STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/21/25 through 04/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # F38011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 04/21/25 through 04/24/25. Event ID# F38011. The following intakes were investigated NC00216256, NC00216304, NC00220453, NC00220546, NC00224783, NC00227033 NC00227117, NC00228184, and NC00229521. 3 of 16 complaint allegations resulted in deficiency. Intake NC00229521 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.45 at tag F760 at a scope and severity of (J). CFR 483.25 at tag F689 at a scope and severity of (G). The tag F760 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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

Electronically Signed | 05/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Medical Director, resident and staff interviews, the facility failed to provide care in a safe manner when staff were assisting a resident (Resident #34) with left side weakness and vascular dementia with incontinent care. The resident was rolled onto her left side then left in her bed unattended with the side rails down. Resident #34 was unable to "hold herself up" and she fell off the side of the bed onto the floor. The resident sustained a laceration to her nose, bruises to her face, and was transferred to the hospital for treatment. She received medical glue to the laceration on her nose, and a hospital CT (computed tomography) scan revealed the resident had suffered a fractured nose due to the fall. The resident was discharged back to the facility on 4/12/25. Resident #34 stated that this was the worst fall she had suffered and was more painful than the birth of her children. This was reviewed for 1 of 3 residents (Resident #34) for the prevention of accidents. Findings Included: Resident #34 was admitted to the facility on 5/16/17 with diagnosis that included hemiplegia (paralysis) and hemiparesis (partial weakness) affecting the left non-dominant side and vascular dementia. Review of a quarterly Minimum Data Set (MDS)	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 2	F 689		

assessment dated 2/26/25 revealed Resident #34 was cognitively intact and had been assessed as being dependent on staff for all activities of daily living and was frequently incontinent of bladder and bowel. Resident #34 was also assessed as requiring bed rails to assist with bed mobility.

Review of a nursing progress note written by Nurse #3 dated 4/12/25 revealed Resident #34 rolled out of bed while her gown was being changed by Nursing Assistant (NA) #1. Siderails on the bed were down. Resident #34 was lying face-down on the floor beside the bed. Moderate amount of bleeding from a laceration to the bridge of her nose. Pressure bandage was applied to the nose and bruising evident on the face. Resident #34 complained of pain in left hip and her head. Resident #34's Responsible Person (RP) was contacted, and she stated a desire to have Resident #34 go to the Emergency Room (ER). Nurse Practitioner (NP) notified. Resident #34 was alert and oriented x4, denied dizziness or nausea. Emergency Management System (EMS) called. Resident #34 left the facility via stretcher with EMS in stable condition. Report called to hospital ER charge nurse.

Review of fall incident report written by Nurse #3 dated 4/12/25 revealed Resident #34 rolled out of bed while her gown was being changed by NA #1. Siderails were down and Resident #34 was lying face down on floor beside the bed. Moderate amount of bleeding from a laceration to the bridge of Resident #34 nose, pressure bandage applied. Bruising evident to Resident #34 face and complaints of pain to left hip and head. RP notified and stated her desire for Resident #34 to be sent to ER. NP also notified. Resident #34 was alert and oriented x4 and denied any loss of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 3	F 689		

consciousness, dizziness, or nausea. EMS was called and Resident #34 left facility via stretcher with EMS in stable condition. Report was called to ER nurse.

Review of a hospital discharge summary dated 4/12/25 revealed Resident #34 from a local skilled nursing facility, non-ambulatory, was receiving personal care and apparently fell from the bed into the floor. She sustained a significant nasal laceration (deep cut on top of nose), bruises to her face and was brought to the Emergency Department (ED) where she was found to have a fractured nasal bridge. Glue was placed for nasal laceration. Resident #34 was discharged back to the skilled nursing facility in stable and improved condition with orders to follow-up with primary care physician.

Review of a nursing progress note written by Nurse #3 dated 4/12/25 revealed Resident #34 returned from ER via EMS at 6:40 AM in stable condition and alert and oriented X4. Neurological checks remain at baseline. Per report from the hospital ER charge nurse, Resident #34's CT scans were negative for head and neck fractures. Fractured nasal bridge with laceration (glued at ER). No new orders received, follow up with NP. Resident #34 was instructed to leave bed in a low position and call for assistance.

Attempted an interview with Nurse #3 and was unsuccessful.

Review of physician progress note written by the NP dated 4/12/25 revealed Resident #34 was being seen for follow-up from fall out of bed requiring visit to ER. Resident #34 had a fractured nose, laceration on forehead, entire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 4	F 689		

face black and purple, eyes, lips, and nose all swollen. At time of assessment, Resident #34's pain was controlled, mentation intact, and no neurological deficits noted. Resident #34's vitals were also stable, and breathing was within normal limits. NP ordered pain medication every four hours as needed, nose spray, and cold compresses as needed to face. RP was at bedside and aware of the incident and NP noted no other concerns at this time.

Review of NP order for Resident #34 dated 4/12/25 revealed the following:
Hydrocodone Acetaminophen 5/325 milligrams (MG) 1 tablet by mouth every 4 hours as needed for treatment of pain.
Flonase nasal spray 1 spray in each nostril two times per day for edema (swelling)
Cold compress to face every 4 hours as needed for edema

Attempted an interview with NP and was unsuccessful.

Review of fall incident statement provided by Resident #34 dated 4/12/25 revealed Resident #34 rang her call light and NA #1 came in and assisted with her care and noted her brief and gown were wet. NA #1 changed her brief and went to get her gown out of the closet. NA #1 returned, and Resident #34 stated she was going to fall, and she proceeded to roll off of the left side of the bed into the floor. Resident #34 stated her bed rails were down at the time of the fall.

Review of fall incident statement written by NA #1 dated 4/12/25 revealed on 4/12/25 at 2:30 AM, NA #1 provided routine care for Resident #34. Upon entering Resident #34's room observed bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 5	F 689		

rails were down and assumed was her preference during care. NA #1 elevated Resident #34's bed and began care by rolling Resident #34 onto her left side. As care progressed, NA #1 removed Resident #34's brief and pad and recommended changing her gown. NA #1 proceeded to get Resident #34's gown and her weight began to take her over the left side of the bed resulting in her fall.

