that were received on 9/8/2025 from pharmacy cannot be accounted for. No other discrepancies identified. 9/17/2025 Ad hoc Quality Assurance Performance	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 11 Improvement meeting was completed. Audits completed on all narcotic sheets on 100/200/300/600/800 med carts to determine if there was any diversion. One area was identified for Resident #98 and Resident #103. Director of Nursing/designee completed audits with all licensed nurses/medication aides of the count process during shift change from 9/18/25-9/21/2025. • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing/Designee re-educated all licensed nurses/medication aides including agency nurses on Chain of Custody Controlled Substances, securing medications, and misappropriation on 9/18/2025. The education included that both outgoing and incoming staff are required to physically visualize each controlled substance and reconcile the count against the log before signing. Reinforced that verbal confirmation alone is not acceptable practice. All newly hired licensed nurses and agency staff will be educated on said process during orientation. Nurse #1 and MA#1 that failed to complete the narcotic count received disciplinary action. The nurse manager who failed to secure medications received disciplinary action as well. The Director of Nursing placed a lock on cabinet in medication room to store medications that need to be returned to pharmacy. Director of Nursing/Designee is conducting unannounced spot checks during shift change. • Indicate how the facility plans to monitor its performance and make sure that solutions are sustained. The Director of Nursing/Designee will audit five random narcotic counts with licensed nurses/medication aides weekly, to ensure accuracy and proper reconciliation of narcotics. The Director of Nursing/Designee will audit medication carts, medication rooms, and nurses' station weekly to ensure narcotics are secured properly. This audit will be completed weekly for 8 weeks. The Director of Nursing/Designee will audit five random residents to ensure that they have no issues with care and services weekly for 8 weeks. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0755 SS = D	Continued from page 12 The facility completed and accepted the plan of correction at an ad hoc QAPI meeting on 9/23/25. Root cause analysis: The facility completed a thorough investigation to determine the root cause of the missing medications. All investigative steps were taken in accordance with internal protocols and applicable regulatory standards. Nevertheless, the missing narcotics were not recovered, and no evidence was found to clarify the nature of the loss. The facility investigation did reveal that nurses/medication aides were not completing the Shift Change Controlled Substances Inventory Log properly during shift change/narcotic counts. Some staff were relying on verbal confirmation and taking each other's word that the count was correct. Additionally, the investigation revealed a nurse manager left medications in unlocked cabinet. Nurse Manager failed to follow facility policy which requires all narcotics to be secured under a double-lock system at all times. • Include dates when the corrective action will be completed. Date of Compliance: 9/24/25 The plan of correction was validated on 2/12/26. Initial audits of the narcotic drawers were reviewed, resident interviews and pain assessments were reviewed, and education provided to staff was reviewed. Nursing staff were interviewed, and they were able to correctly describe the process for narcotic medication counts and when to perform those counts. A change of shift narcotic count was observed and no issues were identified. Narcotic drawers and sheets were reviewed and no issues were identified. The facility's date of compliance of 9/24/25 was validated.	F0755		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with Resident #101's Power of Attorney (POA), Facility Physician, Pharmacist, Nurse Practitioner #1 (NP), and staff, the facility failed to ensure Resident #101 was	F0760	F658 Services Provided Meet Professional Standards/ F760 Sign Med Error 1) Resident #101 was assessed for adverse reactions; no negative outcomes noted. The attending physician and pharmacy were notified immediately upon discovery of the medication error. Nurse #3 was immediately suspended pending facility investigation. 