PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _	B. WING			08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 711 SUSAN TART ROAD DUNN, NC 28335	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 000	Initial Comments	complaint investigation was	E	000			
F 000	conducted onsite from Additional information 10/7/24 and 10/8/24, immediate jeopardy is conducted on 10/8/24 was 10/8/24. The facility was found requirement CFR 48. Preparedness. Even INITIAL COMMENTS A recertification and conducted onsite from Additional information 10/7/24 and 10/8/24, immediate jeopardy is conducted on 10/8/24 was 10/8/24. The following intakes NC00222770, NC002 3 of the 5 complaint a deficiency. Immediate Jeopardy CFR 483.10 at tag Fit CFR 483.12 at tag Fit CFR 483.12 at tag Fit Care. Immediate Jeopardy and was removed on 10/3/24 for F600 and 10/8/24 immediate Jeopardy and was removed on 10/3/24 for F600 and 10/3/24 for F600 and 10/3/24 for F600 and 10/8/24 for F600 and	d in compliance with the 3.73, Emergency at ID #S71J11. complaint investigation was an 9/30/24 through 10/4/24. In was obtained remotely on Onsite validation of the removal plans was 4. Therefore the exit date were investigated: 222520, and NC00221335.	F	TITLE			(X6) DATE

Electronically Signed 10/31/2024

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245225	B. WING	·		С	
	20//255 05 0//25//55	345325	D. WING			10/	08/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page	÷1	F	000			
	An extended survey v	vas conducted.					
F 578 SS=D		ntnue Trmnt;Formlte Adv Dir	F	578			10/31/24
	discontinue treatment	ht to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive.					
	construed as the right the provision of medic	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER	'		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	I	10/00/2027	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 578	or she is able to record Follow-up procedure the information to the appropriate time. This REQUIREMEN by: Based on interviews reviews, the facility of code status election medical record for 1 advanced directives. The findings include Resident #341 adm. Resident #341's phy through 10/01/24 did status. In an interview on 10 said thought that Rea "Full Code" code is resuscitative measu. She said she was to (name not recalled). She said in an emer looked in the medical what his code status resident's chart but it status order. She co	cion to the individual once he elive such information. It is must be in place to provide to individual directly at the or individual directly at the orders dated or individual directly at the order or individual directly and the order order. In order or individual directly and the order	F 5	Immediate action(s) taken for the resident(s) found to have been a include: Resident #341 no longer resides Carrolton of Dunn. During survey, the facility confirm Resident # 341 (or his legal guar responsible parties) desired his constatus to be DO NOT RESUSCIT (DNR). His medical record was appropriately to reflect his DNR so and an order was obtained from physician to support his accurate Status. The order was entered in electronic medical record on 10/0 Identification of other residents his potential to be affected was according to the potential to be affected was according to the potential to be if their medical records do not conaccurate information related to the advanced directives.	at at med that dians / code TATE updated status, his e DNR not the D1/24. aving the emplished all e affected intain neir		
	8/25/24 which indica "code with limitations know what that mea was about to be adn procedure was that	found a hospital note dated ted his code status was s." Nurse #2 said she did not nt. She said when a resident nitted to the facility, the the admissions office staff nat the code status was. She		Actions taken/systems put into please reduce the risk of future occurrer include: An audit of all medical records we completed on October 28, 202. the audit results, a master listing prepared for each patient reflecti	as Utilizing was		

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 10/08/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	100/2024
				7	11 SUSAN TART ROAD		
THE CARE	ROLTON OF DUNN				UNN, NC 28335		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 578	F 578 Continued From page 3		F t	578			
		as no "Do Not Resuscitate" art, Resident #341 would			desired code status.		
	` ′	as full code order and			The master listing was then cross		
	would have received	all measures in case of an			referenced to the medical record to		
	emergency.				confirm accuracy and to ensure that al		
					supporting documents were present in		
		/01/24 at 3:47 PM, the			medical records to validate the wishes	of	
		aid when a resident was			the patients.		
	admitted, she met wit resident's representa			MD Orders were then reviewed to			
		ives were to the resident or			determine that the medical record was		
	RR. If the resident or RR requested a DNR, the				accurate and contained updated MD		
		filled out a form with them			orders and reflecting the accurate wish	es	
		DNR code status and then			of the residents.		
		rge nurse on duty, who			All discrepancies were resolved with		
	would then request a	n order and complete the			residents and their legal guardians to		
	DNR notification form	ı. Resident #341's RR made			ensure that the medical record reflects		
		status because the resident			accurate documentation.		
		nis own wishes known. The					
		order and signed the with			Out of facility transport records were		
		tor. The Admissions Director			audited to ensure that Golden Rods we		
	_	urse but was not aware of			present and accurate for each resident	ın	
		that notification. She said			the facility. The audit was completed		
		r the name of the nurse as new at the time but no			between the dates of 10/20/24 and 10/30/24 and all discrepancies were		
	longer worked at the				resolved immediately.		
	longer worked at the	racinty.			resolved infinediately.		
	Resident #341's Do N	lot Resuscitate Request			In-servicing was completed by the		
		evealed the RR signed the			corporate nurse consultant for the		
		ent #341 was to have a			Administrator, Director of Nursing, Soc	ial	
	DNR order.				Worker, and Admissions Coordinator o	n	
					October 28, 2024. The agenda include	∍d	
		/01/24 at 4:53 PM, the			the regulations and facility policy for		
		DN) said Resident #341 did			Advanced Directives as well as the		
		r and said one was obtained			requirement that medical records		
		n completed on 10/01/24			accurately reflect the desires of the		
	atter the concern was	s identified by surveyor.			patient.		
					How the corrective action(s) will be		

Facility ID: 923073

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C
	ROVIDER OR SUPPLIER	340020		STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335	DDE	10/08/2024
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD B HE APPROPRIA	DATE
F 578	Continued From page		F 5	monitored to ensure the pracecur: The corporate nurse consul designee) will review all new once per week for four wee determine that the medical the wishes of the patient (dasigned). The audit will further review orders for new patients to e orders reflect the wishes of and that they reconcile with documents presented by the families declaring their desiadvanced directives. After four weeks, the corport consultant will audit 2-3 adreweekly for 2 additional week compliance is achieved. Audit records will be review Quality Assurance Performation Improvement (QAPI) community biweekly basis until such tinguistantial compliance has achieved. Corrective action completio 10/31/24	Itant (or w admission ks to record refle ated and all physiciansure that the patient the e resident ares related rate nurse missions ks until red by the ance littee on a me as been	ns cts an he and to
F 580 SS=J	CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the resid consistent with his or representative(s) when	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident	F 5	580		10/31/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING		C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/03/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 580	physician interventic (B) A significant chamental, or psychosod deterioration in heal status in either life-ticlinical complication (C) A need to alter to a need to discontinutreatment due to adcommence a new for (D) A decision to train resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatical is available and prosphysician. (iii) The facility must resident and the resident there is-(A) A change in room as specified in §483 (B) A change in resistate law or regulating (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a communitation accommunitation of the representative (s).	has the potential for requiring on; onge in the resident's physical, cial status (that is, a th, mental, or psychosocial preatening conditions or s); reatment significantly (that is, a e an existing form of overse consequences, or to orm of treatment); or onsfer or discharge the cility as specified in tification under paragraph (g) on, the facility must ensure that the tion specified in §483.15(c)(2) ovided upon request to the also promptly notify the ident representative, if any, or roommate assignment assignment as specified in paragraph on. The record and periodically (mailing and email) and	F 580			

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345325	B. WING			C 10/08/2024	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/0	0/2024	
			, , ,			
ROLTON OF DUNN			DUNN, NC 28335			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE	
F 580 Continued From page 6		F 58	0			
room changes between under §483.15(c)(9).	en its different locations					
Based on observation physician interviews, physician of tube feed through a tube directly were ordered continuor of 2 residents (Reside for an undetermined a instances. During observed off. Not turned Resident #60's and Repumps (the mechanis were observed off. Not turned Resident #60's feedings off without not despite her knowledg were ordered continuous "their stomach needed confirmed this was not either resident and should notifying the physician orders by the without notifying the physician orders. Nur disciplinary action at work in July of 2024 and the physician orders by the physician o	the facility failed to notify the dings (nutrition administered by into the stomach) that cously being turned off for 2 and #60 and Resident #74) amount of time and aservations on 10/3/24 are sident #74's feeding tube are that delivers the nutrition) are #1 confirmed she as and Resident #74's tube are that the tube feedings cously because she believed and a rest". Nurse #1 also not an isolated incident for the had done this before cohysician. Deviating from the curning off the tube feedings could be a see #1 had a history of the facility for substandard and in response she was to		include: On the morning of 10/3/24, Reside 60 and # 74 were observed to have feeding tubes turned to OFF position the nurse that placed the feeding printhe off position did not notify the physician. The same morning, be pumps were turned to the ON posissoon as the Director of Nursing she immediately to the patient rooms to all tube feeders and pumps. Upon checking, all feeding pumps were toon. The physician for both residents, 6 #74, was notified by the Administration the feedings had been stopped and restarted without notification to him physician immediately came to the to assess the patients, and no new were given. Identification of other residents have potential to be affected was accommended.	nts # e their on and oumps th tion as e went o check curned 0 and ator that d were n. The facility o orders		
This deficient practice residents (Resident # reviewed for physicia Immediate jeopardy the Nurse #1 turned off Resident practice.)	e was identified for 2 of 2 60 and Resident #74) n notification. Degan on 10/3/24 when Resident #60's and Resident		The facility has determined that all residents have the potential to be a when staff members deviate from I orders for care provision. Actions taken/systems put into place	MD ce to		
	Continued From page part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on observation physician interviews, physician of tube feed through a tube directly were ordered continued of 2 residents (Resident and the pumps (the mechanism were observed off. Noturned Resident #60's and Figure of the resident and should be were ordered continued their stomach needed confirmed this was not either resident and should be monitored while should be monitored	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74) for an undetermined amount of time and instances. During observations on 10/3/24 Resident #60's and Resident #74's feeding tube pumps (the mechanism that delivers the nutrition) were observed off. Nurse #1 confirmed she turned Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed "their stomach needed a rest". Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician. Deviating from the physician orders by turning off the tube feedings without notifying the physician deprived Resident #60 and Resident #74 of their assessed nutritional needs. Nurse #1 had a history of disciplinary action at the facility for substandard work in July of 2024 and in response she was to be monitored while she was working her shift. This deficient practice was identified for 2 of 2 residents (Resident #60 and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident #74's tube feeding without notifying the physician.	ROLTON OF DUNN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74) for an undetermined amount of time and instances. During observations on 10/3/24 Resident #60's and Resident #74's feeding tube pumps (the mechanism that delivers the nutrition) were observed off. Nurse #1 confirmed she turned Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed "their stomach needed a rest". Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician. Deviating from the physician orders by turning off the tube feedings without notifying the physician deprived Resident #60 and Resident #74 of their assessed nutritional needs. Nurse #1 had a history of disciplinary action at the facility for substandard work in July of 2024 and in response she was to be monitored while she was working her shift. This deficient practice was identified for 2 of 2 residents (Resident #60 and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident	ROLITON OF DUNN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under \$483.15(e)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74) for an undetermined amount of time and instances. During observations on 10/3/24 Resident 860's and Resident #74's feeding tube pumps (the mechanism that delivers the nutrition) were observed off. Nurse #1 tonfirmed she turned Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed "their stomach needd a rest". Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60 and Resident #74's tube feedings without notifying the physician deprived Resident #60's and Resident #74's tube feedings without notifying the physician deprived Resident #74's tube feedings without notifying the physician deprived Resident #74's tube feedings without notifying the physician deprived Resident #74's tube feedings without notifying the physician deprived Resident #74's tube feedi	ROLTON OF DUNN STREETADDRESS, CITY, STATE, 2IP CODE THI SUSAN TART ROAD DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §48a.3 15(c)(9). This RECUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74's for an undetermined amount of time and instances. During observations on 10/3/24 Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed "their resident and she had done this before without notifying the physician deprived Resident for either resident and she had done this before without notifying the physician deprived Resident #60's and Resident #74 of their assessed nutritional needs. Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician deprived Resident #60's and Resident #74 of their assessed nutritional needs. Nurse #1 also working her shift. This deficient practice was identified for 2 of 2 residents (Resident #60's and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident #74) reviewed for physician notification. Actions taken/systems put into place to reduce the risk of future occurrence	

Facility ID: 923073

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE	10/08/2024	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,		
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD		
				DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 580	30 Continued From page 7		F 580			
	when the facility imple	emented an acceptable		The licensed nurse who turned the		
	credible allegation of			feeding pumps off is no longer employ	ed.	
	_	will remain out of compliance		She was suspended and terminated		
	at a lower scope and			during the survey.		
		ed and monitoring systems		daming the salvey.		
	put in place are effect			All licensed nurses were in-serviced		
	pat in place are enect			regarding the facility policy for Notificat	tion	
	The findings included			of Changes, Policy 2.16 by the Directo		
	Review of Nurse #1's personnel file revealed she was employed in February 2024. Nurse #1's personnel file contained 1 employee disciplinary			Nursing (DON), Corporate Nurse		
				Consultant, and Chief Clinical Officer.		
				The in-services began on October 3, 2	024	
				and the education continued through	·	
	-	when she received a first		October 17 - 18, 2024. The Medical		
		ard work. The details of the		Director joined the education session t	o	
	occurrence document			teach and educate regarding the		
	assigned nurse to sur	pervise the medication aide		importance of following orders and		
	and multiple medicati			notifying him when deviance from the		
	medications were not	_		existing orders is necessary.		
	administered.					
				The orientation agenda was updated to		
	During an interview w	rith the Facility Nurse		include a review of Carrolton policy 2.1		
		of Nursing (DON), and Chief		reminding all licensed new employees		
	Clinical Officer on 10/	4/24 at 12:33 pm, the Chief		the company requirement to notify the	MD	
	Clinical Officer stated	the nursing supervision and		when a reason arises for order variance	e.	
	monitoring intervention	ons in place for Nurse #1		New employees are taught that the		
	after the incident in Ju	uly 2024 included daily		company has zero tolerance for failure	to	
	monitoring of essentia	al reports in the electronic		follow orders AND failure to notify the		
	medical record (EMR) to assure nurse		physician of changes in conditions that	t	
	supervision of medica	ation aides and all		dictate order deviance.		
	medications were cor	•				
		cian were completed by the		How the corrective action(s) will be		
	_	tant. The Facility Nurse		monitored to ensure the practice will no	ot	
		ate the length of time for the		recur:		
	•	1 and there was no written		The DON/Designee will review the		
	documentation for this			24-hour report, incident reports and		
		provided by the facility. The		grievances daily for three weeks		
		explained that new nurses		beginning 10/18/24 to ensure complian		
		ncy evaluation with a nurse		with notification of resident changes to	the	
	skills checklist that was completed during			attending physicians.		

