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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING: _____	R-C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted a follow-up survey and complaint investigation on 02/21/23- 02/22/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 226	10A NCAC 13F .0702(b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to issue an appropriate discharge for a resident (#8) as evidence by not providing documentation the safety of other individuals was in danger.	D 226	Autumn Village shall ensure that Discharge of a Resident is appropriate as well as based on facility's inability to meet the Resident's needs; Resident's health no longer requires the services provided; the safety of other individuals in the facility is endangered; the health of others is endangered; or Resident has failed to pay the cost of services and accomodations by the payment due date. Executive Director (ED) will ensure that Residents at risk for discharge are discussed at the weekly "At-Risk" meeting with the management team to determine if the appropriate plan of care and interventions have been put in place for the Resident. Residents given a discharge notice will be sure to have appropriate notifications and documentation completed including, notification of medical Provider as well as Provider's statement of facility's inability to meet the Resident's needs; documentation of completion of care coordination meeting completed by ED, Resident	4/8/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/3/2023

STATE FORM 6899 — 6GNL11 — If continuation sheet 1 of 15

Teresa A. Floyd 04/10/23 Reviewed and Acknowledged

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D 226	Continued From page 1	D 226	Care Coordinator (RCC), and Responsible Party/ Guardian to discuss plan to attempt to meet the Resident's needs and/or reasons that the facility is unable to meet the Resident's needs in addition to the interventions that have been attempted. The ED will ensure that documentation of the above occurs.	
			ED will complete a Resident Rights in-service for all staff.	4/8/23
			Life Enrichment Coordinator (LEC) will review Resident Rights at the beginning of the monthly Resident Council Meetings to ensure that Residents are aware of their rights, and are comfortable to verbalize any concerns.	4/8/23

The findings are:

Review of Resident #6's FL-2 dated 07/25/2022 revealed:
-The admission date was 04/30/22.
-Diagnoses included COVID-19 virus infection and cellulitis of perineum.
-The resident was semi-ambulatory, used a wheelchair and was continent of bowel and bladder.

Review of Resident #8's discharge notice dated 12/28/22 revealed:
-There was documentation the safety of the resident and other individuals in the facility was endangered.
-The date of discharge was 01/27/2023.

Review of Resident #8's Progress Notes revealed:
-The reason for discharge was non-payment of January 2023 cost of care.
-There was no documentation the facility staff discussed a non-payment issue with the resident prior to 01/24/23.
-There was no documentation Resident #8 was a danger to others in the facility.

Interview with the Administrator on 02/02/23 at 12:00pm revealed:
-Resident #8 was issued a discharge notice for both non-payment and safety issues due to a physical altercation in which the resident hit another male resident in the face.
-The resident had a history of engaging in physical altercations with other residents.

Interview with a medication aide (MA) on 02/02/23 at 12:45pm revealed she had no

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D 226	Continued From page 2 knowledge of a recent incident or a history of physical altercations involving the resident. Interview with the Primary Care Provider (PCP) on 02/22/23 at 4:00pm revealed: -PCP was aware of the resident's discharge from the facility. -The resident was not a danger or threat to others.	D 226		
D 230	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications; (E) the resident's current medications; (F) a record of the resident's vaccinations and	D 230	Autumn Village shall provide sufficient preparation and orientation to Residents to ensure a safe and orderly discharge from the facility. ED will complete a Resident Rights in-service for all staff. 4/8/23 LEC will review Resident Rights at the beginning of the monthly Resident Council meetings to ensure that Residents are aware of their Rights, and are comfortable to verbalize any concerns. 4/8/23 ED will ensure that a copy of a Discharge notice presented to a Resident is also sent to the Ombudsman and Adult Home Specialist. 4/8/23 ED will reach out to AHS for technical assistance in situations when appropriate placement is a challenge to obtain. 4/8/23	

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D 230	Continued From page 3	D 230		

TB screening;
(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:
(A) the regional long term care ombudsman; and
(B) the protection and advocacy agency established under federal law for persons with disabilities.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to issue an appropriate discharge placement for a Resident (#6) as evidence by leaving the Resident at a hotel without any services.

The findings are:

Review of Resident #6's FL-2 dated 07/25/2022 revealed:
-The date of admission was 04/30/22.
-Diagnoses included COVID-19 virus infection and cellulitis of perineum.
-The resident was semi-ambulatory, used a wheelchair and was continent of bowel and bladder.

Review of Resident #6's discharge notice dated 12/28/22 revealed:
-There was no information on planned transfer/discharge location provided.
-The date of transfer/discharge was 01/27/2023.

