	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL016018	B. WING		04/2	; 0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE	3020 MARK NEWPORT,	(ET STREET , NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		sure Section conducted a on on 04/18/23-04/20/23.				
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
	• •	e supervision of residents in n resident's assessed needs,				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa according to needs of sampled residents (# choking on food in the prior to being found u	ns, interviews and record iled to provide supervision for the resident for 1 of 2 1) who had an episode of e dining room one week nresponsive in the dining nted falls over 10 weeks.				
	The findings are:					
	12/01/23 revealed dia Alzheimer's dementia hypothyroidism, polyr syndrome and ataxia Review of Resident # revealed she was adr	n, depression, anxiety, neuropathy, restless leg with frequent falls.				
	07/06/20. Review of Resident #	1's current care plan dated				

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

(X6) DATE TITLE

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARTERET HOUSE SUMMARY STATEMENT OF DEFICIENCIES NEWPORT, NC 28570 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
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CARTERET HOUSE 3020 MARKET STREET NEWPORT, NC 28570 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3020 MARKET STREET NEWPORT, NC 28570 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE			HAL016018	B. WING		1	
CARTERET HOUSE NEWPORT, NC 28570 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	CARTERET I	HOUSE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	(VA) ID	SLIMMADV ST			PROVIDER'S DI AN OF CORRECTION		(VE)
DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE DATE
D 270 Continued From page 1 D 270	D 270 C	Continued From page	e 1	D 270			
O2/07/23 revealed: -She was sometimes disoriented, forgetful and needed remindersShe was ambulatory with a rolling walker or wheelchair, was independent with transfers and required limited assistance from staff with ambulationShe had limited range of motion to both upper extremitiesShe did not have any dietary restrictions and required limited assistance from staff to eat mealsShe had a pressure wound on her buttocks with unspecified wound careShe was continent of bowel and bladder and required limited assistance with tolleting. a. Review of Resident #1's electronic progress note dated 03/12/23 at 3:34pm revealed: -She choked on food at lunch on 03/12/23Her primary care provider (PCP) was contacted and suggested she did not eat for dinner and drink only clear liquids or juice. Review of Resident #1's physician order dated 03/12/23 revealed: -There was documentation that an order was received for clear liquids or juice by a medication aide (MA)The order was not signed by the PCP. Review of the facility's Death Report for Resident #1 dated 03/20/23 revealed: -Another resident alerted staff that Resident #1 was slumped overStaff found the resident unresponsive and pulseless on 03/20/23 at 12:26pm.	O - S n - S we read with a d R O - T read R W - S we shall be well as a limited with a d R O - T read R we shall be well as a limited with a	02/07/23 revealed: -She was sometimes needed remindersShe was ambulatory wheelchair, was inderequired limited assis ambulationShe had limited rangextremitiesShe did not have any required limited assis mealsShe had a pressure unspecified wound careful dimited assis mealsShe had a pressure unspecified wound careful dimited assis a. Review of Residen note dated 03/12/23 areful assis a. Review of Residen note dated 03/12/23 areful assis as revealed on food the primary care proposed and suggested she didrink only clear liquid Review of Resident #03/12/23 revealed: -There was documen received for clear liquid aide (MA)The order was not signature was not signature as sumped overStaff found the resident alexical was slumped overStaff found the resident assis ambulatory was slumped over.	disoriented, forgetful and with a rolling walker or pendent with transfers and tance from staff with ye of motion to both upper y dietary restrictions and tance from staff to eat wound on her buttocks with are. If bowel and bladder and tance with toileting. It #1's electronic progress at 3:34pm revealed: at lunch on 03/12/23. voider (PCP) was contacted id not eat for dinner and s or juice. It's physician order dated tation that an order was aids or juice by a medication gned by the PCP. Is Death Report for Resident vealed: rted staff that Resident #1 ent unresponsive and	D 270			

