DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345351**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/23/2026**
NAME OF PROVIDER OR SUPPLIER **Autumn Care of Saluda**		STREET ADDRESS, CITY, STATE, ZIP CODE **501 Esseola Circle , Saluda, North Carolina, 28773**	

(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 survey was conducted on 04/20/26 through 04/23/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22E7C0-H1.	E0000		04/28/2026
F0000	INITIAL COMMENTS An unannounced recertification survey was conducted on 04/20/26 through 04/23/26. Event ID # 22E7C0-H1.	F0000		04/28/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The initial Minimum Data Set (MDS) for Resident #2 dated 1/9/2026 was modified on 4/22/26 by the Minimum Date Set Coordinator (MDS Coordinator) and was resubmitted with the correct information on 4/22/2026. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Minimum Data Set Coordinator (MDS Coordinator) conducted an audit on April 29, 2026, of all residents with pressure injuries to ensure proper coding has taken place on the MDS. No other issues were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The MDS Coordinator will receive the weekly wound report from the facility wound care nurse to ensure accuracy in coding the wounds to the MDS. The Regional Director for MDS educated the MDS Coordinator and MDS Assistant on April 29, 2026, on accurately completing MDS assessments, reviewing the description of each wound stage with definitions	04/30/2026

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

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F0641 SS = D	Continued from page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers (Resident #2). Findings included: Resident #2 was admitted to the facility on 01/07/26. Review of Resident #2's admission skin assessment dated 01/07/26 identified a pressure ulcer located on sacrum (the bone at the base of spine and top inner area of the buttock). The stage of the pressure ulcer was not included in the assessment. Review of a nurse's progress note dated 01/07/26 revealed Resident #2 had a reddened area on the bilateral inner/top area of the buttock that was covered with foam dressing. Review of Resident #2's Medication Administration Record (MAR) revealed a physician's order was transcribed with directions to cleanse the bilateral inner area on the buttock with normal saline and apply a foam border dressing. The treatment was initialed by the nurse to indicate it was done on 01/08/26. Review of a nurse's progress note dated 01/08/26 read in part, "Resident #2's dressing to the sacrum was changed." Review of the admission MDS assessment dated 01/09/26 indicated Resident #2 did not have an unhealed stage one pressure ulcer (intact skin with a localized area of non-blanchable redness usually over a bony prominence) during the look-back period. During an interview on 04/22/26 at 9:48 AM, the MDS Coordinator was asked to clarify if Resident #2 had a pressure ulcer that was present on admission. The MDS Coordinator stated the admission MDS dated 01/09/26 should have been coded to reflect	F0641	Continued from page 1 of the wounds. Any newly hired MDS staff will be educated in orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nursing Home Administrator/Director of Nursing (NHA/DON) will audit 3 MDS assessments with wounds per week for 12 weeks to ensure that wounds are accurately coded prior to submitting. The NHA/DON will report the results of these audits to the QAPI (Quality Assurance and Performance Improvement) Committee monthly for three months. Completion Date: April 30, 2026	04/30/2026

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F0641 SS = D	Continued from page 2 Resident #2 had a stage one pressure ulcer that was present on admission. During an interview on 04/23/26 at 12:55 PM, the Director of Nursing stated MDS assessments should be coded correctly, and she expected Resident #2's admission MDS assessment dated 01/09/26 was coded to show a stage one pressure ulcer was present on admission. An interview with the Administrator was conducted on 04/23/26 at 1:26 PM. The Administrator stated Resident #2's admission MDS assessment dated 01/09/26 should have been correctly coded to reflect a stage one pressure ulcer was present on admission.	F0641		04/30/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation and staff interviews, the facility failed to complete quarterly smoking risk assessments (assessment of a resident to determine if they are safe to smoke where a score between 0-9 indicates a resident was a safe smoker) for 1 of 2 residents reviewed for smoking (Resident #54). The findings included: Resident #54 was admitted to the facility on 06/25/24 with diagnoses which included mood disorder, nicotine dependence, and muscle weakness. Review of the facility's smoking policy dated 09/09/25 revealed a smoking risk assessment must be completed upon admission, quarterly, and upon changes in the resident's condition. Review of Resident #54's annual Minimum Data Set	F0689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The smoking assessment for resident #54 was completed on 4/22/26 by the Director of Social Services. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Social Services audited all residents smoking assessments on 4/27/26 to ensure that they are current, any updates to the assessments were completed at this time. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Nursing Home Administrator educated the Director of Social Services on April 29, 2026, reviewing the completion and updating of resident smoking assessments, updating whenever there is a change in smoking status or change in resident condition and reviewing smoking assessments during quarterly Minimum Data Set (MDS) review. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nursing Home Administrator/Director of Nursing will audit smoking assessments weekly for 12 weeks to ensure that they are being completed timely and	04/30/2026

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F0689 SS = D	Continued from page 3 (MDS) assessment dated 06/06/25 revealed the resident was cognitively intact and coded for tobacco use. Review of Resident #54's quarterly MDS dated 02/27/26 revealed the resident was cognitively intact and independent for most activities of daily living (ADL). The MDS indicated Resident #54 was independent for ambulation. Review of Resident #54's smoking risk assessments revealed smoking assessments were completed on 06/05/25 with a score of 7, 08/28/25 with a score of 8 and 02/26/26 which indicated the resident was not a current smoker. Review of Resident #54's care plan updated 04/10/26 revealed the resident was a supervised smoker. The goal was for Resident #54 to follow the facility's smoking policy. Interventions included explaining the facility's smoking policy to Resident #54 as needed and monitoring Resident #54 for unsafe smoking signs. Resident #54 was observed smoking on 04/21/26 at 11:18 AM. Resident #54 was supervised while smoking and no concerns or issues were noted. An interview was conducted with the Social Worker (SW) on 04/22/26 at 10:02 AM, and she revealed smoking assessments were expected to be completed quarterly by the SW. She indicated the computer notified her when the next quarterly smoking risk assessment was pending. She confirmed she completed Resident #54's last quarterly smoking risk assessment on 02/26/26 and that he was a non-smoker at that time. The SW stated Resident #54 lost his smoking privileges in January 2026 due to escalating behavior he exhibited towards other residents during designated smoking times. She stated Resident #54's smoking privileges were reinstated on 04/10/26 by the Administrator. She confirmed she updated Resident #54's care plan on 04/10/26 to include smoking but did not complete a new smoking risk assessment. She stated she should have completed the smoking safety assessment due to the change in Resident #54's smoking status. During an interview with the Director of Nursing (DON) on 04/22/26 at 10:12 AM, she revealed Resident #54 had smoked at the facility since his admission but lost his smoking privileges in January 2026 due to escalating behaviors. Resident #54's smoking privileges were reinstated by the Administrator on 04/10/26. The DON stated the SW	F0689	Continued from page 3 are up to date. The Nursing Home Administrator/Director of Nursing will report the results of these audits to the QAPI (Quality Assurance and Performance Improvement) Committee monthly for three months. Completion Date: April 30, 2026	04/30/2026

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FORM APPROVED
OMB NO. 0938-0391

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F0689 SS = D	Continued from page 4 should have completed a new smoking risk assessment after Resident #54’s smoking privileges were reinstated, as that was a change in his smoking status. The Administrator was interviewed on 04/22/26 at 10:23 AM and confirmed he revoked Resident #54’s smoking privileges in January 2026 and reinstated them on 04/10/26. His expectation was the smoking risk assessments should be completed quarterly and after changes in a resident’s condition, as stated in the smoking policy.	F0689		04/30/2026