2) On 3/5/26 the Director of Nursing and Assistant Director of Nursing audited all current resident receiving medications with "Do Not Crush" designations was conducted to ensure orders included "Do Not Crush" in special instructions. Additionally, residents who receive their medications crushed were reviewed to	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0760 SS = D	Continued from page 13 free from a significant medication error when Nurse #3 crushed and administered Brivaracetam (anticonvulsant medication used to control partial -onset seizures) 100 milligram (mg) extended-release, Eslicarbazepine 800 mg (anticonvulsant used to treat seizure disorders), Lamotrigine 200 mg (anticonvulsant medication used to control various types of seizures), and Xcopri 150 mg (anticonvulsant used to treat partial-onset seizures), despite physician orders indicating the medications were to be administered whole and not crushed. This deficient practice occurred 1 of 1 resident reviewed for significant medication errors (Resident #101). The findings included: Resident #101 was admitted to the facility on 02/07/2026 with diagnoses that included cerebral infarction, epilepsy, slurred speech, and dysphagia. Resident #101's quarterly Minimum Data Set (MDS) dated 02/11/2026 revealed she was cognitively intact and revealed no physical or verbal behavioral symptoms and no rejection of care. Review of the Medication Administration Record (MAR) revealed on 02/09/2026 at 9:00 PM Nurse #3 initialed the MAR indicating she had administered Brivaracetam 100 mg, Eslicarbazepine 800 mg, Lamotrigine 200 mg, and Xcopri 150 mg to Resident #101. The MAR did not specify whether the medications were to be administered whole or crushed. Review of physician orders revealed Brivaracetam 100mg was ordered on 02/09/2026 to be administered orally twice daily, with special instructions stating “DO NOT CRUSH”; Eslicarbazepine 800 mg was ordered on 02/07/2026 to be administered orally once daily and not crushed; Lamotrigine 200 mg was ordered on 02/07/2026 to be administered orally five times daily and not crushed; and Xcopri 150 mg was ordered on 02/08/2026 to be administered orally twice daily and not crushed. Review of the manufacturer’s Prescribing Information revealed that Brivaracetam Prescribing Information dated January 2021 states that tablets should be swallowed whole and should not be chewed or crushed. The Lamotrigine (extended-release) Prescribing Information dated July 2023 states that tablets should be swallowed whole and must not be chewed, crushed, or divided. The Eslicarbazepine Prescribing Information dated March 2024 states that tablets may be administered whole. The Xcopri Prescribing Information dated April 2023 states that tablets may be taken whole. Failure to administer these anti-seizure	F0760	Continued from page 13 identify any medications that cannot be crushed, so that liquid formulations could be requested for administration. The DON/designee reviewed MARS and medication administration practices for the past 30 days to ensure no additional occurrences. Any identified concerns were addressed immediately with physician notification and staff counseling/ reeducation. 3) The Assistant Director of Nursing provided education on Medication Administration/ Do Not Crush Medication to licensed nurse and medication aides to include agency staff on: Reviewing pharmacy-provided “Do Not Crush” lists Following facility medication administration policy Verification of crushability prior to crushing any medication Physician order clarification if an alternate formulation is required Updated “Do Not Crush” reference lists were placed on all medication carts for easy access. A medication administration competency validation will be completed for all licensed nurses to include agency nurses and medication aides by 3/6/2026. New staff and agency nurses will receive competency validation during orientation. This education will be completed by 3/6/2026 and will be included in new hire orientation. 4) Beginning on 3/5/2026 DON /designee will conduct weekly random medication pass observations for 8 weeks to monitor compliance. Audit findings will be reviewed in the Quality Assurances and Performance Improvement Meeting monthly x 3 months. Any identified concerns will result in immediate corrective action and reeducation as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0760 SS = D	Continued from page 14 medications as recommended by the manufacturer and as ordered by the physician may alter drug effectiveness and can increase the risk for breakthrough seizures, increased adverse reactions, or other complications. An interview conducted with Resident #101's Power of Attorney (POA) on 02/10/2026 at 10:00 AM revealed she stayed the night on 02/09/2026 and was present when Nurse #3 crushed and administered Resident #101's nighttime medications. The medications included