Division of Health Service Regulation

-Emergency medical services (EMS) pronounced

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	r de desiciencies		(V2) MI II TIDI E	CONSTRUCTION	(V3) DATE SUDVEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
		-	A. BUILDING: _		
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		HAL016018	B. WING		04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		3020 MA	RKET STREET		
CARTERE	T HOUSE	NEWPOF	RT, NC 28570		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	Continued From page 2		D 270		
	her time of death on a	arrival.			
	Review of Resident # dated 03/23/23 revea -She was found at 12 dining room leaning of wheelchairShe was unresponsible of the was unresponsible	1's electronic incident report led: :15pm on 03/20/23 in the over to the side in her ve and had passed away. n 04/19/23 at 3:47pm and revealed: electronic progress note er what Resident #1 was led choking at lunch on n Resident #1's PCP about the resident clear 13/12/23. supervise Resident #1 g the choking incident. esent and monitoring all			
	04/19/23 at 10:44am -Resident #1 required meals at timesSometimes the resid the spoon or fork in his she was holding the u-She was more conful head" the week befor -She did not know what about her deceased his for family membersShe was fine the day -She had gotten Residence.	ent needed staff to place er hand properly because utensil in the wrong direction. sed and "talking out of her e she died. hat was happening, talked husband and mistook staff or she died (03/20/23).			

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					_	,
		1141 040040	B. WING		C	
		HAL016018	B. WC		04/2	20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3020 MAR	KET STREET			
CARTERE	T HOUSE		Γ, NC 28570			
			1, NC 20370	I		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
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D 270	Continued From page	∍ 3	D 270			
	lunch on 02/20/22					
	lunch on 03/20/23.	Danidant #4 tha masidant				
		w Resident #1, the resident				
	-	d reaching for the side of her				
	wheelchair.	a alia a coma America da Angua alia				
		r she was trying to make				
	sure the wheelchair w					
		on the table in front of her				
	and she was eating w					
	•	y from the dining room by				
	another resident.					
		to the dining room, the MA				
	was pushing Residen	nt #1 in her wheelchair out of				
	the dining room.					
	-Resident #1 was pal	e and not breathing.				
	-She and 2 MAs assis	sted Resident #1 back to her				
	bed.					
	-The resident turned	blue after she was placed in				
	the bed.					
	-The MAs tried to obt	ain vital signs but did not get				
	any readings.					
	-Resident #1 had a D	NR order.				
	-It all happened out o	f the blue and was a shock				
	to everyone.					
	·					
	Second interview with	n the MA on 04/19/23 at				
	10:29am revealed:					
	-Resident #1 was on	a regular diet with chopped				
	meats and ate indepe	• • • • • • • • • • • • • • • • • • • •				
		e the morning of 03/20/23				
	and the week before.	•				
		er the resident experiencing				
	any changes in condi					
		e resident to dining room for				
	the lunch meal on 03/					
		ent #1 had been eating just				
	before she saw her a	- ·				
		t the lunch meal on				
	03/20/23.	and broads about 19 19 19				
	-Another resident ask	ked her to check on Resident				

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-When she saw Resident #1, the resident was

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			7 50.12510.		c	
		HAL016018	B. WING		1	0/2023
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE		KET STREET			
0,111,2112		NEWPOR	T, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page 4		D 270			
	slumped over in her wiblueShe assisted Reside to her roomAnother MA assisted -Upon checking the reresident was not breat unchewed food around lit took approximately resident from the dining wheelchair. Interview with a reside revealed: -She had been in the #1 on 03/30/23 at lung-Resident #1 always of wheelchair saying "I'm-Resident #1 would eashe was finished eating dining roomResident #1 fed hers pick up her food with table manners"That day at lunch, Rewhen she told the oth table to "hit me in my-the other resident si was also in a wheelch Resident #1Resident #1Resident #1 kept say then all of a sudden selected and told a MA that the MA came over a of the dining room in the state of the side of the side of the dining room in the sudden selected and the side of the dining room in the sudden selected and the sudden selected selected and the sudden selected and the sudden selected and the sudden selected and the sudden selected selected and the sudden selected s	wheelchair and her face was ant #1 in her wheelchair back and called EMS. esident, she found the thing and still had d the front part of her gums. 30 seconds to transport the agroom to her room in her ent on 04/19/23 at 3:05pm dining room with Resident ch. came to the table in her a starving to death". The starving to death at her meal and as soon as ang, she would leave the elf and sometimes would ther fingers, "not the best esident #1 was eating lunch the resident sitting at the back". It ing at the table with her the tair and was not able to help ging 'hit me in my back" and the went limp. It is given the seeded help. The seeded help was happening with her but the seeded help.				

