STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE PO BOX 157, NASHVILLE, North Carolina, 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
E0000	Initial Comments The survey team entered the facility on 7/21/25 to conduct a recertification and complaint investigation survey and exited on 7/25/25. Additional information was obtained on 7/29/25 and 7/30/25. Therefore, the exit date was changed to 7/30/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D0D7D-H1.	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 7/21/25 to conduct a recertification and complaint investigation survey and exited on 7/25/25. Additional information was obtained on 7/29/25 and 7/30/25. Therefore, the exit date was changed to 7/30/25. Event ID #1D0D7D-H1. The following intakes were investigated: 2569411, 862292, 2563249, 862295, 862294, 862287, 862290, 862176, 862285, 862283, 862279, 862277, 862276, and 862244. 6 of 37 complaint allegations resulted in deficiency.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to treat a resident in a dignified and respectful manner when Resident #86 requested toileting assistance from Nurse Aide (NA) #1 to use the bed pan for a bowel movement and the NA told the resident to have a bowel movement in his brief. A reasonable person expects to be assisted with toileting needs by their caregiver and would have experienced embarrassment when told to have a bowel movement in their brief rather than be assisted with toileting needs as requested. This deficient practice affected 1 of 3 residents reviewed for dignity (Resident #86). Findings included: Resident #86 was admitted to the facility on 3/12/25. The admission Minimum Data Set (MDS) assessment dated 3/19/25 revealed Resident #86 was cognitively intact. He had no behaviors and was dependent on staff for toileting and transfers. Resident #86 was coded as continent of bowel and bladder.	F0550		

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F0550 SS = D	Continued from page 2 Review of the facility's investigation documentation completed by the Administrator revealed on 3/29/25 Resident #86 and a family member filed a grievance about him being told to make a bowel movement in his brief when he asked Nurse Aide (NA) #1 for incontinence assistance on 3/28/25 at approximately 9:30 PM. NA #1 confessed this statement to the Administrator via telephone on 3/29/25. It was determined that NA #1 was unsure of her resources to be able to care for the residents appropriately, and she did not know who she could ask for assistance at the time of the incident. She told Resident #86 once he had the bowel movement to turn on his call light prior to the end of her shift at 11:00 PM. At 11:00 PM, NA #2 completed her first round on Resident #86 and asked if he needed to go to the bathroom or if he needed his brief changed. He stated that he did not. NA #2 asked if she could check, and he said that it would be fine. She found Resident #86 to be clean and dry. The facility interviewed alert and oriented residents regarding dignity, and skin checks were performed on all non-interviewable residents. No concerns were found. Corrective actions included mandatory inservice for all staff on resident rights (dignity/respect). In addition, NA #1 was immediately suspended and when she returned to work the following week, she received a one-on-one education on dignity/respect. During a phone interview with Resident #86's family member on 7/21/25 at 2:49 PM they indicated that the resident was discharged from the facility on 4/17/25 and has since expired. During a phone interview on 7/24/25 at 1:44 PM, NA #1 recalled on the evening of 3/28/25 that it was her first day on the floor by herself. It was around 9:30 PM when final rounds were performed, and Resident #86 wanted to use the bedpan. She stated she felt overwhelmed because multiple residents rang the call bell at the same time, and she had never worked with Resident #86 before. All other nursing staff were busy. NA #1 stated she asked Resident #86 politely if he could have a bowel movement in his brief, and she would return to change him. However, she got busy with other residents and forgot to go back to his room before her shift was over at 11:00 PM. She indicated that she now knew what she said to Resident #86 was wrong, and she was suspended for 1.5 weeks during the investigation. Upon return, she received one on one education related to dignity/respect.	F0550		

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F0550 SS = D	Continued from page 3 An interview was conducted with NA #2. She revealed that she worked during the overnight shift on 3/28/25, and she was interviewed by the Administrator on 3/29/25 due to Resident #86's complaint on 3/29/25. She reported that on 3/28/25 at 11:00 PM, she performed her first rounds and Resident #86 was dry/clean. The Director of Nursing (DON) was interviewed on 7/25/25 at 10:28 AM. She revealed that NA #1 was of a small body frame, and Resident #86 was a larger man, and NA #1 informed her she felt she could not put the resident on the bed pan. The DON stated that NA #1 could have retrieved the nurse on duty to help her with the bed pan. She (the DON) indicated NA #1 should have said, "let me find someone else to assist and will return as soon as I can." NA #1 was suspended, educated, and re-initiated in NA training. An interview was conducted with the Administrator on 7/25/25 at 11:14 AM. He revealed that NA #1 should have told Resident #86 when he rang his call bell on 3/28/25 that she would get help and be right back. She was re-educated on dignity and why what she said was not appropriate. The facility provided the following corrective action plan with a completion date of 4/4/25: - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #86 was told that he should go to the bathroom in his brief by his assigned nursing assistant at approximately 9:30 pm on 3/28/25. Resident #86 was checked on during the overnight shift that began on 3/28/25 by the nursing assistant at 11:00 PM, 1:30 AM, 3:00 AM, and 5:30 AM. Per the nurse and nursing assistant assigned to the resident, the resident did not voice any issues or care needs until 5:30 AM at which point the resident had a bowel movement and activities of daily living care was provided. The resident was interviewed by the Director of Nursing and a grievance form was completed. The resident voiced the Administrator on 4/4/25 he was content with the facility's response according to the grievance form. - Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	F0550		

