Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED	
		HAL031018	B. WING	B. WING		4
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	VII I AGE	235 NORT	H NC 41			
AUTUMIN	VILLAGE	BEULAVIL	LE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	X5) IPLETE ATE
D 000	0 Initial Comments		D 000			
	The Adult Care Licensure section completed an annual survey on 10/29/2024-10/31/2024.					
D 317	10A NCAC 13F .0905	6 (d) Activities Program	D 317			
	10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided 14 hours of activities each week.					
	The findings are:					
		cility on 10/29/24 at 8:20am ot an activities calendar n areas of the facility.				
		nt room 27 on 10/29/24 at e was an activity calendar 's room.				
	calendar on 10/29/24 -There were not at lead activities weeklyThere were two activities daily devotion at 9:30 independent exercise -There was a Resider 10/29/24 from 2:00pm -There was a birthday	rities scheduled weekly for am to 10:30am and at 1:00pm to 1:30pm. at 0:00pm. at 0:00pm.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF AND PLAN OF CORRECTION IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL031018	B. WING		10/31/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	AUTUMN VILLAGE 235 NORT					
			LLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 317	Continued From page	e 1	D 317			
	-There was a trick or treat activity scheduled on 10/31/24 at 7:00pm.					
	Review of the facility's dated September 202	s Life Jounery Program 21 revealed:				
		prepare a monthly calendar and posted in a prominent				
	locationThere shall be a minimum of 14 hours of a variety of planned activities to promote socialization, physical interaction, group accomplishment, creative expression, increased					
	knowledge and learni	ng of new skills.				
	Observation of activiti	ies on 10/29/24 at 9:30am, votions observed.				
		ies on 10/29/24 at 1:00pm, ident exercise observed.				
	10/29/24 revealed:	nt Council agenda dated				
	-All residents attende meeting.					
	- I ne time of the meet	ing was not documented.				
		ies on 10/30/24 at 9:30am,				
	there was no daily de	votions observed.				
		ies on 10/30/24 at 1:00pm,				
	there was no indepen	dent exercise observed.				
	Observation of an activity in the dining room on					
	10/30/24 at 10:15am	revealed there were g in dancing and eating an				
	assortment of cookies					
	Interview with a residence revealed:	ent on 10/29/24 at 8:36am				
	-The facility did not of	fer activities to the residents				

Division of Health Service Regulation

STATE FORM 9Y9X11 If continuation sheet 2 of 21

Division of Health Service Regulation

DIVISION	of Health Service Regu	liation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
		HAL031018	B. WING		10	/31/2024	
NAME OF S		0.70557	DDDECC OITY CT	TE 710 000E			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP GUDE			
AUTUMN	VILLAGE		TH NC 41				
		BEULAV	ILLE, NC 28518				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5) COMPLETE	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP		DATE	
				DEFICIENCY)			
D 317	Continued From page	2	D 317				
5017	Continued From page	5					
	daily.						
		o play "butter bean auction".					
		eam party held for the					
	residents last week (date not given).					
	Intervious with a coop	nd resident on 10/29/24 at					
	8:45am revealed:	nd resident on 10/29/24 at					
		the residents on					
	-He played cards with the residents on Wednesday.-Activities were held every two weeks.						
		,					
	Interview with a third	resident on 10/29/24 at					
	8:48am revealed:						
		d bingo once a month.					
	-He colored and stret	ched on his own time.					
		10/00/04					
		h resident on 10/29/24 at					
	9:17am revealed:	ity that was offered to the					
		about every two weeks.					
	~	e was played weekly.					
		nber the last time she and					
	the other residents pl						
	·	-					
	Interview with a perso	onal care aide (PCA) on					
	10/29/24 at 10:19am						
	-She had assisted wit	th the activities when					
	needed.	1 1: 10 1 0					
		o play bingo and the butter e residents could purchase					
	_	they earned from the game.					
		nber the last time she					
	assisted with the activ						
		activities because the facility					
	no longer had an Acti	-					
	Interview with the fee	ility's contracted home					
		ility's contracted home //31/24 at 10:37am revealed:					
		d a monthly group activity					

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with the residents.