A telephone interview was conducted with NA #1 on 4/24/25 at 6:08 PM revealed he was familiar with Resident #34 and provided her care the morning of 4/12/25. He stated that on 4/12/25 around 2:30 AM, he went into Resident #34's room to answer her call-light and she informed him that both her brief and gown were wet, and she needed to be changed. He revealed he elevated Resident #34's bed to right above waist level, rolled her onto her left side and provided Resident #34 incontinence care by cleaning and changing her brief. NA #1 stated he left Resident #34 rolled over onto her left side facing the window, walked over to her closet on the opposite side of the room by the door to get her a clean gown to change into. He revealed as he was coming back towards Resident #34's bed he heard Resident #34 say "I'm falling" and observed her weight take her over the side of the bed and she fell into the floor between the bed and the air conditioner on the wall. He stated he immediately went to the nurse's desk and informed Nurse #2 of the fall and she and Nurse #3 responded to Resident #34 room and began providing treatment he believed to her nose which was bleeding. NA #1 stated Resident #34 did have quarter bed rails that were not raised, and he was later informed that her bed was also not locked. NA #1 also stated the incident was an accident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 6	F 689		

and human error on his part and that he had since been re-educated on incontinence care, making sure assistive devices such as bed rails were being used, and making sure resident beds were locked.

Attempted an interview with Nurse #2 and was unsuccessful.

Review of fall incident statement provided by Nurse #2 dated 4/12/25 revealed on 4/12/25 NA #1 informed her and Nurse #3 that Resident #34 had fallen while in the middle of changing her. When Nurse #2 arrived at Resident #34's room, she was on the left side of the bed (on floor) face down. Nurse #3 assessed Resident #34 while Nurse #2 started pressure to the bleeding areas. Resident #34 stated "I was trying to grab the rail and went over, it was an accident, it wasn't his fault." Resident #34 was lifted off the floor to her bed, was alert and talking. Nurse #2 stayed with Resident #34 until EMS arrived.

An interview and observation with Resident #34 was conducted on 4/23/25 at 2:30 PM and revealed a couple of weeks ago she had suffered a fall from her bed during incontinence care and broke her nose. She stated during the middle of the night she had "wet" herself through her brief and gown and used her call light to ask for staff assistance. She revealed NA #1 came into her room to answer her call light and she informed him she needed to be changed and that her gown was also wet and needed to be changed. Resident #34 stated NA #1 elevated her bed to about his waist and began changing her brief. She revealed after NA #1 finished changing her brief, he then went over to her closet located on the other side of her room to get her a clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 7	F 689		

gown. She stated when NA #1 went to get her new gown she was still rolled over onto her left side in bed facing the window and as NA #1 was coming back towards the bed with her gown was when she fell off the side of the bed onto the floor between the bed and the air conditioner and broke her nose. Resident #34 stated she was 85 years old, and this was the worst fall she had ever suffered and was more painful than the birth of her three children. Observation of Resident #34 revealed laceration to the top of the nose which appeared scabbed over, faint bruising to both sides of nose and underneath both eyes, and faint bruising on top of both the right and left hand.

An interview was conducted with the Medical Director on 4/23/25 at 2:47 PM revealed he was not as familiar with Resident #34 and believed his NP was notified of Resident #34's fall. He stated to his knowledge NP followed up with Resident #34's fall and fractured nose on 4/12/25 after her return from the hospital. The Medical Director revealed based on Resident #34's diagnosis of muscle weakness and being left alone while rolled onto her side with nothing to hold up her weight could have contributed to her fall. He stated staff should follow guidelines to ensure all residents were safe while receiving care.

An interview was conducted with the Physical Therapy Assistant (PTA) on 4/24/25 at 1:45 PM revealed she was familiar with Resident #34, had provided her with therapy services off and on since her admission. She stated Resident #34 had been referred to therapy due to her most recent fall and was currently receiving therapy services for strengthening and movement for her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 8	F 689		

left-sided weakness. She revealed Resident #34 had minimal use of her left side, wore a splint on her left hand during waking hours and a palm guard during her sleeping hours to prevent contracture of the left hand. Quarter rails had been applied to the bed for assistance with bed mobility, and bed placed in lowered position to assist with any falls. The PTA stated any residents could be considered a fall risk while left alone in their bed and rolled onto their side. Staff should not walk off or leave any residents alone in their beds while rolled onto their sides while providing care. She revealed Resident #34 being left alone and rolled onto her weaker side with nothing to assist her with holding up her weight could have contributed to her fall.

An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 4:07 PM revealed she was familiar with Resident #34. The DON stated she received a telephone call on the morning of 4/12/25 from Nurse #3 stating Resident #34 had fallen off the bed during incontinence care, had bleeding from her nose, bruises to her face, was complaining of pain, the on-call physician had been notified, and they were sending Resident #34 out to the ER for further treatment. She revealed she contacted the Administrator, and the Administrator went into the facility on 4/12/25 and initiated the investigation of the fall. She stated her understanding of the fall was that NA #1 had gone into Resident #34's room to assist with incontinent care and after providing her initial care had gone to the closet to get Resident #34 a clean gown and upon his return to the bed was when Resident #34 fell. The DON revealed Resident #34 was sent to the ER and did return with a fractured nose that was treated with ice packs and pain medication and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 9	F 689		

other CT scans to her head, neck, hands, and knees were negative for any further injury. She stated Resident #34 had quarter bed rails to assist with her bed mobility that were not raised, and her bed was not locked prior to care. She revealed she believed Resident #34's fall occurred due to human error and oversight on NA #1's part and since the incident all staff had been educated on incontinence care and assuring all resident beds were locked and assistive devices in place prior to providing care.

An interview was conducted with the Administrator on 4/24/25 at 5:17 PM revealed she was familiar with Resident #34. The Administrator stated on the morning of 4/12/25 she received a telephone call from the DON about Resident #34's fall during incontinence care and that she was being sent out to the ER for further evaluation. She revealed she went into the facility on 4/12/25 to begin the investigation on the fall and received statements from NA #1, Nurse #2 and Resident #34 once she returned from the ER. The Administrator stated she also had nursing staff to complete audits on all other residents with assistive devices making sure they were intact during resident care, all resident beds were locked, and that education with staff on incontinence care including audits of staff providing incontinence care was initiated. She revealed her understanding of the fall was that NA #1 had gone into Resident #34's room to provide incontinence care and while NA #1 was retrieving a gown for Resident #34 to be changed into she fell into the floor between her bed and the wall. The Administrator stated Resident #34's bed rails were not raised, and her bed was not locked while NA #1 was providing her care. She revealed Resident #34 was sent out to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 10	F 689		

hospital ER immediately and CT scan was performed showing her nose was fractured but no other injuries were found. She stated Resident #34 did return to the facility that same day and was seen by the NP who ordered ice packs and pain medication for treatment. The Administrator revealed she believed the incident with Resident #34 was due to human error and oversight on the part of NA #1 and that all staff have been re-educated on incontinent care and making sure residents were not left alone during care, assistive devices including bed rails are in place and all resident beds are locked prior to performing resident care.

