STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 07/25/21 through 07/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #P2U711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/25/21 through 07/28/21. Event ID# P2U711. 1 of the 7 complaint allegations was substantiated without a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to complete and document a resident self-administration of medications for 1 of 1 resident reviewed for self-administration of medications. (Residents #23) Findings included: 1. Resident #23 was admitted to the facility on 12/26/17 with diagnoses which included Diabetes Mellitus and coronary artery disease. Resident #23's quarterly Minimum Data Set dated 7/08/21 indicated she required extensive	F 554	F 554 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #23 had a Self-Administration of Medication assessment completed on 7/28/2021 by the MDS Coordinator. The resident was deemed safe to self-administer medications ordered by the physician and deemed safe to be kept at the bedside. A schedule for quarterly Self-Administration of Medication assessment was set in the electronic	8/20/21

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

Electronically Signed | 08/13/2021

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F 554	Continued From page 1 assistance or total dependence for most activities of daily living, independent for eating, and cognitively intact. Review of the facility's Self-Administration of Medications policy with the implementation date of 10/01/20 read in part that residents who self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent. It also read in part that the interdisciplinary team shall re-assess the resident's ability to self-administer by completing the medication self-administration form every 3 months. Record review indicated Resident #23 had no self-administration of medication assessment. Review of Physician's orders revealed an order dated 9/07/20 for Minerin Dry Skin Cream to be applied to bilateral lower extremities daily for dry skin and may be kept at bedside. Review of Physician's orders revealed an order dated 4/23/21 for Mometasone Cream 0.1% (prescription corticosteroid cream) to be applied to arm and neck twice a day for Eczema (skin condition) and may be kept at bedside. An interview on 7/28/21 at 10:27 AM with Resident #23 revealed she does keep some creams in her room and that staff assist her with their application. An interview on 7/28/21 at 10:32 AM with Nurse #4 revealed they ask Resident #23 if she has applied her creams and document them as completed on the Medication Administration Record.	F 554	record. 2) Address how the facility will identify other residents having potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. An 100% audit was completed on 8/09/2021 by the MDS Coordinator to ensure all residents that can self-administer medications had an assessment completed and the care plan was updated to reflect the findings. Problem areas were addressed and corrected upon the audit. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An in-service was conducted on 8/10/2021 by the Director of Nursing for all nursing staff. Topics covered included: protocol for self-administration of medications, the self-administration assessment procedure and the importance of all staff to report any findings of medications at the bedside. 4) Indicate how the facility plans to monitor it performance to make sure that solutions are sustained: The Director of Nursing or designee will conduct audits weekly x 4 weeks, then every two weeks x 2 weeks, then monthly x 1 month to ensure that no medications are in the resident□s possession and ensure a self-administration assessment is completed and the practice deemed safe. All results from the audits will be taken to the monthly QAPI meeting x 3 months for continued compliance.	

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F 554	Continued From page 2 An interview on 7/28/21 at 10:33 AM with the Director of Nursing (DON) revealed that Resident #23 should have had a self-administration assessment completed but she did not. She stated she was not the DON at the time the medication was given to the resident and could not state why this had not been completed. An interview on 7/28/21 at 10:52 AM with the Administrator revealed she did not know why this had not been done.	F 554	5) Include dates when corrective action will be completed: 8/20/2021.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		8/20/21

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F 656	Continued From page 3 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review the facility failed to develop a comprehensive care plan to address pain for 1 of 1 resident (Resident #53) reviewed for pain. Findings included: Resident #53 was admitted to the facility on 6/9/2021 with diagnoses that included rheumatoid arthritis. A review of a recent hospital discharge summary dated 6/9/2021 revealed on 5/7/2021 Resident #53 had a right hip fracture with an open reduction internal fixation (ORIF) surgery. A nursing admission note dated 6/9/2021 revealed Resident #53 had contractures of her bilateral fingers from arthritis.	F 656	F-656 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An assessment was completed on resident #53 by the MDS Coordinator on 7/26/2021 to ensure that the care plan reflected appropriate care plan interventions for pain management. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice, especially all residents who experience pain. An 100% audit of care plans was completed on 8/09/2021 for resident	

