STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/11/25 through 02/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T4HJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/11/25 through 02/14/25. Event ID# T4HJ11. The following intakes were investigated: NC00226899, NC00225772, NC00224183, NC00219026 and NC00217567. Two (2) of the eight (8) complaint allegations resulted in deficiency.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §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, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with residents and staff, the facility failed to protect the resident's right to be free from misappropriation of controlled narcotic pain medications for 3 of 4 residents reviewed for misappropriation of property (Resident #46, #1, and #18). Findings included:	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

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F 602	Continued From page 1	F 602		

The facility's Abuse, Neglect, and Exploitation policy, last revised 7/11/24 revealed the facility would not tolerate misappropriation of resident property defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings without consent.

a. Resident #46 was admitted to the facility on 12/16/22. Resident #46's diagnoses included osteoarthritis and right hip pain.

A physician's order dated 4/9/24 revealed Resident #46 received hydrocodone-acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication used to relieve pain) 5-325 milligram (mg) tablet before meals and at bedtime for right hip pain.

The significant change in status Minimum Data Set (MDS) dated 4/17/24 revealed Resident #46's cognition was intact. Resident #46 received scheduled and as needed pain medication, had no presence of pain, and was taking an opioid medication.

A review of the controlled narcotic medication declining records for Resident #46 revealed on 4/21/24 at 8:00 AM Nurse #1 signed she removed one tablet of hydrocodone-acetaminophen 5-325 mg and used her signature as the second nurse witness to indicate the medication was wasted. On 4/21/24 at 11:30 AM Nurse #1 signed she removed two tablets of hydrocodone-acetaminophen 5-325 mg and administered both. The wasted and extra dose of hydrocodone-acetaminophen 5-325 mg were subtracted from the amount of medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 602	Continued From page 2	F 602		

remaining.

A review of the Medication Administration Record (MAR) for Resident #46 revealed on 4/21/24 at 8:00 AM and 4/21/24 at 11:30 AM Nurse #1 initialed she administered one tablet of hydrocodone-acetaminophen 5-325 mg.

During an observation and interview on 02/11/25 at 9:51 AM Resident #46 revealed he received scheduled and as needed pain medication. Resident #46 did not recall a time he did not receive his pain medication and stated nurses were good administering his pain medication on time and shared no concerns of uncontrolled pain. Resident #46 showed no signs of pain during the interview.

b. Resident #1 was admitted to the facility on 7/30/16. Resident #1's diagnoses included vascular dementia, spinal stenosis, osteoarthritis, and chronic pain.

The annual MDS assessment dated 3/12/24 revealed Resident #1's cognition was severely impaired. Resident #1 received scheduled pain medication, had no presence of pain, and was taking an opioid medication.

A physician's order dated 4/24/24 revealed Resident #1 received oxycodone/acetaminophen (a combination of a narcotic opioid analgesic and a non-narcotic medication used to relieve pain) 5-325 mg give one tablet before meals and at bedtime for chronic pain.

A review of the controlled narcotic medication declining record for Resident #1 revealed on 5/17/24 at 8:00 AM Nurse #1 signed she removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 3	F 602		

two tablets of oxycodone/acetaminophen 5-325 mg and wasted one and administered one. Nurse #1 used her signature as the second nurse witness to indicate the medication was wasted. On 5/24/24 at 8:00 AM Nurse #1 signed she removed two tablets of oxycodone/acetaminophen 5-325 mg and wasted one and administered one. A second nurse signature was included to indicate a witness observed Nurse #1 waste the medication. The two wasted doses of oxycodone/acetaminophen were subtracted from the amount remaining.

A review of the MAR for Resident #1 revealed Nurse #1 initialed on 5/17/24 at 8:00 AM and 5/24/24 at 8:00 AM to indicate she administered one tablet of oxycodone/acetaminophen 5-325 mg.