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Telephone interview with Resident #1's family

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HAL016018 B. WING DAI/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 MARKET STREET NEWPORT, NC 28570 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER CARTERET HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 3020 MARKET STREET NEWPORT, NC 28570 (X4) ID PREFIX TAG D 270 Continued From page 5 member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating STREET ADDRESS, CITY, STATE, ZIP CODE STATE ADDRE				7 50.25			
CARTERET HOUSE SUMMARY STATEMENT OF DEFICIENCIES NEWPORT, NC 28570 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 5 member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating			HAL016018	B. WING		1	
CARTERET HOUSE NEWPORT, NC 28570 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 5 member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating	NAME OF PROVIDER (R OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEWPORT, NC 28570 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 5 member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating	CARTERET HOUS	SE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 5 member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 270 D 270 D 270 D 270			NEWPORT	, NC 28570			
member on 04/27/23 at 4:06pm revealed: -Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
-Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eatingResident #1 had a history of choking while eating	D 270 Continu	nued From page	5	D 270			
esophagus. -She died in the dining room, but her death certificate said she died from Alzheimer's. -No autopsy was done so he did not know if she choked on food she was eating. Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed: -She was aware of Resident #1's choking incident on 03/12/23. -The PCP ordered a clear liquid diet that evening. -There were no other orders. -Staff were no intstructed to specifically supervise Resident #1 at meals. -Staff were always present to supervise all residents in the dining room during meals. -She did not think an electronic incident report was completed for the choking incident on 03/12/23. -An electronic incident report should have been completed for a medical incident with increased supervision implemented because the choking incident was an event. -Resident #1 should have been supervised during meals for any changes. Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed: -The PCP only ordered a clear liquid diet for the dinner meal on 03/12/23. -The MA should have clarified when to return to her regular diet.	memberstaff has resided choked choked resided choked resided r	ber on 04/27/23 had called him had called him had a him	at 4:06pm revealed: twice in the 3 months before 20/23) and reported she story of choking while eating atal hernia and narrow g room, but her death ed from Alzheimer's. e so he did not know if she was eating. sident Care Coordinator 12:56pm revealed: esident #1's choking incident clear liquid diet that evening. orders. cted to specifically supervise . esent to supervise all g room during meals. electronic incident report e choking incident on at report should have been cal incident with increased ated because the choking t. have been supervised during es. ministrator in Training (AIT) m revealed: ed a clear liquid diet for the /23.	D 270			