The facility provided the following Corrective Action Plan with a correction date of 4/15/25:

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

Certified Nursing Assistant #1 was performing incontinence care on 04/12/25 and changing Resident #34's gown while she was in bed and the quarter rails were not in a raised position. CNA #1 assisted Resident #34 to turn and the bed was not locked and rolled away from the wall and Resident #34 rolled out of bed onto the floor between bed and wall. Resident #34 was assessed by nurse, Provider and Resident #34's responsible party was notified on 4/12/2025. Resident #34 was sent to hospital on 4/12/2025 for evaluation. Resident #34 returned from the hospital on 4/12/2025 and noted to have a nasal bone fracture. Provider assessed upon return on 4/12/2025 and gave orders for ice packs every 4 hours as needed to face for edema, Flonase

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 11	F 689		

nasal spray 1 spray in each nostril two times per day for edema and Hydrocodone acetaminophen 5/325 milligrams every 4 hours as needed for pain. Resident #34 continued to complain of pain and on 4/14/205 Provider ordered chest, thoracic, lumbar, bilateral hands and right knee x rays. Results of x rays were all negative. CNA #1 was suspended by the Director of Nursing on 4/12/205 pending investigation.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

The Director of Nursing and or Designee audited current residents who use side rails to ensure they were up while residents were in bed and assessed if the residents still required or requested side rails. This audit was completed on 4/14/2025. The Director of Nursing and or Designee audited current beds in the facility to ensure they were locked. This audit was completed on 4/14/2025. No areas of concern were identified.

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

To prevent this from happening again the Director of Nursing and or Designee started education on 4/12/2025 for nursing staff including Agency Nursing staff currently working in facility to ensure residents safety during care when resident is in the bed, including not leaving resident unattended while turned in the bed and if walking away from the resident to ensure resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 12	F 689		

is in a safe position and any assistive devices needed are in place and that the bed is locked prior to providing care. Examples, Bed rails for positioning, pillows and or wedges. This education was provided to all certified nursing assistants by the Director of Nursing and or Designee, also included safe handling during Bed Mobility to include not leaving resident unattended while turned in the bed and if walking away from the resident to ensure resident is in a safe position, adjusting bed to proper height, stand on side of bed to which the resident will roll, Position arms/legs appropriately; position residents arm, which is closest to you, out to the side of their body, flex the resident knee furthest from you, position residents furthest arm across their chest and roll resident towards you by placing one hand behind the residents shoulder and the other on their hip, The Director of Nursing and or Designee observed with return demonstration incontinent care, turning and repositioning in bed and bed mobility with all certified nursing assistants to ensure they were competent. These observations were completed by 4/14/2025. Nursing staff not currently working in facility were educated via phone or in person by the Director of Nursing and or Designee by 4/14/205 and will not be allowed to work until they have received this education. Any Nursing staff on leave or paid time off will be provided the education prior to working their next shift by the Director of Nursing and or Designee. The Director of Nursing has list of any nursing staff that are on leave or paid time off that need this education prior to working. This education will be provided in new hire orientation for nursing staff. Agency nursing staff will receive this education prior to working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 13	F 689		

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

To monitor and maintain compliance starting 4/17/2025 the Director of Nursing and or Designee will observe care being provided to 5 residents weekly for 8 weeks and monthly for 1 month to ensure residents safety during care when resident is in the bed, including not leaving resident unattended while turned in the bed and if walking away from the resident to ensure resident is in a safe position and any assistive devices needed are in place and that the bed is locked prior to providing care.

The Administrator and Director of Nursing discussed Resident #34's incident on 4/13/2025 and determined the need to have an ADHOC Quality Assurance Process Improvement (QAPI) meeting. ADHOC QAPI was held on 4/14/2025 with the Interdisciplinary team to discuss the incident with Resident #34 and educate the team on the interventions that were put into place to prevent further incidents. The Medical Director was notified by the Director of Nursing via phone on 4/14/2025 regarding the incident and the interventions that were put in place for Resident #34 and the plan of correction to prevent further incidents and or accidents.

The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and or Designee during the QAPI meeting for the next 3 months to ensure sustained compliance. If noncompliance is identified during these three months, immediate correction, re-education of staff members and an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 689	Continued From page 14	F 689		

ADHOC QAPI meeting will be held to address the noncompliance and make recommendations for adjustments to the plan. The Administrator and Director of Nursing will ensure the corrective action plan is implemented.

Date of Compliance: April 15, 2025

On 4/24/25, the facility's corrective action plan effective 4/15/25 was validated by the following: Observations of residents being provided incontinence care, assistive devices being used during care including bed rails, and resident beds being in a locked position while in use with no issues or concerns noted. Nursing staff interviews revealed they had received education on providing incontinent care to residents safely, making sure all assistive devices for residents used while in bed or during care were present, and resident beds were locked prior to providing care. Administrative staff interviews revealed they provided staff education on ensuring resident safety, assistive devices were in place and resident beds were locked prior to performing resident care. Administrative staff completed return demonstrations with staff and were also completing weekly audits of resident care to ensure safety of residents during care, positioning of residents during care, resident assistive devices are present and being used correctly, and resident beds are locked prior to providing care. Auditing tools and documents were reviewed from the Facility Quality Assurance and Performance Improvement (QAPI) committee meeting minutes of the audit results.