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL031018	B. WING		10/31/2024	
			1		1 10/0	11/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
AUTUMN	VILLAGE	235 NOR				
	BEULAVII		LLE, NC 28518	Ţ		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
D 047	0 " 15		D 047			
D 317	Continued From page	e 3	D 317			
		on 10/30/24 around 10am,				
	"Name that Tone" and	d snacks were provided.				
	Interview with the Om	nbudsman on 10/31/24 at				
	10:14am revealed:	ibudsilian on 10/31/24 at				
	-Residents had expre	essed their concerns of not				
		regular basis and only being				
	offered to play bingo.	, ,				
	-The facility reduced	their group activities				
	because the corporat	e office phased out the				
	Activity Director posit					
	-She visited the facilit	y on 06/17/24, 08/22/24,				
	09/17/24 and 10/23/2	4 and had not observed any				
	residents engaging in					
	-During her visit on 10	0/30/24 she observed the				
	residents enjoying a	dance activity.				
	Interview with the Tra	nsportation Coordinator on				
	10/31/24 at 11:02am					
	-She assisted with ac					
		with some of the residents				
	last weekend.					
	-She had not assisted	d with activities on any other				
	days.	,				
	Interview with the Adr 9:27am revealed:	ministrator on 10/31/24 at				
	-	ctivities calendar monthly.				
		Director position had been				
		to a Corporate decision.				
	_	orporate activity's calendar				
		te the facility's activity				
	calendar.	to the radinty o activity				
		activities with the residents.				
		ercise activity was where				
	-	s throughout the building.				
		ne will restart in November				
		sidents liked the game and				
	had requested to play					
		e health agencies completed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL031018	B. WING		10	0/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
AUTUMN	VILLAGE		RTH NC 41 /ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 317	D 317 Continued From page 4		D 317			
	-	for completing the activity g the activities were carried				
D 319	10A NCAC 13F .0905	(f) Activities Program	D 319			
	participate in at least	Il have the opportunity to one outing every other erested in being involved in				
		ns and interviews, the facility sidents were offered at least				
	The findings are:					
		cility on 10/29/24 at 8:20am ot an activities calendar n areas of the facility.				
		nt room 27 on 10/29/24 at e was an activity posted in				
	Review of the Octobe 10/29/24 revealed the scheduled for the resi	S .				
	Review of the facility's dated September 202	s Life Jounery Program 11 revealed:				

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STATE FORM 9Y9X11 If continuation sheet 5 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL031018	B. WING		10/	31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
AUTUMN	VILLAGE	235 NORT	TH NC 41			
AUTOWIN	VILLAGE	BEULAVII	LLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 319	Continued From page	e 5	D 319			
	-Each resident will have the opportunity to participate in at least one outing every other month. -Residents who are interested in being involved in the community will be encouraged to do so. Interview with a resident on 10/29/24 at 8:36am revealed the facility did not take them shopping. Interview with a second resident on 10/29/24 at 8:45am revealed: -The facility used to take the residents to shop and out to eat. -She had not been out shopping in a while.					
	Interview with a third resident on 10/29/24 at 8:48am revealed: -The residents went on outings sometimesHe could not remember the last time an outing was offered to the residents.					
	9:17am revealed: -The staff would go s	n resident on 10/29/24 at				
	asked. -Residents did not go	out shopping often.				
	10:14am revealed: -Residents had expre having outingsThe facility reduced	e office phased out the				
	10/31/24 at 11:02am -She completed her s taking the residents s	schedule and would include				

