STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF WAYNESVILLE	360 OLD BALSAM ROAD WAYNESVILLE, NC 28786

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/19/25 through 05/22/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: V4OT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 05/19/25 through 05/22/25. Event ID: V4OT11. The following intakes were investigated: NC00230762, NC00230582, NC00229404, NC00228397, and NC00226552. 4 of the 11 complaint allegations resulted in a deficiency.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.	F 551		6/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2025

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F 551	Continued From page 1	F 551		

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
(iii) To the extent practicable, the resident must be

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F 551	Continued From page 2 provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family interviews, the facility failed to determine if a resident with cognitive impairment had a Resident Representative before allowing the resident to sign admission paperwork for 1 of 1 resident (Resident #91) reviewed for resident rights. Findings included: Resident #91was admitted to the facility on 3/6/25 with diagnosis that included dementia. Resident #91was discharged from the facility to another skilled nursing facility on 4/18/25. A hospital discharge summary dated 3/6/25 stated Resident #1 had advanced dementia. Resident #91's face sheet was reviewed and revealed Resident #91 was listed as the first primary contact as the "primary financial contact receive account receivable (A/R) statement." Resident #91's [Family Member] was listed as the second contact as the "emergency contact." An additional family member was listed as the third contact as the "Resident Representative." Resident #91's Spouse was not listed on her contact list. Review of Resident #91's facility admission agreement paperwork revealed the paperwork had been signed by Resident #91 on 3/11/25 and was witnessed by the former Admission Coordinator. The admission Minimum Data Set (MDS)	F 551	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. 1.Resident #91 has been discharged from the facility on 4/18/2025 2.To identify other potentially like residents, the Administrator (NHA)/Designee audited admission documents of current residents with diagnosis (DX) of dementia and or cognitive impairment to ensure that the signer for those residents with diagnosis of dementia and or cognitive impairment was the Power of Attorney (POA) and or Responsible Party (RP)on 5/29/2025. The Admission Coordinator contacted the RP/POA of the 9 residents who had DX of dementia and or cognitive impairment and had signed their own admission agreement and offered the RP/POA to sign a new admission agreement on 6/12/2025. All POA/RPs verbalized that they were present when resident signed and or felt resident was capable of signing the paperwork on admission. 3.To prevent this from reoccurring the NHA/Designee educated all staff responsible for completing admission paperwork on identifying residents with	

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F 551	Continued From page 3 assessment dated 3/12/25 revealed Resident #91 had severe cognitive impairment. An interview was conducted with Resident #91's Family Member, who was her legal representative on 5/21/25 at 12:10 PM. She reported it was not until Resident #91 left the facility and the Family Member had signed admission paperwork for Resident #91 at the new facility that she became concerned about the admission paperwork because she had not signed any of it when Resident #91 was admitted to the facility on 3/6/25. The Family Member stated she called the facility after Resident #91 had moved to ask about who had signed the admission paperwork for Resident #91 and was told by the former Admission Coordinator Resident #91 had signed the paperwork. The Family Member explained Resident #91 had dementia and would not understand anything she signed. She verbalized the facility had told her, Resident #91's Spouse had been present in the room when Resident #91 had signed the admission paperwork. The Family Member stated the facility did not say why they did not have Resident #91's spouse sign the paperwork instead of Resident #91. She recalled the former Admission Coordinator "was very quick to say" Resident #91 had signed but her Spouse was present. The Family Member stated the Spouse was present and they could have had him sign the paperwork, but they had Resident #91 sign it. The Family Member stated Resident #91 was not competent to sign the paperwork. The Family Member explained Resident #91 knew who she was but was not aware of her surroundings. She felt the facility should have known from Resident #91's medical history that she could not sign paperwork. The Family Member explained Resident #91's Spouse was	F 551	DX of dementia and or cognitive impairments and that they are not to sign admission paperwork and to attempt to have a POA or representative complete all admission documents. This education was completed on 6/5/2025. Any staff who have not completed the required education by 6/6/2025 will be required to receive education prior to the start of the next scheduled shift. Any newly hired staff who may be responsible for completion of the admission paperwork will have the education completed during the new hire orientation process. 4.To monitor and maintain compliance the NHA will audit all admission agreements weekly for 4 weeks and then audit 3 admission agreements weekly for 8 weeks to ensure the RP/POA signed the admission agreement if the admitting resident has a DX of dementia and or cognitive impairment. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months. . Date of Compliance: 6-16-2025	

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F 551	Continued From page 4	F 551		

overwhelmed and would not have known what he was signing. She said he would not have understood the paperwork either and that "he would have just signed it." The Family Member stated she had been at the facility "a lot" and if she was not there the facility could have called her, and she would have come to sign the paperwork. The Family Member reported she felt the admission paperwork for Resident #91 should have been signed by someone who understood what the paperwork was, and that the admission paperwork would "have been a foreign language to her parents."