Brivaracetam, Eslicarbazepine, Lamotrigine and Xcopri. Resident #101's Power of Attorney stated she informed Nurse #3 that the medications should not be crushed according to the physician's orders, which she had a copy of. Resident #101's Power of Attorney stated Nurse #3 informed her that she had already crushed the medications and that if Resident #101 did not take the crushed medications, she would not receive them again until the next night. Resident #101's Power of Attorney stated that within 40 minutes of taking the medication, side effects occurred. She stated Resident #101 felt extremely nauseated, experienced slurred speech beyond baseline, sweating, feeling extremely hot, and weakness. Resident #101's Power of Attorney stated she informed Nurse #3 of the symptoms. Nurse #3 stated she would check on Resident #101; however, the Power of Attorney stated Nurse #3 only checked on Resident #101 once during the night to obtain vital signs. Interview with Resident #101 on 02/10/2026 at 10:15AM revealed Nurse #3 told her to take the crushed medication on 02/09/2026 because it would not hurt her. Resident #101 stated she took the medication because it was important for her seizures, and Nurse #3 stated she would not receive the medication again until the next night if she refused to take it. Resident #101 stated she felt nauseated, experienced slurred speech, sweating, feeling hot, and weakness. Resident #101 stated she could not recall exactly how long the symptoms lasted but reported they began an hour after taking the medication. Resident #101 stated she was unable to participate in physical therapy on 02/10/2026 because her symptom of weakness was present. Review of Resident #101's vital signs taken by Nurse #3 revealed on 02/10/2026 at 12:51 AM, Resident #101's temperature was 98 degrees Fahrenheit, pulse 80 beats per minute, respirations 18 per minute, blood pressure 118/69 mmHg, and oxygen saturation 98%. On 02/10/2026 at 9:41 AM, Resident #101's temperature was 98 degrees Fahrenheit, pulse 72 beats per minute, respirations 18 per minute, blood pressure 126/60 mmHg, oxygen saturation 95%.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0760 SS = D	Continued from page 15 An interview conducted with Nurse Aide (NA) #2 on 02/10/2026 at 11:35 AM revealed she cared for Resident #101 on 02/09/2026. NA #2 stated Resident #101 informed her that she was scared when Nurse #3 crushed her medications instead of administering them whole. NA #2 stated that around 9:00 PM, Resident #101 was sweating more than usual. NA #2 reported assisting Resident #101 by washing her up, changing her into a gown, and removing her blanket. The NA #2 indicated that Resident #101 did not express complaints of nausea or weakness at that time. NA #2 further stated she did not obtain Resident #101's vital signs. An interview conducted with Nurse #3 on 02/10/2026 at 6:17 PM revealed 02/09/2026 from 11:00 PM to 7:00 AM on 2/10/2026 was her first day working for the facility and first time working with Resident #101, as she was an agency nurse. Nurse #3 stated she crushed Resident #101's medications on 02/09/2026 because the facility had not specified otherwise and the nurse from the morning shift of 02/09/2026 stated Resident #101's medications needed to be crushed. Nurse #3 stated she assumed Resident #101's night medications should have been crushed because the resident had a history of stroke. Nurse #3 stated stroke patients often receive crushed medication, and she thought Resident #101 needed her medications crushed. Nurse #3 stated Resident #101's family did not express concerns about the crushed medications until after they were administered. Nurse #3 stated she got vital signs on Resident #101 at 4:00 AM on 02/10/2026, and the resident appeared to be fine. An interview conducted with the Pharmacist on 02/10/2026 at 6:01 PM revealed that crushing Brivaracetam, Eslicarbazepine, Lamotrigine, and Xcopri could decrease the effectiveness of the active ingredients needed to control seizures and other diagnoses. The Pharmacist stated that the symptoms may have resulted from the medications being administered in crushed form and administered all at once. The Pharmacist further stated she did not believe the crushed medications would be a significant concern, as Resident #101 would have already had the medications in her system from previous doses. An interview conducted with the Nurse Practitioner #1 (NP) on 02/10/2026 at 6:52 PM revealed she assessed Resident #101 on 02/10/2026 at 5:00 PM and reported that Resident #101 was stable with no observed side effects or complications. The NP#1 reported that nursing staff did not contact her at the