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		UAI 024040	B. WING		10/31/2024	
		HAL031018			10/3	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		235 NOR	TH NC 41			
AUTUMN VILLAGE BEULAVI		LLE, NC 28518				
240.15	CLIMMADV CT				ı.	0.5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 319	Continued From nego	. 6	D 319			
טופט	Continued From page	; 0	D 319			
	-She had not kept a s	chedule of the shopping				
	outings.					
	-The facility van was I	handicapped assessable				
	and was equipped to	transport four residents at a				
	time with one residen	t being nonambulatory.				
	-She could make dec	isions on what outings to				
	offer to the residents.					
	-The Resident Care Coordinator (RCC) was her supervisor.					
		ss Office Manager (BOM)				
	on 10/31/24 at 10:56a					
		nator only provided copies of				
		mpleted transports of				
	clinical appointments.					
		C on 10/31/24 at 11:10am				
	revealed:					
	-She had not supervis					
	coordinator for sched					
		ransportation coordinator for				
		eted medical and mental				
	health appointments.					
		pordinator had taken the				
		tings and the last outing				
	was 10/26/24.					
	Interview with the Adr	ninistrator on 10/31/24 at				
	9:27am revealed:	Tillistrator on 10/31/24 at				
		re scheduled on an as				
	-Resident outings were scheduled on an as needed basis and on Fridays.					
		gs were scheduled for the				
	residents.	go word soriculied for the				
		umented, and copies were				
	given to the BOM.	amented, and copies were				
	-The RCC supervised	I the transportation				
	coordinator.	i ilo ilalisportation				
	oodidilatol.					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COM	LLTLD
		HAL031018	B. WING		10	/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
AUTUMN	VILLAGE		TH NC 41 ILLE, NC 28518			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	= CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 7	D 358			
D 358	10A NCAC 13F .1004(a) Medication Administration		D 358			
	(a) An adult care hor preparation and adm prescription and nonby staff are in accord (1) orders by a licens which are maintained (2) rules in this Sectionard procedures. This Rule is not met Based on observation reviews, the facility fawere administered as (#5) observed during pass including errors	as evidenced by: as evidenced by: as, interviews, and record ailed to ensure medications the morning medication with medications used to and strokes, vitamin				
	depression, and med symptoms.	ication used to treat allergy				
	The findings are:					
		rate was 27% as evidenced opportunities during the pass on 10/29/24.				
	revealed diagnoses in hypertension, depress hemiplegia affecting panic disorder, and g disease.	25's FL-2 dated 12/26/23 included stroke, sion, adjustment disorder, eft side, agoraphobia with astroesophageal reflux int #5's FL-2 dated 12/26/23 in order for Amlodipine 5mg				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL031018	B. WING		10	/31/2024
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STATE	E, ZIP CODE		
AUTUMN	VILLAGE		TH NC 41 ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Diservation of the model 10/29/24 revealed the not administer Amloding Resident #5. Review of Resident # medication administrate administered at 8:00a 10/01/24-10/28/24 and hold. Observation of Resident hand on 10/29/24 at 2-There was not a bub 5mg dated 10/29/24 -There was a bubble dated 10/30/24 Wedner Refer to interview with 10:00am. Refer to telephone introntracted pharmacy Refer to interviews with 10:029/24 at 9:48ar Refer to interviews with 10:05 and 10/29/24 at 9:48ar Refer to interviews with 10/29/24 at 9:48ar Ref	orning medication pass on e medication aide (MA) did ipine 5mg available to 5's October 2024 electronic ation record (eMAR) 5mg was documented as am daily from ad 10/29/24 was placed on ent #5's medications on 2:10pm revealed: ble pack with Amlodipine Tuesday morning available. pack with Amlodipine 5mg nesday morning available. h Resident #5 on 10/29/24 at terview with the facility's on 10/31/24 at 10:40am. with the medication aide (MA) m and 2:10pm.	D 358			
		terview with Resident #5's (PCP) on 10/30/24 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_			
		HAL031018	B. WING		10/31/	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUTUMN	VILLAGE	235 NORTH				
			_E, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	8 Continued From page 9		D 358			
	9:40am. b. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Aspirin (ASA) 81mg enteric-coated coated once daily. (ASA is used help prevent heart attacks or strokes.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer ASA 81mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed ASA 81mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with ASA 81mg dated 10/29/24 Tuesday morning availableThere was a bubble pack with ASA 81mg dated 10/30/24 Wednesday morning available.					
	Refer to interview with 10:00am.	h Resident #5 on 10/29/24 at				
		terview with the facility's on 10/31/24 at 10:40am.				
	Refer to interviews wi on 10/29/24 at 9:48ar	ith the medication aide (MA) m and 2:10pm.				
	Refer to interviews wi Coordinator (RCC) or 2:15pm.	ith the Resident Care n 10/29/24 at 9:53am and				
	Refer to interview with 10/29/24 2:27pm.	h the Administrator on				