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F0550 SS = D	Continued from page 4 All cognitively intact residents were interviewed by the Nurse Supervisor and the Manager on Duty by 3/31/25 to ensure they had not been instructed by staff members to use their brief instead of assisting the resident to the bathroom. They were also asked if they felt safe or threatened. Skin checks were performed on cognitively impaired residents by the Nurse Supervisor and the Manager on Duty by 3/31/25 to identify care issues or any skin breakdown that could have been a result of a lack of care. No new issues were found. - Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrator and designees educated all staff on residents' rights pertaining to dignity and respect. Education was initiated on 3/29/25 and completed by 4/3/25, on treating all resident as valued individuals in that help should be provided to maintain health and mental well-being. All new hires will be educated during orientation. Those that could not be educated prior to 4/3/25 were educated by the Director of Nursing via telephone and a signature was obtained upon their next scheduled shift. - Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The decision to take the plan of correction and monitoring to the Quality Assurance Performance Improvement Committee was determined on 3/31/25. The Administrator or designee will complete an interview audit by interviewing 5 random cognitively intact residents weekly to determine if any staff member had refused care when asked, and 5 skin assessments on cognitively impaired residents weekly to identify care issues for 12 weeks. The audits will be presented to and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The Quality Assurance and Performance Improvement Committee may extend the monitoring period or change the plan of correction to ensure compliance. The corrective action plan completion date was 4/4/25. The facility's corrective action plan was verified on 7/25/25 by the following: Interviews and record review verified Resident #86 was provided with incontinence care after NA #1 told him to make a bowel movement in his brief and before 11:00 PM.	F0550		

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F0550 SS = D	Continued from page 5 He did not require further care until 5:30 am. Record review revealed all cognitively impaired residents had skin assessments completed on 3/31/25 and cognitively intact residents were interviewed on 3/31/25 to identify any signs of mistreatment including incidents involving dignity issues. No issues were identified. Interviews with nursing staff revealed they were educated on treating residents with dignity, providing care to residents when they are asked for assistance and immediately reporting resident mistreatment to include incidents involving dignity issues. Record reviews of residents and interviews with cognitively intact residents confirmed weekly audits were completed by the senior management team for the duration of the monitoring period. The compliance date of 4/4/25 was validated.	F0550		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when	F0580		

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F0580 SS = D	Continued from page 6 there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, resident, and Medical Director interviews, the facility failed to notify the physician of a significant change when the resident's feeding tube site was identified by staff as visibly irritated, leaking, and caused the resident pain when touched for 1 of 1 sampled resident reviewed for feeding tube care (Resident #64). Findings included: Resident #64 was readmitted to the facility on 7/10/25 with diagnoses that included gastrostomy status (an artificial opening into the stomach through the abdomen wall to provide nutritional support). Review of Resident #64's physician orders revealed that on 4/5/25 a new order was initiated for nurses to clean the gastronomy tube (g-tube) site with normal saline and then apply a calcium alginate cover with split gauze twice daily until healed. Resident #64's quarterly Minimum Data Set (MDS) assessment dated 4/21/25 revealed that Resident #64 was	F0580		

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F0580 SS = D	Continued from page 7 moderately cognitively impaired and she had a feeding tube. Review of the treatment administration record (TAR) for Resident #64 during the month of July 2025 revealed that Nurse #1 signed off on the order for g-tube site care on 7/23/25. During an interview with Nurse Aide (NA) #3 on 7/24/25 at 8:35 AM, she revealed that during care this morning, Resident #64's g-tube site had a smell and gurgling sounds/movements. The site looked very red, the gauze was saturated, and it needed to be removed during Resident #64's bath that morning. NA #3 stated she told Nurse #1 about her concerns when she observed Resident #64's g-tube site this morning. An observation of Resident #64's g-tube site was conducted in conjunction with an interview on 7/24/25 at 8:40 AM. Resident #64 gave permission to observe her g-tube site. There was a large area of redness (excoriation) indicating irritation on the outer area of the skin fold holding the g-tube. The surgical site could not be seen entirely due to Resident #64's positioning causing a large skin fold holding the g-tube in between. A white discharge was observed leaking causing buildup inside the skin fold. When asked, Resident #64 stated she felt pain when the skin fold was opened, or the red area was touched. There was no gauze surrounding the site. Nurse #1 was interviewed on 7/24/25 at 8:55 AM. She stated that when she cleaned Resident #64's g-tube site on 7/23/25 during the day, she observed an odor like curdled milk from the feeding that leaked. The leaking and odor were new observations. She also noticed redness around the site, which was a daily occurrence for Resident #64, and she did not complain of pain on 7/23/25. Nurse #1 stated she had not had a chance to clean it yet this morning. An interview and observation of Resident #64 were conducted with the ADON on 7/24/25 at 8:59 AM. She revealed that Nurse #1 was the unit manager for the 300-hall, but Nurse #1 would cover the cart if there was a call out. The ADON confirmed the presence of leakage and an excoriated area around the g-tube site. She further confirmed Resident #64 stated the area was painful to the touch. She stated that Nurse #1 should	F0580		

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F0580 SS = D	Continued from page 8 have addressed this concern yesterday and notified the provider on 7/23/25 because the pain, leaking, and discomfort was a significant change. During the interview and observation of the resident with the ADON, Nurse #1 entered Resident #64's room at 9:04 AM. She observed the g-tube site and stated it looked about the same, just not as red as yesterday. Nurse #1 indicated that NA #3 told her earlier that morning the gauze was wet and removed during the bath this morning due to being soiled. She said if she thought there was an issue, she would have notified the provider on 7/23/25. Nurse #2, who worked overnight on 7/23/25 beginning at 11:00 PM, was interviewed on 7/25/2025 at 8:59 AM. She confirmed that the area was red (excoriated) around Resident #64's g-tube site where the gauze was placed and when she administered medications via the tube, the flow machine (a medical device used to allow a controlled liquid flow through a tube) said that it was clogged. However, that did not seem to be the case because she was able to administer the medications and flushes. Nurse #2 stated that she did not look at the actual g-tube surgical opening to assess. Resident #64 had been in and out to the Emergency Department (ED) several times during July due to g-tube site complications, and they sent her back saying it was fine. She stated when she had concerns with the g-tube site in the past, she called the on-call provider, and they suggested for the Medical Director to look at it the next morning. Nurse #2 stated she would have sent Resident #64 out to the ED to be evaluated and ensure the tube feed infusion was sufficient. However, due to her experience with notifying the provider, she stated she notified Nurse #1 (the oncoming day shift nurse on 7/24/25) instead. Nurse #1 told her that she had the same problem with Resident #64's tube feeding site this past week. During an interview with the Director of Nursing (DON) on 7/25/25 at 10:11 AM, she revealed the red skin around the g-tube site had been a chronic issue, and the resident was seen by the wound provider last year. She indicated if Nurse #2 reported an issue to Nurse #1 about Resident #64's g-tube site leaking and being painful to the touch, Nurse #1 should have evaluated the area and notified the Medical Director, who was in the building the morning of 7/24/25. Since Resident #64's g-tube site issue was not a life-threatening emergency, having the oncoming dayshift nurse address	F0580		