The facility's action plan was validated to be completed as of 4/15/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, family, and physician interviews, the facility failed to ensure oxygen was delivered at the prescribed rate (Resident #86). This deficient practice occurred for 1 of 3 residents reviewed for respiratory care and services. Findings included: Resident #86 was admitted to the facility on 04/17/2025. Resident #86 had diagnoses which included myoneural disorder (a neuromuscular disorder which leads to progressive muscle weakness and paralysis which affects breathing). Review of the Electronic Medical Record (EMR) revealed a physician order for Resident #86 dated 04/17/2025 at 10:17 AM for oxygen at 3 liters per minute (LPM) via nasal cannula (NC) continuously to relieve hypoxia. Review of the baseline care plan dated 04/17/2025 revealed Resident #86 was receiving oxygen at 3 liters per minute (LPM) via nasal cannula (NC) continuously to relieve hypoxia.	F 695	F 695 Respiratory Services •Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The Director of Nursing audited oxygen for Resident #86 to ensure it was set to 3L/NC per orders on 4/24/2025. The Director of Nursing educated the nurse assigned, that Resident #86 had oxygen ordered at 3L/NC and to ensure her oxygen is set to 3L/NC and that Certified Nursing Assistants are not to apply, adjust, or change out oxygen tanks on 4/24/2025. The Director of Nursing educated the Certified Nursing Assistant assigned that CNA's cannot apply, adjust or change out oxygen tanks for any residents on 4/24/2025. To identify like residents the Director of Nursing /Designee completed a 100% audit of all residents with orders for	5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 695	Continued From page 16 Resident #86's 5-Day Minimum Data Set (MDS) assessment was in progress and not yet completed. Review of the Brief Interview for Mental Status (BIMS) dated 04/17/2025 revealed Resident #86 was cognitively intact. An observation of Resident #86 was completed on 04/21/2025 at 11:53 AM. Resident #86 was in her room sitting up in her wheelchair with her nasal cannula in her nostrils and her portable oxygen tank was set at 2 LPM. On 04/22/2025 at 11:55 AM Resident #86 was observed lying in bed with her NC in her nostrils and the oxygen concentrator was set at 1.5 LPM. An additional observation of Resident #86 was made on 04/22/2025 at 4:03 PM. Resident #86 was in her room sitting up in her wheelchair with her NC in her nostrils and the portable oxygen tank was set at 1.5 LPM. Resident #86 was observed to not be in distress. An interview was conducted with Resident #86 on 04/22/2025 at 4:04 PM. Resident #86 stated she had been on oxygen since she was hospitalized with a severe respiratory illness about a year ago. Resident #86 also stated she does not adjust the oxygen flow rate on her oxygen concentrator or the portable oxygen tank. Resident #86 stated the nursing staff take care of her oxygen settings. An observation of Resident #86 was conducted on 04/23/2025 at 11:06 AM. Resident #86 was in her room sitting up in her wheelchair with her NC in her nostrils and her portable oxygen tank was set at 2 LPM. Resident #86 was observed to not	F 695	oxygen to ensure they were on prescribed liters of oxygen per orders. This audit was completed 4/4/29/25. No negative findings were noted. To prevent this from happening again the Director of Nursing/Designee reeducate all Licensed Nurses to ensure residents are receiving the correct liter of oxygen per orders, that oxygen is physicians order and unlicensed staff are not allowed to adjust, apply or change oxygen tanks. The Director of Nursing/Designee education all Certified Nursing Assistants that only Licensed Nurses are allow to apply, adjust or change out oxygen tanks, this education will be completed on 4/24/25. All Agency Licensed Nurses, Medication Aides and Certified Nursing Assistants will received this education prior to working their first shift. This education will be provided in orientation to newly hired Licensed Nurses, Medication Aides and Certified Nursing Assistance. To monitor and maintain on going compliance the Director of Nursing /Designee will audit 5 residents with orders for oxygen weekly for 4 weeks and 2 resident weekly for 8 weeks to ensure residents are on correct liters of oxygen per orders. The Director of Nursing/Designee will interview 3 licensed staff per weekly for 12 weeks to ensure only Licensed Nurses are applying, adjusting or changing out oxygen tanks for residents. Results of the audits will be submitted to the QAPI committee monthly for 3 months for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 695	Continued From page 17 be in distress. An interview was completed on 04/23/2025 at 11:10 AM with nursing assistant (NA) #2 who was assigned to Resident #86. NA #2 stated she always made sure the NC was in the resident's nostrils correctly and she checked to make sure the oxygen concentrator was plugged up in the electrical outlet. NA #2 stated she did not do anything with oxygen settings or adjust the oxygen flow rate on the oxygen concentrator or the portable oxygen tank. An interview was conducted on 04/23/2025 at 12:18 PM with Nurse #5 who was assigned to Resident #86 on 04/22/2025 and 04/23/2025. Nurse #5 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the flow rate. Nurse #5 also stated the flow rate should be set as ordered by the physician. Nurse #5 further stated she checks the oxygen flow rate during her morning rounds and medication pass but she had not checked Resident #86's oxygen settings on 04/23/2025. Nurse #5 further explained if a resident got up to the wheelchair, the NA would turn the portable tank on and set the flow rate. An interview was conducted with the Assistant Director of Nursing (ADON) on 04/23/2025 at 12:32 PM. The ADON stated the nurses should check to make residents are receiving the correct oxygen flow rate as prescribed by the physician. The ADON stated the licensed nurses should be managing the oxygen flow rates on the oxygen concentrators and the portable oxygen tanks. The ADON further stated the NAs should not be setting, adjusting, or changing the oxygen flow rates on the oxygen concentrator or the portable	F 695	further review and recommendations. Date of Compliance 5/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 695	Continued From page 18	F 695		

oxygen tanks.

An interview was conducted with the Medical Director on 04/23/2025 at 2:03 PM. The Medical Director stated all residents receiving oxygen required an active physician's order for the prescribed LPM of oxygen they were to receive. The Medical Director further stated nursing staff should follow the physician's orders for providing oxygen including the prescribed flow rate.

An interview was conducted with NA #3 on 04/24/2025 at 9:00 AM. NA #3 stated the nurses were supposed to adjust the flow rate of oxygen for residents and turn on the oxygen concentrator and the portable oxygen tanks.

An interview was conducted with NA #4 on 04/24/2025 at 9:45 AM. NA #4 stated he did set the oxygen levels on portable oxygen tanks when changing residents from the oxygen concentrator to the portable oxygen tank or if the portable oxygen tank was empty and he needed to replace it with a full tank. NA #4 further explained he usually looked at the settings on the oxygen concentrator for the correct liters and he would set the portable oxygen tank to the same oxygen flow rate as the oxygen concentrator.