Division of Health Service Regulation

completed so all staff would have been aware,

STATE FORM 6899 KONM11 If continuation sheet 6 of 37

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL016018	B. WING		04	C 1/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	, -	
			RKET STREET	,		
CARTERE	ET HOUSE		RT, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 6	D 270			
	and Resident #1 wou 72 hours, especially o	ld have been monitored for during those meals.				
	note dated 01/03/23 a	t #1's electronic progress at 6:38pm revealed her (PCP) was notified of a fall uries.				
	dated 01/07/23 at 1:5	1's electronic progress note 5am revealed her family at 6:30am that she was				
	dated 01/14/23 at 3:2	1's electronic progress note 8pm revealed her PCP was ut injury trying to transfer to				
	dated 01/17/23 at 11:	1's electronic progress note 09pm revealed she was d sent to the emergency				
	dated 01/17/23 revea -She was found lying the bed at 8:39pm. -She told staff "it" mo	on her back with her feet on ved and she fell her head and left shoulder. ER and her PCP was				
	check sheet dated 01 -There was documen 10 minutes from 3:00	tation of her location every pm until 8:50pm. where staff documented the eir initials.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL016018	B. WING		04/2	0/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	E ZIP CODE	1 04/2	0/2020
			RKET STREET	2,211 0052		
CARTERE	T HOUSE	NEWPOR	T, NC 28570			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 270	a line to 8:40pm and 8 Review of Resident # dated 01/18/23 at 9:3 notified she fell without Review of Resident # dated 01/20/23 at 4:0 notified she fell without Review of Resident # dated 01/20/23 at 8:5 lower leg bruising since Review of Resident # dated 01/21/23 at 2:2 -There was document recorded on 02/03/23 -Resident #1 fell on 0 PCP was notified. Review of Resident # dated 01/21/23 at 3:1 family member were refered to the floor and sent to the floor and sent to the floor found on the floor flo	floor" was documented with 8:50pm. 1's electronic progress note 4am revealed her PCP was ut injury. 1's electronic progress note 8am revealed her PCP was ut injury. 1's electronic progress note 1pm revealed she had right be the fall. 1's electronic progress note 6am revealed: tation that the note was at 9:27am. 1/21/23 at 2:26am and her 1's electronic progress note 5am revealed the PCP and notified she was found on the ER at 2:56am. 1's electronic progress note 8am revealed there was A spoke to the PCP to being sent to the ER after for and complaining of right 1's electronic incident report led:	D 270			
		on the floor at the foot of				

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PRINTED: 05/01/2023 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING.		
	HAL016018	B. WING		C 04/20/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARTERET HOUSE		KET STREET , NC 28570		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
notified72 hour fall monitorial Review of Resident as services (EMS) reported the resident was alea appropriately and reported for the resident was alea appropriately and reported for the resident and the resident and the resident and the resident was far and then she got bet falls72 hour fall monitorial reported for the resident and reported for the resident and remains and the remember section of the remember remember falls50 am on 01/21/2370 and 01/21/2370 and 01/21/2371 and 01/21/2371 and 01/21/2372 and 01/21/2373 and 01/21/2374 resident was fall and then she got bet falls54 could not remember resident and resident and residents were sent.	er and her PCP was Ing was implemented. It is emergency medical redated 01/21/23 revealed to the treaching questions ported to technicians she fell reaching for her call bell. It is increased supervision 1/20/23 to 01/21/23 revealed: Intation of her location every opm on 01/20/23 until so where staff documented the reir initials. Intation she was in her im on 01/20/23 until 2:20am intation that she was out of the am to 2:50am on 01/21/23. Intentation that she fell. With a third shift medication 23 at 9:55pm revealed: everything that happened in the recommendation of the fells on 01/07/23, 23. Illing frequently for a while the read did not have more imber the timeframe when when the falls stopped. It to the ER for unwitnessed ent reported hitting their head	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7.1. 20122.110.	LDING: COM OA ITY, STATE, ZIP CODE REET 8570 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE AGC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	HAL016018	B. WING		C 04/20/2023
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CARTERET HOUSE	3020 MAI	RKET STREET		
CARTERET HOUSE	NEWPOR	RT, NC 28570		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE
D 270 Continued From page 9)	D 270		
concave mattressResident #1 required s getting in and out of bee -She would "throw" hers -She did not look before up out of the bed and p wheelchairResident #1 required s toileting and bathingShe was able to assist but some staff preferred residentWhen Resident #1 fell PCP's office in the morr or faxed the PCP's office Interview with the Admit on 04/20/23 at 1:54pm -Resident #1 had a hist therefore she questione statement documented report dated 01/21/23She did not know why that time. Review of Resident #1's dated 01/25/23 at 4:05p notified she fell without pressure was a little elect Review of Resident #1's check sheet dated 01/2 -There was documentat 10 minutes from 3:00pm	staff assistance with d. self into her wheelchair. e sitting down, she hopped lopped down hard into her staff assistance with Resident #1 by herself, d two staff to assist the she either called the hing before leaving work se. nistrator in Training (AIT) revealed: ory of confusion and ed the accuracy of in the resident's EMS the resident was awake at selectronic progress note om revealed her PCP was injury and her blood evated. si increased supervision 5/23 revealed: tion of her location every in until 8:50pm. There staff documented the initials. tion that she was in the			