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F0580 SS = D	Continued from page 9 it seemed to be appropriate. The Medical Director was interviewed by phone on 7/30/25 at 8:38 AM. He stated that historically, Resident #64 has had issues with her g-tube being replaced. He indicated that he had not seen the g-tube site recently (within the last few months). He stated if there was a new or active concern such as new discomfort/pain/excoriation, he was not made aware. The Medical Director stated he would want to be notified of the concerns observed on 7/23/25 and 7/24/25 because the symptoms could worsen if not addressed.	F0580		
F0602 SS = D	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, staff and resident interviews, Pharmacy Manager and Medical Director interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication for 2 of 3 residents reviewed for misappropriation of property (Resident #96 and Resident #18). The findings included: The facility's Abuse, Neglect, and Exploitation policy last revised on 7/11/24 revealed it was the facility's policy to report all allegations to the Administrator/Abuse Coordinator. The policy further read that the Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. The policy defined misappropriation as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without consent. a. Resident #96 was admitted to the facility on 2/04/25 with diagnoses which included joint replacement surgery. Resident #96 discharged from the facility on	F0602	"Past Noncompliance - no plan of correction required"	

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F0602 SS = D	Continued from page 10 3/03/25. Resident #96 had a physician order dated 2/04/25 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet; give one tablet by mouth every 4 hours as needed for pain for up to 7 days. The order was discontinued on 2/11/25. The Medication Administration Record (MAR) for February 2025 revealed Resident #96 was administered the oxycodone 5 mg tablet on 2/06/25 at 10:25 am for pain by Nurse #3 and was noted as effective. No other doses were documented as administered. A review of Resident #96's prescriptions for schedule II-IV controlled medication revealed hand-written prescriptions for oxycodone 5 mg tablet x 30 tablets were sent to the pharmacy and received at the facility on the following dates in February 2025: 2/06/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff. 2/13/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff. 2/18/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff. 2/24/25 oxycodone 5 mg tablet x 30 tablets were received by the facility staff. b. Resident #18 was admitted to the facility on 4/25/23 with diagnoses which included osteoarthritis, fracture of right ulna (forearm bone), and gout. Resident #18 had a physician order dated 4/30/24 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet, administer 1 tablet every 4 hours as needed for pain. A review of Resident #18's prescriptions for schedule II-IV controlled medication revealed hand-written prescriptions for oxycodone 5 mg tablet x 30 tablets were received at the facility on the following dates in February 2025: 1/31/25 oxycodone 5 mg tablet x 30 tablets were ordered and were delivered to the facility on 2/04/25. 2/12/25 oxycodone 5 mg tablet x 30 tablets were ordered and were delivered to the facility on 2/18/25. 2/18/25 oxycodone 5 mg tablet x 30 tablets were ordered	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE PO BOX 157, NASHVILLE, North Carolina, 27856

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F0602 SS = D	Continued from page 11 and delivered to the facility on 2/24/25. The Medication Administration Record (MAR) for February 2025 revealed Resident #18 was administered the oxycodone 5 mg tablet on the following dates and times: 2/04/25 at 9:41 pm by Nurse #4 and the medication was noted as effective. 2/05/25 at 7:40 pm by Nurse #4 and the medication was noted as effective. 2/11/25 at 8:25 pm by Nurse #4 and the medication was noted as effective. 2/12/25 at 8:24 pm by Nurse #4 and the medication was noted as effective. 2/17/25 at 9:04 pm by Nurse #4 and the medication was noted as effective. 2/24/25 at 7:32 pm by Nurse #4 and the medication was noted as effective. 2/26/25 at 10: 25 am by Nurse #5 and the medication was noted as effective. 2/28/25 at 7:42 pm by Nurse #4 and the medication was noted as effective. An interview was conducted with Resident #18 on 7/25/25 at 1:10 pm. Resident #18 revealed her pain was controlled and she had no issues getting pain medication when needed. Resident #18 stated she did not often have pain and she did not recall a time when she could not get the medication. A review of the initial allegation report revealed the facility became aware of the misappropriation of facility property on 2/28/25 at 12:00 pm when the Director of Nursing (DON) determined narcotic medications were delivered for a resident that no longer had an active physician order. An allegation of diversion of facility drugs was submitted for Resident #96 and Nurse #3 was suspended pending the outcome of the investigation. The Administrator submitted the initial allegation report on 2/28/25 at 2:48 pm. A review of the 5-day investigation report dated 3/06/25 revealed the allegation of diversion of facility drugs was substantiated by the facility and identified two residents (Resident #96 and Resident #18) who were affected. The DON noted the number of narcotic count down sheets (used to record the	F0602		