An interview was conducted with the former Admission Coordinator on 5/21/25 at 2:33 PM. She stated the admission paperwork was completed and signed electronically using a tablet device. She recalled Resident #91, and stated she was aware Resident #91 had a diagnosis of dementia from her hospital admission paperwork but that she was not aware of the extent of her dementia. She recalled completing the admission paperwork with Resident #91 and her Spouse. The former Admission Coordinator said she had talked with Resident #91 and her Spouse about the paperwork and that Resident #91's cognition seemed perfectly fine. The former Admission Coordinator stated she had asked if Resident #91 had a power of attorney (POA) and the Spouse and Resident #91 had said no. She reported that both Resident #91 and her Spouse participated in the conversation. The former Admission Coordinator reported she felt they understood what was being discussed. The former Admission Coordinator stated she was unsure if Resident #91 or her Spouse were able to retain the information discussed. The former Admission Coordinator stated she was aware of what

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F 551	Continued From page 5	F 551		

dementia was and agreed memory impairment and short-term memory loss were features of dementia. The former Admission Coordinator reported the Spouse had said to let Resident #91 sign the admission paperwork and that was why she had let Resident #91 sign the documents. She explained if a resident was cognitive enough to sign or there was a family member in the room who said the resident was coherent enough to sign she let the resident sign. She stated if a resident was able to sit up, talk, tell her where they were, and was very aware then the resident was okay to sign the admission paperwork. She reported if a resident was not alert/ oriented enough to sign their admission paperwork she would reach out to the POA or family to complete the paperwork. She said if the Spouse or legal representative was in the room then they should be the person who signed the paperwork. The former Admission Coordinator explained she had not been aware Resident #91 had a POA until Resident #91 was getting ready to discharge from the facility. She stated Resident #91's [Family Member] had called and asked about who had signed Resident #91's admission paperwork and the daughter had told her at that time she was Resident #91's POA. The former Admission Coordinator said the facility did not have a copy of Resident #91's POA paperwork. She reported that Resident #91's daughter emailed the POA (Health Care) paperwork to the facility close to the day of the resident's discharge, but did not give an exact date. After the former Admission Coordinator received the POA paperwork she added it to Resident #91's medical record.

An interview was conducted on 5/21/25 at 3:10 PM with the Director of Nursing (DON). The DON reported that the admission paperwork should be

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F 551	Continued From page 6 signed by the Resident Representative (RR) or POA if a resident had cognitive impairments. The DON said even if a spouse or POA was in the room and said to let them sign, they could not because they would be signing a legal document they did not understand. The DON recalled Resident #91 and said she did not think Resident #91 was competent to sign her own admission paperwork. An interview was conducted with the Administrator on 5/22/25 at 2:04 PM. The Administrator stated he remembered Resident #91 and was aware she had dementia. He reported Resident #91 should not have signed her admission paperwork because they were legal documents and she had dementia. The Administrator stated Resident #91's authorized legal representative should have signed the papers. He said he had not been aware of the situation previously and was not sure what had happened.	F 551		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		6/12/25

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F 600	Continued From page 7 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect a severely cognitively impaired resident (Resident #65) from the right to be free of physical abuse. On 3/07/27 around 10:30 PM, when Nursing Assistant (NA) #1, and NA #2 were providing care for Resident #65, the resident became agitated and combative. NA #2 struck the resident with an open hand on her lower left arm. The deficient practice occurred for 1 of 4 residents reviewed for abuse. Findings included: Resident #65 was admitted to the facility on 8/22/22 with diagnoses which included dementia and hypertension. Resident #65's care plan revised 4/02/25 revealed a problem area of cognitive loss/dementia due to progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to a diagnosis of dementia. The goal was for the resident to maintain her highest level of cognition. Approaches included: to be patient with resident; break tasks and activities into manageable subtasks; give one instruction at a time; and gently redirect the resident when she made inappropriate actions. Resident #65's significant change Minimum Data Set dated 12/31/24 revealed she was severely cognitively impaired and was dependent or required substantial assistance for activities of	F 600	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 600 Develop Abuse/Neglect Policy 1.The Nurse aide #2 was suspended by the Licensed Nursing Home Administrator on 03/07/25 per the abuse/neglect policy. Law Enforcement was contacted regarding the incident that occurred 03/07/2025 by the Licensed Nursing Home Administrator. Resident # 65 was assess by nursing and had no s/s of abuse. Resident #65 was provided reassurance and psychosocial follow up and had not adverse effects from incident. 2.To identify like residents, the Director of Nursing(DON)/Designee conducted interviews on residents with a BIMS of 12 or above if they are aware of any abuse on 6/6/2025. No concerns noted. The DON/Designee completed skin checks on residents with BIMS below 12 on 6/6/2025.to ensure no sign and symptoms of abuse. No concerns noted. 3.To prevent this from reoccurring the Interdisciplinary Team was educated by the Director of Nursing on the Abuse/Neglect policy on 6/5/2025. This education included when abuse is	

