STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0000	INITIAL COMMENTS A complaint investigation was conducted on 05/13/26 through 05/14/26. Event ID #231E2E-H1. The following intakes were investigated: 2999503, 2999387 and 311031. 1 of the 7 complaint allegations resulted in deficiency.	F0000		06/02/2026
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.	F0580	On 04/21/2026 Nurse #1 incorrectly placed an order for subcutaneous fluids into the Electronic Medical Record of the Resident #2. Nurse #1 then started the Sub-Q fluids on Resident #2, realized the error, discontinued the Sub-Q fluids, then started the ordered Sub-Q fluids on the intended resident. The Director of Nursing and the Provider were made aware on 4/24/2026. On 04/24/2026 the Nurse Practitioner was notified and assessed the resident immediately, an abdominal x-ray was obtained and it was determined there were no negative outcomes. The Responsible Party for resident #2 informed the Director of Nursing on 04/24/2026. On 04/24/2026 the facility Administrator visited with resident #2 and discussed options of having a psychological visit by the facility's psych services. Resident #2 declined the initial psych offer but stated that she would like to be seen by psych on the next scheduled visit. Nurse #1 was terminated by the facility on 04/28/2026 for not adhering to the 5 rights of medication administration and for not immediately reported the incident when it occurred on 4/21/2026. On 5/20/2026 the Director of Nursing reviewed all risk events, including medication errors, since 4/21/2026 to ensure the Director of Nursing, the provider and the Responsible Party were notified timely. Any issues identified were corrected by notifying the provider and RP of the incident. No issues were noted.	06/02/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0580 SS = D	Continued from page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when 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 record review and staff and Physician interviews, the facility failed to notify the resident's Physician and Responsible Party when Resident #2 received subcutaneous (administered under the skin) fluids ordered for the roommate (Resident #4), resulting in an error. This error constituted a treatment error that required physician notification. This deficient practice affected 1 of 3 residents reviewed for notification of change (Resident #2). Findings included: Resident #2 was admitted on 9/24/2025 with diagnosis which included end stage renal disease. Review of Resident #2's quarterly Minimum Data Set (MDS) dated 4/2/26 indicated the resident was cognitively intact and received dialysis. Review of Resident #4's electronic health record revealed a physician order dated 4/21/26 at 2:49 PM received by Nurse #1 for sodium chloride 0.9% solution (a mixture of salt and water utilized for hydration) administer one (1) liter of fluid subcutaneously at 70 milliliters per hour one time	F0580	Continued from page 1 On 04/24/2026 the Director of Nursing and/or Designees educated all facility nurses on timely notification of events to the provider and the responsible party. Education began on 04/24/2026 and was completed on 04/28/2026. Nurses that were unable to be educated received the education prior to their next scheduled shift. All newly hired nurses will receive education on timely reporting of events to the provider and the responsible party. To ensure compliance the Director of Nursing or designee will audit all resident risk events 5x week for 12 weeks to ensure the provider and responsible party were notified timely. Any risk events that are identified and not reported to the provider and the responsible party of the affected resident will be reported immediately by the Director of Nursing or designee and the nurse will received immediate re-education and/or progressive disciplinary action. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months.	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0580 SS = D	Continued from page 2 starting at 2:00 PM. A nursing progress note in Resident #2's electronic health record dated 4/24/26 at 2:00 PM written by the Unit Manager revealed that the resident requested to speak with the Director of Nursing regarding an incident on 4/21/26 in which she was stuck in the abdomen and administered subcutaneous fluids that were intended for her roommate (Resident #4). The Nurse Practitioner was made aware of the error. An order was received for an x-ray of the abdomen due to Resident #2 reporting abdominal pain. Review of a written statement by Nurse #1, dated 4/24/26 at 2:26 PM, indicated that she received a verbal order for Resident #4 to receive one liter of normal saline subcutaneously. The statement noted that Nurse #1 wrote the order on a piece of paper and then removed the fluids from the automated secure medication and supply dispensing system under Resident #2's profile and gathered the supplies needed to administer the fluids. According to the statement, Nurse #1 hung the bag of normal saline and initiated a hypodermoclysis infusion (a technique in which fluids are infused via a needle into the subcutaneous tissue) to Resident #2's mid-abdomen. The