During an observation and interview on 02/11/25 at 1:51 PM Resident #1 had no visible signs of pain and stated she was doing good. Resident #1 was unable to confirm she received pain medication.

c. Resident #18 was admitted to the facility on 1/3/23. Resident #18's diagnoses included chronic pain and left knee pain.

A review of the physician order dated 5/8/24 revealed Resident #18 received oxycodone (a narcotic opioid analgesic) extended release 10 mg tablet every twelve hours.

The quarterly MDS assessment dated 5/29/24 revealed Resident #18's cognition was intact. He had received scheduled pain medication, occasionally had pain rated 4 out of 10, and was taking an opioid medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 4	F 602		

A review of the controlled narcotic medication declining record for Resident #18 revealed on 5/26/24 at 8:00 AM Nurse #1 signed she removed two tablets of oxycodone 10 mg extended release. Nurse #1 signed she wasted one tablet and administered the other. There was a second nurse signature to indicate a witness verified Nurse #1 wasted the medication. The wasted dose of oxycodone 10 mg extended release was subtracted from the remaining amount.

A review of the MAR for Resident #18 revealed on 5/26/24 at 8:00 AM Nurse #1 initialed she administered one oxycodone 10 mg extended release tablet.

During an interview and observation on 02/12/25 at 8:48 AM Resident #18 revealed he had chronic back pain back and nerve damage in his leg. Resident #18 stated he received scheduled and as needed pain medication, and it was effective, and he did not recall a time he had not received his pain medication. Resident #18 showed no signs of pain during the interview.

A review of the initial 24-hour report revealed on 5/27/24 at 1:00 PM the facility became aware of an alleged diversion of resident drugs when staff noticed double signatures for the same date and time for the administration of residents' narcotic medications with unknown witness signatures for medications being wasted. The report named Resident #1, Resident #18, and Resident #46 and Nurse #1 as the accused employee. Law enforcement was notified on 5/27/24 at 1:15 PM and the State Agency on 5/27/24 at 2:59 PM.

A review of the facility's 5-day investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 5	F 602		

revealed law enforcement filed criminal charges against Nurse #1 who refused to write a statement and a complete a drug screen test. The investigation revealed audits were completed of residents with narcotic medications, drug diversion education was provided to nurses including agency staff, and medication administration nurse skill checks were done. Resident pain assessments determined there was no harm. The allegation was substantiated and identified the Director of Nursing (DON) as the investigator and included written statements from staff.

On 2/13/25 at 11:08 AM an attempt to interview Nurse #1 was unsuccessful.

A review of the statement written by Nurse #2 revealed narcotic medication declining records signed by Nurse #1 indicated possible drug diversion and Unit Manager #1 was notified.

During a phone interview on 2/13/25 at 5:04 PM Nurse #2 revealed she identified a pattern when Nurse #1 signed the controlled narcotic medication declining records, and she made copies of those records and notified Unit Manager #1. Nurse #2 revealed that when a controlled narcotic medication was wasted a second nurse needed to observe and co-sign the declining record as a witness it was wasted and put in a dissolving solution kept on the med cart.

A review of the statement written by Unit Manager #1 revealed on 5/27/24 she was asked to review the narcotic controlled medication records on the days Nurse #1 worked. Her review identified concerns with Resident #46, #1, and #18 records and noted medications were removed and signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 6	F 602		

twice for the same time and date and she notified the DON.

During an interview on 2/14/25 at 11:24 AM Unit Manager #1 revealed on 5/27/24 she reviewed the controlled narcotic medication declining records signed by Nurse #1. She identified controlled narcotic medications were wasted and then administered for the same date and time and she did not recognize the second nurse signature used as a witness. Unit Manager #1 revealed Nurse #1 was removed from the medication cart and the Administrator and DON were notified. After questioned, Nurse #1 was unable to provide an explanation and escorted out of the facility. Unit Manager #1 revealed after drug diversion was identified education was provided to nurse staff on what to look for on the controlled medication declining records and included to check signatures. Unit Manager #1 stated she completed random observations of nurse staff during medication administration, interviewed alert and oriented residents about their pain, and completed pain assessment using the facial pain scale for residents that were unable to make their needs known and voice they were in pain.