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STATE FORM 9Y9X11 If continuation sheet 10 of 21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING:			
		HAL031018	B. WING		10)/31/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		70172024
AUTUMN	VILLAGE	235 NOF	RTH NC 41			
AUTUMN	VILLAGE	BEULAV	/ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 10	D 358			
		terview with Resident #5's (PCP) on 10/30/24 at				
	c. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Centrum Silver 8mg, 400mg, 50mcg once daily. (Centrum Silver is used treat vitamin deficiency.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Centrum Silver to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Centrum Silver was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold.					
	hand on 10/29/24 at 2 -There was not a bub Silver dated 10/29/24 -There was a bubble	ent #5's medications on 2:10pm revealed: ble pack with Centrum Tuesday morning available. pack with Centrum Silver lesday morning available.				
	Refer to interview with 10:00am.	n Resident #5 on 10/29/24 at				
		terview with the facility's on 10/31/24 at 10:40am.				
	Refer to interviews wi on 10/29/24 at 9:48ar	th the medication aide (MA) n and 2:10pm.				
	Refer to interviews wi Coordinator (RCC) or 2:15pm.	th the Resident Care n 10/29/24 at 9:53am and				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETE		
		HAL031018	B. WING	B. WING		10/31/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•		
AUTUMN	VILLAGE	235 NOR					
			LLE, NC 28518				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE	
D 358	Continued From page 11		D 358				
	Refer to interview with the Administrator on 10/29/24 2:27pm.						
	Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. d. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Cholecalciferol (Vitamin D3) 50mcg once daily. (Vitamin D3 is used to treat a vitamin deficiency.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Cholecalciferol 50mcg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Cholecalciferol 50mcg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold.						
	hand on 10/29/24 at 2 -There was not a bub 50mcg dated 10/29/2 available. -There was a bubble	ble pack with Cholecalciferol					
	Refer to interview with 10:00am.	n Resident #5 on 10/29/24 at					
		terview with the facility's on 10/31/24 at 10:40am.					

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Division of Health Service Regulation