time of the medication error. NP #1 stated she was made aware of the medication error by the Director of Nursing on	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0760 SS = D	Continued from page 16 02/10/2026. NP #1 indicated that if a medication error occurs, the dose may be wasted and re-administered as appropriate. NP #1stated the Brivaracetam was designed to be extended-release over time. NP #1 stated administering the Eslicarbazepine, Lamotrigine, and Xcopri crushed and all at once, rather than allowing it to release gradually, could contribute to potential side effects. The NP #1stated the side effects the resident experienced were a direct result of the medications being crushed. An interview conducted with the facility's Physician on 02/12/2026 at 11:00 AM revealed he was unaware of the medication error involving Resident #101. The facility's Physician stated that Eslicarbazepine, Lamotrigine, and Xcopri could be crushed if necessary. The Facility's Physician stated Brivaracetam should not be crushed because it is an extended-release medication that absorbs into the bloodstream more quickly when crushed. The Facility's Physician stated the symptoms occurred as a side effect of the medications being crushed and administered all at once. An interview conducted with the Director of Nursing (DON) on 02/12/2026 at 12:48 PM revealed Nurse #3 was hired as an agency nurse. The DON stated Nurse #3 obtained vital signs at midnight for Resident #101, and no abnormal vital signs were found. The DON further stated she was made aware of the medication error on 02/10/2026 by Resident #101's POA. An interview conducted with the Administrator on 02/12/2026 at 1:57 PM revealed he was made aware of the medication error involving Resident #101 by the DON.	F0760		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident:	F0791	F791 Routine/Emergency Dental Services 1) Resident #95 no longer resides in the facility. 2) On 3/5/26 the Social Services Director completed an audit of current residents to identify those who: Have not had a dental exam within 12 months. Have documented dental issues without follow-up. Require assistance with scheduling or transportation to dental appointments. Any identified residents requiring services were scheduled for routine or urgent dental appointments as indicated.	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0791 SS = D	Continued from page 17 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Power of Attorney (POA), the Nurse Practitioner, three dental offices, the dental Chief Compliance Officer, Chief Medical Officer, and facility staff, the facility failed to ensure necessary assistance was provided to obtain routine and emergency dental services for 1 of 1 resident reviewed (Resident #95). The findings included: Resident #95 was admitted to the facility on 7/31/2017 with diagnoses of unspecified dementia, anoxic brain damage, unspecified intellectual disability, and hypertensive heart disease without heart failure.	F0791	Continued from page 17 3) On 3/4/26 the Administrator reeducated the Social Services Director and Nurse Management on the Dental Services Policy to include: Routine dental examinations are offered at least annually. Emergency dental needs are addressed immediately. Assistance with scheduling, transportation, and coordination is clearly assigned. Social Services Director will be responsible for ensuring appointments are scheduled and completed. Nursing staff will notify Social Services immediately upon identification of dental concerns. 4) The administrator or designee will audit 5 residents weekly for 8 weeks to ensure dental assessments completed, timely scheduling of appointments, and completion of recommended services. Audit findings will be reviewed in the Quality Assurances and Performance Improvement Meeting monthly x 3 months. Any identified concerns will result in immediate corrective action and reeducation as necessary. Date of compliance: 3/6/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0791 SS = D	Continued from page 18 Resident #95 discharged from the facility on 10/13/2025. Resident #95 was care planned on 08/19/2025 with no identified dental health problems. The quarterly Minimum Data Set (MDS) dated 10/13/2025 coded Resident #95 as cognitively intact, receiving a therapeutic diet, with no significant weight loss. The MDS further indicated no mouth or facial pain and no discomfort with chewing. Resident #95 required partial/moderate assistance with ADL, including bathing and toileting, setup or clean-up assistance for oral hygiene, did not ambulate, and required substantial assistance for transfers. Review of the electronic