A review of the DON statement revealed on 5/27/24 she was notified of possible drug diversion and frequent wasting for controlled narcotic medications signed by Nurse #1 with a co-signature that was not familiar. Nurse #1 was interviewed and admitted she had co-signed and there was no second nurse witness to verify narcotic medications were wasted. Nurse #1 did not remember where she wasted the narcotic medications and thought it was either the trash or sharps container. The Unit Manager was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 7	F 602		

instructed to check all sharp containers, and no controlled narcotic medications were found. Nurse #1 was asked to write a statement and provide a urine sample for a drug screen test that she refused and was escorted out of the facility.

Interviews were conducted on 2/13/25 at 1:20 PM and 2/14/25 at 10:24 AM with the DON. The DON revealed the investigation focused on reviewing residents controlled narcotic medications records signed by Nurse #1 on the dates she worked and the medication cart she was assigned. The DON stated in all five narcotic medications were diverted. She revealed Resident #46 records identified on 4/21/24 at 8:00 AM Nurse #1 signed she removed one tablet of hydrocodone/acetaminophen 5-325 mg and wasted it without a second nurse witness signature and on 4/21/24 at 11:30 PM signed she removed two tablets of hydrocodone/acetaminophen 5-325 mg. Her review of Resident #1 records identified on 5/17/24 at 8:00 AM Nurse #1 signed she removed two tablets of oxycodone 5-325 mg and wasted one without a witness second nurse signature and on 5/24/24 at 8:00 AM signed she removed two tablets of oxycodone 5-325mg and wasted one with an unknown second nurse signature. Her review of Resident #18 records identified on 5/26/24 at 8:00 AM Nurse #1 signed she removed 2 tablets of oxycodone 10 mg extended release and wasted one with an unknown second nurse signature. The DON revealed Nurse #1 was interviewed and asked to write a statement and take a drug screen test and initially agreed but then declined and stated she needed legal counsel.

The Administrator statement revealed on 5/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 8	F 602		

he conducted an interview with Nurse #1 to discuss the second nurse signature was not recognized. Nurse #1 initially stated she did not remember who the second nurse was then admitted the other signatures were hers and no other nurse witnessed her waste the controlled narcotic medications. Nurse #1 stated she wasted three narcotics in the sharps container then changed her story to she threw them in the trash. No narcotics were found in the sharps container and Nurse #1 was asked to write a statement and she agreed. Nurse #1 was asked to complete a drug screen test and initially agreed then stated she took pain medication for a previous accident then refused to write a statement and complete a drug screen test stating she needed representation. Unit Manager #2 was asked to escort Nurse #1 from building.

During an interview on 2/14/25 at 3:35 PM the Administrator revealed he was notified by Unit Manager #1 on 5/27/24 that there was a problem with drug diversion and asked to review the controlled narcotic medication records signed by Nurse #1. The Administrator revealed he noticed something was off with signatures and interviewed Nurse #1 with other Department Head staff present. He revealed Nurse #1 was asked to provide the name of the second nurse signature that witnessed her waste controlled narcotic medication and was unable to provide that information. Nurse #1 was asked to write a statement and take a drug screen test and when she refused was asked to leave the building. The Administrator revealed they started their investigation, and he called the police and reported concerns of drug diversion, and the Police Officer came to facility and a report was made. The Administrator revealed family

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	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 602	Continued From page 9	F 602		

members or if cognitively intact the resident were notified of the diversion and the DON reported Nurse #1 to the North Carolina Board of Nursing (NCBON). He revealed on 5/27/24 members of Quality Assurance and Performance Improvement (QAPI) put a plan of correction in place and the audit tools were reviewed at following meeting. The Administrator revealed Nurse #2 recognized drug diversion and knew what to look for when reviewing the controlled medication declining records.