			(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL031018	B. WING		10/31/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALITUMNI	VIII ACE	235 NORTI	H NC 41			
AUTUMN	VILLAGE	BEULAVIL	LE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLI	ETE.
D 358	Continued From page	2 12	D 358			
	Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm.					
	Refer to interview with 10/29/24 2:27pm.	n the Administrator on				
		terview with Resident #5's (PCP) on 10/30/24 at				
	e. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Citalopram 20mg once daily. (Citalopram is used to treat depression.)					
	Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Citalopram 20mg to Resident #5.					
	medication administra revealed Citalopram 2 administered at 8:00a	20mg was documented as				
	hand on 10/29/24 at 2 -There was not a bub 20mg dated 10/29/24 -There was a bubble	ent #5's medications on 2:10pm revealed: ble pack with Citalopram Tuesday morning available. pack with Citalopram 20mg lesday morning available.				
	Refer to interview with 10:00am.	n Resident #5 on 10/29/24 at				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		HAL031018	B. WING		10	0/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AUTUMN	VILLAGE		RTH NC 41 (ILLE, NC 28518			
				DDOV/DED'S DI AN OF C	ODDECTION	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 13	D 358			
		terview with the facility's on 10/31/24 at 10:40am.				
	Refer to interviews w on 10/29/24 at 9:48a	ith the medication aide (MA) m and 2:10pm.				
		ith the Resident Care n 10/29/24 at 9:53am and				
	Refer to interview wit 10/29/24 2:27pm.	h the Administrator on				
	-	terview with Resident #5's r (PCP) on 10/30/24 at				
	revealed there was a once daily. (Clopidog prevent platelets fron	t #5's FL-2 dated 12/26/23 n order for Clopidogrel 75mg rel is a blood thinner used to n sticking together and to neart attacks, and strokes.)				
	10/29/24 revealed the	orning medication pass on e medication aide (MA) did logrel 75mg to Resident #5.				
	medication administrative revealed Clopidogrel administered at 8:00a	75mg was documented as				
	hand on 10/29/24 at a -There was not a bub 75mg dated 10/29/24 -There was a bubble	ent #5's medications on 2:10pm revealed: bble pack with Clopidogrel Tuesday morning available. pack with Clopidogrel 75mg nesday morning available.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		OOWII EETEB
		HAL031018	B. WING		10/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
AUTUMN	VILLAGE	235 NORT	TH NC 41 LLE, NC 28518		
240.15	CLIMMADY CT		<u> </u>	PROVIDER'S PLAN OF CORRECTION	ON OUT
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 14	D 358		
	Refer to interview wit 10:00am.	h Resident #5 on 10/29/24 at			
		terview with the facility's on 10/31/24 at 10:40am.			
	Refer to interviews w on 10/29/24 at 9:48ar	ith the medication aide (MA) m and 2:10pm.			
	Refer to interviews w Coordinator (RCC) or 2:15pm.	ith the Resident Care n 10/29/24 at 9:53am and			
	Refer to interview wit 10/29/24 2:27pm.	h the Administrator on			
	Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am.				
	revealed there was a	t #5's FL-2 dated 12/26/23 n order for Lisinopril 7.5mg is used to treat high blood			
	10/29/24 revealed the	orning medication pass on e medication aide (MA) did oril 7.5mg to Resident #5.			
	medication administra revealed Lisinopril 7.9 administered at 8:00a	5mg was documented as			
	hand on 10/29/24 at 2	ent #5's medications on 2:10pm revealed: ble pack with Lisinopril			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	HAL031018	B. WING		10	31/2024
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
AUTUMN VILLAGE		TH NC 41 LLE, NC 28518			
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Refer to interview with 10:00am. Refer to telephone interviews with on 10/29/24 at 9:48am Refer to interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator (RCC) on 2:15pm. Refer to telephone interviews with Coordinator on 10/29/24 revealed the symptoms.) Observation of the mor 10/29/24 revealed the language to the lang	Tuesday morning ack with Lisinopril 7.5mg sday morning available. Resident #5 on 10/29/24 at rview with the facility's in 10/31/24 at 10:40am. In the medication aide (MA) and 2:10pm. In the Resident Care 10/29/24 at 9:53am and rview with the /24 2:27pm. rview with Resident #5's PCP) on 10/30/24 at #5's FL-2 dated 12/26/23 order for Loratadine 10mg is used to treat allergy rning medication pass on MA did not administer rsident #5. S October 2024 electronic ion record (eMAR) long was documented as	D 358	SETIMEN.		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
			AL BOILBING.			
		HAL031018	B. WING		10)/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
AUTUMN	VILLAGE	235 NOR	TH NC 41			
AOTOMIN	VILLAGE	BEULAV	ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 16	D 358			
	hand on 10/29/24 at 2 -There was not a bub 10mg dated 10/29/24 -There was a bubble dated 10/30/24 Wedn Refer to interview with 10:00am. Refer to telephone int contracted pharmacy Refer to interviews wi on 10/29/24 at 9:48ar Refer to interviews wi	ble pack with Loratadine Tuesday morning available. pack with Loratadine 10mg lesday morning available. In Resident #5 on 10/29/24 at lerview with the facility's on 10/31/24 at 10:40am. Ith the medication aide (MA) m and 2:10pm.				
	Refer to interview with the Administrator on 10/29/24 2:27pm.					
		terview with Resident #5's (PCP) on 10/30/24 at				
	pharmacy on 10/31/2 -The pharmacy had n morning medications 10/29/24.	vith the facility's contracted 4 at 10:40am revealed: ot received a request for the that were not given on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251110.			
		HAL031018	B. WING		10/31/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN VILLAGE 235 NORT						
			LE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
D 358	Continued From page	e 17	D 358			
	Thursday 10/21/24 ar seven-day supply.	nd the facility received a				
	Resident #5's morning. She informed Reside to locate the bubble pubble pubble pubble pubble informed the Resident (RCC) that she was upack for Resident #5'. She only administered day they were labeled. Interview with the Resident (RCC) on 10/29/24 at revealed she notified pharmacy that they not resident information.	and 2:10pm revealed: becate the bubble pack for g medications. ent #5 that she was unable back for her morning sident Care Coordinator unable to locate the bubble is morning medications. ed the medications on the di. sident Care Coordinator is 9:53am and 2:15pm the facility's contracted				
	were not available; she said that when they ordered medications it would take about 6 hours for the medications to arrive. Interview with the Administrator on 10/29/24 2:27pm revealed: -The MA should have administered the morning medications on 10/29/24 using the bubble pack labeled 10/30/24The MA should have called the pharmacy and have them send a morning pack of medications to be administered on 10/30/24. Telephone interview with Resident #5's contracted primary care provider (PCP) on 10/30/24 at 9:40am revealed: -She was not concerned with Resident #5 only missing one dose of her scheduled morning medications.					