An interview was conducted with the Director of Nursing (DON) on 04/24/2025 at 3:53 PM. The DON stated she expected the nursing staff to check the physician's order for the prescribed oxygen flow rate and check to make sure residents were receiving the correct oxygen flow rate. The DON further explained she expected the nursing staff to provide oxygen at the prescribed flow rate as ordered by the physician. The DON explained the NAs should not adjust

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 695	Continued From page 19 the flow rate on the oxygen concentrators or the portable oxygen tanks. The DON further explained the NAs should leave the resident on the oxygen concentrator and the nurse should switch the resident over to the portable oxygen tank and set the flow rate as ordered by the physician. The DON also stated oxygen was considered a medication, and the licensed nursing staff should follow the physician's order for the prescribed oxygen flow rate, ensure residents were receiving the correct flow rate of oxygen, and make any adjustments or changes to the flow rate. An interview was conducted on 04/24/2025 at 4:58 PM with the Administrator. The Administrator stated she expected the nursing staff to follow the physician's order for providing oxygen including the correct flow rate and only the licensed nurses should set, adjust, or change the oxygen flow rate based on the physician's order.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 732	Continued From page 20 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain daily posted staffing sheets for 134 of 385 days (9/21/2024-12/31/2024, 1/4/2025, 1/5/2025, 1/11/2025, 1/12/2025, 1/18/2025, 1/19/2025, 1/25/2025, 1/26/2025, 2/1/2025, 2/2/2025, 2/8/2025, 2/9/2025, 2/15/2025, 2/16/2025, 2/22/2025, 2/23/2025, 3/1/2025, 3/2/2025, 3/8/2025, 3/9/2025, 3/15/2025, 3/16/2025, 3/22/2025, 3/23,2025, 3/29/205, 3/30/2025, 4/5/2025, 4/6/2025, 4/12/2025, 4/13/2025, 4/19/2025, 4/20/2025) reviewed for daily posted staffing information.	F 732	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F732: Staff Posting The Director of Nursing implemented a new process and filing system for staff posting and daily staffing assignments sheets on 4/24/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 732	Continued From page 21 The findings included: Review of the daily posted staffing sheets for September 2024 revealed no information was available for the days of 9/21/2024- 9/30/2025 Review of the daily posted staffing sheets for October 2024 revealed no information was available for the days of 10/1/2024- 10/31/2024. Review of the daily posted staffing sheets for November 2024 revealed no information was available for the days of 11/1/2024- 11/30/2024. Review of the daily posted staffing sheets for December 2024 revealed no information was available for the days of 12/1/2024- 12/31/2024. Review of the daily posted staffing sheets for January 2025 revealed no information was available for 1/4/2025, 1/5/2025, 1/11/2025, 1/12/2025, 1/18/2025, 1/19/2025, 1/25/2025, 1/26/2025. Review of the daily posted staffing sheets for February 2025 revealed no information was available for 2/1/2025, 2/2/2025, 2/8/2025, 2/9/2025, 2/15/2025, 2/16/2025, 2/22/2025, 2/23/2025. Review of the daily posted staffing sheets for March 2025 revealed no information was available for 3/1/2025, 3/2/2025, 3/8/2025, 3/9/2025, 3/15/2025, 3/16/2025, 3/22/2025, 3/23,2025, 3/29/205, 3/30/2025. Review of the daily posted staffing sheets for April 2025 revealed no information was available for 4/5/2025, 4/6/2025, 4/12/2025, 4/13/2025,	F 732	The Director of Nursing audited the last 2 weeks of staff postings to ensure they were completed 7 days per week and were filed appropriately on 4/29/2025 On 4/29/25, The DON educated the Scheduler on the new process and filing system for staff posting and daily assignment sheets, this education also included that staff posting is required to be posted 7 days per week. The Nursing Home Administrator educated the Interdisciplinary Team on staff posting is required to be posted 7 days per week on 4/29/2025. The NHA added to check for daily staff posting to the Weekend Manager on Duty checklist. This education will be added to orientation for any newly hired schedulers and IDT members. To monitor and maintain compliance the DON and or Designee will audit that the staff posting sheet is posted 7 days per week and is filed appropriately per the new process weekly for 12 weeks. Any areas identified will be corrected immediately. Results of audits will be submitted to the QAPI committee the next 3 months for further review and recommendations. Alleged Compliance date: 5/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 732	Continued From page 22	F 732		

4/19/2025, 4/20/2025.

An interview was conducted with the scheduler on 4/24/2025 at 10:56 am revealed the scheduler started in the position in January of 2025. The scheduler stated she had been trained by the previous scheduler and received help from the Director of Nursing and Assistant Director of Nursing. The scheduler was not aware daily posted staffing sheets had to be completed on the weekends and verified no posted daily staffing sheet had been completed on the weekends since she had worked as the scheduler. The scheduler was not aware daily posted staffing sheets had to be kept for 18 months. The scheduler thought there had been daily posted staffing sheets for September through December 2024 but they were not able to be located.

During an interview with the Director of Nursing (DON) on 4/24/2024 at 1:10 pm the DON stated the scheduler was responsible to complete and maintain the daily posted staffing sheets. The DON stated there was not a designated staff member to complete daily posted staffing sheets on the weekends. The DON stated the former scheduler and Assistant Director of Nursing had helped to train the new scheduler. The DON was aware the daily posted staffing sheets needed to be completed every day and maintained for 18 months.

During an interview on 4/24/2025 at 2:18pm the Administrator stated the scheduler was responsible for the daily posted staffing sheets. The Administrator expected the daily posted staffing sheets to be completed daily and maintained for 18 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 23	F 760		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Director and Consulting Pharmacist interviews, the facility failed to prevent a significant medication error when Nurse #1 administered 30 units of insulin glargine (a long acting insulin that lasts for 24 hours and does not have a peak of onset) intended for Resident #31 to Resident #16. Resident #16 did not have a diagnosis of diabetes or a physician's order for insulin. Resident #16 was assessed by the Nurse Practitioner (NP) and immediately started on intravenous (IV) dextrose (a solution that contains sugar) fluids for 24 hours. The NP also ordered finger stick blood sugars every hour for 24 hours with instructions to notify the provider if Resident #16's blood sugar was below 90 (Normal range is between 70-99). Resident #16's blood sugar dropped to 61 during the night, Nurse #2 notified the on-call provider and gave Resident #16 eight ounces of orange juice and a snack while she waited for a response from the provider. The on-call provider responded and ordered glucagon (a medication used to increase a resident's blood sugar level) 1milligram (mg) and for Resident #16's blood sugar to be rechecked after 15 minutes. Nurse #2 administered glucagon 1mg subcutaneously (SQ) and the blood sugar recheck was 152. Hypoglycemia (defined as a blood sugar level below 70) can be serious and life threatening if gone untreated; symptoms include tremors, palpitations, anxiety, sweating,	F 760	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 24	F 760		

dizziness, weakness, drowsiness, confusion, altered mental status, loss of consciousness, or seizures. There was a high likelihood for serious harm. This was for 1 of 3 residents reviewed for unnecessary medications (Resident #16).