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F0602 SS = D	Continued from page 12 administration of the medication) and the number of narcotic medication cards that were unaccounted for was 7 in total. Resident #96 was found to be missing 4 medication cards and declining count sheets for oxycodone 5 mg tablets and Resident #18 was found to be missing 3 medication cards and declining count sheets for oxycodone 5 mg tablets. Each medication card contained 30 tablets. Nurse #3 was terminated and reported to the North Carolina Board of Nursing. An attempt to conduct a telephone interview with Nurse #9, who reported the narcotic concern to the DON on 7/25/25 at 3:34 pm was unsuccessful. A telephone interview was conducted on 7/25/25 at 12:33 pm with the Pharmacy Manager who revealed when the facility submitted the hand written prescriptions for the oxycodone 5 mg tablets the orders would be processed and delivered to the facility with the next pharmacy delivery unless the prescription was ordered too early, in which case it would be sent when next available. The Pharmacy Manager stated that when narcotics were delivered to the facility the medication would have a narcotic count down sheet for each 30 pack of tablets sent and the receiving nurse would have to sign the delivery sheet that the medication was received. The Pharmacy Manager reported the pharmacy was notified of the missing narcotics, confirmed the narcotics were not returned to pharmacy, and assisted the facility with their investigation. An interview was conducted with the Medical Director on 7/25/25 at 3:07 pm who revealed he previously had left a few signed blank prescription slips at the facility for emergency use, normally with the DON or Assistant Director of Nursing (ADON). The Medical Director stated he no longer provided the facility with the signed blank prescription slips since he was able to electronically submit prescriptions to the pharmacy at any time for the needs of the residents. The Medical Director stated Nurse #3 was previously employed by the facility as the ADON before she returned as a staff nurse, but he was unable to confirm when Nurse #3 obtained the signed blank prescription slips to order narcotics from the pharmacy for Resident #96 and Resident #18. During an interview on 7/25/25 at 11:47 am with the Director of Nursing she revealed that Nurse #9 who reported a concern regarding Resident #96's narcotics due to finding a declining count sheet on the floor at the nursing station. The DON stated she began an investigation on 2/28/25 and found that Resident #96's oxycodone had been ordered several times after the	F0602		

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F0602 SS = D	Continued from page 13 order was discontinued. The DON stated that during the investigation the facility determined that Resident #18 also had multiple prescriptions sent to the pharmacy for oxycodone 5 mg tablets and based on the medication administration documentation and interview, Resident #18 had not taken the oxycodone pain medication often enough to require multiple prescriptions. The DON stated she spoke with Resident #18 upon identification of the findings and Resident #18 stated she did not use the pain medication often but she had no concerns regarding her pain management or availability of the medication. The DON stated Nurse #3 was interviewed when she identified that the handwriting on the oxycodone prescriptions for both residents belonged to Nurse #3 and she stated Nurse #3 initially denied all suspicions and was suspended until the investigation could be completed. The DON stated that after Nurse #3's suspension, Nurse #3 contacted the DON and admitted that she wrote the prescriptions and took the medications from the facility. The DON stated the investigation determined that the ordered narcotics as well as the narcotic count down sheets for Resident #96 and Resident #18 were removed from the facility upon delivery by Nurse #3. The DON stated Nurse #3 ordered the medications on days that she worked so they would be delivered to the facility before she ended her shift and removed the narcotics from the medication carts along with the declining count sheets so there was no way of tracking the medications. The DON stated they were unable to locate any of the ordered narcotics or count down sheets at the facility and she confirmed with the pharmacy that the narcotics ordered for Resident #96 and Resident #18 were not returned. The DON stated Nurse #3 was terminated and she was reported to the North Carolina Board of Nursing (NCBON) for diversion of narcotics. The Administrator was interviewed on 7/25/25 at 3:43 pm who revealed when the facility became aware of the possible drug diversion the facility immediately reported the allegation to the appropriate authorities and initiated a full investigation. The Administrator stated the DON was responsible for the investigation and determined that Nurse #3 had written the prescriptions and removed Resident #96's and Resident #18's ordered oxycodone from the facility when the medications were delivered. Upon discovery of the occurrence, the facility implemented the following quality assurance measures: On 2/28/25 it was determined that there were narcotics delivered to a resident that no longer had an order for	F0602		

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F0602 SS = D	Continued from page 14 the medications. The medications were not in the facility and had not been returned to the pharmacy. On 2/28/25 the DON contacted the pharmacy and obtained copies of the written prescriptions that had been faxed from the facility fax machine and the investigation conducted. A root cause analysis was completed and it was determined that there was no system in place to ensure medications were actually received on delivery and the facility had no system to ensure medications and declining count sheets were removed from the cart appropriately. The decision to monitor the system for receipt of narcotics and removal of medication and count down sheets from medication carts was made on 3/06/25 by the Administrator and Director of Nursing and was presented to the Quality Assurance Performance Improvement (QAPI) Committee on 3/06/25 during an Ad-Hoc (as needed) meeting. The facility provided the following corrective action plan with completion date of 3/07/25. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/28/25 The Director of Nursing (DON) interviewed the identified residents regarding pain medication administration, pain medication availability, and pain management with no identified concerns. On 2/28/25 the Regional Director of Clinical Services initiated a review of the pharmacy delivery tickets and conducted an interview with the Nurse that was scheduled on the dates the prescriptions were faxed to the pharmacy. The Nurse (Nurse #3) was interviewed and suspended pending further investigation. On 2/28/25 at 1:00 pm the Administrator notified law enforcement of the reasonable suspicion of a crime. On 2/28/25 at 2:48 pm the Administrator submitted the initial allegation report to the State Agency regarding diversion of facility drugs.	F0602		

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F0602 SS = D	Continued from page 15 On 3/03/25 at 11:04 am the DON submitted information to the North Carolina Board of Nursing (NCBON) regarding Nurse #3 and diversion of narcotics. On 3/03/25 the Administrator educated the Medical Director not to provide any staff members, nursing administration included, with signed blank prescription slips at the facility. On 3/06/25 the Administrator notified the Department of Social Services regarding misappropriation of resident property. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/28/25 the DON searched each nursing station for any signed blank prescriptions with no issues identified. The DON posted information at each nursing station that no pre-signed prescriptions were to be used by nursing staff. On 2/28/25 the DON completed a pain assessment for all cognitively impaired residents in the facility; the pain assessments were documented in the electronic health record. No issues were identified during the assessments. On 2/28/25 The DON interviewed all cognitively intact residents in the facility regarding pain medication availability, administration of pain medication, and pain management. There were no negative findings from the interviews. On 3/05/25 the Regional Director of Clinical Services conducted an audit of all narcotic delivery tickets from 2/01/25 through 3/02/25 and compared to declining count sheets to ensure each medication delivered to the facility was accounted for. The negative findings included a total of 9 declining count sheets and 9 missing medication cards were identified. Upon further investigation in coordination with the Pharmacy it was determined that in total the facility had 7 missing medication cards and declining count sheets for 2 identified residents. The 7 missing medications and declining count sheets were for the medication oxycodone 5 milligram tablets and were ordered for	F0602		