Review of statement written by Unit Manager #2 revealed controlled narcotic medication declining records signed by Nurse #1 had several instances of the same medication being wasted with an unrecognizable second nurse signature as the witness then removed same medication again. After an interview with Administrator, DON, and Unit Managers, Nurse #1 admitted the second nurse signature was hers and stated she gave the medication. Nurse #1 was informed that the incident would be reported and asked to write a statement and offered a drug screen test. Nurse #1 refused to complete a written statement and declined the drug screen and stated she needed legal representation. Unit Manger #2 escorted Nurse #1 out of the building.

During an interview on 2/14/25 at 12:43 PM Unit Manager #2 revealed controlled narcotic medication declining records signed by Nurse #1 identified concerns medications were wasted with an unknown second nurse signature as a witness. Unit Manager #2 revealed Department Heads interviewed Nurse #1 about the unknown second nurse's signature and she admitted it was hers. Unit Manager #2 revealed Nurse #1 was asked to take a drug screen test and stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 602	Continued From page 10	F 602		

was taking pain medication and when asked to provide the prescription she did not and refused a drug screen test. Unit Manager #2 revealed Nurse #1 was asked to write a statement and refused stating she needed lawyer and on 5/27/24 was escorted out of the facility.

The facility provided the following corrective action plan with the correction date of 5/30/24:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Upon Discovery on 5/27/24 Nurse #2 observed discrepancies on facility narcotic count sheets Nurse #1 was unable to account for. The facility, in accordance with our Quality Assurance Performance Improvement (QAPI) program, leadership implemented the following corrective action measures:

5/27/24 Facility staff notified Unit Manager of the discrepancies on the narc count sheet. Unit Manager notified Director of Nursing and Nursing Home Administrator.

5/27/24 Director of Nursing immediately replaced Nurse #1 in question with facility Unit Manager. Nurse #1, in question left the facility prior to face to face interview.

5/27/24 Director of Nursing (via phone), Nursing Home Administrator, and Unit Managers interviewed Nurse #1 on discrepancies. Nurse #1 in question refused a drug screen and to write a comprehensive statement.

5/27/24 Director of Nursing and Nursing Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 602	Continued From page 11	F 602		

Administrator notified Regional Vice President of Operations, Regional Director of Clinical Services, Police Department, Pharmacy Representative, Medical Director, Nurse Practitioner, and families of Resident #1, Resident #46, and Resident #18.

During the facility investigation, it was determined there were 5 pills unaccounted for pertaining to Resident #1, Resident #46, and Resident #18. Any missing narcotics would have been obtained from the facility Omni cell (facility dispensing unit for medications, including narcotics) which is owned by the facility and pulled under house stock and not billed to the resident.

5/27/24 Quality Assurance Performance Improvement meeting was completed.

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. The Director of Nursing/Designee completed pain audits on all residents receiving narcotics.

5/27/24 Director of Nursing/Designee completed full narcotic counts on all medication carts.

5/27/24 Director of Nursing/Designee initiated education on medication administration, wasting narcotics, receiving narcotics, administration and wasting of fentanyl patches, notification of narcotic discrepancies.

5/27/24 Director of Nursing/Designee completed a complete pain assessment audit on all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

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F 602	Continued From page 12	F 602		

residents for anyone that receives narcotics.

Interviews completed on all alert and oriented residents with a Brief Interview for Mental Status of 12 or above. A Wong Baker Scale was completed on all residents with a Brief Interview for Mental Status below 12 to determine if there was any pain. No negative findings were noted. These audits were completed on 5/28/24.

Audits completed on all narcotic sheets to determine if there was any diversion. Five areas were identified for Resident #1, Resident #46, and Resident #18. The Unit Managers completed medication pass observations that was completed on all facility nurses. This audit was started on 5/27/24 and completed on 5/30/24.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur.

The Director of Nursing/Designee educated all licensed nurses including agency on drug diversion and medication rights. This education was completed on 5/27/2024, nurses who were not working that day were educated via phone. On 5/27/2024 notification was sent to all agencies that the facility utilized in regard to facility expectation and accountability. Any licensed nurses on PTO/Vacation will be educated prior to working. All newly hired licensed nurses will be educated on said process during orientation. All agency licensed nurses will receive training prior to the start of their next shift.