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F 656	Continued From page 4 A Physician order dated 6/9/2021 revealed acetaminophen 325 mg, give 2 tablets every 4 hours as needed for pain or fever. A care plan initiated on 6/10/2021 revealed no care plan or interventions to address Resident #53's rheumatoid arthritis or pain. An admission Minimum Data Set (MDS) dated 6/16/2021 revealed Resident #53 was mildly cognitively impaired and able to make her needs known and understood others. The MDS indicated there was functional limitations in range of motion (ROM) on both upper extremities. It was coded no for pain in the last 5 days during the 7 day look back assessment period. An observation and interview on 7/26/2021 at 10:30 am revealed Resident #53 was resting in bed with her eyes closed. Her arms were stretched out beside her and her hands/fingers were observed with contractures. During the interview Resident #53 stated her leg was hurting. She stated the nurse had given her acetaminophen for pain earlier. Resident #53 stated she hurt every day. An interview with Nurse Aide (NA) #2 on 7/26/2021 at 1:15 pm revealed she worked with Resident #53 on a regular basis. She stated when Resident #53 told her that she was in pain or displayed signs of pain she would tell the nurse and the nurse would give the Resident a pain pill. NA #2 stated Resident #53 seemed to have more pain after therapy. An interview with Nurse #5 on 7/26/2021 at 2:50 pm revealed she was responsible for completing	F 656	presenting with pain management needs with appropriate interventions. Problem areas were immediately corrected. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An in service was conducted for all licensed nurses on 8/6/2021 by the Director of Nursing. Topics included: completing a pain assessment on admission, quarterly and with any acute changes related to pain or changes in pain medication as well as care planning residents for who trigger for pain management. The Director of Nursing completed an in-service on 8/10/2021 with the MDS Coordinator on ensuring proper care planning of residents with pain management needs. 4) Indicate how the facility plans to monitor its performance make sure that solutions are sustained: 10% audit of all care plans will be completed by the Director of Nursing and/or designee two times weekly x 1 month, then weekly x 1 month then monthly for 1 month. All negative findings will be addressed immediately. All audit results will be taken to the QAPI meeting monthly by the DON and/or designee. 5) Include dates when corrective action will be completed: 8/20/2021	

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F 656	Continued From page 5 Resident #53's care plan. She stated because the Resident had a diagnosis of rheumatoid arthritis a care plan for pain should have been included. Another observation and interview on 7/27/2021 at 11:00 am revealed Resident #53 was resting in bed with her eyes closed. She stated her hands were hurting. During an interview with the Director of Nursing on 7/27/2021 at 10:30 am she reported Nurse #5 was responsible for the care plans and updates. She stated a care plan for pain should have been included in Resident #53's care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to routinely monitor and assess resident's skin condition for 2 of 2 (Residents #1 and #24) reviewed for skin conditions. Findings included: 1. Resident #1 was admitted to the facility on 11/08/13 with diagnoses which included Diabetes Mellitus and Alzheimer's Dementia. Resident #1's annual Minimum Data Set dated 7/06/21 indicated he was at risk of developing pressure ulcers or injuries and had a pressure	F 658	F-658 1) Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 had a skin assessment completed in the EMR by a licensed nurse on 7/28/2021. Resident #24 had a skin assessment completed in the EMR by a licensed nurse on 7/28/2021. Assessments revealed no skin conditions or issues.	8/20/21

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F 658	Continued From page 6 reduction device for his bed. He was coded as having no skin conditions and no pressure ulcers. Resident #1's care plan last revised on 7/06/21 included a focus for risk of skin breakdown or development of pressure ulcers related to moderate risk for pressure ulcer. The intervention for this focus included to place the resident on a pressure relieving product. Review of a spreadsheet provided by the Director of Nursing (DON) with no date indicated residents should have skin assessments completed weekly, with condition change, and as needed. Theses skin assessments should be documented on the Skin Observation Tool form. Record review indicated Resident #1 had no weekly skin assessments documented since 5/10/21. An interview with Nurse #1 on 7/28/21 at 9:03 AM revealed she completed skin assessments when they 'popped up' in the computer on her task list for her assigned residents. An interview with Nurse #2 on 7/28/21 at 9:09 AM revealed she was aware residents should have skin assessments completed weekly and it 'popped up' on her computer task list when it was to be done. An interview with Nurse #4 on 7/28/21 at 9:14 AM revealed she did not know how often skin assessments were to be completed but she did them when they were on her computerized resident task list. An interview with the Director of Nursing (DON)	F 658	2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice, including residents with high risk for impaired skin integrity. An 100% audit of weekly skin checks was completed on 8/09/2021 by the Floor Nurses. Audits revealed no negative findings with documentation provided in the EMR. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: The Director of Nursing conducted an in-service on 8/06/2021 for all licensed nurses. Topics included: all residents are to have a weekly skin assessment with documentation completed in the EMR. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A 10% audit of all residents will be completed by the Director of Nursing and/or designee weekly x 1 month, then every 2 weeks x 1 month then monthly x 1 month. Any negative findings will be corrected immediately. Director and/or designee will take findings to the monthly QAPI committee x 3 months. 5) Indicate the plan of correction will be completed: 8/20/2021.	

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F 658	Continued From page 7	F 658		

on 7/28/21 at 9:20 AM revealed the facility had changed computer charting systems in May. She stated she was not aware the weekly skin assessments were no longer showing up as a task for the nurses to complete. The DON also stated all residents should have a weekly skin assessment and she confirmed Resident #1 had not had a weekly skin assessment since 5/10/21.

An interview with the Administrator on 7/28/21 at 10:52 AM revealed all residents should have a weekly skin assessment and she believed this task was lost when they switched computer systems in May.

2. Resident #24 was admitted to the facility on 7/18/18 with diagnoses which included Diabetes Mellitus and hypertension.