Facility ID: 923073

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345325 B. WING			1	C / 08/2024		
	ROVIDER OR SUPPLIER	l	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335			1 10	100/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	orientation. Nurse #* checklist was unable Review of the nursing 8/8/24 through 10/3/2 assigned to Resident hall 32 days. The ass Nurse #1 shifts worke am until 3:30 pm and a. Resident #60 was 8/7/24 with diagnoses brain damage, dysph chronic obstructive prespiratory failure. The Registered Dietic assessment dated 8/Resident #60 needed 1708 cubic centimeter grams (g) of protein of tube feeding. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory failure. Review of the RD's prespiratory of the RD's prespiratory failure. Review of the RD's prespiratory failure.	l's competency skills to be located. g assignment sheets from 24 revealed Nurse #1 was #60's and Resident #74's signment sheet also revealed ed were double shifts (7:00 3:30 pm until 11:30 pm). re-admitted to the facility s which included anoxic agia (difficulty swallowing), ulmonary disease, and acute cian's (RD) nutritional 21/24 recommended d 1728 kilocalories (kcal) with ers (cc) free water and 90.4 daily from her continuous rogress note for Resident vealed a readmission 4. Resident #60's weight er tube feeding order was a per hour (ml/hr) with 135 cc 6 hours. No be feeding adequate as erated with weight stability.	F	580	Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) bi-weekly until su time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 10/08/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/00/2024
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 580	An empty tube feed feeding tube pole. In an interview on 1 #1 she indicated sh Resident #60 on nigam). When Nurse tube pump was off she intentionally tubecause she "thougrest". Nurse #1 exp formula was thick a feeding tubes and sneeded a rest". Nuthe decision on her pump off for 2 to 3 rest." Nurse #1 indi #60 was on continuphysician orders. Notify the physician tube pump off for Rwas no significant of #1 did not remember feeding tube pump 10/3/24. The following addition of Resident #60: - 10/3/24 at 3:53 ar pump continued to - 10/3/24 at 7:53 ar pump was on with a dated 10/3/24 at 5:stube pole	ding tube pump was turned off. ding bottle was hanging on the 10/3/24 at 3:43 am with Nurse he was the nurse assigned for 19th shift (11:00 pm until 7:30 pm	F 58		
		d she turned Resident #60's off when she "thought her			

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` · ·		(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335		0/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	was not a regular thin she "felt [the resident did not give a specific times she had turned or when she first beg tube pump. She state feeding pump] off who resident's stomach] is she did not notify the tube feeding off on a did not notify the tube feeding off on a did not notify the tube feeding off on a did not notify the tube feeding off on a did not notify the tube feeding off on a did not notify the tube feeding off on a did not not feed not not feed not not not feed not not not feed not not not feed not not feed not not not not feed not not not feed not not not not not not feed not	est". Nurse #1 stated "this ang" and she did this when a preded a break". Nurse #1 conswer as to how many a the feeding tube pump offician turning off the feeding ed she "turned [the tube are she thought [the areeded a rest". She revealed physician she turned the any previous instance. With the Registered Dietician and the area of the area	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345325	B. WING _		C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	_	10/00/2024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag	e 11 cian's (RD) nutritional	F 5	80		
	assessment dated 7, Resident #74 neede 1963 cubic centimete	/22/24 recommended d 1980 kilocalories (kcal) with ers (cc) free water and 83 ily from her tube feeding for				
	his tube feeding inclu- continuous tube feed milliliters per hour (m for 22 hours estimate 8:00 am until 10:00 a	e physician orders related to uded the following orders: eding via pump at 55 nl/hr) for nutritional support ed 2 hours (scheduled for am) downtime to allow for ag (ADL) care (initiated on				
	Resident #74's feedi A tube feeding bottle	0/3/24 at 3:10 am revealed ng tube pump was turned off. with approximately 100 c) was hanging on feeding				
	#1 she indicated she Resident #74 on niglam). When asked N pump was off for Reintentionally turned the because she "thought rest". Nurse #1 explation formula was thick and feeding tubes and should reded a rest". Nurse #1 edecision on her opump off for 2 to 3 horest." Nurse #1 indic #74 was on continuous physician orders. Nurse #1	avas the nurse assigned for an the shift (11:00 pm until 7:30 urse #1 why the feeding tube sident #74, she replied she are feeding tube pump off at her stomach needed a sined the tube feeding downetimes clogged the are just "thought her stomach se #1 explained she made own to "turn the tube feeding purs to give her stomach a lated she was aware Resident us tube feeding per rese #1 further stated she did an when she turned the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 0/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		0/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	there was no signif Nurse #1 did not rethe feeding tube put The following addit of Resident #74: - 10/3/24 at 3:55 as pump continued to - 10/3/24 at 7:55 as pump was on with dated 10/3/24 at 4: In a second intervie Nurse #1 she state feeding tube pump stomach needed a was not a regular tishe "felt [the resided did not give a spectimes she had turn or when she first be tube pump. She state feeding pump] off vesident's stomach she did not notify the tube feeding off on During an interview (RD) on 10/3/24 at #74's weight had be aware of Resident turned off and did reintentionally turned without notifying the	off for Resident #60 because icant change in her condition. Immember what time she turned imp off for Resident #74. It ional observations were made Imported the Resident #74's feeding tube be turned off. Imported the Resident #74's feeding tube a new bottle of tube feeding 30 am. It is on 10/3/24 at 3:26 pm with dishe turned Resident #74's off when she "thought her rest". Nurse #1 stated "this ning" and she did this when interest in the feeding tube pump off egan turning off the feeding ated she "turned [the tube when she thought [the in needed a rest". She revealed he physician she turned the any previous instance. If with the Registered Dietician 9:00 am, he stated Resident een stable. The RD was not interest in the RD indicated in the physician. The RD indicated	F 58			
	continuous tube fer short amount of time living or due to a cl	e physician. The RD indicated edings may be turned off for a lie to perform activities of daily nange in condition, but not for 2 e unless ordered by the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING		C 10/08/2024	
	ROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 580	had a physician's of to be turned off 2 had for ADL care. The Fineeded a physician tube pumps, and had to the physician. The feeding tube puweight loss; however calories and nutrient feeding. In an interview on 1 Director of Nursing tube feedings should physician's order. The was unaware of Nurther stated assessed the resident #74 which disregard DON further stated assessed the resident Resident #74) and inchanges in their condecisions on her own expected the nursing physician's orders any significant chart from the orders. During an interview the Physician, he stated the nursing physician further stated that could have expected the nursing physician further stated that could have expected the nursing physician further stated that could have expected that could have expected that could have expected turned off; however and the turned off; however and turned off; however a	further indicated Resident #74 rder for her feeding tube pump ours a day to allow downtime RD further explained Nurse #1 's order to turn off the feeding had not recommended this he RD further stated turning mp off could have caused her, his concern was the loss of hts provided by the tube 0/3/24 at 9:15 am with the (DON), she stated continuous d not be turned off without a he DON further stated she rese #1 turning the feeding Resident #60 and Resident ded the physician's order. The Nurse #1 should have hents (Resident #60 and hotified the physician of any hodition before making any hours and the stated she hours and hotified the polysician and hotified the physician of any hodition before making any hours and hotified the hours and hotified she	F 580			

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER			7′	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	10/0	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	turning off the tube fe #60 and Resident #74 calories and the nutric feeding. Another con was the fact that Nurs feeding tube pumps of before taking this actine did not like the nur decisions on their own The Physician indicat happen as a result of being turned off. He freason for the feeding off was not a good en make that decision. The Administrator wa Jeopardy on 10/4/24 The facility provided the allegation of immediate the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance. On 10/3/24 the feeding and #74 were observational money and the non-compliance.	ane of his concerns with edings was that Resident 4 were not receiving the ents provided from the tube incern noted by the physician is e #1 intentionally turned the off without notifying him on. The Physician indicated reses to make unreasonable in without any notification. The tube feeding pumps urther explained Nurse #1's grube pumps being turned arough reason for Nurse #1 to so in so in the following credible to jeopardy removal: The following credible to jeopardy removal:	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		10/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	All residents in the frisk for serious adverse actions of Nurse #1 On the morning of 1 the problem, the Dirimmediately to the rrosidents were foun were "on" and both currently dated and MD orders. The Director of Nursemedical records for morning of 10/3/24. There was no evide Nurse #1. The physician was reand behavior of the notified by the Admi	sidents #60 and #74. facility are deemed to be at erse outcome based on the . 0/3/24, upon notification of rector of Nursing went rooms of Residents #60 and ube feeding status. Both do to have feeding pumps that residents were found to have timed feedings infusing per sing reviewed the patient physician notification on the ence of MD notification by motified of the order deviance nurse on 10/3/24. He was inistrator.	F 5			
	enteral feedings, ind #74, were resumed ordered by the phys made on the mornir 9:00 am by the Dire On 10/3/24 the Dire Clinical Officer calle interview. Nurse # follow MD orders ar her conversations d surveyors. Nurse #1 acknowled	ed that all residents with cluding residents # 60 and and infusing at the rate sician. This confirmation was ag of 10/3/24 at approximately actor of Nursing. Actor of Nursing and the Chief and Nurse #1 to the facility for 1 was notified of her failure to a she was interviewed about turing the night with the adged that she did not have a top the tube feedings and did				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILE				
		345325	B. WING				08/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
0.5 D				7	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			С	DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	The Board of Nursing was completed and re the evening of 10/3/2 was conducted by the Clinical Officer, and N Prior to suspension, to Officer counseled and about her deviant pra After consultation with and the Chief Operatisuspended at approximate Education sessions wall licensed nurses are subjects: " Consult and notify the and need to alter treat" Provision of care to followed at all times, if feedings. The DON and Corport Clinical Officer conduted Education sessions was members until 100% received education. The Director of Nursing managers will review daily to ensure that all material effectively are members worked prion No licensed nurses we they have received the The Chief Clinical Off Nurse Consultant on nursing staff will be the education will continual understanding of the of significant changes.	an of the deviant practice. Complaint Evaluation Tool eviewed with Nurse #1 on 4. The employee meeting and Administrator, DON, Chief lurse Clinical Consultant. The DON and Chief Clinical dire-educated Nurse #1 octices. In the Chief Clinical Officer and Officer, she was imately 7:30 pm. Ivere begun on 10/3/24 with and included the following are MD of resident changes timents ensure that MD orders are including orders for enteral are Clinical Nurse and Chief cted the education sessions. It is a continue with all staff of the licensed nurses have education session sign ins a staff have received the and to ensure that no staff or to receiving it. It ill be allowed to work until	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	- '	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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) COMPLETION DATE
F 580	ZERO tolerance poson 10/3/24 the Chied Director of Nursing for to complete education returning to work. The nurses at the beginn would be held prior to the tolerance of the licensed Date of immediate jet. Validation of the immediate jet.	ents significantly, and our ition for rogue employees. f Clinical Officer notified the or the need and requirement on prior to employees he DON notified the hall ing of shifts that an inservice to the shift beginning. It is sions will continue until the nurses have been trained. It is popardy removal: 10/4/24	F 5	80		
F 600 SS=J	licensed nurses verified on consulting and not resident changes an and ensuring that phall times to include of licensed nurse worker receiving the educat tube feeding were of for accuracy: Reside 74, 80, and 341. All or on hold as ordere	ried education was providing obtifying the physician of d need to alter treatments sysician orders are followed at orders for tube feeding. No ed after 10/3/24 without ion. The following residents' observed, and orders checked ent #s 4, 28, 38, 41, 60, 64, tube feedings were running d. ardy removal date of 10/4/24	F 6	00		10/31/24