Division of Health Service Regulation

bathroom at 4:20pm, returned to the parlor at

STATE FORM 6899 KONM11 If continuation sheet 10 of 37

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL016018	B. WING		04/2	; 0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE	3020 MA	RKET STREET			
CARTERE	1 11 11003E	NEWPOF	RT, NC 28570			
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	OULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 10	D 270			
	until 5:50pmThere was no docum	ne dining room from 4:40pm				
	Review of Resident #1's electronic progress note dated 02/01/23 at 3:36pm revealed: -She fell reaching for a piece of candyShe complained of hitting her head and pain in					
	her head, back and b					
	Upon request on 04/1 Resident #1's electron 02/01/23 was not pro-	nic incident report dated				
	check sheet dated 02 -There was documen 15 minutes from 3:00 -There were columns time, location, and the -There was documen	tation of her location every pm until 11:00pm. where staff documented the eir initials. tation that she was on the ::15pm and out of the facility				
	dated 02/14/23 at 5:2 -She slid out of her w	heelchair looking for candy. y injuries but had a high ng.				
	check sheet dated 02 -There was documen 30 minutes from 5:00	tation of her location every pm until 11:00pm. where staff documented the				

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-There was documentation that she was on the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOIMBER.	A. BUILDING: _			
		HAL016018	B. WING		04/2	; 0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE		KET STREET , NC 28570			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
D 270	Continued From page	2 11	D 270			
	floor at 5:00pm and in the dining room from 5:30pm until 6:00pm. Review of Resident #1's electronic progress note dated 02/16/23 at 7:23am revealed her PCP was notified she was found on the floor at 6:03am. Review of Resident #1's increased supervision check sheet dated 02/15/23 to 02/16/23 revealed: -There was documentation of her location every 15 minutes from 11:00pm on 02/15/23 until 7:00am on 02/16/23There were columns where staff documented the time, location, and their initialsThere was documentation that she was on in her bedroom from 11:00pm on 02/15/23 until 7:00am on 02/16/23There was no documentation she fell.					
	dated 02/20/23 at 5:1	1's electronic progress note 7pm revealed her PCP was d on the floor at 4:20pm on				
	check sheet dated 02 -There was document 15 minutes from 3:00 -There were columns time, location, and the -There was document	tation of her location every pm until 11:00pm. where staff documented the				
		1's electronic progress note 1pm revealed she had arm				
		1's electronic progress note 30pm revealed her PCP				

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STATE FORM 6899 KONM11 If continuation sheet 12 of 37

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			30.25.110.		c
		HAL016018	B. WING		04/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CARTERE	T HOUSE		RKET STREET		
97.11.1			T, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 12	D 270		
	was sent a fax notificathe fall.	ation of shoulder pain since			
		1's electronic progress note 8pm revealed her PCP was with an injury.			
	Interview with a MA o	·			
	•	en Resident #1 fell on ıld not remember what			
	was placed on every	assist rail on her bed and 15- or 30-minute checks. or additional fall and injury			
	prevention intervention	ns such as keeping the aff while she was awake, a			
	Upon request on 04/1 Resident #1's electron 02/20/23 was not pro	nic incident report dated			
	dated 02/28/23 at 9:3				
	recorded on 03/08/23	tation that the note was at 7:15pm. tation her PCP was notified			
	she fell on 02/28/23 a				
	dated 03/07/23 at 9:1	1's electronic progress note 1pm revealed her PCP was ut of bed without injury.			
	check sheet dated 03 -There was documen 15 minutes from 3:00	tation of her location every pm until 11:00pm. where staff documented the			

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STATE FORM 6899 KONM11 If continuation sheet 13 of 37