statement indicated that a short time later, Nurse #1 returned to the nurse's station and saw that her written note reflected that the fluids were ordered for Resident #4, who was Resident #2's roommate. She then went to the resident's room, stopped the infusion, and removed the hypodermoclysis device from Resident #2. The statement further indicated that Nurse #1 obtained a new hypodermoclysis device and initiated the fluids on Resident #4. The statement did not indicate that Nurse #1 informed the Physician, Resident #2 or the resident's responsible party of the error nor did it indicate that the resident was assessed for adverse effects. An interview was conducted by phone with Nurse #1 on 5/13/26 at 3:55 PM. Nurse #1 reported that she was no longer employed at the facility. She stated that on 4/21/26 she received a new order to administer subcutaneous fluids. According to Nurse #1, it was a hectic day, and she felt overwhelmed due to frequent interruptions. Nurse #1 explained that after receiving the order, she gathered the necessary supplies. She stated that she believed the order was for Resident #2 and noted that she often confused Resident #2 and Resident #4, who shared a room. Nurse #1 indicated that she entered the room and initiated the subcutaneous fluids on Resident #2. Nurse #1 stated that a short time later,	F0580		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0580 SS = D	Continued from page 3 she returned to the nurse's station, saw the order on the desk, and realized it was written for Resident #4, not Resident #2. Upon recognizing the error, she returned to the room, discontinued the fluids for Resident #2, and initiated them on the correct resident. Nurse #1 stated that she did not assess Resident #2, nor did she notify the Physician, Resident #2 or Resident #2's responsible party about the error. Nurse #1 stated that she did not report the incident because it was a busy day and she felt overwhelmed. A nursing progress note written by the Director of Nursing (DON) dated 4/24/26 at 5:39 PM indicated Resident #2 and her responsible party requested to speak to the DON regarding a concern. Resident #2 stated that on 4/21/26 a nurse came in and started fluids on her. The nurse came in later and discontinued the fluids. The DON stated that he would investigate. The DON met with the provider that ordered the fluids and informed her of the error. An abdominal x-ray report dated 4/24/26 at 7:20 PM in Resident #2's electronic health record indicated no acute abnormality. A Nurse Practitioner (NP) note dated 4/24/26 indicated that Resident #2 was assessed following an accidental error that occurred on 4/21/26 in which the resident received subcutaneous sodium chloride (normal saline) in error. The amount of fluid infused was unknown. An attempt was made to interview the Nurse Practitioner that was assigned to Resident #1 on 4/21/26. The Nurse Practitioner was no longer employed at the facility and was not available for interview. Resident #2 was in the hospital for a planned medical procedure unrelated to the treatment error on 4/21/26 during the investigation on 5/13/26 and 5/14/26 and was unavailable for interview. An interview conducted by phone with Resident #2's Responsible Party on 5/13/26 at 3:18 PM revealed that she had not been notified of the treatment error that occurred on 4/21/26. She reported that during her visit with the resident on 4/24/26, the resident stated that on 4/21/26 a nurse entered the room, inserted a needle into her abdomen, and initiated fluid administration. The Responsible Party expressed that it was upsetting to learn that an invasive procedure had been performed in error. An interview with the Physician on 5/14/26 at 12:50	F0580		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0580 SS = D	Continued from page 4 PM revealed that she had not been informed of the treatment error in which Resident #2 received fluids that were ordered for Resident #4. She stated that she expected physician-ordered fluids to be administered to the correct resident according to the order. The physician further noted that the provider who issued the order should have been notified of the error immediately for further assessment, monitoring and orders. An interview was conducted with the DON on 5/14/26 at 1:50 PM. The DON reported that on 4/24/26, the Unit Manager informed him that Resident #2 had received fluids in error. The DON stated that Nurse #1 failed to notify the Physician of the error. The DON indicated that it was his expectation that the nurses would notify the Physician and the Responsible Party of errors in resident treatment. The DON stated it was important to notify the Physician to obtain further orders for monitoring.	F0580		06/02/2026