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD DUNN, NC 28335	10/	50/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's me \$483.12(a) (1) Not use physical abuse, corporation involuntary seclusion. This REQUIREMENT by: Based on record reviand physician intervie protect the residents' when Nurse #1 did not care and services as the physician to Resident on 10/03/24 Nurse # tube feedings (nutrition tube directly into the section of the physician's orders off depriving the resident nutritional needs. She new practice for her apreviously for both renumber of times. When	right to be free from abuse, tion of resident property, efined in this subpart. This lited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. If werbal, mental, sexual, or or oral punishment, or is not met as evidenced few, observation, and staff fews, the facility failed to right to be free from neglect of provide the necessary assessed and ordered by dent #60 and Resident #74. If turned their continuous on administered through a stomach) off because she chs needed a rest." Nurse only in the facility is orders, she led them, and she the decision to deviate from a and turn the tube feedings lents of their assessed e revealed this was not a and she had done this sidents an undetermined	F	600	Immediate action taken for the resident found to have been affected: On 10/3/24 the feeding pumps for Residents # 60 and # 74 were observe off for an undetermined amount of time Both Residents # 60 and # 74 were determined to be at risk for neglect bas on the actions of Nurse # 1. Nurse #1 was removed from the facility approximately 7:30 pm on 10/3/24. Nurse #1 was terminated on 10/4/24. The facility will ensure that both Reside # 60 and # 74 are free from neglect at a times. Identification of other residents having potential to be affected: All residents in the facility are deemed be at risk for neglect, based on the actions of Nurse #1.	d ed at ents all	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 10/08/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/03/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 600	risk of serious harm history of disciplinary substandard work in she was to be monito her shift. This deficie	e 19 yn, it places all residents at and/or death. Nurse #1 had a y action at the facility for July of 2024 and in response pred while she was working ent practice affected 2 of 2 or neglect (Resident #60 and	F 60	On the morning of 10/3/24, upon notification of the problem, the Dire Nursing immediately went to the ro all tube feeders (9 in total) to asses pump settings, dates and times of currently hung feedings, that pump	oms of ss the
	Resident #74). Immediate jeopardy Nurse #1 disregarde turned off Resident # tube feeding. Immed on 10/5/24 when the acceptable credible a jeopardy removal. Th compliance at a lower	began on 10/3/24 when d physician's orders and #60's and Resident #74's diate jeopardy was removed facility implemented an allegation of immediate he facility will remain out of er scope and severity D to completed and monitoring		on appropriately (per MD settings) that feedings were infusing accurat (based on MD orders). Actions taken / systems put into pla reduce the risk of future occurrence include: On the morning of 10/3/24 at approximately 8:30 am, the survey notified the Administrator of the tub feeding problem. All feeding pump checked, and no additional feeding were identified to be off.	and rely ace to e ors le ss were
	was employed in Fel personnel file docum the facility policies at written tests on these Nurse #1's personne employee disciplinar action was on 7/25/2 warning for substance occurrence documer assigned nurse to su and multiple medical medications were not administered.	s personnel file revealed she bruary 2024. Nurse #1's pented orientation training of and procedures which included a policies and procedures. If file also contained 1 by form. The first disciplinary 44 when she received a first flard work. The details of the anted Nurse #1 was the approvise the medication aide cions including seizure at documented as		The facility will ensure that all residincluding residents # 60 and #74, a always free from neglect. The Administrator, Director of Nurs (DON), and corporate clinical team monitor the facility and patient care delivery every shift to ensure that the nutrition and hydration needs of all patients are met based on MD order that no patient suffers neglect. The team will utilize our newly hired administrative nurse managers (incompassion Assistant Director of Nursing (ADOMDS nurses, treatment nurse, and resource nurses) facility management team, and lead CNAs to accomplise	ing will the
		with the Facility Nurse irector of Nursing (DON),		,	h the

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		ATE SURVEY OMPLETED	
345325		345325	B. WING			C 10/08/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	10/00/2024	
				711 SUSAN TART ROAD	_		
THE CAR	ROLTON OF DUNN			DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 20	F 60	00			
		ficer (CCO) on 10/4/24 at		was initiated on 10/3/24.			
	12:33 pm, the CCO			was illitiated off 10/5/24.			
	-	itoring interventions in place		The facility initiated Angel Ro	unds to he		
		e incident in July 2024		done every day by senior teal			
		oring of essential reports in		to ensure that no residents ha			
	_	al record (EMR) to assure		neglected or abused. The da			
		medication aides and all		are documented and reviewe			
		mpleted timely and as		morning meetings. The Admi			
	ordered by the physic	cian were completed by the		DON, ADON, and nurse man	agers will		
		not state the length of time		ensure that appropriate and n			
		Nurse #1 and there was no		action has been taken to rem	edy all		
		n for this plan of action for		identified negative findings.			
		provided by the facility. The					
		new nurses hired have a		The Director of Nursing will e			
	competency evaluati			the MD is notified timely of all			
		oleted during orientation.		discrepancies and plans for c	orrection.		
	unable to be located.	ncy skills checklist was		The Administrator, Director of	Nursing		
	unable to be located.			Corporate Nurse Consultant a			
	Review of the nursing	g assignment sheets from		MDS Nurse conducted educa			
		24 revealed Nurse #1 was		sessions beginning 10/4/24 w			
		t #60's and Resident #74's		that included the following sul			
		signment sheet also revealed		-Resident rights to be free fro	•		
		ed were double shifts (7:00		and neglect			
	am until 3:30 pm and	l 3:30 pm until 11:30 pm).		-Reporting abuse and neglect	t		
				-Carrolton policy # 3.10 Abuse	e, Neglect,		
	a. Resident #60 was	re-admitted to the facility		and Exploitation			
		s which included anoxic		-Definitions of abuse and neg			
		nagia (difficulty swallowing),		-Carrolton policies to ensure			
	-	ulmonary disease, and acute		are free of neglect and rogue	employees.		
	respiratory failure.						
	Desident #001	when dated 4/45/04		Education sessions will contin			
		plan dated 4/15/24 revealed		staff members until 100% of t			
	T	ube feeding related to		employees have received edu	ucation.		
		rventions included to monitor,		No employee will be allowed	to work until		
	document, report any	ortness of breath (SOB), tube		they have received the educa			
		alfunction. Resident #60 was		residents will be free from abo			
	_	feeding and water flushes.		neglect at all times.	acc and		

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING		C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	Continued From pa	ge 21	F 600			
	Data Set (MDS) ass revealed she was so Resident #60 had be impairment of the upper completely depended of daily living and concept Resident #60's weignounds. Review of Resident following: - 6/3/24 255.0 pour - 7/2/24 249.8 pour - 7/2/24 249.8 pour - 8/8/24 267.8 pour - 9/9/24 247.5 pour Resident #60's activities tube feeding inconcept - every day and night milliliters per hour (19/30/24) - every 6 hours flushed concept flushed Registered Die assessment dated 8	nds nds nds nds /e physician orders related to luded the following: nt shift tube feeding at 60 ml/hr) continuous (initiated on n with 135 cubic centimeters es (initiated on 8/7/24) tician's (RD) nutritional 8/21/24 recommended		New hires are trained in orientation, a education will continue within the faci ensure understanding of abuse and neglect prevention, including our ZEF TOLERANCE position for rogue employees. The Chief Clinical Officer reviewed th general orientation requirements with Clinical Nurse Consultant. This meet was held on 10/3/24 the requirement abuse training was re-enforced. How the corrective action will be monitored to ensure the practice will recur: Results from the shift-to-shift roundinchecking the status of feeding pumps be reviewed weekly in QAPI. Instance potential abuse and / or neglect will be analyzed to review root cause analys and weekly implementation of a plan ensure the incident is isolated and wirecur. Angel rounds will be reviewed daily be DON and biweekly by the Quality	e the ing for not g will ses of e is to Il not	
	1708 cubic centime	ed 1728 kilocalories (kcal) with ters (cc) free water and 90.4 daily from her continuous		Assurance Performance Improvement (QAPI) committee for the next 6 week ensure that patients remain free of all and neglect at all times.	rs to	
	#60 dated 8/21/24 r evaluation on 8/21/2 was 268 pounds. The noted as 50 ml/hr w	progress note for Resident evealed a readmission 24. Resident #60's weight ne tube feeding order was ith 135 cc water flushes every mendations, tube feeding		Corrective action completion date: 10/31/24		