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F 600	Continued From page 8 daily living. She was not assessed to have behavioral problems during the lookback period. Nurse Aide (NA) #2's handwritten statement was undated and read "I changed (Resident #65's) bed while NA #3 and NA #1 gave her a shower. Got her in bed and she likes to hit. I blocked her with my arm and grabbed her hands so she wouldn't hit. NA #1 and NA #3 were in the room, and I never hit her she hit me!" A telephone interview with NA #2 was attempted but unsuccessful. A typed statement from NA #1 dated 3/09/25 read, Around [9:50 PM] [NA #1, NA #2, and NA #3] went to [Resident #65's] room who was in bed and agitated. (NA #2 and NA #1) transferred [Resident #65] on the lift while [NA #3] handled the lift. [NA #3 and NA #1] gave [Resident #65] the shower in the shower room while [NA #2] stayed in the room and changed the linen. [Resident #65] finished her shower and was brought back to her room and placed back in bed with the lift. [NA #2 and NA #1] rolled [Resident #65] to get the lift pad and towels from under her. [Resident #65] was rolled towards [NA #2], while [NA #1] was drying her back [Resident #65] was hit [NA #2] several times. When [Resident #65] was placed on her back, [NA #2] struck [Resident #65] on the left forearm. She went down [Resident #65's] face and said, "Get you're a-s over". Afterwards [NA #2] stated to [NA #1 and NA #3] she has no sympathy for (resident). An interview on 5/21/25 at 12:55 PM with NA #1 revealed she was present in the room at the time of the incident between Resident #65 and NA #2 which occurred on 3/07/25 around 10:30PM. She	F 600	observed staff has the obligation to stop the abuse and report the abuse immediately. The Director of Nursing/Designee educated all staff on the Abuse/Neglect policy on 6/6/2025. This education included when abuse is observed staff has the obligation to stop the abuse and report the abuse immediately. Staff on LOA or vacation will receive this education prior to working their next shift. This education will be provide to newly hired staff in orientation and Agency staff prior to working their first shift. 4.To monitor and maintain compliance the DON /Designee will interview 2 residents with a BIMS 12 or above weekly for 12 weeks if they have experienced or witness any abuse that was not reported. The DON/Designee will perform skin observations on 2 residents with a BIMS less than 12 weekly for 12 weeks for any signs and symptoms of abuse. DON/Designee will interview 2 staff members weekly for 12 weeks if they have any knowledge of abuse occurring. The DON/Designee will observe 2 staff performing care weekly for 12 weeks to ensure no abuse occurs. Any negative outcomes noted will be followed up on immediately. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months. Date of Compliance: 6-16-2025	

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stated she and NA #2 were settling Resident #65 in bed after her shower. She stated NA #3 was in the room and she did not know what he had heard or seen. As NA #1 and NA #2 were turning Resident #65 to remove the lift pad and wet linens from under her, NA #1 observed the resident hit NA #2. NA #1 stated she observed NA #2 hit Resident #65 with her open hand on the resident's left lower arm. The resident did not say or do anything in response to being hit on the arm. NA #2 stated to NA #1 that she did not care anymore and had no sympathy for the resident. NA #1 stated she did not say anything to NA #2 about seeing NA #2 hit the resident. NA #1 stated she just froze and didn't know what to say or do. NA #1 stated she and NA #2 and NA #3 exited the room. NA #1 stated she was in shock and did not know what to do. NA #1 stated she got off work at 10:30 PM, so she clocked out and left the facility right after the incident. She stated she was afraid to report the incident to the on-duty nurse, Nurse #1, because she was afraid of a confrontation with NA #2. NA #1 indicated she did not report it until after she got home, which was about a 15-minute drive. NA #1 further stated she contacted the Director of Nursing and reported the incident, but did not remember the time of the call.