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL		E SURVEY PLETED	
		HAL031018	B. WING		10	/31/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
AUTUMN	VILLAGE		RTH NC 41 /ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 18	D 358			
	-She was concerned medications were not administered on Tues	available to be				
D 366	10A NCAC 13F .1004 Administration	4 (i) Medication	D 366			
	10A NCAC 13F .1004	1 Medication Administration				
	medication administra staff person who adm immediately following medication to the res					
	reviews, the facility fa staff who administere observed 1 of 5 resid	ns, interviews, and record hilled to ensure medication and medications actually ents (#5) taking their ne morning medication pass				
	The findings are:					
	revealed diagnoses in hypertension, depres hemiplegia affecting I panic disorder, and g disease.	sion, adjustment disorder, eft side, agoraphobia with astroesophageal reflux				
	Observation of the m 10/29/24 at 9:50am r -Resident #5 was lyir -The Medication aide	ng in her bed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	JILTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETEL	, I
		HAL031018	B. WING		10/31/20	024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	VII I AGE	235 NOR	TH NC 41			
AOTOMIN	VILLAGE	BEULAVI	LLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE C	(X5) COMPLETE DATE
D 366	Continued From page medications to admin		D 366			
		wo medications in a plastic				
	-The MA set the plast	ic cup on Resident #5's ntained the medications and				
		erve Resident #5 take her				
	medications.	ack into Resident #5's room				
	-The MA did not go back into Resident #5's room after leaving medications on the bedside table.					
	Interview with Reside	nt #5 on 10/29/24 at				
		at some of the MAs left her				
	swallow them.	om and did not watch her				
	Interview with the MA revealed:	on 10/29/24 at 1:07pm				
	residents take their m					
	-She was not sure wh Resident #5 take her	ny she did not observe medications.				
	Interview with the Resident Care Coordinator (RCC) on 10/29/24 at 2:15pm revealed:					
		rained and knew they were residents take all their				
	-If the MA did not obs	erve Resident #5 take her				
	medications the resid					
	could ingest the medi	aking or another resident cations.				
	Interview with the Clir (CNC) on 10/31/24 at	nical Nurse Consultant : 9:46am revealed:				
	-MAs had been traine	ed not to leave medications				
	in a resident's room.	edication administration a				
	=	nich included not leaving				
	medications in reside					

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP		E SURVEY PLETED	
		HAL031018	B. WING		10	/31/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
AUTUMN	VILLAGE	235 NOR BEULAVI	TH NC 41 LLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page	2 20	D 366			
	2:27pm revealed: -The MAs should obs medicationsIf Resident #5 was no medications, the resident	erve the residents take their of observed taking her dent might not take the er resident could take the				

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STATE FORM 9Y9X11 If continuation sheet 21 of 21