Facility ID: 923073

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP 711 SUSAN TART ROAD DUNN, NC 28335	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIA	
F 600		e 22 , and well tolerated with	F 6	600		
	#60: - 10/3/24 at 3:08 am pump was turned off	ation was made of Resident Resident #60's feeding tube An empty tube feeding n the feeding tube pole				
	#1 she indicated she Resident #60 from 1 7:30 am on 10/03/24 Nurse #1 why the fee Resident #60, she re the feeding tube purher stomach needed the tube feeding form sometimes clogged to just "thought her stor #1 explained she mato "turn the tube feed to give her stomach is she was aware Residube feeding per phy stated she did not not turned the feeding tu #60 because there wher condition. Nurse	he feeding tubes and she mach needed a rest". Nurse de the decision on her own ling pump off for 2 to 3 hours a rest." Nurse #1 indicated dent #60 was on continuous sician orders Nurse #1 offy the physician when she be pump off for Resident was no significant change in #1 did not remember what eeding tube pump off for				
	of Resident #60: - 10/3/24 at 3:53 am pump continued to b - 10/3/24 at 7:53 am pump was on with a	Resident #60's feeding tube e turned off. Resident #60's feeding tube new bottle of tube feeding am hanging on the feeding				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		1	C 0/08/2024
	ROVIDER OR SUPPLIER	1 0.0020		STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335	10/08/2024 P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	record (EMR) reveal documented turning Nurse #1. Review of Resident Administration Recorded order every day feeding formula] at 6 initials electronically (12HR) on 10/2/24. In a second interview Nurse #1 she stated feeding tube pump of stomach needed a right was not a regular the "felt they needed a beautined the feeding tube first began turning of stated she "turned the their stomachs need was asked when she pump back on, Nurse feeding tube pump of a new bottle of tube 10/3/24. During an interview (RD) on 10/3/24 at 9 #60 had lost some of and out of the hospir readmitted from the	#60's electronic medical led no progress notes which the feeding tube pump off by #60's October Medication and (MAR) revealed enterally and night shift [name of tube 60 ml/hr with Nurse #1's signed for the night hours w on 10/3/24 at 3:26 pm with she turned Resident #60's off when she "thought her est". Nurse #1 stated "this ing" and did this when she preak". Nurse #1 did not give to how many times she had abe pump off or when she fif the feeding tube pump. She had a rest". When Nurse #1 et urned the feeding tube to e #1 indicated Resident #60's was turned on when she hung feeding at 5:43 am on with the Registered Dietician of the control o	F 60	00		
	was not aware of Repump being turned of	hospital on 8/7/24. The RD esident #60's feeding tube off and did not understand ionally turned the feeding				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	· · · · · ·	10/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	RD indicated a contiturned off for a short activities of daily livir in condition, but not unless ordered by the explained Nurse #11 turn off the feeding to recommended this to further stated turning could have caused voncern was the loss provided by the tube. Review of the RD's provided by the tube. Resident #60's tube weight loss. Resident #60's tube weight loss. Resident be 255 pounds with weight regain, and IN as attributing to weight loss. Bresident #74 was 7/11/24 with diagnos (difficulty swallowing and type 2 diabetes. The Registered Dieti assessment dated 7. Resident #74 needed 1963 cubic centimeter grams (g) protein da 22 continuous hours. Resident #74's care focus for tube feedin interventions include any signs/symptoms.	at notifying the physician. The fluous tube feeding may be amount of time to perform a g (ADL) or due to a change for 2 to 3 hours at a time e physician. The RD further needed a physician's order to tube pump, and he had not to the physician. The RD at the feeding tube pump off veight loss; however, his sof calories and nutrients feeding. Torogress note for Resident evealed he increased feeding on 9/19/24 due to the 460's weight was noted to brior weight loss and noted of fluids during hospital stay the fluctuations. To admitted to the facility on the es which included dysphagia had always and the feeding on 19/19/19/19/19/19/19/19/19/19/19/19/19/1	F 60				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 10/08/2024	
NAME OF P	ROVIDER OR SUPPLIER	V.1002	<u> </u>	_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2024
THE CAR	ROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	tube feeding and water Review of Resident # Data Set (MDS) asservealed she was sex Resident #74 requirer staff with activities of feeding tube. Review of Resident # following weights: - 7/11/24 154.9 pound - 8/6/24 154.9 pound - 8/6/24 156.6 pound - 9/6/24 160.0 pound Resident #74's active his tube feeding incluction - continuous tube feemilliliters per hour (ml for 22 hours estimate 8:00 am until 10:00 a activities of daily living 7/11/24) - water flushes every The following observation was turned off. approximately 100 cubanging on feeding to lin an interview on 10/#1 she indicated she Resident #74 from 11 7:30 am on 10/03/24	t #74 was dependent with er flushes. 74's quarterly Minimum ssment dated 8/7/24 verely cognitively impaired. d maximum assistance from daily living and coded for a 74's weights revealed the disclasses by the following orders: ding via pump at 55 l/hr) for nutritional support d 2 hours (scheduled for m) downtime to allow for g (ADL) care (initiated on 3 hours of 120 milliliters ation was made of Resident Resident #74's feeding tube A tube feeding bottle with libic centimeters (cc) was	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345325	B. WING _			C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 711 SUSAN TART ROAD DUNN, NC 28335	DE	10/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	the feeding tube purher stomach needed the tube feeding for sometimes clogged just "thought her sto #1 explained she mato "turn the tube fee to give her stomach she was aware Resitube feeding per phyfurther stated she di when she turned the Resident #60 becauchange in her condiremember what time pump off for Resident progress notes whice feeding tube pump of Review of Resident Administration Reconstruction Reconstruction Reconstruction Reconstruction Resident #74: - 10/3/24 at 3:55 ampump continued to be 10/3/24 at 7:55 ampump was on with a dated 10/3/24 at 4:3	eplied she intentionally turned in poff because she "thought it a rest". Nurse #1 explained mula was thick and the feeding tubes and she mach needed a rest". Nurse ade the decision on her own ding pump off for 2 to 3 hours a rest." Nurse #1 indicated dent #74 was on continuous visician orders. Nurse #1 d not notify the physician is feeding tube pump off for see there was no significant ition. Nurse #1 did not eshe turned the feeding tube int #74. #74's EMR revealed no h documented turning the off by Nurse #1. #74's October Medication and (MAR) revealed the very shift for nutritional action [name of tube feeding with Nurse #1's initials if for the night hours on onal observations were made. Resident #74's feeding tube are turned off. Resident #74's feeding tube new bottle of tube feeding	F 6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345325	B. WING _			C 0/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335		0/06/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	feeding tube pump of stomach needed a rewas not a regular thir "felt they needed a be a specific answer as turned the feeding tulfirst began turning off stated she "turned the their stomachs needed was asked when she pump back on, Nurse feeding tube pump was a new bottle of tube fam. During an interview was (RD) on 10/3/24 at 9: #74's weight had bee aware of Resident #7 turned off and did not intentionally turned the without notifying the protocommon to time living or due to a charto 3 hours at a time uphysician. The RD furned a physician's ord to be turned off 2 hours for ADL care. The RD furneded a physician's tube pumps, and he led to the physician. The the feeding tube pump weight loss; however	she turned Resident #74's if when she "thought her ist". Nurse #1 stated "this ng" and did this when she reak". Nurse #1 did not give to how many times she had be pump off or when she if the feeding tube pump. She em off when she thought ed a rest". When Nurse #1 turned the feeding tube e #1 indicated Resident #74's as turned on when she hung feeding at 10/3/24 at 4:30 with the Registered Dietician 00 am, he stated Resident en stable. The RD was not if '4's feeding tube pump being t understand why Nurse #1 he feeding tube pump off ohysician. The RD indicated ings may be turned off for a to perform activities of daily nge in condition, but not for 2	F6	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				-		(C
		345325	B. WING			10/	08/2024
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	711 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN				DUNN, NC 28335		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	28		600			
1 000	· -		-	600			
	In an interview on 10/3/24 at 9:15 am with the						
		OON), she stated continuous					
		not be turned off without a e DON further stated she					
		e #1 turning the feeding esident #60 and Resident					
		ed the physician's order. The					
	DON further stated N						
	assessed the residents (Resident #60 and Resident #74) and notified the physician of any						
	,	lition before making any					
		. The DON indicated she					
	expected the nursing						
	physician's orders as						
	resident's necessary						
	During an interview o	n 10/3/24 at 12:00 pm with					
	the Physician, he stat	ted he was not aware of					
		Resident #74's feeding tube					
	pumps were being tu	rned off. The Physician					
	further stated if there	had been a change in the					
	residents' condition s	uch as shortness of breath					
	(SOB), vomiting, or g	urgling that could have					
	explained the feeding	tube pumps being turned					
	off; however, he was	not notified of this for					
	Resident #60 or Resi						
		one of his concerns were					
		sident #74 not receiving the					
		ients provided from the tube				ĺ	
	· ·	ncern noted by the Physician					
		se #1 intentionally turned the				ĺ	
		off without notifying him				ĺ	
		ion. The Physician indicated				ĺ	
		rses to make unreasonable				ĺ	
		n without any notification.				ĺ	
	_	ted that weight loss could				ĺ	
		the tube feeding pumps				ĺ	
		urther explained Nurse #1's					
	reason for the feeding	g tube pumps being turned					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED	
		345325	B. WING		C 10/08/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 600	make that decision.	enough reason for Nurse #1 to	F 600		
	allegation of immediate Identify recipients was to suffer a serious at the non-compliance. On 10/3/24 the feed and # 74 were observant of time. But were determined to on the actions of Nurse #1 was remarked approximately 7:30 Nurse #1 was terminated for serious advineglect, based on the on the morning of the problem, the Di went to the rooms of assess the pump securrently hung feed appropriately (per Nurse infusing accurate or produced in the problem of the problem	ding pumps for Residents # 60 erved off for an undetermined oth Residents # 60 and # 74 be at risk for neglect based urse # 1. oved from the facility at pm on 10/3/24. inated on 10/4/24. facility are deemed to be at erse outcome including he actions of Nurse #1. 10/3/24, upon notification of rector of Nursing immediately of all tube feeders (9 in total) to ettings, dates and times of lings, that pumps were "on" MD settings) and that feedings rately (based on MD orders). the entity will take to alter the event serious adverse urring or recurring.			
		10/3/24 at approximately 8:30 notified the Administrator of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345325	B. WING _			C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	'	10.00.2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Administrator notifie approximately 8:40 went immediately to and #74 to assess the residents were found that were "on", both currently dated and MD orders. The facility will ensure residents # 60 and # all times. The Admi Corporate team will patient care delivery nutrition and hydrati met based on MD or The team will utilize administrative nurses MDS nurses, treatmenurses) facility mana CNAs to accomplish This rounding was in additional personner rounding, they will be The DON, ADON, a review findings first that appropriate and taken to remedy all the Director will ensure timely of all discrepance rounced.	e state notification, the d the DON. The time was am. The Director of Nursing the rooms of Residents #60 ne tube feeding status. Both d to have feedings pumps residents were found to have timed feedings infusing per re that all residents including f74 are free from neglect - at histrator, DON, and monitor the facility and revery shift to ensure that the on needs of all patients are rders. Our newly hired managers (including ADON, ent nurse, and resource agement team, and lead in the shift to shift rounding. Initiated on 10/3/24. As is utilized to complete this e educated. Ind nurse managers will thing every morning to ensure indentified negative findings. Sure that the MD is notified	F	600			
	Clinical Director and education sessions included the following	RN / MDS Nurses began on 10/4/24 with all staff and ng subjects: be free from abuse and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING				C 08/2024	
	ROVIDER OR SUPPLIER		•	7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD DUNN, NC 28335		3 0/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	of neglect and rogue Education sessions of members until 100% received education. No employee will be have received the education will continue within the understanding of about including our ZERO rogue employees. To reviewed the general with the Clinical Nurse was held on 10/3/24 training was re-enfort. The Director of Nurse managers will review ensure that all staff in staff members work poate of immediate jet. Validation of the creatives was completed on 10/3/24. Nurse #1 was suspessionally nurse #1 was terminal ling review of Nurse #1 records revealed doc disciplinary forms an Nursing (NCBON) Commended.	e and neglect ensure all residents are free employees. will continue with all staff of the employees have allowed to work until they ducation. It is in orientation and education are facility to ensure use and neglect prevention, TOLERANCE position for the Chief Clinical Officer orientation requirements are Consultant. This meeting the requirement for abuse ced. Ing. ADON, and nurse or education session daily to have received and that no prior to receiving it. It is pardy removal - 10/5/24 Itible allegation of IJ removal 10/8/24: Indeed from the facility on atted on 10/4/24. It's Human Resource (HR)	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER	1.0020	-	5	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	<u> 10/</u>	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	(BON) for Nurse #1 of There was a signed of departments who part abuse and neglect data. There was a signed of participated in in-service following the physicia 10/4/24. The in-service following resident 10/4/24. The following resident observed, and orders. Resident #s 4, 28, 38 341. All tube feedings were ordered. On 10/8/24 at 11:30 a assistants, the newly Nursing (second day) were interviewed. All abuse/neglect in-service in action-service. The Director of Nursing the daily on-going in have an order for tube status of the pump stof feed per physician.	ed with the Board of Nursing on 10/7/24 at 10 am. oster of staff in all ticipated in in-service for ated 10/3/24 and 10/4/24. oster of nursing staff who rice for tube feeding and in order dated 10/3/24 and ces were completed by ts' tube feeding were checked for accuracy: 4, 41, 60, 64, 74, 80, and e running or on hold as am 2 nurses, 4 nursing hired Assistant Director of and 1 housekeeping staff at staff had participated in vice and nursing staff eed/following physician ddition to the abuse and provided documentation audits of all residents that the feeding to evaluate the atus/infusion rate and type	F	600			
F 636 SS=D	was validated. Comprehensive Asse	essments & Timing	F	636			10/31/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345325	B. WING				0
		345325	D. WING			10/	08/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				711 SUSAN TART ROAD		
7712	102101101 201111			I	DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					,		
F 636	Continued From page CFR(s): 483.20(b)(1)(§483.20 Resident Ass	(2)(i)(iii)	F	636			
	a comprehensive, acc	luct initially and periodically curate, standardized nent of each resident's					
	§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.						
	(xi) Dental and nutritic (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation	ts and procedures. ing. of summary information nal assessment performed gered by the completion of ot (MDS).					

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			10/	08/2024
	ROVIDER OR SUPPLIER	1 0,002		71	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	107	06/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When a timeframes prescribe chapter, a facility must assessment of a reside timeframes specified through (iii) of this seep prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii) Not less than once This REQUIREMENT by: Based on record revifacility failed to complicate Set (MDS) asset timeframe for 1 of 1 in reviewed for MDS asset timeframe for 1 of 1 in reviewed for MDS asset in the second	ation and communication well as communication with need direct care staff s. required. Subject to the d in §413.343(b) of this et conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility r absence for hospitalization e every 12 months. T is not met as evidenced iew and staff interviews, the lete the admission Minimum ressment within the required newly admitted resident sessments (Resident #341). dmitted on 9/09/24. ission Minimum Data Set had not been completed	F	636	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #341 was discharged from the facility on 10/14/2024. The MDS Team completed a Comprehensive Assessme for resident # 341 on 10/1/2024. Identification of other residents having a potential to be affected was accomplish by: All residents of this facility have the potential to be affected by this practice. Actions taken/systems put into place to reduce the risk of future occurrence.	ent the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 636	assessments that hat because there had because there had befor approximately 3 remarks that we assessments that we During an interview of Administrator stated there were MDS assessments there were MDS assessments that we are more than the state of the	d not been completed een no full-time MDS staff months until 9/30/24. The c-tracking to complete all ere not completed. on 10/04/24 at 1:15 pm, the he was made aware that essments that had not been e stated the facility had hired es, and remote MDS nurses	Fé	include: The facility hired two Regresponsible for all MDS pincluding developing Cornesponsible for all MDS pincluding developing Cornesponsible for all MDS pincluding developing Cornesponsible for all MDS processes 2024. MDS Coordinators 100% facility audit on our assessments to be completed assessments to be completed for folionical Officer met with the Director of Nursing and A October 10, 2024, to reviand to discuss the distribution The MDS team was also the importance of completed comprehensive, accurate reproducible assessment residents functional ability meeting. How the corrective action monitored to ensure the recur: The Facility Nurse Consumpletion of compreher assessments weekly for monthly for 2 months. Audit results will be reviet the Quality Assurance Pelimprovement (QAPI) unticonsistent substantial co	corrocesses, mprehensive aber 30, 2024. cer initiated an on October 2, s completed a tstanding bleted on October cer and the Chief the MDS team, Administrator on iew audit results bution of duties. Te-educated on eting a timely e, standardized t of each ties during this an(s) will be practice will not ultant or member eam will audit at as for timely nsive 4 weeks and then ewed biweekly by erformance il such time	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
						l	C	
		345325	B. WING _			10/	08/2024	
NAME OF PE	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARE	ROLTON OF DUNN			71	1 SUSAN TART ROAD			
THE OAK	OLION OF BONN			D	UNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	Continued From page	≥ 36	F	636	been achieved as determined by the committee. Corrective action completion date: 10/31/24			
	Qrtly Assessment at L CFR(s): 483.20(c)	Least Every 3 Months	F	638			10/31/24	
	and approved by CMs once every 3 months. This REQUIREMENT by: Based on record revifacility failed to compl Set (MDS) assessme 14-day timeframe afte Reference Date (ARE assessment look-bac residents' MDS asses #s 5, 10, 13, 49, 62, 6 Findings included: a. Resident #49 was a Resident #49's quarte an Assessment Refer day of the assessment 7/19/24 was incomplet 10/3/24. b. Resident #5 was as	a resident using the ument specified by the State S not less frequently than is not met as evidenced lew and staff interviews, the lete quarterly Minimum Data ints within the required er the Assessment D, the last day of the k period) for 8 of 21 issments reviewed (Resident 63, 69, and 71). Admitted on 2/9/21. erly MDS assessment with rence Date (ARD, the last int look-back period) of ete when reviewed on inditted on 12/24/13.			F 638 Qrtly Assessment at Leas Every 3 Months SS E Immediate action(s) taken for the resident(s) found to have been affected include: The MDS team completed quarterly assessment on the following residents: -Resident #5 on 10/4/24 -Resident #10 on 9/24/24 -Resident #13 on 10/15/24 -Resident #49 on 10/15/24 -Resident #62 on 10/2/24 -Resident #63 on 10/8/24 -Resident #69 on 10/21/24 -Resident #71 on 10/10/24 The facility □s new MDS nurses have	i		
	Assessment Reference	•			implemented calendars to ensure timel completion of all upcoming quarterly assessements. Identification of other residents having			

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/03/2024
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 638	c. Resident #71 was		F 63	potential to be affected was accorby: All residents of this facility have	
	an Assessment Refe	rence Date (ARD, the last nt look-back period) of in progress and was		Actions taken/systems put into preduce the risk of future occurred include: The facility hired two Registered	ractice. place to nce Nurses
	d. Resident #13 was admitted on 2/1/22. Resident #13's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/16/24 was noted as in progress and was incomplete as of 10/2/24.			responsible for all MDS processincluding developing Compreher Assessments on September 30, The Chief Operating Officer initial audit of MDS processes on Octo 2024. MDS Coordinators compl 100% facility audit on outstanding	nsive 2024. ated an ober 2, eted a
	an Assessment Reference day of the assessment	admitted on 9/7/22. erly MDS assessment with rence Date (ARD, the last nt look-back period) of as completed on 10/2/24.		assessments to be completed or 8, 2024. The Chief Operating Officer and Clinical Officer met with the MDS Director of Nursing and Administ	n October the Chief S team,
	f. Resident #63 was admitted on 2/29/24. Resident #63's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/15/24 was signed as completed on 9/24/24.			October 10, 2024 to review audition and to discuss the distribution of The MDS team was also re-educate importance of assessing residusing the quarterly review instruspecified by the State and approximately and specified by the state and approximately review.	t results f duties. cated on idents ment
	Resident #69's quarte an Assessment Refe day of the assessme	admitted on 12/22/22. erly MDS assessment with rence Date (ARD, the last nt look-back period) of as completed on 9/24/24.		CMS no less than once every th months during this meeting. How the corrective action(s) will monitored to ensure the practice	ree be
	9/25/23. Resident #10's quarte	admitted to the facility on erly MDS assessment with rence Date (ARD, the last		recur: The Corporate Nurse Consultan member of the corporate clinical audit at random 5 resident recortimely completion of quarterly	team will