Review of Resident #6's Progress Notes revealed:
-The Administrator spoke with the resident on 01/24/23 regarding his plan for post discharge.
-The Resident told Administrator that he wanted to go to a hotel.

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-The Administrator assisted the Resident in booking a hotel room for 1/25/23.
-The Administrator informed the Resident that discharge care would not be available due to having a non-permanent address.

Interview with the Long Term Care Ombudsmen on 02/02/23 at 11:06am revealed:
-The Ombudsmen did not receive a discharge notice from the facility for the resident.
-Resident #8 stated facility staff could not locate another placement, so they took him to a hotel and left him there without services.

Interview with the Administrator on 02/02/23 at 12:00pm revealed:
-Resident #8 was issued a discharge notice for both non-payment and safety issues.
-Other facilities were contacted but would not accept the resident for admission due to his non-payment status.
-The resident chose to be discharged from the facility to a hotel.
-She contacted a home health agency regarding services for the resident, but was informed services could not be provided because a hotel is not considered to be a permanent address.
-She assisted the resident in booking a hotel room and provided transportation.

Interview with the Primary Care Provider (PCP) on 02/22/23 at 4:00pm revealed:
-The facility staff informed her Resident #8 was involved in a physical altercation where he hit another resident (not sure of date).
-She was aware of the resident's discharge from the facility.
-She was not aware that the resident was discharged to a hotel.
-She had no concerns in regard to the resident's

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D 230	Continued From page 5 ability to care for himself.	D 230		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record, and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#9, #10, #11) observed during the medication passes including errors with a medication to prevent heart attack and stroke (#9), a rapid-acting insulin used to treat diabetes (#10) and a medication for mild to moderate pain and inflammation (#11). The findings are: The medication error rate was 11% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00am, 11:30am and 12:00pm medication passes on 02/22/23. a. Review of Resident #10's current FL-2 dated 09/28/22 revealed diagnoses included type II diabetes mellitus, anemia, and hypertension. Review of Resident #10's physician's orders dated 11/28/22 revealed:	D 358	Autumn Village shall ensure that the preparation and administration of medications and treatments by staff are according to Provider's orders, which are maintained in the Resident's Record; according to facility's policies and procedures; and according to rule area .1004. Area Clinical Director (ACD) will perform random med pass observations at a minimum of 3 observations per month. Observations will be reviewed with the Med Tech for educational feedback, as well as the RCC and ED. 4/8/23 RCC will ensure "Do Not Crush" list is available on each medication cart for Med Tech use. 4/8/23 ED and RCC will conduct monthly Med Tech meetings to provide ongoing education related to medication administration including Diabetic Education and timing of medications. 4/8/23 This will have clinical oversight of the ACD for guidance. Med Techs will be re-educated and monitored to ensure that they understand the importance of wasting 2 units of insulin prior to dialing the ordered dose when administering insulin via an insulin pen. RCC will pull EMAR compliance 4/8/23	

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D 358	Continued From page 6 -There was an order to check blood sugar and inject Humalog insulin three times per day before meals according to the following sliding scale: 200-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; greater than 400 = 10 units and call primary care provider (PCP). (Humalog is a rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Humalog Kwikpen should be primed with a 2 unit air dose before each use to remove air bubbles from the cartridge and needle that may collect to ensure the pen is working properly. If not primed before each injection, too much or too little insulin may be received. Once the needle is inserted into the skin, the dose knob is to be pushed all the way in and held for a slow count of 5 seconds to allow for full delivery. Humalog insulin is to be injected within 15 minutes before a meal.) Observation of the 11:30am medication pass on 02/22/23 revealed: -Resident #10's blood sugar was 362 at 11:06am. -The medication aide (MA) placed a needle on the Humalog Kwikpen and dialed the dose to 8 units. -The MA injected Humalog insulin into the resident's abdomen at 11:08am and withdrew the needle after 2 seconds. -The MA did not prime the insulin pen by performing the 2 unit air shot to remove any air bubbles and to make sure the insulin was flowing freely. -The MA did not hold the insulin pen in the skin after injecting the needle and pressing the dose knob to allow time for the full amount of insulin to be injected. Observation revealed Resident #10 was served lunch at 11:48am and began eating at 11:50am, 42 minutes after being administered Humalog, a	D 358	reports daily, and review for accuracy and compliance of administration. Reports will be discussed with ED daily in management meeting for any needed follow-up. Med Techs will complete weekly MAR to cart audits per facility schedule to ensure accurate and adequate meds on hand as appropriate. RCC will also complete weekly cart audits for QA to ensure the cart is neat and orderly, and is stocked with appropriate and accurate medications. Completed cart audits will be verified by the ED.	4/8/23

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rapid-acting insulin.