NA #3's emailed statement dated 3/08/25 at 12:24 AM read, "Hello [Administrator], The following is my report on the events of the period of time (roughly 10:00-10:25 PM) in which the incident discussed allegedly occurred: [NA #1] and myself had just finished giving [Resident #65] a shower. We used the full mechanical lift to transport [Resident #65] from the shower chair to her bed, where she was then laid down on her side. I left the room for about 10 seconds while I

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moved the lift out of the room and retrieved washcloths to finish cleaning [Resident #65]. During this period, [Resident #65] exclaimed pain/discomfort several times, which is not at all unusual for any of us, seeing as she has experienced this discomfort with most forms of movement for the entirety of my employment. [NA #1 and NA #2] finished cleaning and preparing [Resident #65] for bed while I mostly either stood by for occasional help or worked on cleaning the floor ([Resident #65] had also defecated while being transferred), so I can't say I observed the entire interaction. In regard to the matter at hand, I did hear [NA #2] exclaim some frustration with [Resident #65] for hitting her while we finished cleaning her, but at no point did I hear or see anything that indicated to me that [NA #2] hit [Resident #65]. Please let me know if there are any further details that you would like me to clarify."

An interview on 5/21/25 at 9:29 AM with NA #3 revealed he was present in the room on 3/07/25 at the time of the incident. He stated he was cleaning the floor and heard NA #2 tell Resident #65 not to hit her. He was unaware of the incident until he was driving home and received a call from the Administrator. NA #3 indicated he did not have any further conversations with NA #1 or NA #2 that evening.

Nurse #1's progress note dated 3/07/25 11:58 PM (recorded as late entry on 3/08/25 at 8:34 AM) read in part that Resident #65 was assessed from head to toe. No new discoloration, swelling, bruising, injury noted. Patient appears to have no pain or discomfort noted. On-call physician was notified. Law Enforcement Officer escorted NA #2 out of the facility.

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(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
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An interview on 5/21/25 at 3:34 PM with Nurse #1 revealed she was on duty on 3/07/25 when the physical abuse incident occurred between NA #2 and Resident #65. She stated she was unaware of the incident until the Director of Nursing (DON) called her after 11:00 PM. She did not remember the exact time but she took the telephone to NA #2 so she could talk with the DON. She stated a Law Enforcement Officer arrived at the facility, talked with NA #2 and escorted her out of the facility. Nurse #1 assessed Resident #65 who had no bruises, welts, discoloration or other injuries noted and no discomfort was observed.

An interview on 5/21/25 at 2:36 PM with the Director of Nursing (DON) revealed that NA #1 had called her after 11:00 PM on 3/07/25 to report the incident. NA #1 stated that she had observed Resident #65 hit NA #2 and NA #2 hit the resident. NA #1 also stated she felt uncomfortable reporting the incident to Nurse #1, so she waited until she got home to call the DON to report the incident. The DON indicated she had called the facility, talked to Nurse #1 and NA #2 was asked to leave the building. She stated she personally talked to NA #2 on the telephone, told her she was being suspended and asked her to leave the building. NA #2 was still in the facility working her shift when the DON called the facility and talked with Nurse #1 and NA #2. As NA #2 was leaving the facility, a Law Enforcement Officer arrived at the facility and escorted her out of the building. The DON instructed Nurse #1 to complete a full skin assessment on Resident #65 and notify the on-call physician.

An interview on 5/22/25 at 9:31 AM with the Administrator revealed he had been notified by

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F 600	Continued From page 12 the DON that NA #1 had observed NA #2 hit Resident #65 on her left lower arm immediately after she was notified by NA #1 which was after 11:00 PM on 3/0725. The Administrator stated he contacted Law Enforcement. During the investigation, he talked with NA #2 who stated that NA #1 perceived the incident incorrectly. The allegation was investigated, and the facility did not substantiate it. The Administrator stated NA #2 was terminated for poor customer service. The police did not press charges against NA #2. The facility provided a corrective action plan which was not acceptable to the State Agency due to not including observations of nurse aides providing care in their audits to ensure the deficient practice will not recur.	F 600		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F 605		6/16/25

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involuntary seclusion and any
physical or chemical restraint not required to treat the resident's medical
symptoms.
§483.12(a) The facility must-. . .
§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints
imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.
. . . .
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-
(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or
(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the

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F 605	Continued From page 14 facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, Lorazepam, prescribed	F 605	"Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for	