Facility ID: 923073

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345325	B. WING		1	C 0/08/2024
NAME OF PI	ROVIDER OR SUPPLIER	1 0.0020		STREET ADDRESS, CITY, STATE, ZIP CO		0/06/2024
THE CARROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 638	Continued From page	e 38	F 63	8		
		nt look-back period) of as completed on 9/24/24.		assessments biweekly for 8 then monthly for 2 months.	weeks and	
	10/3/24 at 5:06 pm, s MDS assessments w 14 day time frame pr were no consistent M complete the assessi MDS nurse who work further explained that aware the completion assessments were be administration asked department to get ca During an interview w 10/3/24 at 4:57 pm, s work at the facility on there were several qualiscovered on 9/30/2 and they were working assessments. She further working assessments were the fourteen days of the working During an interview working Consultant on 10/3/2 quarterly MDS assess	her to help the MDS ught up. with MDS Nurse #1 on the stated she started to 19/30/24. She explained uarterly MDS assessments 4 which were incomplete, ng to complete these rther explained that quarterly were to be completed within		Audit results will be reviewed the Quality Assurance Performment (QAPI) Community Such time consistent substate compliance has been achied etermined by the committee Corrective action completion 10/31/24	ormance nittee until untial ved as ee.	
	10/3/24 at 4:50 pm, hassessments needed regulatory fourteen dinterview on 10/4/24 when he started at the	with the Administrator on the stated the quarterly MDS of to be completed within the ay time frame. In a follow up at 1:15 pm, he explained the facility on 8/30/2024 he was behind in completing				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 10/08/2024
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN		:	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10.00202	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 638	had hired two MDS r nurses to help the fa the quarterly MDS as	esments. He stated the facility nurses and remote MDS cility catch up in completing ssessments	F 638		
F 644 SS=D	S483.20(e) Coordinal A facility must coordinal A facility must coordinal A facility must coordinal Pre-admission screet (PASARR) program of this part to the male avoid duplicative test includes: §483.20(e)(1)Incorporation from the PASARR lead PASARR evaluation assessment, care placare. §483.20(e)(2) Referrall residents with new serious mental disorder related condition for a significant change. This REQUIREMENT by: Based on record reviacility failed to ensure diagnoses of mental Level 2 Preadmission Review (PASRR) after the present the serious mental condition for the serious mental disorder the serious ment		F 644	Immediate action(s) taken for the resident(s) found to have been affected include: A Level II Preadmission Screening and Resident Review (PASARR) was submitted for Resident # 26 on 10-02-26 however the request contained an error A representative from North Carolina Medical Orders for Scope of Treatment (NC MOST) deleted the request on	1 24 or.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			l	08/ 2024	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2024	
					11 SUSAN TART ROAD			
THE CARE	THE CARROLTON OF DUNN				UNN, NC 28335			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 644	Continued From page	e 40	F 6	644				
		ed 6/22/2015 indicated meet the federal definition mental retardation.			10-31-24 and a new, corrected Level II PASARR was submitted. A new Minimum Data Set (MDS)			
	8/2/24 with diagnoses serious mental health people think, feel and	ental illness characterized			Assessment will be completed immediately when the PASARR Level approved. The new assessment will not his diagnoses correctly as well as his medications. Identification of other residents having	ote the		
	#26 was ordered Hale	ed 8/2/24 recorded Resident operidol (an antipsychotic ms twice a day for paranoid			potential to be affected was accomplish by: All residents in the facility have the potential to be negatively affected.			
	was not currently con PASRR process to ha	9/24 noted Resident #26 sidered by the state level II have a serious mental illness.			Actions taken/systems put into place to reduce the risk of future occurrence include: An audit was completed on October 30 all the PASARRs to ensure that the PASARRs are accurate and coordinate	of		
	the use of antipsycho schizophrenia. Intervo administering antipsy physician ordered and effectiveness.	chotic medications as d monitoring for			with MDS assessments appropriately. A new notebook was implemented with the PASARRs printed in alphabetical order by patient in order such that a weekly audit can be completed based on all new admissions. The PASARR process will be managed by		on I by	
	schizophrenia and a Resident #26's histor hallucinations, the ref verbal aggression. The for treatment consiste #26's medication region A quarterly MDS asset	26 had a history of paranoid bipolar disorder and reported y of behaviors included fusal of foods, agitation and ne psychiatric physician planed of no change in Resident			How the corrective action(s) will be monitored to ensure the practice will no recur: Corporate nurse consultant completed educated the Dunn senior leadership of 10-26-24 regarding the importance of PASARR definitions, the PASARR Leverocess, the audit, and the newly implemented PASARR management	ot n		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335	DE	10/00/2024
(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 IE APPROPRIATE	(X5) COMPLETION DATE
F 644	Continued From page	e 41	F 6	44		
	received antipsychotic basis. A review of the Septer 2024 Medication Admit documented Resident medications as a behind medication	mber 2024 and October ninistration Record t #26's refusal of avior. Haloperidol 2 ded as given daily as view with the Social Worker n, she explained Resident or to her employment at the september 2024. She stated I Resident #26's diagnoses acility and this should have mission. She explained Revel 1 determination ty days from the time of arther explained she had or a PASRR Level 2 after there had been an sident #26's PASRR status. With the Clinical Nurse dministrator present on he stated the Social Worker d a PASRR Level 2 for Resident #26's admitting hrenia and bipolar disorder.		protocol. Corporate nurse consultant a weekly audit to ensure tha admissions have accurate P based on patient specific mediagnoses. Audit results will be reviewed the Quality Assurance Perfor Improvement (QAPI) Comm such time consistent substant compliance has been achieved determined by the committee Corrective action completion 10/31/24	t all new ASARRs edications and d biweekly by rmance ittee until ntial ved as e.	
F 655 SS=D	Baseline Care Plan	-(3)	F 6	55		10/31/24
	, , , , , , , , , , , , , , , , , , , ,	sive Person-Centered Care				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	TE SURVEY MPLETED
		345325	B. WING			C 1 0/08/2024
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		10/08/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON TO THE APPROPRIES OF THE APPROPRIES	JLD BE	(X5) COMPLETION DATE
F 655	implement a baselin that includes the ins effective and persor that meet professior The baseline care p (i) Be developed wit admission. (ii) Include the minimacessary to proper including, but not lin (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy service (E) Social services. (F) PASARR recombers (F) PASARR recombersive care plan if the combersion (ii) Is developed with admission. (iii) Meets the require (b) of this section (e) the baseline care limited to: (ii) A summary of the dietary instructions. (iii) Any services are	e Care Plans acility must develop and e care plan for each resident tructions needed to provide n-centered care of the resident hal standards of quality care. Ilan must- hin 48 hours of a resident's num healthcare information ly care for a resident nited to- ed on admission orders. S. s. mendation, if applicable. acility may develop a e plan in place of the baseline prehensive care plan- nin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the presentative with a summary plan that includes but is not of the resident. e resident's medications and	F 65			

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 10/08/2024
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	1 10/05/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 655	of the comprehensive This REQUIREMENT by: Based on record refacility failed to created 48 hours of a resident residents (Resident care plans. The findings included Resident #341 was 9/9/24 with diagnost intracerebral hemoral dysphagia (trouble see Resident #341's Mirassessment dated 9 speech, could rarely others, was unable that assessment, and has wound (a wound downwound (a wound downwound failed and the see Resident #341. In an interview on 10 Director of Nursing in baseline care plate #341. She said the little was no docur medical record of a Resident #341.	commation based on the details be care plan, as necessary. It is not met as evidenced view and staff interviews, the te a baseline care plan within int's admission for 1 of 2 #341) reviewed for baseline d: admitted to the facility on es including nontraumatic rhage (brain bleed) and swallowing). Inimum Data Set (MDS) 1/16/24 noted he had no or or was unable to understand to participate in the ad an unhealed Stage IV win to the bone). Inimum Data Set (MDS) 1/16/24 noted he had no or or was unable to understand to participate in the ad an unhealed Stage IV win to the bone). Inimum Data Set (MDS) 1/16/24 noted he had no or or was unable to understand to participate in the ad an unhealed Stage IV win to the bone). Inimum Colo3/24 at 4:54 PM, the (DON) confirmed there was an completed for Resident baseline care plan should and by the charge nurse within	F 65	Immediate action(s) taken for the resident(s) found to have been affer include: Resident # 341 discharged from the facility on 10/14/2024. His comprescare plan initiated on 9/10/24 was completed on 9/18/24 by the MDS Identification of other residents have potential to be affected was accome by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place reduce the risk of future occurrence include: The facility hired two Registered N responsible for all MDS processes, including developing baseline care on September 30, 2024. Interdisciplinary care plan team me responsible for completing baseline plans were re-educated on the facility policy and procedure for developing Baseline Care Plans, by the Chief Operating Officer and the Chief Clief Officer on October 10, 2024.	e whensive nurse. ving the uplished ce to e urses plans embers e care elity's g
				A 100% audit of all residents admit the last 14 days was initiated the w October 27, 2024, by the Chief Clir	eek of

Facility ID: 923073

C C 10/08/2	3/2024
10/00/2	3/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CARROLTON OF DUNN 711 SUSAN TART ROAD	
DUNN, NC 28335	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COOKS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655 Continued From page 44 F 655 Continued From page 44 F 655 Officer to ensure that base line care plans are completed within 48 hours of admission to the facility. All baseline care plans had been completed timely. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Corporate Nurse Consultant or designee will conduct a weekly audit of admissions to ensure that baseline care plans have been completed within 48 hours of admission to the facility and summaries are provided to residents/resident representatives. The Corporate Nurse Consultant will send any discrepancies found to the Director of Nursing and Administrator for immediate follow-up. This review will continue weekly for four (4) consecutive weeks. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. F 677 SS=D ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	0/31/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345325	B. WING			C 10/08/2024
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	l	10/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	representative inter	ge 45 eview, observation, resident view, and staff interviews, the vide incontinence care to a ependent on staff for activities	F 6	Immediate action(s) taken for t resident(s) found to have been include: Incontinence care was immedia	affected	
	of daily living (ADL) (Resident #20). Findings included:	for 1 of 1 resident reviewed		provided for resident # 20 in the of the surveyor. The Chief Clinical Officer met w Director of Nursing, Facility Nur Consultant and Lead Nursing A	e presence with the rse ssistant to	
	Resident #20 was admitted to the facility on 3/15/21 with diagnoses included non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS)			review the nursing assistant ass for 10/2/24. Nursing Assistant assignments were revised to accommodate for new admission 400 hall.	•	
	was moderately cog frequently incontine quarterly MDS indic partial assistance w Resident #20's care	7/25/24 indicated the resident gnitively impaired and was ent of urine and stool. The cated Resident #20 required with toileting. e plan that was last reviewed esident #20 was at risk for a		Identification of other residents potential to be affected was accepy: The facility has determined that residents have the potential to laffected.	complished	
	not performing ADL impaired cognition. providing extensive needs. Resident #2 focus for bowel and Interventions includ #20 for incontinence cleaning the perine and genitals) with e On 10/2/24 at 11:20 Resident #20's Resident #23 (who roommate), Reside adult brief had not be	due to impaired mobility and Interventions included staff assistance with toileting 0's care plan also included a I bladder incontinence. Led staff monitoring Resident e of urine and stool and um (space between the anus ach incontinent episode. Diam in an interview with dident Representative, was also Resident #20's not #23 stated Resident #20's peen changed since 9:00 pm and #23 stated no one had been		Actions taken/systems put into reduce the risk of future occurre include: The Director of Nursing (DON)/. Director of Nursing (ADON)/Nursupervisors instituted a daily renursing assistant assignments that the distribution of residents accurate and conducive to the ptimely care, including timely incorare. In-service education was conducted the Director of Nursing Services 14 -18, 2024 for all certified nursus assistants addressing the imporproper and timely incontinence	Assistant rsing eview of to assure is corovision of continence ucted by a October sing rtance of	

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN A. BUILDING B. WING THE CARROLTON OF DUNN	STATE, ZIP CODE	C 10/08/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S 711 SUSAN TART ROAD	STATE, ZIP CODE	_
711 SUSAN TART ROAD	STATE, ZIP CODE	
DUNN, NC 28335		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
breakfast. Resident #23's quarterly MDS assessment dated 7/12/24 indicated he was cognitively intact and he was observed during interviews alert and oriented to person, place, time and situation. On 10/2/24 at 11:25 am an interview was conducted with Resident #20. When Resident #20 was asked if her adult brief needed changing, she stated she did not think she was wet. Resident #20 agreed for nursing staff to check the adult brief for incontinence. On 10/2/24 at 11:26 am upon request of the surveyor, Nurse Aide (NA) #2 was observed checking Resident #20's adult brief for incontinence. Resident #20's adult brief was observed saturated with dark amber colored urine at the top of the adult brief. NA #2 stated Resident #20's adult brief was soaked and the pad underneath the resident was wet with urine also. There was no redness observed to Resident #20's skin. NA #2 was observed providing incontinent care to Resident #20, applying a clean adult brief and a new pad under Resident #20. On 10/02/24 at 11:30 am in an interview with NA #2, she explained NA #3 was the assigned nurse aide for Resident #20. On 10/2/24 at 11:33 am in an interview with NA #3, she stated at that time she had not checked Resident #20 for incontinence of urine or stool since she began her shift at 7:15 am. She stated	ing assistants will receive sion of timely by the litty Nurse Consultant ation process. We action(s) will be ure the practice will not dis will round daily for 4 and halls to assure that ce care is being management team erview all residents on the are able to interview on of incontinence care oncerns to the hall nurse the provision of the and report any all nurse immediately.	

