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	07/25/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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 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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Nurse Practitioner and Consultant Pharmacist interviews, the pharmacy failed to notify the facility of a clinical high priority recommendation that required a prompt response. This failure contributed to the facility not administering the antibiotics cefdinir and doxycycline prescribed to a resident (Resident # 4) for sepsis due to pneumonia from 7/17/25 through 7/20/25. This occurred for 1 of 5 residents reviewed for medication administration. Findings included:Resident # 4 was admitted on [DATE] with diagnosis of chronic respiratory failure with hypoxia, congestive heart failure, and chronic obstructive pulmonary disease. Resident #4's hospital Discharge summary dated [DATE] indicated the resident was discharged back to the facility in stable condition after treatment for acute hypoxic respiratory failure related to sepsis secondary to bilateral pneumonia. The hospital course further stated Resident # 4 was to continue antibiotics for the treatment of pneumonia upon discharge. The current discharge medication list indicated Resident # 4 was to start taking cefdinir 300 milligrams (mg) by mouth every 12 hours for 3 days and doxycycline monohydrate 100 mg capsule by mouth every 12 hours for 3 days for pneumonia. Review of a pharmacy consultation report completed by Pharmacist #1 dated 7/18/25 indicated a clinical priority recommendation for Resident #4 with prompt response requested was submitted to the facility. The recommendation indicated Resident # 4 was recently admitted to the facility and the medication review process revealed the following discrepancies on the admission orders: antibiotic orders for doxycycline and cefdinir for 3 days are not active in the computer system. The pharmacy consultation report further stated that the current hospital discharge orders were not re-entered into the computer system, so the current physician orders are from prior to her discharge to the hospital. The recommendation indicated to clarify the medication orders, communicate with the prescribing provider and the pharmacy. The report was signed by the Director of Nursing on 7/21/25. A review of Resident # 4's physician orders revealed orders dated 7/21/25 entered by Unit Manager #2 for cefdinir 300 mg. twice per day and doxycycline 100 mg twice per day. An interview with Unit Manager #2 on 7/23/25 at 11:30 AM revealed that she did not receive the pharmacy consultation report for Resident #4 until 7/21/25 and she did not receive a phone call from the pharmacy on 7/18/25 regarding the medications. Unit Manager #2 stated on 7/21/25 after receiving the pharmacy consultation report, she informed the Nurse Practitioner of the medication error and received the orders for the antibiotics cefdinir and doxycycline. An interview was conducted with the Nurse Practitioner on 7/23/25 at 4:30 PM. The Nurse Practitioner stated she became aware that Resident # 4 had not received the ordered antibiotics doxycycline and cefdinir when she saw the pharmacy consultation report on 7/21/25. The NP indicated that given resident's comorbidities, not starting the antibiotics had the potential to worsen Resident #4's condition. An interview was conducted with the Consultant Pharmacist on 7/25/25 at 10:30 AM. The Consultant Pharmacist stated that the pharmacy had a process for reviewing the orders within 24 hours when a resident is admitted or readmitted to the facility. The Consultant Pharmacist stated the reviews consisted of the pharmacist comparing the hospital discharge summary with the physician orders that the facility enters in the computer system. The medication regimen reviews are sent via email to the Director of Nursing and the Unit Managers. If there is an urgent issue that requires prompt attention, the pharmacist is to call the facility. The Consultant Pharmacist stated that the facility should have been notified on 7/18/25 that the antibiotic orders for Resident #4 were not entered into the computer system. The Consultant Pharmacist indicated that the medication review for Resident #4 was marked as priority and the pharmacy policy is that all priority recommendations are to be called in to the facility for immediate response. The Consultant Pharmacist stated there was no indication that Pharmacist #1 notified the facility of the priority recommendations regarding the antibiotics for Resident #4. Pharmacist #1 was out of the office and was unavailable for interview during the survey. Attempts were made twice on 7/25/25 to interview the Pharmacy Services Manager with voice mails sent with no return phone call received. An interview was conducted with the Director of Nursing (DON) on 7/25/25 at 11:00 AM. The DON stated that the pharmacy consultation report was listed as priority and should have been addressed. The DON indicated that the emailed pharmacy consultation report was sent to his facility email account on 7/20/25 which was a Sunday, and he was not working at the facility that day. The DON stated he did not see the email from the pharmacy until Monday 7/21/25 when he returned to work. The DON stated that if he had been informed of the issues regarding the medications on 7/18/25, he would have addressed them immediately and investigated why the issues