health record (EHR) from 11/20/2024 through 07/09/2025 showed no evidence of a dental examination for Resident #95. A Unit Manager #1 progress note dated 7/10/2025 indicated Resident #95 returned from Dental Office #1 for an initial dental exam with no new orders and was not seen due to inability to ambulate. A Unit Manager #1 progress note dated 7/29/2025 indicated Resident #95 returned from Dental Office #3 with a diagnosis of gum disease and required extractions of tooth #10, #11, #12, #13, #15, #28, #29, and #30. A progress note dated 8/27/2025 indicated prior authorization was completed for Dental Office #3. A Social Work progress note dated 10/07/2025 indicated Dental Office #3 could not treat Resident #95 unless he was able to transfer independently from his wheelchair to the dental chair. A Social Work progress note dated 10/07/2025 indicated Resident #95 was scheduled for an in-house dental appointment on 10/17/2025 for an initial dental examination. An interview with the POA on 02/10/2026 at 7:08 PM revealed ongoing concerns regarding Resident #95's dental needs beginning in April 2025. The POA stated Resident #95 had not been seen by a dentist at the facility despite repeated requests. He reported notifying the Social Worker on more than one occasion that Resident #95 required a dental evaluation due to complaints of pain and difficulty chewing. The POA stated he observed Resident #95 during visits appearing uncomfortable while eating and he reported Resident #95	F0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0791 SS = D	Continued from page 19 verbally complained of mouth pain when chewing food. The POA stated he communicated these concerns to facility staff, including the Social Worker, but was informed that Unit Manager #1 was attempting to locate a dentist. The POA stated he independently scheduled the first dental appointment at Dental Office #1 on 07/10/2025. He reported Dental Office #1 communicated directly with the facility and he was unaware of any referral to Dental Office #2. The POA indicated that he removed Resident #95 from the facility due to the length of time it took the facility to follow up on the resident's dental needs. Unit Manager # 1 was interviewed on 02/11/2026 at 2:33 PM and stated that she recalled family concerns regarding Resident #95's teeth. She stated Resident #95 required assistance transferring to a dental chair and the facility did not have the appropriate resources to assist with transfers at the dental office. Unit Manager #1 indicated that nursing staff and the Social Worker attempted to locate dental offices that could accommodate Resident #95's transfer needs. She stated the appointment scheduler was responsible for communication with Dental Office #1. Unit Manager #1 stated she was unaware of any referral appointments at Dental Office #2. Unit Manager #1 stated the facility communicated with outside physician and dental offices by placing appointment paperwork, referrals, and written instructions in a communication binder that traveled with Resident #95. On 02/11/2026 at 3:31PM the Social Worker stated she first learned about Resident #95's dental concerns from the POA in July 2025. During that conversation, the POA did not mention that Resident #95 was in pain or discomfort. The Social Worker stated she could not recall the specific dental concerns but frequently spoke with the POA regarding scheduling dental appointments. The Social Worker stated she was responsible for planning in-house dental appointments and nursing staff were responsible for outside appointments. The Social Worker stated the facility used an in-house dental provider that came to the facility once every three months for dental hygiene and basic extractions and was present in October 2025. The Social Worker could not recall or provide documentation indicating whether Resident #95 had ever been seen by the in-house dental provider since admission. The Social Worker stated she was notified by Unit Manager #1 that Resident #95 was sent back from Dental Office #3 because he could not transfer to the dental chair. Social Worker stated she was in communication with Resident #95's POA in August 2025, and the POA informed her he would schedule the dental appointments because	F0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0791 SS = D	Continued from page 20 it was taking too long for the facility to. The Social Worker stated it was taking too long for the facility to meet Resident #95's dental needs. She stated she informed the POA that it would take time to locate a dental office that would accept Resident #95's managed insurance. She also stated the Nurse Practitioner #2 (NP) needed to complete authorization for Resident #95 before dental services could be provided. The Social Worker stated she believed dental services had been provided for Resident #95 from August 2025 through September 2025 because she did not receive any follow-up communication from nursing staff or the NP #2. The Social Worker stated Resident #95's POA called in October 2025 regarding dental services that had not been provided. At that time, she offered the in-house dental appointment scheduled for 10/17/2025, and the POA agreed. Social Worker stated the POA informed her of his intent to discharge Resident #95 from the facility on 10/13/2025 due to delays in obtaining necessary dental services. The Social Worker further stated there was no established process in place to follow up on outside dental appointments, and she was unaware of any scheduled appointment with Dental Office #2. An interview with the NP #2 on 02/11/2026 at 3:30 PM revealed she was not aware of an appointment with Dental Office #2 for Resident #95. The NP #2 stated the delay in treatment was related to finding a facility that could accommodate his physical needs and that most dental offices may not accept Resident #95's managed insurance. The NP #2 stated she completed authorization in August 2025 for Resident #95 and that caused additional delays for dental services while waiting for approval. An interview with NA #3 on 02/11/2026 at 4:00 PM revealed she was responsible for transporting Resident #95 to dental appointments. NA #3 stated she did not take Resident #95 to Dental Office #1 on 7/10/2025 because she was on leave. NA #3 stated she transported Resident #95 to Dental Office #3 on 8/27/2025 and no orders were indicated in Resident #95's communication binder. NA #3 stated she did not stay during Resident #95's dental appointment because the POA wanted to attend instead. NA #3 stated Resident #95 required a mechanical lift for transfers and was non-ambulatory. She reported learning from the POA that Dental Office #3 declined treatment because Resident #95 could not transfer from his wheelchair to the dental chair. NA #3 stated she did not have equipment available to facilitate a safe transfer for the dental visit. An interview with the Dentist at Dental Office #1 on	F0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Marshville	**311 W Phifer Street , Marshville, North Carolina, 28103**

(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
F0791 SS = D	Continued from page 21 02/12/2026 at 11:40 AM revealed Resident #95 was seen on 7/10/2025 for dental consultation. The Dentist stated Resident #95 had periodontal disease and needed five extractions due to tooth decay and seven extractions due to cavities. The Dentist stated Resident #95's teeth appeared not to have been properly cared for, which contributed to nerve damage. The Dentist stated that due to the condition of Resident #95's teeth, he would have experienced pain. The Dentist stated he referred Resident #95 to an oral and maxillofacial specialist (Dental Office #2) for extractions and that the referral was placed in Resident #95's communication binder with instructions for the facility to call Dental Office #2 to schedule the appointment. The Dentist stated Dental Office #1 verbally communicated with the transporter regarding the referral. An interview with the Dentist at Dental Office #2 on 02/12/2026 at 12:00 PM revealed there was no record of treatment for Resident #95 and no documentation of contact from the facility. An interview with the Chief Compliance Officer at Dental Office #3 on 02/12/2026 at 12:56 PM revealed Resident #95 was seen on 7/29/2025 and received only a cleaning and X-ray. Dental Office #3 revealed no treatment orders were communicated to the facility because the visit was an initial appointment scheduled by Resident #95's POA. An interview with the Director of Nursing (DON) on 02/12/2026 at 1:42 PM revealed she was not employed at the facility during the time of Resident #95's dental concerns. The DON stated she learned from the Social Worker that when NA #3 was out on leave, a nursing staff member was responsible for transportation for outside appointments. The DON stated that the nursing staff member had not been identified. The DON revealed that the referral for Dental Office #2 may have been lost in communication. An interview with the Administrator on 02/12/2026 at 2:17 PM revealed he was not made aware of Resident #95's dental concerns because he was hired after Resident #95 discharged from the facility. The Administrator stated he expects nursing staff and social work to follow up on dental needs for residents in the facility.	F0791		