Facility ID: 923073

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
		345325	B. WING _			l	08/2024
	ROVIDER OR SUPPLIER		•	71	REET ADDRESS, CITY, STATE, ZIP CODE I1 SUSAN TART ROAD UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	providing ADL care to planning to address incontinent needs needs incontinent needs incontinent needs incontinent needs needs incontinent needs	y two hours and had been to other residents and was Resident #20's bath and ext. ew with NA #3 on 10/2/24 at 10/2/24 was the first time to since she was readmitted explained before dent #20 would inform the ter adult brief needed to be need Resident #20 informed to brief did not need changed the three to with feeding her ted she did not check time. NA #3 admitted needs had changed since the included assisting the eding and the need to have because the resident to the bathroom and wasn't communicate incontinent. In in a phone interview with the had worked the 7:00 pm to 1/24 and was assigned to	F	377	the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24		
	incontinent care, over requesting not to che	g her with Resident #20's rheard Resident #23 eck Resident #20 during the ed Resident #20 had not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
		345325	B. WING		C 10/08/2024
	ROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD 1UNN, NC 28335	10/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 677	verbalized the need her night shift. She in Resident #20's A longer able to walk call bell to verbalize readmission to the notify the nurse or r day shift on 10/2/24 been checked or checause NA #3, wh #20 on 10/2/24, has she left the facility. On 10/2/24 at 4:40 he stated he had he #20's adult brief on recalled seeing NA (Resident #20's rep talking and stated h Resident #23 telling #20 for ADL care do #4 stated nurse aid every 2-3 hours and On 10/2/24 at 4:43 with Resident #23, room of Resident #23, room of Resident #21 hot to come into check on Resident #21 hot to check Resident #21 hot to check Resident #220's room needs. The DON's facility due to a cha	I for incontinent care during reported there was a change DL abilities as she was no to the bathroom and use the incontinent needs since facility. NA #1 said she did not hurse aide reporting for the that Resident #20 had not hanged during the night o was assigned to Resident donot reported to work before pm in an interview with NA #4, elped NA #1 changed Resident the evening of 10/1/24. NA #4 #1 and Resident #23 resentative and roommate) edid not recall hearing NA #1 not to check Resident uring the night of 10/1/24. NA es were to check all residents	F 677		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 10/08/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/00/2021
THE CAR	DOLTON OF BUNN			711 SUSAN TART ROAD	
THE CAR	ROLTON OF DUNN			DUNN, NC 28335	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 677	Continued From page	e 49	F 67	7	
	incontinent needs ev	ery two hours.			
F 684	Quality of Care		F 68	4	10/31/24
SS=D	CFR(s): 483.25				
	\$ 400 0F Outlife of a				
	§ 483.25 Quality of c	are Indamental principle that			
		nt and care provided to			
		sed on the comprehensive			
	_	dent, the facility must ensure			
		treatment and care in			
	accordance with prof	essional standards of			
	· ·	nensive person-centered			
	care plan, and the re				
	This REQUIREMENT by:	Γ is not met as evidenced			
	Based on record rev	iew and staff interviews, the		Immediate action(s) taken for the	
	facility failed to condu	uct and document an		resident(s) found to have been affect	ted
	_	assessment to identify and		include:	
		anges in the resident's		The nursing admission assessment f	
	cognitive and function			resident # 20 was completed on Octo	
		of 1 resident reviewed for		2, 2024, by the facility resource nurse	е.
	activities of daily livin	g (Resident #20).			
				Identification of other residents havin	_
	Findings included:			potential to be affected was accompl	isnea
	Pasident #20 was ad	mitted to the facility on		by: The facility has determined that all	
	3/15/21, with diagnos	mitted to the facility on		The facility has determined that all residents admitted to the facility have	the
	_	entia. Resident #20 was		potential to be affected.	s uie
		facility on 9/23/24 and		potential to be affected.	
		cility on 9/27/24 with a		Actions taken/systems put into place	to
		ed a fracture to right hip.		reduce the risk of future occurrence	
		·		include:	
	The significant chang	ge Minimum Data Set (MDS)		In-service education programs were	
		0/3/24 was reported as in		conducted by the Director of Nursing	on
		t complete. The quarterly		October 14-15, 2025, with all license	
	· -	ndicated resident #20 was		nurses to address the importance of	
		ly impaired and required		completing nursing assessments in a	1
	assistance setting up	her meal for eating, and		timely manner.	

		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343323	B: WiiNO	STREET ADDRESS, CITY, STATE, ZIP COD		0/08/2024	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	JE		
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page	e 50	F 68	34			
	assistance with toilet	ity and transfers and partial ing. The MDS also indicated equently incontinent of urine		The following items were disc -Carrolton PCC Admission C (detailing assessments due v hours)	Checklist		
	Resident #20's re-ad communicating the c function of Resident	g documentation since mission to the facility ognitive state and level of #20 in the electronic medical		-Importance of communicatin assessments not competed to oncoming shift.	o the		
	(an assessment that Resident #20's cogni located in Resident #	sion screening assessment would determine changes in tive and functional levels) 20's electronic medical Imission on 09/27/24.		How the corrective action(s) monitored to ensure the practicur: The Director of Nursing (DON designee, will monitor all facily admissions to ensure that as have occurred as scheduled Corrector PCC Admission Chemical	tice will not N), or lity sessments using the		
	on 10/2/24 at 11:47 a readmission to the fa able to recognize her	ne Director of Nursing (DON) im, she stated on cility, Resident #20 "was not incontinent needs, and staff on Resident #20 every 2		Carrolton PCC Admission Checklist. The Corporate Nurse Consultant or designee will conduct a daily audit of admissions from the preceding day to ensure that all admission assessments have been completed in a timely manner. The FNC will send any discrepancies			
	In an follow up interview with the DON on 10/2/24 at 4:34 pm, she stated Resident #20's admission screening assessment that would identify and communicate changes in Resident #20 when she was re-admitted to the facility after hospitalization			found to the Director of Nursi immediate follow-up. This re begin the week of 10/27/24 a daily for four (4) consecutive	ng for view will and continue		
	within 24 to 48 hours The DON further stat assigned to Resident Resident #20 returne not complete the adn assessment. The DO with Resident #20's a	N stated she left a packet admission screening		Audit results will be reviewed the Quality Assurance Perford Improvement (QAPI) Commits such time consistent substant compliance has been achieved determined by the committee Corrective action completion	mance ttee until ttial ed as		
		the nurses station and did urse #5, who was working		10/31/24			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(С
		345325	B. WING _			10/	08/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CADI	ROLTON OF DUNN			7	11 SUSAN TART ROAD		
THE CAR	ROLION OF DONN			D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	7:00pm to 7:00 am (n need to complete Res screening assessmen In an interview with N am, she stated she w am (night shift) on 9/2 Resident #20 returned 9/27/24, the DON ass responsible for complescreening assessmen reported to her on 9/2 that Resident #20 need screening assessmen not seen a packet for	ight shift) on 9/27/24 of the sident #20's admission at. urse #5 on 10/3/24 at 3:20 orked from 7:00 pm to 7:00 e7/24. She explained if d to the facility at 6:00pm on igned to Resident #20 was eting the admission at. Nurse #5 stated no one 7/24 upon reporting to work	F	684			
F 692 SS=E	on 10/3/24 at 4:35 pm #20 was re-admitted to DON assigned to Restarted Resident #20' assessment to detern changes. She explain to complete Resident assessment, the DON communicated the neadmission screening completed to Nurse # shift on 9/27/24. Nutrition/Hydration St CFR(s): 483.25(g)(1)-\$483.25(g) Assisted r (Includes naso-gastric both percutaneous er	ed for Resident #20's assessment to be 5 who was working the night atus Maintenance	F	692			10/31/24

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _				08/2024	
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	ensure that a resident §483.25(g)(1) Mainta of nutritional status, significant desirable body weigh balance, unless the redemonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydrates §483.25(g)(3) Is offer there is a nutritional provider orders at the This REQUIREMENT by: Based on observation physician interviews, administer tube feedings ordered by the phyreviewed for nutrition Resident #74, and Resident #74, and Resident #60 was 8/7/24 with diagnoses brain damage, dysphehronic obstructive purespiratory failure. Review of Resident #(MDS) dated 8/21/24 cognitively impaired. completely dependent	d on a resident's syment, the facility must telesis acceptable parameters uch as usual body weight or trange and electrolyte esident's clinical condition is is not possible or resident otherwise; and sufficient fluid intake to ation and health; and the health care rapeutic diet. It is not met as evidenced ans, record reviews, staff and the facility failed to a gastrostomy tube avsician for 3 of 3 residents maintenance (Resident #60, resident #341). The re-admitted to the facility is which included anoxic agia (difficulty swallowing), almonary disease, and acute and the second severely in the facility is which included anoxic agia (difficulty swallowing), almonary disease, and acute	F	392	Immediate action(s) taken for the resident(s) found to have been affected include: All residents with enteral feedings, including residents #60, #74 and #341, were checked to assure that tube feedings were infusing at the rate order by the physician. Nurse #1 was suspended on October 3 2024, pending the outcome of the investigation and consultation with the North Carolina Board of Nursing (NCBON). Nurse #1 was terminated or October 4, 2024, and subsequently reported to the NCBON. Identification of other residents having potential to be affected was accomplish by:	red s, n		

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 0/08/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP COD	•	0/08/2024
NAME OF T	TOVIDER OR GOLF EIER			711 SUSAN TART ROAD)L	
THE CAR	ROLTON OF DUNN			DUNN, NC 28335		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 692	Continued From page	e 53	F 69	02		
F 692	Resident #60's active her tube feeding inclu-every day and night milliliters per hour (m 9/30/24) - every 6 hours flush (cc) for water flushes The Registered Dietic assessment dated 8/Resident #60 needed 1708 cubic centimete grams (g) of protein of tube feeding. Review of the RD's p #60 dated 8/21/24 rereadmission evaluation new recommendation adequate as ordered weight stability. The following observe #60: - 10/3/24 at 3:08 am pump was turned off bottle was hanging of Review of Resident #following weights:	e physician orders related to uded the following: shift tube feeding at 60 I/hr) continuous (initiated on with 135 cubic centimeters (initiated on 8/7/24) cian's (RD) nutritional 21/24 recommended 1728 kilocalories (kcal) with ers (cc) free water and 90.4 daily from her continuous rogress note for Resident vealed completed a on on 8/21/24 and noted no ns, the tube feeding was and well tolerated with Resident #60's feeding tube An empty tube feeding in the feeding tube pole.	F 69	Weights for all residents on e feedings were reviewed for the months to identify any trends loss or residents needing interelated to weight loss. No newere noted. The facility has determined the residents that receive enteral have the potential to be affect. Actions taken/systems put intereduce the risk of future occur include: Education for Licensed Nurse All licensed nurses were inserted the Director of Nursing (DON Nurse Consultant (October 3-regarding the facilities expect providing enteral feedings as including: -Following MD orders (tube for rates, flushes and treatment of Notifying the MD of any resident change in conditionTube feedings are not to be a MD order to do so. Education for Certified Nursing All certified nursing assistants in-serviced by the DON/Corp	ne past three in weight erventions egative trends nat all feedings sted. to place to irrence es: erviced by)/Corporate -4, 2024), tations for ordered, eeding type, duration) dent ding or held without ng Assistants: s will be orate Nurse	
		ds ds		Consultant/Nursing Supervise 4-5) regarding the following: -If a feeding pump is noted to the alarm is sounding, the nu notified immediatelyAll residents with enteral fee be positioned with the head of	b be off, or arse is to be	

Facility ID: 923073

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 10/08/2024	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD	I	10/00/2024	
THE CAR	ROLTON OF DUNN			DUNN, NC 28335			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	feeding tube pump woreplied she intentional pump off because she needed a rest". Nurse decision on her own to pump off for 2 to 3 horest." Nurse #1 indica #60 was on continuous physician orders which necessary care and some cessary care and s	asked Nurse #1 why the as off for Resident #60, she ally turned the feeding tube e "thought her stomach e #1 explained she made the to "turn the tube feeding turn to give her stomach a ated she was aware Resident tus tube feeding per ch is part of Resident #60's services. 60's electronic medical ed no progress notes which the feeding tube pump off by the feeding tube pump off. Resident #60's feeding tube turned off. Resident #60's feeding tube the bottle of tube feeding	F 69	,	raining on y the istant orporate rientation ill be ce will not ole for all rge nurses and to monitor eports in ectronic		
	feeding tube pump of turning off the feeding #1 was asked when s pump back on, Nurse	iny times she had turned the if or when she first began g tube pump. When Nurse she turned the feeding tube #1 indicated Resident #60's as turned on when she hung eeding at 5:43 am on		Unannounced visits will include week for 4 weeks, 1 visit per m months (at a minimum). These unannounced visits will be made DON/ADON/FNC or CCO. Observation will include general practice, medication administration of enteral ferman seeks of the seeks	nonth for 2 e de by the al nursing ation and		