The findings included:

Resident #16 was admitted to the facility on 4/23/2019. Resident #16 did not have a diagnosis of diabetes mellitus.

Resident #16's annual Minimum Data Set (MDS) assessment dated 2/1/25 indicated she was severely cognitively impaired; Resident #16 was coded that she had not received insulin.

Review of Resident #16's physician's orders dated April 2025 revealed no active orders or insulin.
Review of Resident #16's April 2025 Medication Administration Record (MAR) revealed no active orders for insulin glargine.

Review of Resident #31's physician's orders dated April 2025 revealed an active order for insulin glargine inject 30 units SQ every morning for type 2 diabetes mellitus.

Review of Resident #16's medical record revealed a Nurse Practitioner progress note dated 4/14/2025 read in part: Resident #16 was seen today after she was given 30 units of long-acting insulin. No hypoglycemia. She is alert and seated in her wheelchair, conversant. Seated in wheelchair in no acute distress. Plan: Administer D5W (dextrose 5% in water- an infusion used to provide the body with extra water and calories from sugar) at 75 milliliters (ml) an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 25	F 760		

hour for 24 hours. Close monitoring of blood sugar and vital signs, see orders.

Review of Resident #16's physician's orders from the NP for 4/14/2025 revealed the following:

-Monitor blood sugar for 24 hours- check blood sugar every hour- notify NP if blood sugar is less than 90.
-Monitor for signs and symptoms of hypoglycemia- paleness, shakiness, sweating, headache, hunger/nausea, rapid/irregular heartbeat, fatigue, dizziness/lightheadedness, changes in level of consciousness every hour
-Monitor vital signs every hour x 8 hours then every 4 hours x 4
-Condition change charting for 72 hours related to medication error
-D5W at 75 milliliters (ml) /hour for 24 hours
-D5 1/2NS (dextrose 5% in normal saline- an infusion used to provide the body with extra fluids and calories from sugar) at 75ml/hour for 24 hours

The Nurse Practitioner was not available for interview during the survey.

A nursing progress note written by Nurse #1 on 4/14/2025 at 10:08 am revealed she had made a medication error for Resident #16. The note revealed orders received for intravenous (IV) fluids, blood sugar and vitals were to be checked every hour for 24 hours, resident representative had been notified, and blood sugars were 138 and 129.

A telephone interview was conducted with Nurse #1 on 04/23/25 at 9:41 AM. Nurse #1 stated on 4/14/2025 two residents were sitting at the table

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 26	F 760		

in the dining room, and she (Nurse #1) administered insulin to Resident #16, insulin that was ordered for Resident #31. Nurse #1 stated she immediately realized her mistake and reported the error to the NP and received orders to check blood sugars and vitals every hour. Nurse #1 was unsure of the exact amount of insulin she had administered to Resident #16 but stated it was the dose intended for Resident #31. Nurse #1 stated she reported the medication error to the assistant Director of Nursing (ADON) and Director of Nursing (DON) and Resident 16's family member. On 4/14/2025 Nurse #1 was scheduled to work 7am-7pm on a hall she was not normally assigned. Nurse #1 stated she failed to administer the right medication to the right resident when she failed to verify the resident's identity prior to insulin being administered and by administering medication in the dining room and not in the resident's room. Nurse #1 stated as soon as the insulin was administered to Resident #16, Nurse #1 realized Resident #31, who was seated next to Resident #16, was intended to receive the insulin. Nurse #1 stated the medication error was a total mishap, a human error and she was normally more focused. Nurse #1 stated Resident #31 received her insulin as ordered after the medication error with Resident #16.

A nursing progress note written by Nurse #4 on 04/14/2025 at 10:25 am revealed a subcutaneous (SQ) IV was placed in the left lower quadrant of Resident #16's abdomen. D5W was infused at 75 ml per hour for 24 hours.

During a telephone interview on 04/23/25 at 10:49 AM Nurse #4 stated on 4/14/2025 she (Nurse #4) was assigned to Resident #16's hall from 7am to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 27	F 760		

11pm. Nurse #4 was informed that Nurse #1 had administered insulin to Resident #16 who was not a diabetic and did not require insulin. Nurse #4 assessed and monitored Resident #16 through the rest of her shifts on 4/14/2025 and 7am to 3pm on 4/15/2025. Nurse #4 entered the orders received from the NP and checked Resident #16's blood sugar and vital signs every hour as ordered. Nurse #4 stated she did not observe any hypoglycemic episodes while she monitored Resident #16. Nurse #4 stated Resident #16 was alert to self and place, and some of Resident #16's family had visited Resident #16 on 4/14/2025. Nurse #4 stated the NP orders indicated to notify the NP if Resident # 16's blood sugar went below 90. Nurse #4 stated Resident #16's blood sugars had not been below 90 during her shifts. Nurse #4 stated she instructed the nursing assistants to monitor if Resident #16 did not eat well at meals and extra snacks would be given if needed. Nurse #4 stated Resident #16's vital signs remained stable. During a follow up interview on 4/24/2025 at 9:48am Nurse #4 stated Resident # 16 was not able to communicate with a nurse that she was not supposed to receive insulin.

Review of Resident #16's medical record revealed her blood sugar was 61 documented at 12:35 am on 4/15/2025, and 77 documented at 1:13 am on 4/15/2025 by Nurse #2.

Review of a progress written by Nurse #2 on 04/15/25 revealed that she notified the on-call provider and received orders on 4/15/2025 for Glucagon reconstituted solution 1mg injection- give 1milligram (mg) SQ and recheck blood sugar (BS) in 15 minutes related to low blood sugar. And to check blood sugar at hour of sleep if BS is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 28	F 760		

greater than 90 NO rechecks are required.