Resident #24's annual Minimum Data Set dated 4/20/21 indicated she was at risk of developing pressure ulcers or injuries and had a pressure reduction device for her bed. She was coded as having no skin condition and no pressure ulcers. She was also coded as total dependence with most activities of daily living, extensive assistance for bed mobility, independent for eating, and moderately impaired cognition.

Resident #24's care plan last revised on 7/01/21 included a focus for risk of skin breakdown or development of pressure ulcers related to moderate risk for pressure ulcer. The intervention for this focus included to provide incontinence care after incontinent episodes or toileting.

Review of a spreadsheet provided by the Director of Nursing (DON) with no date indicated residents should have skin assessments completed

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F 658	Continued From page 8	F 658		

weekly, with condition change, and as needed. Theses skin assessments should be documented on the Skin Observation Tool form.

Record review indicated Resident #24 had no weekly skin assessments documented since 5/10/21.

An interview with Nurse #1 on 7/28/21 at 9:03 AM revealed she completed skin assessments when they 'popped up' in the computer on her task list for her assigned residents.

An interview with Nurse #2 on 7/28/21 at 9:09 AM revealed she was aware residents should have skin assessments completed weekly and it 'popped up' on her computer task list when it was to be done.

An interview with Nurse #4 on 7/28/21 at 9:14 AM revealed she did not know how often skin assessments were to be completed but she did them when they were on her computerized resident task list.

An interview with the Director of Nursing (DON) on 7/28/21 at 9:20 AM revealed the facility had changed computer charting systems in May. She stated she was not aware the weekly skin assessment was no longer showing up as a task for the nurses to complete. The DON also stated all residents should have a weekly skin assessment and she confirmed Resident #24 had not had a weekly skin assessment since 5/10/21.

An interview with the Administrator on 7/28/21 at 10:52 AM revealed all residents should have a weekly skin assessment and she believed this task was lost when they switched computer

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F 658	Continued From page 9 systems in May.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to obtain a physician order for oxygen therapy for 1 of 1 resident reviewed for oxygen therapy (Resident #1). Findings included: Resident #1 was re- admitted to the facility on 1/26/21 from the hospital with diagnoses that included Covid 19 pneumonia. Review of the hospital discharge summary dated 1/26/21 read in part that Resident #1 keep oxygen nasal cannula at 3-5L to keep oxygen saturation greater than 90%, wean off as tolerant. Review of the physician's orders revealed no orders for Resident #1 for oxygen or checking oxygen saturation. A nursing progress note, written by Nurse #5, dated 7/5/21 revealed Resident #1's oxygen	F 695	F-695 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An order for oxygen and monitoring of oxygen saturation was obtained for resident #1 on 7/27/2021 by the floor nurse. 2) Address how the facility will identify other residents having the potential to be affected same deficient practice All residents have the potential to be affected by this deficient practice, especially those who receive oxygen therapy. An audit of all residents that are receiving oxygen therapy, including resident #1, checked for current orders by the Director of Nursing services on 8/04/2021 with problem areas addressed and corrected. 3) Address what measures will be put into place or systemic changes made to	8/20/21

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F 695	Continued From page 10 saturation level was 95% while on 2L (liters) of oxygen via nasal cannula. A review of the most recent Minimum Data Set (MDS) assessment dated 7/6/21 revealed Resident #1 had moderate cognitive impairment. It further revealed the resident had oxygen therapy during the look back period. The Electronic Health Record (EHR) for June and July 2021 revealed Resident #1 had oxygen saturation levels taken while on oxygen for 5 days: 6/1/21, 6/5/21, 6/6/21, 7/3/21, and 7/4/21. These were recorded in the vitals section of the EHR. The EHR further revealed Resident #1 had oxygen saturation levels taken on room air, with saturation levels above 90% on room air. Resident #1 last used oxygen on 7/5/21. During an interview and observation with Resident #1 on 7/25/21 at 9:25AM it was revealed the resident used oxygen as needed. He further stated he used oxygen several nights ago. An oxygen concentrator was observed at Resident #1's bedside. An interview with Nurse #4 on 7/27/21 revealed Resident #1 did not have an order for oxygen. Nurse #4 stated she was unaware how long the resident had been using oxygen. An interview with Nurse #5 on 7/27/21 at 9:39AM revealed Resident #1 had been re-admitted from the hospital in January 2021, at that time, he was on oxygen. An interview was conducted with the Director of Nursing (DON) on 7/27/21 at 8:45AM. The DON stated Resident #1 did not have an order for	F 695	ensure that the deficient practice will not recur: An in-service of all licensed nurses was conducted by the Director of Nursing 8/06/2021. Topic included: residents currently utilizing oxygen therapy should have an active order in the EMAR. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or designee will audit all new admissions and 10% of active charts weekly x 1 month, then every two weeks x 1 month and then monthly x 1 month. Any negative findings will be corrected immediately. The Director of Nursing or designee will bring all findings from the audits monthly to the QAPI x 3 months for review. 5) Include dates when corrective action will be completed 8/20/2021	

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F 695	Continued From page 11 oxygen and the nurse who signed off the order was responsible to place the order for the oxygen on the Medication Administration Record.	F 695		