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F0602 SS = D	Continued from page 16 Resident #96 and Resident #18. The pharmacy was contacted and confirmed there were no documented returns for the missing 7 medication cards and the medications were not located at the facility throughout the investigation. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 2/28/25 the DON implemented a new narcotic count sheet which required the nurses to enter specific details about medications delivered and the details as to when the medication was removed from the medication cart, which would include any narcotic medication brought in by a resident or family upon admission. On 2/28/25 the DON initiated education to all nursing staff which included the newly developed narcotic count sheet, implementation that two nurses are required to sign and validate the narcotic medication and the count sheet were added to the medication cart upon delivery, only administrative nurses will remove completed or returned narcotic from the medication cart and book, and that no nurse was to fill out a pre-signed hard script (prescription). This education was completed on 3/05/25. On 2/28/25 the DON initiated facility wide education on the Abuse policy which included misappropriation of resident property. The education was completed on 3/06/25. Education will be done by the DON or designee at orientation for all new hire nurses on the process of receiving and removing narcotic medication. All new hire staff will be educated on the Abuse policy including misappropriation of resident property upon orientation to the facility. No staff member will be allowed to work until the education has been received and verbalize understanding. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. To ensure ongoing compliance the DON or designee will review the pharmacy delivery tickets 5 times per week for 12 weeks to ensure each narcotic that was delivered to the facility was added to the medication cart correctly.	F0602		

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F0602 SS = D	Continued from page 17 The DON or designee will review the narcotic log book 5 times per week for 12 weeks to ensure each card that was removed from the medication cart was listed correctly on the narcotic count sheet and was validated by the DON or designee. The DON or designee will conduct 2 pain interviews for cognitively intact residents and 2 pain assessments on cognitively impaired residents weekly for 12 weeks. Any issues identified during the monitoring process will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee which consists of the DON, Administrator, Assistant DON, Social Worker, Admissions Coordinator, Activity Coordinator, Minimum Data Set (MDS) Nurse, and the Medical Director. The audits will be reviewed monthly for 3 months by the QAPI team and the plan will be changed or audits extended to ensure ongoing compliance. The alleged date of compliance was 3/07/25. The facility's corrective action plan was verified on 7/25/25 by the following: A random narcotic count sheet and narcotic medication card reconciliation review was conducted with no identified concerns. The review of the receipt and removal of the narcotic medication audits to date revealed no identified concerns. A record review was completed of the staff signature logs for the education with no concerns identified. Record review of resident interviews with cognitively intact residents and pain assessments for cognitively impaired residents confirmed weekly audits were completed to date. Interviews were conducted with random residents who were prescribed narcotic pain medication with no concerns identified regarding pain management. Interviews with nursing staff revealed they were educated on receipt of pharmacy order, the process to add newly received narcotics to the medication cart, and removal of narcotics to be completed by nursing administration. Interviews with staff confirmed education was conducted regarding abuse and misappropriation of resident property. The compliance date of 3/07/25 was validated.	F0602		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)	F0628		

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F0628 SS = B	Continued from page 18 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628		

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F0628 SS = B	Continued from page 19 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F0628		

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F0628 SS = B	Continued from page 20 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F0628		

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F0628 SS = B	Continued from page 21 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to notify the Ombudsman in writing of an unplanned discharge to home for 1 of 3 residents reviewed for discharge (Resident #68). In addition, the facility failed to notify the Resident Representative in writing of the reason for the transfer/discharge to the hospital and failed to provide a copy of the bed hold policy to the resident and Resident Representative for 3 of 4 residents reviewed for hospitalization (Resident #5, Resident #36, and Resident #54). The findings included:	F0628		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE PO BOX 157, NASHVILLE, North Carolina, 27856

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F0628 SS = B	Continued from page 22 1. Resident #68 was admitted to the facility on 6/02/25. The Discharge Against Medical Advice (AMA) form dated 6/16/25 revealed Resident #68 was signed out from the facility by the Responsible Party (RP) against medical advice. The Discharge Against Medical Advice form was signed by the Director of Social Services. The Ombudsman Notification for June 2025 (a list residents that was provided to the Ombudsman to notify of resident transfers/discharges that occurred from 6/1/25 through 6/30/25) revealed Resident #68's AMA discharge from the facility on 6/16/25 was not included in the notification information sent to the Ombudsman. During an interview on 7/24/25 at 8:53 am the Director of Social Services revealed she did not notify the Ombudsman of Resident #68's AMA discharge to home. The Director of Social Services stated that she notified the Ombudsman of transfers to the hospital only and not any residents that discharged home. An interview was conducted with the Administrator on 7/24/25 at 2:59 pm who revealed the Director of Social Service was responsible to notify the Ombudsman of transfers from the facility but he was not sure if that included residents that discharged home. 2. Resident #5 was admitted to the facility on 6/24/2025. The discharge Minimum Data Set (MDS) assessment dated 7/10/2025 revealed Resident #5 was independent with daily decision making. A review of Resident #5's progress notes revealed he was discharged to the hospital on 7/10/2025 and had not readmitted to the facility. Review of Resident #5's medical record revealed no documentation Resident #5, or his Resident Representative received written notification of the reason for his transfer/discharge to the hospital or received a copy of the bed hold policy. Multiple attempts made to contact Resident #5's Representative were unsuccessful. An interview was completed on 7/24/2025 at 3:24 pm with Nurse #4. The Nurse stated she completed Resident #5's hospital discharge paperwork on 7/10/2025. Nurse #4 revealed she completed the written notification of the	F0628		

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F0628 SS = B	Continued from page 23 reason for transfer/discharge form and the bed hold policy, made a copy of both, sent the original with Resident #5 to the hospital and placed the copies in the medical records bin at the nurse's station for the Medical Records staff member to pick up. The Medical Records staff member was unavailable for interview. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident's representative to review the option to pay to hold a resident's bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents' electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident's medical record. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provided the option of paying the fee to	F0628		