Indicate how the facility plans to monitor its performance and make sure that solutions are sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 602	Continued From page 13	F 602		

The Director of Nursing/Designee will audit five random narcotic sheets weekly, to ensure that there is no signs of drug diversion. This audit will be completed weekly for 12 weeks then monthly for 2 months. The Director of Nursing/Designee will audit five random residents to ensure that they have no issues with care and services weekly for 12 weeks then monthly for 2 months. The Director of Nursing/Designee will complete medication pass observation on five nurses weekly to ensure meds are passed appropriately and that no diversion is noted. This audit will be completed weekly for 12 weeks and monthly for 2 months.

The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The facility completed and accepted an ad hoc QAPI meeting 5/27/24
Root cause analysis: The facility completed a thorough investigation to determine the root cause of the diversion. It is the facility's conclusion that Nurse #1 was addicted to pain medication due to her refusal to take a drug screen and her behavior when questioned regarding the narcotics.

Alleged date of compliance: 5/30/24

The facility's corrective action plan with a completion date of 5/30/24 was validated on 2/14/24 by record review, observations, residents, and staff interviews.

A review of the QAPI meeting agenda dated 5/27/24 revealed attendees included the Medical Director, Administrator, DON, and Unit Managers for review and approval of their corrective action

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	345351	A. BUILDING _____ B. WING _____	C 02/14/2025

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F 602	Continued From page 14	F 602		

plan.

A review of police report revealed a warrant was issued on 5/27/24 for the arrest of Nurse #1 for embezzlement/diversion of controlled substances by fraud/forgery.

The facility census on 5/27/24 was 82 residents. Forty-seven resident interviews were completed on 5/28/24 by the Social Worker. Residents were asked do you have any concern about not getting your medications and any concerns about narcotic medication. A facial pain scale rating system completed on 5/27/24 by Unit Manager #1 who observed 35 residents. A total of 82 residents were reviewed for concerns related to medications and pain with no negative findings.

Resident pain evaluations were completed on 5/27/24 that included a numeric pain level, description, and frequency. The pain evaluation for Resident #46 indicated no pain was present. The pain evaluation for Resident #1 indicated no pain was present. The pain evaluation for Resident #18 revealed he was satisfied with his current level of pain rated 7 out 10 and indicated pain was chronic and persistent/daily.

A review of the note signed by the Nurse Practitioner on 5/29/24 revealed Resident #46, #1, and #18 were seen and their pain status assessed. The NP noted Resident #46, #1, and #18 pain was at baseline and well controlled on their current medications.

Urine drug screen test results were completed on resident who received controlled medications to ensure their medications were received. Results for Resident #46 revealed opiates were present.

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F 602	Continued From page 15	F 602		

Results for Resident #1 revealed oxycodone was present. Results for Resident #18 revealed oxycodone was present.

A review of the education provided on 5/27/24 revealed the topics reviewed included the process for wasting narcotics with the objective if resident refused or medication was removed by mistake it must be wasted in the dissolving fluid and witnessed and cosigned by a second nurse. Twenty-one nurses signed they had received the education.

A review of nurses' skills checkoff for medication administration started on 5/27/24 and completed on 5/30/24 revealed no concerns were identified. Medication administration skill checks continued weekly from 6/6/24 through 8/25/24 then monthly on 09/2024 and 10/2024 with no concerns identified.

A review of the notification to the NCBON dated 6/6/24 revealed the DON provided the nurse license number of Nurse #1 and other information obtained from their investigation of drug diversion.

A review of controlled narcotic declining records revealed audits continued weekly from 6/7/24 through 8/25/24 then monthly on 09/2024 and 10/2024 with no concerns identified.

A review of resident audit tool revealed 5 random residents were asked if needs were met and if they had any concerns with medications continued weekly on 6/5/24 through 8/25/24 then monthly on 09/2024 and 10/2024 with no concerns identified.