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F 605	Continued From page 15 for anxiety/restlessness had a stop date of 14 days for 1 or 6 residents (Resident #80) reviewed for unnecessary medications. The findings included: Resident #80 was admitted to the facility on 5/20/24 with diagnoses which included restlessness and agitation. Resident #80's quarterly Minimum Data Set dated 2/17/25 revealed she was severely cognitively impaired and was coded for hospice care. A physician's order dated 12/03/24 at 1:07 PM read for Lorazepam (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for anxiety/restlessness. There was no stop date. Review of the monthly drug regimen review consultation report dated 12/14/24 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The physician's response signed by the Physician and undated read to accept the recommendation above and implement as written. No stop date or discontinuation date was written on the recommendation. A review of Resident #80's December 2024 and January 2025 Medication Administration Records (MARs) revealed the Lorazepam 0.5 mg every 4 hours PRN for anxiety and restlessness remained an active order. Review of Resident #80's February 2025 and March 2025 MARs revealed per staff documentation, Resident #80 had received	F 605	purposes of general liability, professional malpractice or any other court proceeding. F 605 Chemical Restraints 1. Director of Nursing (DON) obtained order for stop date of Residents # 80 PRN Ativan on 5/21/2025. Residents # 80 had no adverse effects from the PRN Ativan. 2. All residents that receive PRN Psychotropic medications have the potential to be affected. On 06/12/2025, the Director of Nursing audited all residents receiving Psychotropic medications to ensure all PRNs had a stop date. Any orders for PRN Anxiolytics identified without a stop date, the DON obtained an order for stop date within 14 days. 3. On 05/23/2025 The Director of Nursing educated the Assistant director of nursing (ADON) and Unit Managers on ensuring all PRN Anxiolytic medications have a stop date within 14 days and that the Provider will need to evaluate the resident to determine if the medication is still required and that the new order must have a stop date. The DON/Designee educated all Licensed Nurses on ensuring all PRN Anxiolytic medications have a stop date within 14 days and that the Provider will need to evaluate the resident to determine if the medication is still required and that the new order must have a stop date. This education was completed on 6/6/2025. Any nurse on LOA or vacation will receive this education prior to working their first shift. This	

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F 605	Continued From page 16 Lorazepam the following doses: 4 doses in February 2025, 14 doses in March 2025, 7 doses in April, and 7 doses between May 1st and 19th, 2025. Review of the monthly drug regimen review consultation report dated 3/23/25 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The physician's response signed by the Physician's Assistant dated 4/02/25 read to add a stop date of 4/15/25 to the Lorazepam order. Review of Resident #80's April 2025, and May (1st through the 19th) 2025 Medication Administration records revealed through staff documentation, Resident #80 received 7 doses of Lorazepam in April, and 7 doses between May 1st and 19th, 2025. Review of the monthly drug regimen review consultation report dated 4/19/25 completed by the Consultant Pharmacist revealed a recommendation to discontinue the PRN Lorazepam or add a stop date. The Physician's response signed by the Physician's Assistant dated 4/28/25 was to decline the recommendation with the rationale it was a hospice patient order. An interview on 5/21/25 at 9:44 AM with Nurse #2 revealed she received the monthly drug regimen review consultation reports, distributed them to the physicians, and ensured the recommendations were completed. She stated that since Resident #80 was on hospice, their Lorazepam PRN order did not require a stop date. Nurse #2 indicated she noted the resident	F 605	education will be provided to Agency Nurses prior to their first shift of working. This education will be provided in orientation to all newly hired Licensed Nurses. 4. To monitor and maintain compliance the DON/Designee will monitor the Psychotropic ordering report weekly for 12 weeks to ensure any PRN medications have a 14 day stop date. Any negative findings will be corrected immediately. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months. Date of Compliance: 6-16-2025	

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F 605	Continued From page 17 was on hospice on the pharmacy consultation report and had not entered a stop date for the December 2024, March 2025 or April 2025 monthly drug regiment review consultation reports. An interview on 5/21/25 at 10:08 AM with Nurse #3 revealed she also received the pharmacy medication reviews, distributed them to the physicians, and ensured the recommendations were completed. She stated that since Resident #80 was on hospice, their Lorazepam PRN order did not require a stop date. Nurse #3 stated it was her understanding that hospice resident PRN psychotropic medications did not require a stop date. An interview on 5/21/25 at 10:13 AM with the Director of Nursing (DON) revealed the staff thought that hospice residents did not require a stop date for their psychotropic medications. The DON indicated she was aware of the regulation which required a stop date for psychotropic medications and was unaware that Nurse #2 and Nurse #3 thought that hospice residents were an exception. She was unaware that Resident #65's Lorazepam did not have a stop date and said the facility should follow regulations. An interview on 5/22/25 at 9:35 AM with the Administrator revealed he believed hospice wanted their residents to have their psychotropic medications to be continued but was aware of the requirement for PRN psychotropic medications to have a stop date.	F 605		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F 607		6/16/25