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F0628 SS = B	Continued from page 24 hold the resident's bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident's electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy. 3. Resident #36 was admitted to the facility on 7/26/2023. The quarterly MDS assessment dated 6/19/2025 revealed Resident #36 was independent with daily decision making. A review of Resident #36's progress notes revealed she was discharged to the hospital on 6/19/2025 and was readmitted to the facility on 6/21/2025. Review of Resident #36's medical record revealed no documentation Resident #36, or her Resident Representative received written notification of the reason for her transfer/discharge to the hospital or received a copy of the bed hold policy. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident's representative to review the option to pay to hold a resident's bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents' electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies	F0628		

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F0628 SS = B	Continued from page 25 were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident's medical record. The Medical Records staff member was unavailable for interview. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provide the option of paying the fee to hold the resident's bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident's electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy. 4. Resident #54 was admitted to the facility on 6/26/2025. The MDS assessment dated 7/1/2025 revealed Resident #54 was cognitively intact. A review of Resident #54's progress notes revealed she was discharged to the hospital on 7/9/2025 and was readmitted to the facility on 7/15/2025. Review of Resident #54's medical record revealed no documentation Resident #54, or her Resident Representative received written notification of the reason for her transfer/discharge to the hospital or received a copy of the bed hold policy. An interview was completed on 7/24/2025 at 1:45 pm with Resident #54. Resident #54 stated she was unable to recall if she received a copy of the bed hold policy when she discharged to the hospital on 7/9/2025. An interview was completed on 7/24/2025 at 4:05 pm with Nurse #10. The Nurse was unable to recall if she completed Resident #54's transfer paperwork on 7/9/2025. Nurse #10 revealed she sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital when a resident transferred to the hospital. Nurse #10 stated she placed copies of those forms in the medical records bin at the nursing station.	F0628		

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F0628 SS = B	Continued from page 26 The Medical Records staff member was unavailable for interview. An interview was completed on 7/23/2025 at 3:48 pm with the Social Worker. The Social Worker revealed she did not send any written notification or bed hold policy information to residents or their representatives. The Social Worker stated the nurses sent the bed hold policy and written notification of transfer/discharge to the hospital when a resident was transferred to the hospital. The Social Worker revealed she used to get a copy of the written notification of reason for transfer/discharge to send to the Resident Representative but no longer did. The Social Worker was unable to state why she stopped getting copies of the notifications. An interview was completed on 7/23/2025 at 3:52 pm with the Business Office Manager. The Business Office Manager stated she was responsible for contacting the resident's representative to review the option to pay to hold a resident's bed while they were admitted into the hospital. The Business Office Manager stated she did not document these discussions in the residents' electronic medical record. An interview was completed on 7/25/2025 at 1:51 pm with the Director of Nursing (DON). The DON revealed nursing staff sent a copy of the bed hold policy and written notification of the reason for transfer/discharge to the hospital. The DON stated nursing also made copies of these forms and placed them in the medical records bin at the nursing station. The DON stated the copies were retrieved the next day and all discharges were discussed during the daily morning clinical meeting. The DON verified the Social Worker attended this meeting. The DON revealed the Medical Records staff member scanned the forms into the resident's medical record. An interview was completed on 7/25/2025 at 1:43 pm with the Administrator. The Administrator stated the bed hold policy was sent with the residents when they were transferred to the hospital. The Administrator revealed the Business Office Manager contacted the Resident Representative the following day to review the bed hold policy and provide the option of paying the fee to hold the resident's bed while they were admitted to the hospital. The Administrator stated it was his expectation that the Business Office Manager document in a resident's electronic medical record discussions with Resident Representatives or a resident regarding the bed hold policy.	F0628		

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F0628 F0656 SS = B SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F0628 F0656		

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F0656 SS = D	Continued from page 28 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan for 1 of 5 residents reviewed for psychotropic medications (Resident #2). The findings included: Resident #2 was admitted to the facility on 2/15/24 with diagnoses that included vascular dementia. Review of a physician's order dated 7/9/25 revealed an order for Olanzapine 2.5 milligrams (MG), take 1 tablet by mouth at bedtime. (Olanzapine is an antipsychotic medication used to treat mental health conditions and regulate your mood, behaviors and thoughts) The Quarterly Minimum Data Set (MDS) Assessment dated 7/11/25 indicated Resident #2 had severe cognitive impairment and received antipsychotic medication on a routine basis. Review of Resident #2 's Comprehensive Care Plan dated 10/29/24 and revised 7/11/25 contained no information or interventions regarding antipsychotic medications. An interview conducted with the MDS nurse on 7/24/25 at 10:00 AM. The nurse was observed to review Resident #2's care plan and stated it must have been an oversight that Resident #2 was not care planned for the antipsychotic medication. On 7/25/25 at 3:55 PM an interview was conducted with the Administrator who stated he expected that antipsychotics would be included in the resident's care plan.	F0656		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	"Past Noncompliance - no plan of correction required"	

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F0755 SS = D	Continued from page 29 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Pharmacy Manager, and Medical Director interviews, the facility failed to have effective systems in place for the inventory of controlled substances which resulted in a narcotic medication being ordered for a resident that did not have a physician order and the medication being diverted from the facility for 1 of 3 residents reviewed for misappropriation of resident's property (Resident #96). The findings included: Review of the Inventory Control of Controlled Substances Policy last revised 8/01/24, read in part "a facility representative should regularly check the inventory records to reconcile inventory". The policy further noted this process should include current and discontinued inventory of controlled substances to the log used in the facility's-controlled medication inventory system. Resident #96 was admitted to the facility on 2/04/25 with diagnoses which included joint replacement surgery. Resident #96 discharged from the facility on 3/03/25.	F0755		