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F 602	Continued From page 16	F 602		

Observation of medication administration revealed nurses reviewed the physician orders, the medication label, and MAR prior to administering resident medication. Controlled medications were kept locked in a separate storage area on the med cart. Residents with controlled narcotic medications had a declining record that matched the remaining amounts. Declining records were signed by the administering nurses with no controlled narcotic medications wasted.

Interviews with nurses including agency nurses revealed they were observed during medication administration. Nurses were able to explain the facility's process for wasting controlled medications in a fluid dissolving liquid and ensure a second nurse observed and signed as the witness. Nurses revealed they review the count of controlled medications with the off-going nurse to ensure the declining records matched the remaining amount of medication and both nurses signed the count was correct before accepting the keys to the medication cart.

An interview with Medical Director revealed he attended the QAPI meeting on 5/27/24 and agreed with corrective action plan put in place and reviewed the audits during the next QAPI meeting.

Interviews with alert and oriented residents revealed no concerns were identified with uncontrolled pain or medication administration.

Interviews with family members of residents unable to make their needs known revealed no concerns were identified related to medication or uncontrolled pain.

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F 602	Continued From page 17 The completion date of 5/30/24 was validated.	F 602		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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 observations and staff interviews, the facility failed to discard potentially hazardous food with signs of spoilage in 1 of 1 walk-in refrigerators, date food items available for residents in 1 of 1 kitchen refrigerators and discard damaged canned goods available for use. This practice had the potential to affect food served to residents. Findings included: a. An observation of the walk-in refrigerator on	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The box of cucumbers, green bell peppers, ham and cheese sandwich, peanut butter and jelly sandwich and dented can of catsup were immediately discarded by the dietary manager on 2/11/25.	2/24/25

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F 812	Continued From page 18 02/26/24 at 08:56 AM revealed the following: - A box containing cucumbers with a received date of 12/31/24 that was shriveled with white on the surface. - A box of green bell peppers with a received date of 1/14/25 that was shriveled with black on the surface. b. An observation of the kitchen refrigerator on 02/26/24 at 08:56 AM revealed the following: - 1 ham and cheese sandwich and 1 peanut butter and jelly sandwich that were not dated. c. An observation of the canned goods rack on 02/11/25 at 10:00 AM revealed the following: - An unopened can of catsup with a dent approximately 3 inches wide across the front of it available for use. An interview on 02/11/25 at 10:01 AM with the Certified Dietary Manager (CDM) revealed that the box of cucumbers and the bell peppers should have been thrown away. He further revealed that vegetables should have been held for 7 days only. He stated that both sandwiches should have been dated, and it must have been an oversite. He stated that it was the staff's responsibility to date the sandwiches when they were made. The CDM indicated that the can of catsup must have fallen on the shelf last night and staff must have just placed the can back on the shelf. He further indicated that the can of catsup should have been placed in the damaged canned goods return area. An interview with the Administrator on 02/14/25 at 12:39 PM revealed that his expectation was that	F 812	2. Address how the facility will identify other resident having the potential to be affected by the same deficient practice. On 2/11/25 the Dietary Manager checked all other products in the coolers, freezers, and dry storage and did not identify any other outdated products or dented cans. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient will not recur. The Dietary Manager educated the dietary staff on 2/11/25 on proper labeling/dating of products and use by dates as well as discarding of dented cans. This education will be provided to any newly hired dietary staff in orientation. On 2/11/25 the Dietary Manager instituted use of stickers for products which identifies product, date received, and use by dates. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted three times per week for 12 weeks by the dietary manager and/or their designee of coolers/freezer and dry storage to ensure all items are stored properly and discarded by their use by dates or if cans are dented. The Administrator and/or their designee will report the results of the monitoring to the QAPI committee for review and recommendations for a minimum of three months.	

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F 812	Continued From page 19 food be stored and dated according to regulatory standards, and vegetables that were showing signs of spoilage be thrown away.	F 812	5. Include dates when corrective action will be completed. Completion Date: 2/24/25	