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Nurse Practitioner and Consultant Pharmacist interviews, the facility failed to: a). administer the antibiotic medications doxycycline and cefdinir per the physician orders on the discharge summary from 7/18/25 through 7/20/25 resulting in 12 missed doses of the antibiotic treatment for pneumonia and b). failed to administer the ordered dose of roflumilast (a medication used to treat severe Chronic Obstructive Pulmonary Disease) for 2 consecutive days. There was no significant outcome due to either of the medication errors. This deficient practice occurred for 1 of 1 resident (Resident #4) reviewed for significant medication errors. Resident #4 was admitted originally on 11/27/24 with diagnosis of chronic respiratory failure, congestive heart failure, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident was cognitively intact with no behaviors. Resident #4 was transferred to the hospital on 7/14/25 and was readmitted to the facility on [DATE] with diagnosis of acute hypoxic respiratory failure related to sepsis due to pneumonia. A nursing progress note written by Nurse #8 on 7/17/25 at 6:38 PM indicated Resident #4 returned to the facility from the hospital via stretcher accompanied by 2 transport workers. a). A review of the hospital Discharge summary dated [DATE] revealed Resident #4's discharge diagnoses were acute hypoxic respiratory failure related to sepsis (a potentially life-threatening condition when the body responds to infection causing injury to the tissues and organs) due to pneumonia and the resident was to continue antibiotic treatment. The current discharge medication list indicated Resident # 4 was to start taking cefdinir 300 milligrams (mg) by mouth every 12 hours for 3 days and doxycycline monohydrate 100 mg capsule by mouth every 12 hours for 3 days for pneumonia. Review of a pharmacy consultation report dated 7/18/25 indicated Resident #4 was recently admitted to the facility. The medication review process revealed the following discrepancies on the admission orders: Antibiotic orders for doxycycline and cefdinir for 3 days are not active in the computer system. The pharmacy consultation stated that the medication orders from the hospital were not entered into the computer system, so the current physician orders are from prior to her discharge to the hospital. The recommendation indicated to clarify the medication orders, communicate with the prescribing provider and the pharmacy as appropriate. The report was signed by the Director of Nursing on 7/21/25. Review of a Nurse Practitioner progress note dated 7/18/25 indicated Resident #4's medications were reviewed. The Nurse Practitioner progress note indicated that Resident #4 was to receive doxycycline 100 mg twice per day for 7 days and cefdinir 300 mg. twice per day for 7 days instead of the 3 days that was specified in the hospital discharge summary. The NP stated she was extending the regimen for a total of 7 days due to the high risk of persistent infection, advanced age, frailty and co-morbidities. The NP progress note indicated that the information regarding the antibiotic orders was relayed to Unit Manager #2. Review of Resident #4's physician orders revealed there were no physician orders dated 7/18/25 for cefdinir or doxycycline. An interview with Unit Manager #2 on 7/23/25 at 11:30 AM revealed that she was working on 7/17/25, the day that Resident #4 was readmitted and on 7/18/25. Unit Manager #2 stated that she did not review Resident #4's discharge summary, did not enter the physician orders nor did she verify the orders with the provider when the resident returned from the hospital on 7/17/25. Unit Manager #2 stated she typically reviewed the discharge summary and the medications the day after a resident was admitted or readmitted , but she did not review Resident #4's orders. Unit Manager #2 did not know why she did not review Resident #4's orders. Unit Manager #2 stated Resident #4's physician orders were not discontinued when the resident was admitted to the hospital and when readmitted the orders from prior to the hospitalization were resumed without being reviewed or verified. Unit Manager #2 stated she did not recall being informed by the Nurse Practitioner on 7/18/25 of any changes to Resident #4's medications. Unit Manager #2 stated that she became aware of the issues with Resident #4's medication orders on 7/21/25 when the Director of Nursing received the pharmacy consultation report and she (Unit Manager #2) informed the Nurse Practitioner. A late entry nursing progress note for 7/21/25 at 9:24 PM was written by Unit Manager #2 on 7/22/25 at 9:24 PM for Resident #4. The progress note indicated Resident #4's admission orders were reviewed by the NP and a new order was received for cefdinir twice per day for COPD exacerbation. Resident #4 was seen on rounds by the Nurse Practitioner. Resident #4's Medication Administration Record was updated. A review of Resident #4's physician orders revealed orders dated 7/21/25 entered by Unit Manager #2 for cefdinir 300 mg. twice per day with no stop date specified and

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to a) label and date opened packages of food for 1 of 1 walk-in cooler in the kitchen; and b) to discard expired foods in a refrigerator in 1 of 3 nutrition rooms (100/200 hall nutrition room). This deficient practice had the potential to affect the food served to the residents.The findings included:An initial tour of the kitchen was conducted on 7/21/25 at 10:34 AM in the presence of the Dietary Manager.a) a) An opened package of French toast sticks and opened package of cauliflower were observed in the kitchen walk-in cooler without an opened date or expiration date. An interview was completed with the Dietary Manager on 7/21/25 at 11:05 AM. The Dietary Manager stated that all opened foods stored in the walk-in cooler should be labeled and dated with the date it was opened and the expiration date. b) b) An observation of the 100/200 hall nutrition room was conducted on 7/23/25 at 12:30 PM in the presence of the Dietary Manager. There were 4 cups of sugar-free orange gelatin with the expiration date 3/17/25 and 4 cups of sugar-free orange gelatin with the expiration date 2/25/25. An interview was completed with the Dietary Manager on 7/23/25 at 11:05 AM. The Dietary Manager stated there was not supposed to be any expired food in the nutrition rooms. She indicated that the staff were not paying close attention to the dates. An interview was completed with the Administrator on 7/24/25 at 12:40 PM. The Administrator stated that she expected the kitchen staff to check for expired food in the kitchen and nutrition rooms and to discard them. She further stated she expected the staff to label and date food stored in the kitchen and nutrition rooms.