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F0755 SS = D	Continued from page 30 Resident #96 had a physician order dated 2/04/25 for oxycodone (an opioid pain medication) 5 milligram (mg) tablet; give one tablet by mouth every 4 hours as needed for pain for up to 7 days. The order was discontinued on 2/11/25. A review of Resident #96's hand-written prescriptions for schedule II-IV controlled medication and the prescription manifest (log of medications received at the facility) confirmed prescriptions for oxycodone 5 mg tablet x 30 tablets per medication card were received at the facility after the physician order was discontinued on 2/13/25, 2/18/24, and 2/24/25. A telephone interview was conducted on 7/25/25 at 12:33 pm with the Pharmacy Manager who revealed when the facility submitted the hand written prescriptions for Resident #96's oxycodone 5 mg tablet the order was processed and delivered to the facility. The Pharmacy Manager stated the written prescriptions received from the facility were considered a physician order and she stated the pharmacy staff were not responsible to confirm that there was an active order in the facility electronic health record prior to processing the order for Resident #96. The Pharmacy Manager stated the facility was responsible for the management the medication once it was delivered to the facility. During an interview on 7/25/25 at 3:07 pm the Medical Director revealed that in the past he had left a few signed blank prescription slips at the facility with the DON or ADON for emergency use only when he was unable to be reached or unable to provide a prescription for resident medication. The Medical Director stated Nurse #3 was previously employed by the facility as ADON before she returned as a staff nurse recently, but he was unable to confirm when Nurse #3 obtained the signed blank prescription slips to order narcotics from the pharmacy for Resident #96 without his knowledge. During an interview on 7/25/25 at 11:47 am with the Director of Nursing she revealed the facility did not have a process in place to make sure that narcotic medication that was delivered to the facility was put in the medication cart and verified as current order. She stated the nurses would sign for the medication and then put the pharmacy manifest (delivery sheet) in a bin in the medication storage room but there was not a process in place for reviewing to make sure the medications were correct, that the order was confirmed, and that the medication was in the cart. The DON stated Nurse #3 was interviewed when she identified that the handwriting on the oxycodone prescriptions for Resident	F0755		

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F0755 SS = D	Continued from page 31 #96 belonged to Nurse #3. The DON stated Nurse #3 was suspended until the investigation could be completed and that Nurse #3 later contacted her and admitted that she wrote the prescriptions for Resident #96's oxycodone and took the medications from the facility. The DON stated Nurse #3 was terminated and she was reported to the North Carolina Board of Nursing (NCBON) for diversion of narcotics. The Administrator was interviewed on 7/25/25 at 3:43 pm who revealed the facility was unable to confirm how Nurse #3 obtained the signed blank prescriptions to order the medication for Resident #96. The Administrator stated the DON was responsible for the investigation and determined that Nurse #3 had written the oxycodone prescriptions for Resident #96 after the order was discontinued and that Nurse #3 had taken the medication from the facility. Upon discovery of the occurrence, the facility implemented the following quality assurance measures: On 2/28/25 it was determined that there were narcotics delivered to a resident that no longer had an order for the medications. The medications were not in the facility and had not been returned to the pharmacy. On 2/28/25 the DON contacted the pharmacy and obtained copies of the written prescriptions that had been faxed from the facility fax machine and the investigation conducted. A root cause analysis was completed and it was determined that there was no system in place to ensure medications were actually received on delivery and the facility had no system to ensure medications and declining count sheets were removed from the cart appropriately. The decision to monitor the system for receipt of narcotics, confirmation of active orders, and the removal of the medication and count down sheets from medication carts was made on 3/06/25 by the Administrator and Director of Nursing and was presented to the Quality Assurance Performance Improvement (QAPI) Committee on 3/06/25 during an Ad-Hoc (as needed) meeting. The facility provided the following corrective action plan with a completion date of 3/07/25. 1. Address how corrective action will be accomplished for those residents found to have been affected by the	F0755		

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F0755 SS = D	Continued from page 32 deficient practice. On 2/28/25 The Director of Nursing (DON) interviewed the identified resident regarding pain medication administration, pain medication availability, and pain management with no identified concerns. On 2/28/25 the Regional Director of Clinical Services initiated a review of the pharmacy delivery tickets and conducted an interview with the Nurse that was scheduled on the dates the prescriptions were faxed to the pharmacy. The Nurse (Nurse #3) was interviewed and suspended pending further investigation. On 2/28/25 at 1:00 pm the Administrator notified law enforcement of the reasonable suspicion of a crime. On 2/28/25 at 2:48 pm the Administrator submitted the initial allegation report to the State Agency regarding diversion of facility drugs. On 3/03/25 at 11:04 am the DON submitted information to the North Carolina Board of Nursing (NCBON) regarding Nurse #3 and diversion of narcotics. On 3/03/25 the Administrator educated the Medical Director not to provide any staff members, nursing administration included, with signed blank prescription slips at the facility. On 3/06/25 the Administrator notified the Department of Social Services regarding misappropriation of resident property. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/28/25 the DON searched each nursing station for any signed blank prescriptions with no issues identified. The DON posted information at each nursing station that no pre-signed prescriptions were to be used by nursing staff. On 2/28/25 the DON completed a pain assessment for all cognitively impaired residents in the facility; the pain assessments were documented in the electronic health record. No issues were identified during the assessments.	F0755		

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F0755 SS = D	Continued from page 33 On 2/28/25 The DON interviewed all cognitively intact residents in the facility regarding pain medication availability, administration of pain medication, and pain management. There were no negative findings from the interviews. On 2/28/25 the DON started a review of all current narcotic delivery tickets in the pharmacy management system and the pharmacy website to ensure the delivered narcotics were for residents with active orders, no other concerns were identified. On 3/05/25 the Regional Director of Clinical Services conducted an audit of all narcotic delivery tickets from 2/01/25 through 3/02/25 and compared to declining count sheets to ensure each medication delivered to the facility was accounted for. The delivery tickets were also reviewed by the Regional Director of Clinical Services to ensure that all narcotic delivery tickets from 2/01/25 through 3/2/25 were written for prescribed narcotics and were for active orders. The only narcotic delivered to the facility for a resident without an active order were for the affected resident, Resident #96. The pharmacy was contacted and confirmed there were no documented returns for the ordered medication and the medication was not located at the facility throughout the investigation. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 2/28/25 the DON implemented a new narcotic count sheet which required the nurses to enter specific details about medications delivered and the details as to when the medication was removed from the medication cart, which would include any narcotic medication brought in by a resident or family upon admission. On 2/28/25 the Director of Nursing initiated an audit tool for review and confirmation of all narcotic delivery tickets in the pharmacy management system and the pharmacy website to ensure the delivered narcotics were for residents with active orders. On 2/28/25 the DON initiated education to all nursing staff which included that no nurse was to fill out a pre-signed hard script (prescription) for resident medications and the process for the newly developed narcotic count sheet. Education also included the implementation that two nurses are required to sign and	F0755		