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F 607	Continued From page 18 §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 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, staff, and Adult Protective Services (APS) Social Worker (SW) interviews, the facility failed to follow and implement their abuse policy and procedures in the areas of protecting, investigating, and reporting to the Administrator, the State Agency, and/or law enforcement for 2 of 4 residents (Resident #51 and Resident #65) reviewed for	F 607	"Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 607 Develop/Implement Abuse/Neglect Policies	

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F 607	Continued From page 19 abuse. Nursing Assistant (NA) #1 observed NA #2 strike Resident #65 with an open hand during care and did not immediately intervene, did not report the incident immediately to the Administrator, and NA #2 continued to work on the floor with other residents. This failure resulted in a lack of protection for other residents. The findings included: Review of the facility policy titled "North Carolina Resident Abuse Policy", revised 7/11/24 indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/ Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedure in this policy. If a staff member is accused or suspected of abuse, the facility will immediately remove the staff member from resident care area. The accused staff member will be removed from the facility pending the outcome of the investigation. 1. Resident #65 was admitted to the facility on 8/22/22 with diagnoses which included dementia. Resident #65's significant change Minimum Data Set dated 12/31/24 revealed she was severely cognitively impaired. The initial allegation report was completed by the Administrator and dated 3/07/25. The incident date was 3/07/25. The date the facility became aware of the incident was 3/07/25 at 10:00 PM.	F 607	1. Upon becoming aware of the allegation of abuse involving resident #51 that was submitted through APS, the facility administrator (NHA) initiated an investigation which was reported to DHHS and the police on 5/22/2025. Facility investigation and APS investigation found the allegation of abuse involving resident #51 to be unsubstantiated. The Allegation of abuse involving resident # 65, was reported on 3/7/2025 to DHHS and police, however the witnessing staff member nurse aide #1 did delay reporting the allegation until after the alleged incident occurred, allowing for the staff member who was alleged to have caused the abuse (nurse aide #2) to remain working for a period of time. Nurse aide #1 was educated on 3/9/2025 of the requirements to immediately get resident to safety as well as to immediately report all alleged and suspected allegations of abuse to the facility administrator. 2. To identify like residents the NHA/Director of Nursing (DON)/Designee interviewed all alert and oriented residents with BIMS of 12 or above to identify any potential unreported allegations of abuse, to which none were noted. This audit was completed by 6/6/2025. The DON/Designee conducted skin checks on all residents with BIMS below 12 for any signs of abuse, to which none were noted. This audit was completed by 6/6/2025. All staff were asked in interviews by the NHA/DON/Designee if they had witnessed or suspected any unreported abuse, to	

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F 607	Continued From page 20 Allegation details reported that staff alleged witnessing NA #2 strike Resident #65 while providing care. An interview on 5/21/25 at 12:55 PM with NA #1 revealed she was present in the room at the time of the incident which occurred on 3/07/25 around 10:30PM. She stated she and NA #2 were settling Resident #65 in bed after her shower. She stated NA #3 was in the room and she did not know what he had heard or seen. NA #1 stated she observed NA #2 hit Resident #65 with her open hand on the resident's left lower arm. NA #2 stated to NA #1 that she did not care anymore and had no sympathy for the resident. NA #1 stated she and NA #2 and NA #3 exited the room. NA #1 stated after the incident, she observed NA #2 walk down the hall where she was assigned and she was available to provide care for the facility residents. NA #1 stated she was in shock and did not know what to do. NA #1 stated she got off work on 3/07/25 at 10:30 PM, so she clocked out and left the facility right after the incident. She stated she was afraid to report the incident to the on-duty nurse, Nurse #1, because she was afraid of a confrontation with NA #2. She did not report it until after she got home, which was about a 15-minute drive. NA #1 stated she contacted the Director of Nursing and reported the incident, but did not remember the time of the call. An interview on 5/21/25 at 3:34 PM with Nurse #1 revealed she was on duty on 3/07/25 when the physical abuse incident occurred. She stated she was unaware of the incident until the Director of Nursing (DON) called her after 11:00 PM. She did not remember the exact time but took the telephone to NA #2 so she could talk with the	F 607	which all said they had not. These interviews completed by 6/12/2025. 3. To prevent this from happening again the DON/Designee educated all staff including agency on the abuse policy and procedure including protecting residents from abuse, investigating and reporting all witnessed or suspected abuse immediately. All staff will were educated by 6/6/2025. Any new hired staff will receive this education in orientation. Any staff on LOA or on vacation will receive this education prior to working their first shift. Agency will receive this education prior to working their first shift. 4. To monitor and maintain compliance the NHA/DON/Designee will interview 5 random staff members weekly for 12 weeks on their knowledge and understanding of the policy and procedure to protect residents from abuse, investigating abuse allegations, and reporting abuse. The NHA/DON/Designee will interview 5 random staff and 5 random residents with BIMS of 12 or above weekly for 12 weeks inquiring if they have witnessed or suspected any unreported abuse. Any negative findings will be followed up immediately by the facility administrator and investigated following all federal and state guidelines. All abuse investigations will be audited by RVPO or RDCS to ensure compliance with all required components of abuse investigation and reporting monthly for the next 3 months. Any negative findings will	