Facility ID: 923073

PRINTED: 11/19/2024 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M	<i>).</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		PLETED
		345325	B. WING				C / 08/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				71	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	UNN, NC 28335		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 692	Continued From page	e 55	F	692			
. 002	-			032	A pursing skills fair/somnetoney		
		vith the Registered Dietician 00 am, he stated Resident			-A nursing skills fair/competency assessment will be conducted for all		
	` '	eight possibly due to being in			licensed nurses beginning October 10		
	and out of the hospita	• • •			2024, to verify basic nursing skills to	,	
		nospital on 8/7/24. The RD			include, but not limited to:		
		sident #60's feeding tube			Enteral Feeding- skills verification to b	e	
	pump being turned off and did not understand				completed by 10/30/24	_	
	why Nurse #1 intentionally turned the feeding				Trach Care		
	tube pump off withou			Wound Care			
	RD indicated a contin			Medication and IV Administration			
	turned off for a short						
	activities of daily living			Additional Monitoring:			
	in condition, but not for			The DON/ADON will amend the week	У		
		e physician. The RD further			wound and weight meeting to include		
		eeded a physician's order to			weekly monitoring of weights for all		
		be pump, and he had not			residents receiving enteral feedings.		
		the physician. The RD			monitoring will occur weekly for the ne	xt	
		the feeding tube pump off			eight weeks, and at least monthly		
		eight loss; however, his			thereafter. This plan will be amended		
		of calories and nutrients			more frequent monitoring and addition		
	provided by the tube	reeding.			interventions for any noted weight loss	٠.	
	In an interview on 10	/3/24 at 9:15 am with the			The DON/ADON/FNC are responsible	for	
		OON), she stated continuous			reviewing reports, monitoring trends a		
	- '	not be turned off without a			ensuring timely corrective action is tak		
		e DON further stated she			as needed for all negative findings.		
	· •	e#1 turning the feeding tube			3		
		t #60 which disregarded the			Audit results will be reviewed biweekly	by	
		he DON further stated Nurse			the Quality Assurance Performance	•	
		ssed Resident #60 and			Improvement (QAPI) Committee until		
		of any changes in her			such time consistent substantial		
	condition before mak	ing any decisions on her			compliance has been achieved as		
		ated she expected the			determined by the committee.		
	_	the physician's orders as					
		resident's necessary care			Corrective action completion date:		
	and services.				10/31/24		
		n 10/3/24 at 12:00 pm with ted he was not aware of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CATION NUMBER:		IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING	_			C	
NAME OF D		345325	B. WING		TREET ADDRESS CITY STATE ZID CODE	10/	08/2024	
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	off. The Physician fibeen a change in the shortness of breath that could have explibeing turned off; howall. The Physician ewas Resident #60 nethe nutrients provide Another concern not fact that Nurse #1 in tube pump off without this action. The Physician ewas resident weight their own without an indicated that weight result of the tube feeding tube pump is good enough reason decision. 2. Resident #74 was 7/11/24 with diagnost (difficulty swallowing and type 2 diabetes The Registered Diet assessment dated 7 Resident #74 needed 1963 cubic centimet grams (g) protein da 22 continuous hours Review of Resident (MDS) dated 8/7/24 cognitively impaired maximum assistance	ing tube pump being turned urther stated if there had er residents' condition such as (SOB), vomiting, or gurgling ained the feeding tube pump wever, he was not notified at explained one of his concerns of receiving the calories, and ed from the tube feeding. It is tentionally turned the feeding ut notifying him before taking is cian indicated he did not like unreasonable decisions on y notification. The Physician it loss could happen as a reding pump being turned off. If Nurse #1's reason for the being turned off was not a in for Nurse #1 to make that is admitted to the facility on sees which included dysphagia good in the property of the sees which included dysphagia good in the sees which included dysphagia good in the sees which included dysphagia good in the sees which included dysphagia good included dysp	F	692				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C / 08/2024	
	ROVIDER OR SUPPLIER	1.022		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	1 10	106/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 692	her tube feeding inci-continuous tube feemilliliters per hour (r for 22 hours estimat 8:00 am until 10:00 activities of daily livi 7/11/24) - water flushes ever The following obser #74: - 10/3/24 at 3:10 am pump was turned of approximately 100 changing on feeding Review of Resident following weights: - 7/11/24 154.9 - 7/22/24 154.9 - 8/6/24 156.6 pour - 9/6/24 160.0 pour In an interview on 1 #1 she indicated she Resident #74. Whe feeding tube pump or replied she intentior pump off because s needed a rest". Nur decision on her owr pump off for 2 to 3 h rest." Nurse #1 indici #74 was on continue.	re physician orders related to sluded the following orders: eding via pump at 55 ml/hr) for nutritional support at 2 hours (scheduled for am) downtime to allow for ng (ADL) care (initiated on y 3 hours of 120 milliliters vation was made of Resident at Resident #74's feeding tube at 1 he feeding bottle with a tube centimeters (cc) was tube pole. #74's weights revealed the pounds pounds ands ands 0/3/24 at 3:43 am with Nurse are was the nurse assigned for an asked Nurse #1 why the was off for Resident #74, she hally turned the feeding tube he "thought her stomach as at 2 he was aware Resident at 3 he was aware Resident and the seeding per inch is part of Resident #74's	F 6	92			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, 2 711 SUSAN TART ROAD DUNN, NC 28335	ZIP CODE	10,00,202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	DATE
F 692	Continued From pag		F6	692		
	record (EMR) reveal	#74's electronic medical ed no progress notes which the feeding tube pump off by				
	of Resident #74: - 10/3/24 at 3:55 am pump continued to b - 10/3/24 at 7:55 am	Resident #74's feeding tube new bottle of tube feeding				
	Nurse #1 she stated feeding tube pump o stomach needed a re this "now and then" to answer as to how ma feeding tube pump o turning off the feeding #1 was asked when pump back on, Nurse feeding tube pump was asked with the feeding tube pump was asked when pump back on, Nurse feeding tube pump was asked with the feeding tube pump was asked with	on 10/3/24 at 3:26 pm with she turned Resident #74's ff when she "thought her est". Nurse #1 stated she did out did not give a specific any times she had turned the ff or when she first began g tube pump. When Nurse she turned the feeding tube es #1 indicated Resident #74's was turned on when she hung feeding at 4:30 am on				
	(RD) on 10/3/24 at 9 #74's weight had bee aware of Resident #7 turned off and did no intentionally turned the without notifying the continuous tube feed short amount of time living (ADL) or due to	with the Registered Dietician 1:00 am, he stated Resident 1:00 am, he stated Resident 1:00 am, he stated Resident 1:00 am, he stated was not 1:00 am, he feeding tube pump being 1:00 am, he feeding tube pump off 1:00 physician. The RD indicated 1:00 am a to perform activities of daily 1:00 a change in condition, but 1:00 am, he stated 1:00 am and 1:00 a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		10/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692	#74 had a physician pump to be turned of allow downtime for explained Nurse #1 turn off the feeding recommended this further stated turning could have caused concern was the lost provided by the tuber Consultant, Director Clinical Officer on 1 the nursing supervisinterventions in place incident in July 202 essential reports in (EMR) to assure nualides and all medicand as ordered by the unannounced facilities evening, night, and written documentatismonitoring Nurse #1 Chief Clinical Office hired have a compessible checklist that in orientation. Nurse #1 Chief Clinical Office hired have a compessible checklist was unable to interview on 1 Director of Nursing tube feedings shoul physician's order. The was unaware of Nurpump off for Reside	RD further indicated Resident n's order for her feeding tube off 2 hours a day (2hrs/day) to ADL care. The RD further needed a physician's order to tube pumps, and he had not to the physician. The RD g the feeding tube pump off weight loss; however, his as of calories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. with the Facility Nurse of Colories and nutrients are feeding. The feeding of Colories and nutrients are feeding.	F6	92		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		10/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692	P2 Continued From page 60		F 6	92		
	notified the physicia condition before ma own. The DON indinursing staff to follow written as a part of a and services. During an interview the Physician, he sta	essed Resident #74 and n of any changes in their king any decisions on her cated she expected the w the physician's orders as a resident's necessary care on 10/3/24 at 12:00 pm with ated he was not aware of				
	off. The Physician f been a change in th shortness of breath that could have expl being turned off; how all. The Physician e was Resident #74 n the nutrients provide	ing tube pump being turned urther stated if there had e residents' condition such as (SOB), vomiting, or gurgling ained the feeding tube pumps wever, he was not notified at explained one of his concerns of receiving the calories, and ed from the tube feeding.				
	fact that Nurse #1 in tube pump off withouthis action. The Phy the nurses to make their own without an indicated that weigh result of the tube fee He further explained feeding tube pump by	ted by the physician was the tentionally turned the feeding at notifying him before taking sician indicated he did not like unreasonable decisions on y notification. The Physician t loss could happen as a eding pump being turned off. I Nurse #1's reason for the being turned off was not a n for Nurse #1 to make that				
	with diagnoses incluintracerebral hemori dysphagia (trouble s gastrostomy tube (a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345325	B. WING _			C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	•	10/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	Continued From page 61		F 6	92			
	9/16/24 noted he wassessment, had an consciousness, had a g-tube and consucalories and more ti (cc) of fluids through indicated he had an wound down to the Resident #341's photoed he was to reformula at 50 cc an rate of 200 ml every Observation on 9/30 Resident #341 was closed. He did not resident had a g-tube. The pump sec of formula every fluid every 6 hours. cc remaining in the color of the resident formula was infusin Observation on 09/30 Resident #341 was closed. He did not resident had a g-tube to infuse 40 cc of formilliliters (ml) of fluid to infuse 40 cc of formilliliters (ml) of fluid fluids hanging the resident's g-tube to infuse 40 cc of formilliliters (ml) of fluids a g-tube to infuse 40 cc	l a tracheostomy, and he had med more than 51% of his han 501 cubic centimeters in the g-tube. The MDS unhealed Stage IV wound (a bone). ysician orders dated 9/12/24 beive tube feeding 1.5 calorie hour and a water flush at a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345325	B. WING _			C 10/08/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	<u> </u>	10/00/2024
(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 CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 692	1:55 PM. There were to indicate who had stubing was the color of indicating the formula resident's stomach. Observation on 10/01 Resident #341's g-tut set to infuse 40 cc of milliliters (ml) of fluid was the color of the ruthe formula was infus stomach. The formula started on 9/30 at 1:5 than 200 cc left in the were dated 9/30/24 a full. In an interview on 10/2 said she had started formula on 9/20/24. Sformula and fluid rate programmed into the the rate with the orde seen any coughing, ruthen she had worked would cause her to re She said one of the necalled) told her the a few days ago and to been reduced by the sure if the doctor was She looks for the mos confirmed the pumps infuse the formula at fluids to be set to 200	no nurse's name or initials tarted the formula. The of the resident's formula, was infusing into the //24 at 2:17 PM revealed be pump settings were still formula every hour and 100 every 6 hours. The tubing esident's formula, indicating ing into the resident's a bottle was labeled as being 5 PM and there was less bottle. The bag of fluids and was approximately half //01/24 02:23 PM, Nurse #2 Resident #341's g-tube the said she wrote down the based on what was already pump but had not confirmed rs. She said she had not esidual, reflux, or distress d with him that week that educe the rate of the feeding. Ight shift nurses (name not resident had been coughing nought the rate may have night nurse. She was not a notified about the coughing.	F 6	92		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(c
		345325	B. WING _			10/	08/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CARE	ROLTON OF DUNN			7	11 SUSAN TART ROAD		
IIIL CAN	COLION OF BONN			D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	9/28-9/30/24 were not 19/28-9/30/24 were not 10/28 In an interview on 10/28 Registered Dietitian (I formula rate had been nutrients for the resident wou calories for the wound the resident to receive In an interview on 10/28 Resident #341's Physical needed to receive the wound healing. The Fewas getting approximation was not enough The Physician was not Resident #341 had be any symptoms that were not 10/28 in the properties of the province of	the nurse who worked on t successful. 03/24 at 10:43 AM, the RD) said Resident #341's increased to provide extragent's Stage IV wound. He ld still be getting enough the did still be getting enough the ordered nutrients. 03/24 at 12:06 PM, sician said the resident error of formula for Physician said the resident eately 300 fewer calories, in to help heal his wound. Out notified by any staff that even coughing or that he had ould indicate a need to te. He said nurses should esident's feeding rate	F	392			
F 727 SS=D	Director of Nursing (Dishould have received and she had not beer distress which would rate lower. RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1)- §483.35(b) Registere §483.35(b)(1) Except paragraph (e) or (f) of must use the services	d nurse	F	727			10/31/24

