STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 5/21/2025 to 5/22/2025. Event ID # M2R011. The following intake was investigated NC00230578. Five of the five allegations did not result in a deficiency.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		6/3/25

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

Electronically Signed | 06/03/2025

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 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.

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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical	F 842	F842	

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F 842	Continued From page 2 Doctor interviews, the facility failed to enter a physician's order into the electronic medical record and document the administration of a medication for 1 of 4 residents reviewed for medication administration documentation (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/5/2025 for surgical aftercare following surgery on the digestive system. Documentation in a nursing progress note dated 5/8/2025 at 12:59 PM written by Nurse #1 revealed Resident #1 was observed vomiting, the physician was notified, and an order was obtained for ondansetron (a medication used to prevent nausea and vomiting) 4 milligrams (mg) every 6 hours as needed. There was no documentation in the electronic medical record of a physician's order for ondansetron or documentation on the medication administration record (MAR) of its administration ondansetron for Resident #1 during the resident's stay at the facility. Nurse #1 was interviewed on 5/21/2025 at 11:36 AM. Nurse #1 explained she was notified on the morning medication pass on 5/8/2025 by a family member of Resident #1 that Resident #1 was vomiting and feeling very nauseous. Nurse #1 further explained she called Medical Doctor (MD) #1 and received the order for ondansetron to be administered to Resident #1. Nurse #1 indicated that the medication ondansetron was available for the residents in medication storage. Nurse #1 did not recall if she gave the medication ondansetron to Resident #1 and could not explain why the medication ondansetron did not appear on the	F 842	The provider was notified on 05.08.2025 that resident #1 was experiencing nausea and vomiting. A telephone order was obtained for Ondansetron 4mg every 6 hours as needed but was never entered into the electronic medication administration record. On 05.09.2025 resident #1 was transferred to the hospital for the nausea and vomiting with no documentation that the Ondansetron was provided. Resident #1 is no longer in the community. The Director of Nursing or designee will review the nursing progress notes since 05.01.2025 for all current residents to ensure all documented telephone orders were appropriately added to the electronic medication administration record and given as needed. All improperly transcribed orders will be reported to the provider for appropriate follow up. The audit will be completed by 06.03.2025. To prevent this from recurring, the Director of Nursing/designee will educate all nurses on ensuring all telephone orders are added to the electronic medical record and documentation accuracy by 06.03.2025. Any nursing staff that cannot be reached by 06.03.2025 for their education will not take any assignment until they have received this education. Newly hired nursing staff will have this education during their orientation. To ensure ongoing compliance the Director of Nursing/designee will review	

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F 842	Continued From page 3 physician orders or the MAR for Resident #1. Nurse #3 was interviewed on 5/21/2025 at 12:01 PM. She explained that she took over the medication cart from Nurse #1 on 5/8/2025 at approximately 12:00 PM. In the nursing report given to her from Nurse #1 on that day, it was explained that Resident #1 was vomiting, an order for ondansetron was obtained, and ondansetron was administered. Nurse #3 confirmed her awareness that Resident #1 would require monitoring after receiving the ondansetron on that day. MD #1 was interviewed on 5/21/2025 at 4:09 PM. He stated he was not the physician for Resident #1, but because he was the facility medical director, he was sometimes called for medical orders for other residents. MD #1 did not recall giving the order for ondansetron for Resident #1 on 5/8/2025 due to the frequency with which he received calls regarding residents. MD #1 confirmed that if he gave a verbal order, he would expect the order to be documented and implemented. The Director of Nursing (DON) was interviewed on 5/22/2025 at 8:21 AM. The DON stated she did not find any documentation or evidence in the electronic medical record of Resident #1 indicating an order for the medication ondansetron was entered into the record or the administration of ondansetron. The DON thought ondansetron was likely given to Resident #1 on 5/8/2025 but she could not confirm that. The DON stated she expected that the nurses would enter the physician orders into the electronic medical record once received and then document the administration of the medication on the MAR.	F 842	the nursing progress notes 5 x week for 8 weeks to ensure all documented telephone orders were added to the electronic medication administration record correctly. Any issues identified will be reported to the provider and the nurse will receive re-education. The Director of Nursing/designee will report the results of the monitoring to the Quality Assurance Performance Improvement Committee meeting monthly for 3 months. The QA team may change the plan of the correction or extend the monitoring to ensure ongoing compliance.	

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F 842	Continued From page 4 The DON felt the documentation was important for the continuity of care and the monitoring of Resident #1 if she received the medication ondansetron.	F 842		