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and the Physician, the facility failed to ensure that subcutaneous (administered under the skin) fluids were administered in accordance with the physician's order for one resident reviewed for parenteral fluid administration (the delivery of fluid through an intravenous, subcutaneous, intramuscular, or mucosal route) (Resident #2). Resident #2 received subcutaneous fluids that were ordered for her roommate, Resident #4. This deficient practice did not result in an adverse outcome. Findings included: Resident #2 was admitted on 9/24/2025 with diagnosis which included end stage renal disease, hypertensive heart disease and diabetes. Review of Resident # 2's quarterly Minimum Data	F0694	On 04/21/2026 Nurse #1 incorrectly placed an order for subcutaneous fluids into the Electronic Medical Record of Resident #2. Nurse #1 then started the Sub-Q fluids on Resident #2, realized the error, discontinued the Sub-Q fluids, then started the ordered Sub-Q fluids on the intended resident. The Director of Nursing and the Provider were made aware on 4/24/2026. On 04/24/2026 the Nurse Practitioner was notified and assessed the resident immediately, an abdominal x-ray was obtained and it was determined there were no negative outcomes. The Responsible Party for resident #2 was aware and present at bedside on 04/24/2026. On 04/24/2026 the facility Administrator visited with resident #2 and discussed options of having a psychological visit by the facility's psych services. Resident #2 declined the initial psych offer but stated that she would like to be seen by psych on the next scheduled visit. Nurse #1 was terminated by the facility on (date) for not adhering to the 5 rights of medication administration and for not immediately reporting the incident when it occurred on 4/21/2026. On 5/20/2026 the Director of Nursing reviewed all intravenous and hypodermoclysis orders since 4/21/2026 with the provider to ensure each order was entered into the electronic medical record correctly. No discrepancies were noted. The Director of Nursing or designee will conduct Medication Administration Observations for all nurses by 5/24/2026 to ensure medications are administered using the 5 rights of medication administration. No	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0694 SS = D	Continued from page 5 Set (MDS) dated 4/2/26 indicated the resident was cognitively intact and received dialysis. Review of Resident # 4's electronic health record revealed a physician order dated 4/21/26 at 2:49 PM received by Nurse #1 for sodium chloride 0.9% solution (a mixture of salt and water utilized for hydration) administer one (1) liter of fluid subcutaneously at 70 milliliters per hour one time starting at 2:00 PM. A nursing progress note in Resident # 2's electronic health record dated 4/24/26 at 2:00 PM written by the Unit Manager revealed that the resident requested to speak with the Director of Nursing regarding an incident on 4/21/26 in which she was stuck in the abdomen and administered subcutaneous fluids that were intended for her roommate. The Nurse Practitioner was made aware of the error. An order was received for an x-ray of the abdomen due to pain. A nursing progress note written by the Director of Nursing (DON) dated 4/24/26 at 5:39 PM indicated Resident #2 requested to speak to the DON regarding a concern. Resident #2 stated that on 4/21/26 a nurse came in and started fluids on her. The nurse came in later and discontinued the fluids. The DON stated that he would investigate. The DON met with the provider that ordered the fluids and informed her of the error. A Nurse Practitioner note dated 4/24/26 indicated that Resident #2 was assessed following an accidental medication error in which the resident received subcutaneous sodium chloride (normal saline) in error. The amount of fluid infused was unknown. According to the note, Resident #2 reported experiencing lower abdominal pain during placement of the hypodermoclysis (a technique used to infuse fluids into the subcutaneous tissue) device. It was documented that Resident #2 had undergone hernia repair surgery on 4/13/26. The plan of care noted that the NP discussed next steps with Resident #2 and agreed to obtain a STAT (immediate) abdominal x-ray due to the recent hernia repair and abdominal tenderness. Review of Resident #2's electronic health record revealed the result of the abdominal x ray dated 4/24/26 at 7:20 PM indicated no acute abnormalities. A Nurse Practitioner progress note dated 4/24/26 at 9:16 PM indicated that the results of Resident #2's abdominal x ray were no acute abnormalities.	F0694	Continued from page 5 abnormal findings. On 04/24/2026 the Director of Nursing and/or Designees educated all facility nurses on the process of ensuring medication orders are entered into the Medication Administration Record per the providers orders and that the administration of such orders are completed on the correct resident by using the photo on the MAR, door tags and/or asking the resident to identify themselves. Education began on 04/24/2026 and was completed on 04/28/2026. Nurses that were unable to be educated received the education prior to their next scheduled shift. All newly hired nurses will receive education on ensuring medication orders are entered correctly and that the nurse is checking the 5 rights of medication administration prior to administering a medication. To ensure compliance the Director of Nursing or designee will conduct 3 medication administration observations weekly for 12 weeks to ensure nurses are administering medications using the 5 rights of medication administration. In addition, intravenous and hypodermoclysis orders will be reviewed by the Director of Nursing and the Provider weekly for 12 weeks to ensure the orders were entered into the electronic medication record correctly. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months.	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0694 SS = D	Continued from page 6 Review of a written statement by Nurse #1, dated 4/24/26 at 2:26 PM, indicated that she received a verbal order for Resident #4 to receive one liter of normal saline subcutaneously. The statement noted that Nurse #1 wrote the order on a piece of paper and then removed the fluids from the automated secure medication and supply dispensing system under Resident #2's profile and gathered the supplies needed to administer the fluids. According to the statement, Nurse #1 hung the bag of fluids and initiated a hypodermoclysis infusion to Resident #2's mid-abdomen. The statement indicated that a short time later, Nurse #1 returned to the nurse's station and saw that her written note reflected that the fluids were ordered for Resident #4, who is Resident #2's roommate. She then went back to the resident's room, stopped the infusion, and removed the hypodermoclysis device from Resident #2. The statement further indicated that Nurse #1 obtained a new hypodermoclysis device and initiated the fluids on Resident #4. An interview was conducted by phone with Nurse #1 on 5/13/26 at 3:55 PM. Nurse #1 reported that she was no longer employed at the facility. She stated that on 4/21/26 she received a new order to administer subcutaneous fluids. According to Nurse #1, it was a hectic day, and she felt overwhelmed due to frequent interruptions. Nurse #1 explained that after receiving the written order, she gathered the necessary supplies. She stated that she believed the order was for Resident #2 and noted that she often confused Resident #2 and Resident #4, who shared a room. Nurse #1 indicated that she entered the room and initiated the subcutaneous fluids on Resident #2. She reported that she did not recall whether Resident #2 questioned the administration of the fluids. Nurse #1 stated that she did not know why the provider had ordered fluids and when she received the order she did not ask the provider what the diagnosis or indication was. Nurse #1 stated that a short time later, she returned to the nurse's station, saw the order on the desk, and realized it was written for Resident #4, not Resident #2. Upon recognizing the error, she returned to the room, discontinued the fluids for Resident #2, and initiated them on the correct resident. Nurse #1 stated that she did not assess Resident #2, nor did she notify the provider, the resident, or the responsible party about the error. She reported that she did not report the incident because it was a busy day and she felt overwhelmed. She indicated that she did not observe any changes in Resident #2's condition that day and did not know how much fluid had infused before the error was discovered. A few days later, according to	F0694		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Shallotte	**237 Mulberry Street , Shallotte, North Carolina, 28459**

(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
F0694 SS = D	Continued from page 7 Nurse #1, the Unit Manager asked about the incident, and she learned that the Director of Nursing had already spoken with the resident and the responsible party. Nurse #1 reported that she provided a written statement to the Director of Nursing and was later terminated The Nurse Practitioner that was assigned to Resident #2 and Resident #4 on 4/21/26 was no longer employed at the facility and was not available for interview. Resident #2 was in the hospital on 5/13/26 and 5/14/26 for a planned medical procedure and was unavailable for interview. An interview with the Physician on 5/14/26 at 12:50 PM revealed that she had not been informed of the error. She stated that she expected physician-ordered fluids to be administered to the correct resident according to the order. She indicated that there was no risk of harm to the resident, as she estimated the amount of fluid administered in error was minimal due to the route and method of administration. An interview was conducted with the Director of Nursing (DON) on 5/14/26 at 1:50 PM. The DON reported that on 4/24/26, the Unit Manager informed him that Resident #2 had received fluids in error. The Unit Manager also notified the DON that the resident's responsible party wished to discuss the incident. According to the DON, Resident #2 stated that on 4/21/26, the nurse entered the room, administered the fluids, later removed the administration device, and then began administering fluids to the other resident (Resident #4) in the room. The DON stated that the nurse was suspended pending the investigation. Following the investigation, Nurse #1 was terminated. The DON indicated that Nurse #1 failed to properly identify the correct resident prior to administering the fluids, and that the error occurred due to misidentification. He stated that he would have expected Nurse #1 to administer the fluids according to the physician's order. The facility provided a plan of correction that was not approved.	F0694		06/02/2026