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F 607	Continued From page 21 DON. She stated a Law Enforcement Officer arrived at the facility, talked with NA #2 and escorted her out of the facility. Nurse #1 assessed Resident #65 who had no bruises, welts, discoloration or other injuries noted. An interview on 5/21/25 at 2:36 PM with the Director of Nursing (DON) revealed that NA #1 had called her after 11:00 PM on 3/07/25 to report the incident. The DON had called the facility, talked to Nurse #1 and NA #2 was asked to leave the building. NA #1 reported to the DON that she had observed Resident #65 hit NA #2 and NA #2 hit the resident. NA #1 also stated she felt uncomfortable reporting the incident to Nurse #1, so she waited until she got home to call the DON to report the incident. The DON indicated she had called the facility, talked to Nurse #1 and NA #2 was asked to leave the building. She stated she personally talked to NA #2 on the telephone, told her she was being suspended and asked her to leave the building. NA #2 was still in the facility working her shift (2:30 PM - 6:30 AM) when the DON called the facility and talked with Nurse #1 and NA #2. As NA #2 was leaving the facility, a Law Enforcement Officer arrived at the facility and escorted her out of the building. The DON instructed Nurse #1 to complete a full skin assessment on Resident #65 and notify the on-call physician and the resident representative. The facility notified the Department of Social Services of the incident. An interview on 5/22/25 at 9:31 AM with the Administrator revealed he had been notified about the incident and an investigation had been completed. He stated that NA #1 should have reported the incident immediately, but she had been afraid to report the incident with NA #2	F 607	be reviewed with the facility administrator and corrected immediately. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for 3 months. Date of Compliance: 6/16/2025	

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present.

2. Resident #51 was admitted to the facility on 8/22/23 with a diagnosis of dementia.

The annual Minimum Data Set (MDS) dated 3/25/25 revealed Resident #51 had short-term and long-term memory problems. The MDS noted her cognitive skills for daily decision making were moderately impaired.

Resident # 89 was admitted to facility on 1/7/25 with diagnoses that included bipolar disorder (psychiatric disorder).

The admission 5-day MDS dated 1/13/25 revealed Resident #89 was cognitively intact.

During a phone interview with an Adult Protective Services (APS) Social Worker (SW) on 5/21/25 at 12:25 PM she revealed she came to the facility on 3/14/25 to investigate a staff to resident abuse allegation. The APS SW stated she had talked with the facility SW and explained she was investigating an alleged staff to resident abuse allegation for Resident #51 that had been reported by the resident's roommate, Resident #89. The APS SW recalled the facility SW stating she did not know anything about it and that Unit Manager (UM) #1 would be better to talk to about it. The APS SW stated the facility SW took her to UM #1's office. The APS SW recalled herself, UM #1, and the facility SW sitting in UM #1's office and talking about the allegation. The APS SW reported she told UM #1 she was at the facility to investigate a staff to resident abuse allegation involving Resident #51 that had been reported by Resident #89. The APS SW stated the abuse

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	345110	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF WAYNESVILLE	360 OLD BALSAM ROAD WAYNESVILLE, NC 28786

(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
F 607	Continued From page 23	F 607		

allegation was not substantiated.

The facility SW was unavailable for interview.