During a telephone interview on 4/23/2025 at 10:58 am Nurse #2 stated on 4/14/2025 she was scheduled to work 7pm to 7am and received report that Resident #16 had received the insulin by mistake, Resident #16 was not diabetic. Nurse #2 took over care for Resident #16 at 11pm on 4/14/2025. Nurse #2 stated the facility was out of D5W IV fluids, and new orders were received to start D5 1/2NS at 75ml per hour for remainder of the order. Nurse #2 stated Resident #16's blood sugar dropped to 61 around midnight and Resident #16 was given orange juice and a snack while Nurse #2 waited for a response from the on-call NP. Nurse #2 stated she received the order for glucagon 1mg, and it was administered to Resident #16 as ordered. Nurse #2 stated she stayed with Resident #16 for about 2 hours while the blood sugars were low, and Resident #16 remained alert and able to eat the snacks and drink fluids with no signs of hypoglycemia.

During an interview on 4/23/2025 at 1:40 pm the Medical Director stated if a non-diabetic resident received 30 units of long-acting insulin it could cause hypoglycemic events.

During a telephone interview on 4/24/2025 at 12:44 pm the Consulting Pharmacist stated if a non-diabetic resident received 30 units of long-acting insulin it could have caused blood sugars to drop, pain or hypoglycemic issues.

During an interview on 4/24/2025 at 1:10 pm the Director of Nursing (DON) stated she expected nurses not to administer medications in the dining room and for the correct medication to be administered to the correct resident. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 29	F 760		

stated she expected nurses to follow the 6 medication rights which included the right medication, right dose, right route, right rate and the right time for the right resident. The DON stated that the medication error occurred when Nurse #1 administered insulin in the dining room and failed to verify the identity of the resident prior to medication being administered.

During an interview on 4/24/2025 at 2:18pm the Administrator stated she expected the nurses to follow the 6 medication rights when they administer medication.

The Administrator was notified of immediate jeopardy on 4/23/2025 at 4:15 pm.

The facility provided the following corrective action plan with the completion date of 4/17/2025:

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

On 4/14/2025 at 8:34 am Nurse #1 administered Lantus 30 units to Resident #16 who did not have an order for Lantus and immediately reported this to the Director of Nursing and the Provider. The Provider immediately assessed Resident #16 and gave orders to check finger stick blood sugar every hour until 9:00am on 4/15/2025, notify Provider if finger stick blood sugar is below 90 milligrams (mg) per deciliter, Dextrose IV solution for 24 hours and monitor for signs and symptoms of hypoglycemia until 4/15/2025. On 4/14/2025 Provider gave order to monitor Resident #16's vital signs every hour for 8 hours and then vital signs every 4 hours for 16 hours. Resident #16's vital signs remained stable throughout monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 30	F 760		

On 4/15/2025 at 12:30 am Resident #16 finger stick blood glucose was 61 milligrams per deciliter, on call was notified and while awaiting return call Nurse #2 gave 8oz of orange juice and a snack, Resident #16 was alert and oriented with no signs and symptoms of distress. Nurse #2 rechecked Resident #16's finger stick blood glucose at 1:00 am and was 77 milligrams per deciliter, on call Provider returned call at 1:10 am and gave order to administer Glucagon 1mg now times one dose and recheck finger stick blood sugar in 15 minutes. Nurse #2 administered Glucagon 1mg to Resident #16 at 1:15 am and Nurse #2 rechecked Resident #16's finger stick blood glucose at 1:32 am and Resident #16 finger stick blood glucose was 152 milligrams per deciliter. The remaining hourly blood sugar checks were 90 or above.

The Resident #1's Responsible Party was notified of medication error on 4/14/2025 at 10:08am.

Nurse #1 was suspended pending investigation on 4/14/2025. The Director of Nursing contacted the Board of Nursing regarding the medication error on 4/15/2025.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

On 4/14/2025 the Director of Nursing and or Designee reviewed the finger stick blood glucose levels of all residents who require glucose monitoring from 4/13/2025 to 4/14/2025, which captured 24 hours prior to incident to ensure residents had no levels that would indicate signs and symptoms of hypoglycemia. The Director of Nursing and or Designee audited residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 31	F 760		

had active orders for blood glucose monitoring and insulin on 4/14/2025 to ensure the insulin was administered per orders. No concerns were identified.

On 4/15/2025 the Director of Nursing interviewed cognitively intact residents with Brief Interview Mental Status score of 12 or above to ensure they had no concerns with receiving incorrect medications and cognitively impaired residents with Brief Interview Mental Status score below 12 were assessed by the Director of Nursing and or Designee to ensure no signs and symptoms of hypoglycemia were noted. No concerns were identified.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?

To prevent this from happening again the Director of Nursing and or Designee started education on 4/14/2025 for all Licensed Nurses and Medication Aides including Agency Licensed Nurses and Medication Aides currently working in facility on not administering medications in the dining room and to follow the 6 rights of medication administration, to include the medication is administered to the right resident by verifying using the picture of each resident in the electronic health record. Licensed Nurses and Medication Aides not currently working in facility were educated via phone or in person by the Director of Nursing and or Designee by 4/15/2025 and will not be allowed to work until they have received this education. Any Nurse on leave or paid time off will be provided the education prior to working their next shift by the Director of Nursing and or Designee. The Director of Nursing has list of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 32	F 760		

Licensed Nurses and/or Medication Aides that are on leave or paid time off that need this education prior to working. The Director of Nursing was educated on 4/15/2025 by the Regional Director of Clinical Services on ensuring any Licensed Nurse or Medication Aide who is on leave or on paid time off received this education prior to their first shift of working. This education will be provided in new hire orientation for all Licensed Nurses and Medication Aides. Agency Licensed Nurses and/or agency Medication Aides will receive this education prior to working. The Director of Nursing called and spoke with each agencies credentialing and/or education specialist regarding education needed for the medication error plan of correction and sent the facility specific plan of correction education packet to the 2 agencies that provide contract staff to this facility 4/14/2025. The agency ensures the Licensed Nurses and or Medication Aides received this education prior to being scheduled at this facility. The Agencies provided confirmation to the Director of Nursing via individual staff education email that all agency Licensed Nurses and/or Medication Aides had received this education prior to working in facility.

The Director of Nursing educated the Scheduler on ensuring continuity of staff to attempt to keep them on the same assignment as much as possible to prevent medication errors. This education was completed on 4/15/2025.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

To monitor and maintain compliance starting 4/17/2025 the Director of Nursing and or Designee will observe 3 medication passes for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 33	F 760		

Licensed Nurses and/or Medication Aides weekly to include all three shifts for 8 weeks and then monthly for 1 month to ensure medications are administered as ordered.
Starting 4/17/2025 the Director of Nursing and or Designee will observe 5 residents in Dining Room weekly for 8 weeks and then monthly for 1 month to ensure no medications are being passed in the dining room.

