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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnosis which included end stage renal disease. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] 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 (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, she returned to the nurse's station, saw the order on the desk, and realized it was written for Resident #4, not Resident (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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 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.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnosis which included end stage renal disease, hypertensive heart disease and diabetes.Review of Resident # 2's quarterly Minimum Data Set (MDS) dated [DATE] 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. 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 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.