An interview was conducted with UM #1 on 5/21/25 at 2:09 PM. UM #1 reported she remembered an APS SW coming to the facility to visit Resident #89 and Resident #51. She recalled talking with the APS SW but did not remember the details of the conversation. UM #1 reported she did not recall the APS SW saying she was investigating a staff to resident abuse allegation for Resident #51 that was reported by Resident #89.
Review of the Facility Reportable Incidents revealed there was no record of the alleged staff to resident abuse incident reported to APS by Resident #89 for Resident #51.

An interview was conducted with the Administrator on 5/20/25 at 11:00 AM. The Administrator was not aware of an abuse allegation involving Resident #51 from February 2025 or March 2025. The Administrator explained he would continue to look for information.

On 5/20/25 at 2:45 PM the Administrator provided a letter dated 3/14/25 addressed to the Administrator titled "North Carolina Department of Health and Human Services Division of Aging and Adult Services Notice to Administrator: Completion of Evaluation." The letter revealed the following information: APS received a phone call from Resident #51's roommate, Resident #89, reporting that Resident #51 had "gotten beat up last night." The timeline told to APS from Resident #89 was "a bit scattered" and it was unclear if this happened last night or a couple of days or weeks ago. Resident #89 was unable to

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F 607	Continued From page 24 state who the perpetrator was, but she indicated it was not a resident and "alluded to it being a staff person." When telling APS the information, Resident #89 "seemed scared, like someone was listening." The APS SW's investigation on 3/14/25 did not confirm/substantiate abuse or the need for protection as the APS SW did not know who the alleged perpetrator was, what time of day it happened, or what day it happened. An additional interview was conducted with the Administrator on 5/20/25 at 2:45 PM. The Administrator stated the facility SW was unavailable due medical leave. He reported he had found the letter APS regarding the abuse allegation and investigation involving Resident #51 in a file located in the SW's desk. The Administrator stated the SW had not mentioned the letter to him. The Administrator explained he had not been aware of the letter or allegation before he found the letter today (5/20/25). The Administrator said if he had been aware of the staff to resident abuse allegation he would have followed the facility's abuse investigation and reporting process, which would have included reporting the allegation to the state agency and law enforcement. An interview was conducted with the Director of Nursing (DON) on 5/21/25 at 3:02 PM. The DON stated she had not been aware of the staff to resident abuse allegation involving Resident #51 or that APS had come to the facility and completed an investigation.	F 607		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		6/12/25

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F 812	Continued From page 25 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove four containers of fortified nutritional shake nectar consistency that had a used by date of 1/27/25. The four expired containers were found in 1 of 2 nourishment rooms. These practices had the potential to affect any residents that used nectar thickened consistency. The findings included: On 5/22/25 at 8:25 AM the east side nourishment room was observed and in one of the cupboards there were four containers of fortified nutritional shake with nectar consistency that had a used by date of 1/27/25.	F 812	1.Dietary Manager immediately removed the expired containers of nectar thick fortified nutritional shake out of the nourishment room on 5/22/2025 and discarded. 2.All residents receiving nutritional shake have the potential to be affected. The Dietary manager completed a 100% audit of the nourishment rooms to ensure all items were within date on 5/22/2025. No other expired items were identified. 3.To prevent this reoccurring the NHA educated the Dietary Manager on ensuring all nutritional shakes and no other items in the nourishment rooms are not expired on 5/27/2025. The Dietary Manager educated all kitchen staff on	

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F 812	Continued From page 26 On 5/22/25 at 9:13 AM an interview was conducted with the Dietary Manager. The Dietary Manager stated she had no idea how the 4 containers of nutritional shake were missed. The Dietary Manager stated that she inspects both nourishment rooms daily and somehow it got missed. The Dietary Manager stated after hearing about the expired nutritional shakes she inspected both nourishment rooms and all the nutritional shake products she had in the kitchen to ensure there were no other expired containers. The only explanation for the product being missed could possibly be the Dietary Manager's newer staff stocking the nourishment room and placing new products in front of the older product. On 5/22/25 at 10:37 AM an interview was conducted with the Administrator. He stated that he had been made aware of the expired nutritional shake, and he can't explain how it was missed, but would expect the product to be removed. All food products should be inspected and removed if they are expired.	F 812	ensuring all nutritional shakes and any other items in the nourishment rooms are not expired on 5/28/25. This education will be added to orientation for any newly hired Dietary Manager and kitchen staff. To monitor and maintain compliance the Dietary Manage/Designer will audit the nourishment rooms weekly for 12 weeks to ensure no expired items noted. Any negative findings will be corrected immediately. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months. Date of Compliance: 6/16/2025	