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		COMPLETED	(
	345325	B. WING			.
	1 0.02		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/06/202	.4
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPI	(5) LETION NTE
Continued From pag	ge 64	F 7	27		
§483.35(b)(2) Except paragraph (e) or (f) must designate a redirector of nursing of several se	of when waived under of this section, the facility gistered nurse to serve as the n a full time basis. irrector of nursing may serve any when the facility has an ancy of 60 or fewer residents. T is not met as evidenced wiew and staff interviews, the a registered nurse daily for 8 or days a week for 3 of 60 or 24, 8/18/24 and 9/15/24). ty's daily nurse staffing totals sheets for August and documented there was no sent for dates 8/3/24, 1. w with the prior Director of essful. om an interview was chief Clinical Officer. The restated there was not a sent as required on 8/3/24, 1. The schedule only had arses and medication aides ack of registered nurses. The facility had offered		Immediate action(s) taken for the resident(s) found to have been affer include: The facility will ensure than an RN assigned to work 7 days per week, hours per day every day - not inclust the Director of Nursing (DON). Three RNs have been hired and has completed orientation. The Chief Operating Officer educated Administrator, DON, Scheduler, and Manager on the RN coverage requirements 8 hrs per day / 7 days week. Education was completed of Monday, October 12, 2024. Identification of other residents have potential to be affected was accombly: All residents in the facility have the potential to be negatively affected; however, none have been negative impacted.	will be 8 ding ve ed the d Unit s per n ing the plished	
-					
	(EACH DEFICIEN REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF STATE OF THE REGULATORY OF THE REGULATOR	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5:30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present as required on 8/3/24, 8/18/24, and 9/15/24. The schedule only had licensed practical nurses and medication aides scheduled due to a lack of registered nurses available at the time. The facility had offered overtime and bonuses to the existing staff to	ROVIDER OR SUPPLIER ROLTON OF DUNN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 \$483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. \$483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5:30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present as required on 8/3/24, 8/18/24, and 9/15/24. The schedule only had licensed practical nurses and medication aides scheduled due to a lack of registered nurses available at the time. The facility had offered overtime and bonuses to the existing staff to cover. On 10/3/24 at 5:40 pm an interview was	ROLIDING 345325 ROVIDER OR SUPPLIER ROLTON OF DUNN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECUED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 \$483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. \$483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This RECUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5:30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present as required on 8/3/24, 8/18/24, and 9/15/24. The schedule only had licensed practical nurses and medication aides scheduled due to a lack of registered nurses available at the time. The facility had offered overtime and bonuses to the existing staff to cover. On 10/3/24 at 5:40 pm an interview was On 10/3/24 at 5:40 pm an interview was	A BUILDING ON THE PROCESS ARE TRANSPORTED TO STREET ADDRESS. CITY, STATE, ZIP CODE THIS USAN TART ROAD DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCES FLAN OF COMPRETED THIS USAN TART ROAD DUNN, NC 28335 COntinued From page 64 Continued From page 64 S483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. \$483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This RECUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5.30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5.30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5.30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5.30 pm an interview was conducted with the Chief Clinical Officer. The Chief Office

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED			
		345325	B. WING _			C 10/08/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE		
F 727	' '	e 65 lack of registered nurses for	F 7	Staffing and assignments wiby the Administrator, DON, adaily during the morning meensure the staffing for the nesufficient and covered. Sponsored ads have been padditional staff members to sufficient staffing is available. Three RNs have been hired facility on a full-time basis. Additional orientation session up to ensure that new staff roriented as quickly as possil. Chief Clinical Officer educat leadership on 10-05-24 regaimportance of knowing the oweekly schedules always. Chief Operating Officer educat leadership on 10-05-24 regaimportance of knowing that a weekly schedules always. Chief Operating Officer educated NHA, DON, Department head Manager, and Scheduler on importance of knowing that a present 7 days per week, 8 and that the presence of the documented on the daily assistent. This was completed of the documented on the daily assistent. This was completed of the documented to ensure the prarecur: NHA, DON, and Unit Manageschedules daily to ensure 2 assignments include RN conhours per day / 7 days per weekly 7 days per weekly 8 per day / 7 days per weekly 9 per weekly 9 per day / 7 days per weekly 9 per weekly 9 per day / 7 days per weekly 9 per	and scheduler eting to ext day is placed for hire to ensure et. to work in the cons will be set members are ble. ed the senior arding the daily and cated the eds, Unit the en RN is hours per day et RN is signment on 10-05-24. will be ctice will not ger will review 4-hour verage 8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 55.25			С	
		345325	B. WING _			10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335			
(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 CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 727	CFR(s): 483.45(c)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(2)(1)(2)(1)(2)(1)(2)(1)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	w, Report Irregular, Act On (2)(4)(5) imen Review. ug regimen of each resident least once a month by a view must include a review ical chart. earmacist must report any tending physician and the ctor and director of nursing, lest be acted upon. de, but are not limited to, any criteria set forth in paragraph an unnecessary drug. noted by the pharmacist lest be documented on a	F 7	will initial the daily assignment si every day to acknowledge review Schedule results will be reviewed daily afternoon stand-down mee Audit results will be reviewed bive the Quality Assurance Performal Improvement (QAPI) Committee such time consistent substantial compliance has been achieved a determined by the committee. Corrective action completion dat 10/31/24	w. d in the ting. weekly by nce until	10/31/24	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING		C 10/08/2024		
	ROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	10/00/2024		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475		
F 756	minimum, the resider and the irregularity th (iii) The attending phyresident's medical recirregularity has been action has been take be no change in the rephysician should doc the resident's medical \$483.45(c)(5) The farmaintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by: Based on record rev Consultant Pharmaci to address recommen Consultant Pharmaci reviewed for unneces #84). Findings included: Resident #84 was ad 8/14/24 with diagnose Alzheimer's disease. A physician order dat to receive the followin Fumerate (an antipsy medication) 50 milligridementia.	nt's name, the relevant drug, e pharmacist identified. Assician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in all record. Collity must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take iffies an irregularity that in to protect the resident. To is not met as evidenced item, staff interviews and it interview, the facility failed indations made by the ist for 1 of 5 residents is sarry medications (Resident medications). Resident #84 in medications: Quetiapine	F 756	Immediate action(s) taken for the resident(s) found to have been affected include: A review of the medication regimen an identified recommendations was conducted by the Director of Nursing for resident(s) #84 on October 3, 2024. Irregularities included the need to complete an Abnormal Involuntary Movement Scale (AIMS) for resident # The AIMS assessment was completed the facility resource nurse on October 2023. Identification of other residents having potential to be affected was accomplis by: All residents of the facility have the potential to be affected by this practice.	d or 84. by 3, the		

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45005					c	
		345325	B. WING _			10/	08/2024	
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARE	ROLTON OF DUNN			71	11 SUSAN TART ROAD			
THE OAK	TOLION OF BOILIN			D	UNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	e 68	F 7	756				
	assessment dated 8/	21/24 indicated Resident			The Director of Nursing reviewed and t	ook		
	#84 was severely cog	gnitively impaired and			action on the current pharmacy report,			
	received antipsychoti	ic medications on a routine			dated September 27, 2024 (including a	all		
	daily basis.				outstanding medication regimen review	V		
					recommendations) from October 3			
		#84's EMR reported monthly			through October 7, 2024.			
	_	Reviews (MRR) were						
	conducted on 8/16/2				Actions taken/systems put into place to)		
	Consultant Pharmaci				reduce the risk of future occurrence			
	recommendation each	Resident #26 receiving an			include: A facility procedure regarding the timel	v		
		nitoring the side effects			review and action taken on identified	у		
		sychotic drug therapy.			medication regimen review			
		eyemene anag anerapy.			recommendations was developed on			
	There was no written	response to the pharmacy			October 9, 2024, by the Carrolton Faci	lity		
		an AIMS assessment on the			Management Chief Clinical Officer (CC	-		
	Nursing Recommend	lations from Pharmacist			and the Scriptworx, LLC Consulting			
	forms dated 8/16/24	and 9/26/24.			Pharmacist.			
	There was no abnorr	mal Involuntary Movement			The CCO reviewed the Carrolton Polic	y #		
		ment (an assessment to			12.5, Addressing Medication Regimen			
	assess the severity of	•			Review Irregularities/Recommendation	ıs,		
	_	movements, in patients			with the Director of Nursing (DON),			
		tic/neuroleptic medications)			Corporate Nurse Consultants on Octob	per		
	in Resident #84 elect	tronic medical record (EMR).			10, 2024.			
	•	ember 2024 and October			The Director of Nursing reviewed the			
	2024 Medication Adn	ninistration Record (MAR)			guidelines with the staff nurses and nu	rse		
		34 received the Quetiapine			managers on October 10, 2024.			
	Fumerate 50 mg as o	ordered.						
	la a abancistossi	with the Companies			Newly hired nurses and medication aid	les		
	In a phone interview				will receive training on medication			
		24 at 2:00 pm, she explained identified a concern with			regimen review by the DON/Assistant Director of Nursing/Corporate Nurse			
		not being completed for			Consultant during the orientation proce	286		
	residents on antipsyc				Sonsultant during the offentation proce	,		
		ailed the Administrator,			How the corrective action(s) will be			
		DON) and the facility's			monitored to ensure the practice will no	ot		
		it the concern. She stated			recur:			

Facility ID: 923073

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _				08/2024
NAME OF PR	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2024
					11 SUSAN TART ROAD		
THE CARE	ROLTON OF DUNN				UNN, NC 28335		
					<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 69	F 7	756			
	Resident #84 nursing AIMS assessment was 2024 when admitted a MMR for September assessment had not I she was unsure if the September pharmacy Resident #82's AIMS recall reaching out to 2024 since Resident an interview with the (Interim DON) on 10/3 she was the Interim Estated she was unabled received Resident #8 recommendation date assessment. She experience to be completed to assess for side effect antipsychotics/neurol nursing staff would have conduct Resident #8 She further stated she informing the nursing assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment on Resident #8 September 2024. She the pharmacy recommendation assessment with	recommendation for an as initially written in August and was re-requested in the 2024 since the AIMS been conducted. She stated a new DON had seen the recommendation for assessment and did not the Interim DON in August #84 was a new admission. The Clinical Nurse Consultant 3/24 at 4:32 pm, she stated DON in August 2024. She are to recall whether she 4's pharmacy nursing and 8/16/24 for an AIMS plained AIMS assessments and quarterly acts of the properties of the properties of the properties are to recall staff to complete the AIMS assessment. The DON on 10/3/24 at 3:15 that as the DON in the stated she had received mendations for September			Nurse Managers will address any irregularities/recommendations identific in the medication regimen review within days of receipt of the pharmacy report. Documentation will be provided of activitation for each irregularity/recommendation noted. Physician recommendations will be scanned to the medical record within 1 days of the report date. The Director of Nursing will audit the pharmacy report and corresponding documentation for (3) months to ensurcompliance with all pharmacy recommendations. Audit results will be reviewed biweekly the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	n 7 on 5	
F 761 SS=D	2024 and had not add nursing recommenda conduct an AIMS ass	dressed the pharmacy's tion dated 9/26/24 to essment on Resident #84. to provide a reason why the tion had not been	F 7	761			10/31/24

Facility ID: 923073

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			40"	
NAME OF P	ROVIDER OR SUPPLIER	343323	B: Wilto	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/0	08/2024
THE CAR	OU TON OF BUNN			7	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			0	DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of §483.45(h)(1) In accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel to have accordance federal laws, the faci biologicals in locked of temperature controls, personnel	of Drugs and Biologicals as used in the facility must be with currently accepted and include the yand cautionary expiration date when a proper and biologicals ardance with State and lity must store all drugs and compartments under proper and permit only authorized	F	761	Immediate action(s) taken for the resident(s) found to have been affected		
	insulin aspart flex per	n from 1 of 4 medication edication storage (300-hall			include: The expired insulin found on the 300-hamedication cart was immediately discarded when found by the surveyor 10/3/2024.	all	
	An observation of the 10/3/24 at 3:42 pm wa	300-hall medication cart on as conducted in the			Identification of other residents having potential to be affected was accomplish		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
		345325	B. WING				08/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	DUNN, NC 28335		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 761	Continued From page	e 71	F	761			
	presence of Medicati	on Aide #1. An insulin			by:		
	•	insulin) flex pen with a label			The facility has determined that 100%	of	
		n aspart flex pen dated			residents have the potential to be		
		served on the top drawer of			affected, including all residents that		
		on cart. The expiration date			receive insulin.		
		flex pen was 8/31/26. The					
	300-hall medication of	cart was observed locked by			All medication carts were checked for		
	Medication Aide #1 w	vithout the removal of the			expired medications, including insulin,	on	
	insulin aspart flex per	n discarded			October 9, 2024, by the Director of		
					Nursing (DON).		
		ation on the insulin aspart					
		ed to throw away the insulin			Actions taken/systems put into place to)	
	aspart flex pen 28 da	ys after opening.			reduce the risk of future occurrence include:		
	In an interview with N	/ledication Aide #1 on			Nursing personnel (RNs, LPNs and		
	10/3/24 at 3:42 pm, s	she stated she did not know			Medication Aides) were in-serviced on		
	when the insulin aspa	art flex pen would have			October 15-16, 2024, by the Pharmacy		
		label opened 8/23 because			Nurse Consultant/ Director of Nursing		
		ad different expiration time			(DON)/Assistant Director of Nursing		
	periods after the med	lication was opened.			(ADON).		
		n of the 300-hall medication			The in-services included the following		
		51pm was conducted in the			information:		
		ctor of Nursing (DON). The			Medication Administration:		
		n was observed with 50 units ge with a label attached to			-Rights of Medication Administration		
		en 8/23. The DON was			Medication Storage:		
		and discarding the insulin			-Medication Carts		
		the 300-hall medication cart.			-Checking for expired medications,		
	aspair nox pon nonn	and 550 Hall Modification bart.			including insulin		
	In an interview with the	ne DON on 10/3/24 at 3:52			-Medication Disposal		
		n aspart flex pen expired			and another Disposal		
	-	er the opening date of 8/23			Newly hired licensed nurses and		
		n discarded on 9/19/24. She			medication aides will receive training of	n	
		he 300-hall medication cart			Medication Administration and Medicat		
		r expirations and was unable			Storage by the Director of Nursing		
		pired insulin aspart flex pen			(DON)/Assistant Director of Nursing		
	was on the 300-hall r				(ADON) /Corporate Nurse Consultant		
					during the orientation process.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			C		
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN				STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLE DAT		
F 761	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 76	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			