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F0755 SS = D	Continued from page 34 validate the narcotic medication and the count sheet were added to the medication cart upon delivery, only administrative nurses will remove completed or returned narcotic from the medication cart and book, and that the narcotic delivery tickets were to be returned to the DON or designee for review and confirmation of resident active orders. This education was completed on 3/05/25. Education will be done by the DON or designee at orientation for all new hire nurses on the process of ordering, receiving, and removing narcotic medication. All new hire staff will be educated on the Abuse policy including misappropriation of resident property upon orientation to the facility. No staff member will be allowed to work until the education has been received and verbalize understanding. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. To ensure ongoing compliance the DON or designee will review the pharmacy delivery tickets and the pharmacy management system 5 times per week for 12 weeks to ensure each narcotic that was delivered to the facility was added to the medication cart correctly and the delivered narcotic was for residents with an active order. The DON or designee will review the narcotic log book 5 times per week for 12 weeks to ensure each card that was removed from the medication cart was listed correctly on the narcotic count sheet and was validated by the DON or designee. The DON or designee will conduct 2 pain interviews for cognitively intact residents and 2 pain assessments on cognitively impaired residents weekly for 12 weeks. Any issues identified during the monitoring process will be reviewed by the Quality Assurance Performance Improvement Committee which consists of the DON, Administrator, Assistant DON, Social Worker, Admissions Coordinator, Activity Coordinator, Minimum Data Set Nurse, and the Medical Director. The audits will be reviewed monthly for 3 months by the QAPI team and the plan will be changed or audits extended to ensure ongoing compliance. The alleged date of compliance was 3/07/25. The facility's corrective action plan was verified on	F0755		

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F0755 SS = D	Continued from page 35 7/25/25 by the following: A random narcotic count sheet and narcotic medication card reconciliation review was conducted with no identified concerns. A random pharmacy manifest log and active order review was completed with no identified concerns. A record review was completed of the staff signature logs for the education with no concerns identified. The review of the receipt and removal of the narcotic medication audits to date revealed no identified concerns. The narcotic delivery and active order audit was reviewed with no identified concerns to date. Record review of resident interviews with cognitively intact residents and pain assessments for cognitively impaired residents confirmed weekly audits were completed to date. Interviews were conducted with random residents who were prescribed narcotic pain medication with no concerns identified regarding pain management. Interviews with nursing staff revealed they were educated on receipt of pharmacy orders, the process to add received narcotics to the medication cart and to return the pharmacy delivery sheet to the DON after the medication was received. The nursing staff also confirmed that education was provided to not use any signed blank prescriptions for any resident medication needs and that removal of all narcotics from the medication carts was to be completed by nursing administration. Interviews with staff confirmed education was conducted regarding abuse and misappropriation of resident property. The compliance date of 3/07/25 was validated.	F0755		
F0842 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.	F0842		

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F0842 SS = D	Continued from page 36 §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; (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.	F0842		

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F0842 SS = D	Continued from page 37 §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 interviews, the facility failed to maintain an accurate medication administration record for 1 of 5 residents reviewed for medication administration (Resident #36). The findings included: Resident #36 was admitted to the facility on 7/26/23 with diagnoses that included seizures. 1a. Review of a physician order dated 5/1/24 revealed Lamotrigine 200 milligrams (mg) was to be administered two times a day for seizures. (Lamotrigine is an anticonvulsant medication used to treat and prevent seizures) Review of Resident #36's June Medication Administration Record (MAR) revealed no documentation of Resident #36's receiving her 8:00 PM dose of Lamotrigine on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, and 6/18/25. 1b. Review of a physician order dated 5/1/24 revealed Phenobarbital 60 mg was to be given at bedtime for seizures. (Phenobarbital is a barbiturate derivative medication used to treat seizures) Review of Resident #36's June MAR revealed no documentation of Resident #36's receiving her 8:00 PM dose of Phenobarbital on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, and 6/18/25.	F0842		

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F0842 SS = D	Continued from page 38 During an interview with Nurse #10 on 7/24/25 at 3:29 PM she stated she was familiar with Resident #36 and worked with her often. Nurse #10 reported Resident #36 usually came to the medication cart to request her evening medications after dinner. Nurse #10 stated there were no issues with Resident #36 refusing her medications. Nurse #10 stated she had administered Resident #36's seizure medications in the evening on 6/2/25, 6/4/25, 6/10/25, 6/11/25, 6/12/25, 6/17/25, 6/18/25. Nurse #10 stated medication administration documentation should have been completed when the medication was given. Nurse #10 stated she had missed the documentation because her assignment was "heavy" and busy. Nurse #10 further indicated she had met the Director of Nursing (DON) (6/19/25) and the missing documentation was brought to her attention. Nurse #10 further stated she was educated by the DON on how to go back into the MAR to complete the missing documentation. Nurse #10 stated she thought she had fixed the missing documentation. An interview was conducted with the DON 7/24/25 at 4:25 PM. The DON stated she went to Nurse #10 on 6/19/25 when she reviewed Resident #36's MAR and saw the missing documentation. The DON stated she educated Nurse #10 on how to edit the MAR to complete the missing documentation. The DON stated she expected that all medications administered would be documented in the MAR. She further stated if the medication was administered and the documentation was missed, she expected the employee would amend the MAR to reflect the administration of the medication. An interview was conducted with the Administrator on 7/25/25 at 3:53 PM. The Administrator stated he expected that all medication doses given would be documented. The Administrator further stated he expected that when missing documentation was brought to staff's attention the missing documentation would have been corrected.	F0842		