Review of Resident #10's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog Kwikpen. Check blood sugar and inject subcutaneously per sliding scale three times a day before meals at 7:30am, 11:30am, and 5:00pm.
-The sliding scale was 200-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; and greater than 400 = 10 units and call PCP.
-The resident's blood sugar ranged from 66 - 446 from 02/01/23 to 02/22/23.

Observation of Resident #10's medications on hand on 02/22/23 at 1:06pm revealed:
-There was a Humalog Kwikpen with an open date of 02/08/23.
-The instructions on the medication label were to check blood sugars and administer per sliding scale three times per day before meals.

Interview with the MA on 02/22/23 at 1:06pm revealed:
-She was not exactly sure when lunch was served but thought it was served around 11:30am.
-She usually administered insulin 30 minutes before lunch because that was when it "pops up" on the eMAR.
-She had received training on the use of insulin pens several years ago and when she started with this facility in August 2022.
-She had been checked off by the facility's registered nurse (RN).
-She described technique for insulin pen use as place needle, set dial to ordered number of units, and cleanse skin, place injection and hold for 10 seconds.

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-She did not recall being taught to do a 2 unit air shot.
- She thought she held the pen for 10 seconds after administering but said she did not count out the
the 10 seconds.

Interview with Resident #10 on 02/22/23 at 12:52pm revealed:
-Her blood sugars were checked three times daily at about the same time.
-She usually received sliding scale insulin with her blood sugar checks because she liked to snack.
-She had never felt symptoms after receiving insulin while waiting for her meals.
-She denied symptoms of low blood sugar.

Interview with the Lead Supervisor on 02/22/23 at 1:39pm revealed:
-The MAs were trained how to administer insulin using insulin pens by the facility's RN.
-The MAs received 5-hour and 10-hour medication training classes upon hire.
-There were periodic in-services about every 6 months.
-She knew to prime insulin pens using the 2 unit air shot and to hold pen for 10 seconds after injecting to make sure all of the insulin had "gone in".
-The MAs should administer insulin with insulin pens using proper technique to include priming with a 2 unit air shot and to hold in place for 10 seconds.
-She would expect insulin to be administered within 30 minutes of mealtime or the resident's blood
sugar could "bottom out".

Interview with the Administrator on 02/22/23 at

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1:43pm revealed:
-The MAs were trained on proper insulin administration using insulin pens by the RN when hired and
annually.
-The Resident Care Coordinator (RCC) did random observations of the MAs.
-The MAs should use proper technique for insulin administration using insulin pens to include priming using the 2 unit air shot and holding the injection for 10 seconds.

Interview with the Area Clinical Director on 02/22/23 at 1:43pm revealed:
-She did medication cart audits quarterly which includes monitoring insulin administration.
-The facility's policy was rapid-acting insulin should be administered within 15 minutes of meals and if the meal was not ready, the MA should give the resident a snack.
-She trained the MAs on proper insulin administration using insulin pens to include the 2 unit air shot and to hold the pen for 10 seconds.

Telephone interview with Resident #10's PCP on 02/22/23 at 3:40pm revealed:
-The MAs should use proper technique to ensure Resident #10 received accurate doses of insulin.
-If not primed or not held in long enough, the resident may not receive enough insulin and blood sugar
may not come down enough.
-Resident #10 liked her sweets and kept snacks in her room.
-She was not too concerned with timing of insulin because Resident #10 liked to eat snacks.
-The facility should follow their policy for the timing of insulin administration.

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b. Review of Resident #9's current FL-2 dated 09/19/22 revealed:
-Diagnoses included dementia without behavioral disturbance, mental retardation, hyperlipidemia, and allergic rhinitis.
-There was an order for Aspirin 81mg tablet, enteric coated (EC) take 1 tablet by mouth daily. (Aspirin is used to prevent heart attack and stroke).

Review of Resident #9's standing house orders dated 11/29/22 revealed all medications may be given by mouth and/or crushed, except for medications on the Do Not Crush list (Check Do Not Crush list) and place in applesauce or pudding, unless otherwise noted.

Observation of the 8:00am medication pass on 02/22/23 revealed:
-The medication aide (MA) prepared morning medications for Resident #9, including one 81mg Enteric Coated Aspirin tablet.
-The MA crushed all of Resident #9's oral medications, including the Aspirin 81mg EC tablet and placed in pudding and administered them to the resident at 7:55am.

Review of Resident #9's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg EC take 1 tablet daily by mouth.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Review of Resident #9's medications on hand on 02/22/23 at 10:13am revealed:
-There was a multi dose pack (MDP) of Aspirin 81mg EC tablets.