The Administrator and Director of Nursing discussed Resident #16's medication error on 4/14/2025 and determined to have ADHOC Quality Assurance Process Improvement (QAPI) meeting. ADHOC QAPI was held on 4/15/2025 with the Interdisciplinary team to discuss the incident with Resident #16 and educate the team on the interventions that were put into place to prevent further incidents. The Medical Director was notified by the Director of Nursing via phone on 4/15/2025 regarding the medication error and the interventions that were put in place for Resident #16 and the plan of correction to prevent the medication errors. The Director of Nursing implemented the plan of correction to prevent medication errors on 4/14/2025. The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and or Designee during the QAPI meeting for the next 3 months to ensure sustained compliance. If noncompliance is identified during these three months, immediate correction, re-education of staff members and an ADHOC QAPI meeting will be held to address the noncompliance and make recommendations for adjustments to the plan. The Administrator and Director of Nursing will ensure the corrective action plan is implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 34	F 760		

On 4/24/25, the facility's corrective action plan effective 4/17/25 was validated by the following: During medication pass observations of licensed nursing staff reviewing residents with an active order for insulin on their electronic medical chart, checking the resident's picture and room number to assure they had the correct resident, and administering the correct dosage of insulin to the correct resident inside their room with no issues or concerns noted. Licensed Nurses and Medication Aide interviews revealed they had received education on 6 rights of medication administration to include checking resident electronic medical chart to ensure resident order for insulin and name, room number, and picture of resident to receive insulin. They were also educated on administering insulin inside resident rooms and not in the dining room during meals and reporting a medication error immediately to their supervisor.

The facility scheduler received education on trying to schedule nursing staff as much as possible to their same assigned halls consistently to help with continuity of care and prevention of medication errors. Administrative staff interviews revealed they provided staff education and completed weekly monitoring audits of ensuring medications including insulin are not being administered in the dining rooms during mealtimes, medication passes for all three shifts to ensure medications including insulin are administered as ordered to the correct resident. Education and Auditing tools were reviewed, with no new issues noted. Documents were reviewed from the Facility Quality Assurance and Performance Improvement (QAPI) committee meeting minutes of the audit results. Medication pass was observed on 4/22/2025 and 4/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 760	Continued From page 35 with 0% error rate. The facility's corrective action plan with an IJ removal date of 04/17/25 was validated. IJ removal date is 04/17/25.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure ready to use dishware was cleaned and dried before being stored, food was dated/labeled in the walk-in freezer, walk-in cooler, and dry goods storage area. This occurred for 1 of 2 kitchen observations. This had the potential to affect food served and distributed to 88 of 88 residents who received an oral diet.	F 812	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 812 Food Procurement, store/Prepare/Serve Sanitary	5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 812	Continued From page 36 The findings included: The initial tour of the kitchen occurred on 04/21/25 at 9:30 AM with the Dietary Manager. The initial observation of the dishware storage area revealed the following: a. Dishware that was ready for use was put away and stacked wet. -4 out of 4 metal serving bins were stacked flat upside down visibly wet with pooled water on the sides and water pooled around the rim. -22 small plastic bowls stacked right side up. 3 out of 22 bowls were observed with small amount of pooled water in the base of the bowls. -2 of 8 clear small plastic dessert bowls were stacked right side up with small amount of pooled water in base of the bowls. b. Dishware that was ready for use was put away/or stacked with food debris/insects on them. -1 of 4 metal serving bins observed with one piece of red food debris dried to the side. -2 of 4 plastic bins observed with visible brown sticky substance to the side and bottom. The substance was dull in appearance and sticky when touched. -1 of 22 small plastic dessert bowls were observed with 2 gnats dead in the bowl in small amount of pooled water. c. Frozen items in the walk-in freezer were observed with no date on packaging. -1 of 1 opened box of frozen green beans observed with no date on box. -1 of 1 opened box of diced green peppers	F 812	Dietary Manager immediately pulled any boxes that were not labeled with date received out of kitchen on 4/21/2025. Dietary manager immediately pulled any dishes that were not stored dry off shelf and rewashed them in dishwasher on 4/21/2025. All residents have the potential to be affected, the Dietary manager completed a 100% audit of the kitchen to ensure all items were labeled and dated on 4/21/2025. The Dietary manager completed 100% audit of all dishes in the kitchen to ensure no items were stored wet. No negatives findings noted. The NHA educated the Dietary Manager on ensuring all items in kitchen were labeled and dated and that no dishes were to be stored wet on 4/21/2025. The Dietary Manager educated all kitchen staff on ensuring all items in kitchen were labeled and dated and that no dishes were to be stored wet on 4/21/2025. This education will be added to orientation for any newly hired Dietary Manager and kitchen staff. To monitor and maintain compliance the Dietary Manager will audit the kitchen weekly for 12 weeks to ensure all items in kitchen were labeled and dated. The Dietary Manager will audit dishes weekly for 12 weeks to ensure no dishes are stored wet. Any negative findings will be corrected immediately. Results of audits will be submitted to the QAPI committee for further review and recommendation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(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 812	Continued From page 37 observed with no date on box. -1 of 1 opened box of French bread observed with no date on box. -1 of 1 opened box of cookie dough observed with no date on box. -1 of 1 opened box of biscuit dough observed with no date on box. d. Opened items in dry good storage area not labeled with opened date/use by date. -2 of 2 bottles of chocolate syrup observed with no date. -2 of 2 opened cereal bags observed with no opened date/use by date label. e. Items in the walk-in cooler were not dated. -1 of 1 box of strawberries observed with no date on box. An interview with the Dietary Manager on 04/22/25 at 1:42 PM revealed she stated that dishware was to be cleaned, dried thoroughly, and stored facing down to prevent pooling water, debris, or insects. She stated food stored in the walk-in freezer, dry goods area, and walk-in cooler should be labeled and dated when opened. An interview with the Administrator 04/23/25 at 2:33 PM revealed she expected food to be labeled and dated, and dishware should be washed, dried thoroughly, and stored before use.	F 812	monthly for 3 months. Date of Compliance: 5/12/2025	