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-The instructions on the label were to administer Aspirin 81mg EC 1 tablet by mouth daily.
-There was no information on the label to indicate the medication should not be crushed.

Review of facility's Do Not Crush (DNC) list revealed Aspirin EC tablets were included as a medication that should not be crushed.

Interview with the MA on 02/22/23 at 10:13am revealed:
-Resident #9 usually requested her medications to be crushed.
-She crushed Resident #9's medications during each medication pass.
-Resident #9 used to only have the large tablets crushed and would swallow the small tablets whole.
-She crushed all tablets including the Aspirin 81mg EC daily and mixed with a small amount of pudding.
-The facility had a DNC list in a notebook at the nurse's station.
-She had not reviewed the DNC list.
-Resident #9 previously had chewable Aspirin 81mg tablets but said that changed with the new contracted pharmacy provider.
-The eMAR and the medication label did not usually have Do Not Crush information noted.

Interview with Resident #9 on 02/22/23 at 10:03am revealed:
-She requested large tablets to be crushed.
-She could swallow small tablets without issue.
-She used to have only the large tablets crushed and would swallow small tablets, but staff now crushed all of them because it was easier for them.
-She denied side effects or gastric upset after taking her medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	R-C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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) COMPLETE DATE
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Interview with the Lead Supervisor on 02/22/23 at 10:22am revealed:
-Resident #9 had a standing order that medications could be crushed.
-She thought the multi dose packs were labeled by the pharmacy if medications were not to be crushed.
-The MAs had a DNC list available, and they should check the Do Not Crush list prior to crushing medications.

Interview with the Administrator on 02/22/23 at 10:32am revealed:
-There was a DNC list on each medication cart.
-She thought the pharmacy labeled the multi dose packs if medications were not to be crushed.
-The MAs should review the DNC list before crushing any medications.

Telephone Interview with Resident #9's primary care provider (PCP) on 02/22/23 at 3:40pm revealed.
-She was not aware Resident #9 requested her pills to be crushed.
-She would be concerned about gastrointestinal irritation and less than ideal absorption when EC Aspirin was crushed.
-The MAs should review the DNC list before crushing medications.

c. Review of Resident #11's current FL-2 dated 10/24/22 revealed:
-Diagnoses included constipation, vascular dementia, residual hemorrhoidal skin tags and other chest
pain.
-There was an order for Ibuprofen 800mg take 1 tablet three times a day with meals. (Ibuprofen is a

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non-steroidal anti-inflammatory used for mild to moderate pain.)

Observation of 12:00pm medication pass on 02/22/23 at 11:16am revealed:
-The medication aide (MA) prepared and administered 1 tablet of Ibuprofen 800mg to Resident #11
with water.
-Ibuprofen 800mg was not administered with a meal as ordered.

Review of Resident #11's February 2023 electronic medication administration record (eMAR) revealed an entry for Ibuprofen 800mg take 1 tablet three times per day with meals scheduled at 8:00am, 12:00pm, and 5:00pm.

Observation of Resident #11 on 02/22/23 revealed she was in the dining room and lunch was served at 11:36am and she began eating at 11:41am.

Interview with the MA on 02/22/23 at 1:06pm revealed:
-She did not administer medication in accordance with meals.
-She administered medication when it "popped up" on the eMAR.
-She was unsure what time lunch was served but thought it was usually served around 11:30am.
-She sometimes administered medications with pudding.
-She did not administer medications in the dining room.

Interview with Resident #11 on 02/22/23 at 4:05pm revealed:
-She took Ibuprofen daily.
-She preferred to eat prior to taking Ibuprofen but

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	HAL031018	A. BUILDING: _____ B. WING _____	R-C 02/22/2023

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sometimes staff got busy and gave it to her before
meals.
-She denied side effects or gastric upset after taking Ibuprofen.

Interview with the Lead Supervisor on 02/22/23 at 1:39pm revealed:
-Medications ordered to be given with the lunch meal were administered 30 minutes before a meal.
-She was not sure of a policy regarding medications ordered to be given with meals.
-Residents sometimes had a snack before lunch.

Interview with the Administrator on 02/22/23 at 1:43pm revealed the MAs should administer medications ordered with meals or immediately after completion of the meal.

Interview with the Area Clinical Director on 02/22/23 at 1:43pm revealed:
-Medications ordered with meals were to be administered immediately after completion of the resident's meal.
-Medications were not to be administered in the dining room.

Telephone Interview with Resident #11's primary care provider (PCP) on 02/22/23 at 3:40pm revealed:
-Ibuprofen was ordered to be administered with meals because it was a non-steroidal anti- inflammatory and could cause corrosive gastritis and stomach upset.
-The MAs should follow the facility's policy for medications ordered to be given with meals.