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING		
		HAL016018	B. WING		C 04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CARTER	T HOUSE	3020 MAF	RKET STREET		
CARTERE	I HOUSE	NEWPOR	T, NC 28570		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 13	D 270		
	bedroom from 8:00pr -On the side margin " documented. Review of Resident # dated 03/16/23 at 3:3 -There was documen recorded on 03/23/23 -There was documen she was found on the 03/16/23. Interview with the Re (RCC) on 04/20/23 at -Resident #1's electro 03/16/23 was marked wrote the note on 03/ on 03/16/23She documented the	fell at 9:10pm" was 1's electronic progress note 0pm revealed: tation that the note was at 3:31pm. tation her PCP was notified floor at 3:55pm on			
	dated 03/16/23 revealusing -She was found sitting 3:50pmShe forgot to press to any injuries72 hour fall monitoring review of Resident # check sheet dated 03-There was documen 30 minutes from 6:00-There were columns time, location, and the There was documen bedroom from 2:30pr	g on the bathroom floor at the call bell and did not have ag was implemented. It's increased supervision Identified the supervision of her location every am until 11:00pm. Where staff documented the eir initials. Itation that she was on in her			

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4:30pm until 5:30pm.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		, , ,	SURVEY PLETED
7.11.2 . 27.11	0. 002011011		A. BUILDING:			
			D WING			С
		HAL016018	B. WING		04	/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CARTER	T 110110F	3020 MA	RKET STREET			
CARTER	ET HOUSE	NEWPOI	RT, NC 28570			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 14	D 270			
	-There was no docum	nentation she fell.				
	04/20/23 at 2:46pm re-She was not working on 03/16/23She initially denied h from 3:00pm to 11:00 supervision check she Resident #1Her initials were door she did not remembe	g at the time Resident #1 fell her initials were documented hym on the increased heet dated 03/16/23 for humented on the sheet, but her the resident falling. with the Office Manager at				
	revealed:	office on 04/19/23 at 9:40am ectly to the staff who was t when she fell in the				
	-The staff had left the more than 30 minutes other residents. -She had discussed h at the facility several -She did not rememb	resident in the bathroom for s because she had to assist her concerns with a manager times. er the names of staff and here was frequent turnover				
	member on 04/27/23 -Resident #1 was me to herHe did not think she -She was no longer a because of neuropath -She normally spent a -She got up into her was the best of the	ntally sharp when he talked had dementia. ble to stand on her own ny in her legs. all day in her bed.				

Division of Health Service Regulation

STATE FORM 6899 KONM11 If continuation sheet 15 of 37

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARTERET HOUSE SUMMARY STATEMENT OF DEFICIENCIES NEWPORT, NC 28570 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 15 her bed on her own. Interview with a second PCA on 04/19/23 at 10:44am revealed: D 270 B . WING	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARTERET HOUSE SUMMARY STATEMENT OF DEFICIENCIES NEWPORT, NC 28570 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 15 her bed on her own. Interview with a second PCA on 04/19/23 at 10:44am revealed:		
CARTERET HOUSE CARTERET HOUSE CARTERET	3	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 15 her bed on her own. Interview with a second PCA on 04/19/23 at 10:44am revealed:		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 15 her bed on her own. Interview with a second PCA on 04/19/23 at 10:44am revealed:		
her bed on her own. Interview with a second PCA on 04/19/23 at 10:44am revealed:	PLETE	
Resident #1 required staff assistance with getting in and out of bed, toileting, and bathing. -The resident was able to stand and pivot with transfers. -She fell frequently trying to get out of bed or reaching for candy on her nightstand. -After each fall, she was placed on every 15- or 30-minute checks for 3 days. -She continued to fall because as soon as she was off the 15- or 30-minute checks she fell again. -She was more confused and "talking out of her head" the week before she died. -She did not know what was happening, talked about her deceased husband and mistook staff for family members. Telephone interview with a MA on 04/20/23 at 11:34am revealed: -PCAs were responsible for checking to make sure the call light was within reach and assist with any needs such as toileting when doing every 15- or 30-minute checks. -She was responsible for rounding every 2 hours and ensuring PCAs were completing every 30-minute checks. Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed: -She was responsible for ensuring PCAs and MAs were completing their assigned tasks. -She observed residents, PCAs and MAs when she completed rounds every 2 hours. -After a fall the resident was placed on every 30-minute checks for 3 days. -If a resident continued to fall then they would		

Division of Health Service Regulation

STATE FORM 6899 KONM11 If continuation sheet 16 of 37

DIVISION	n Health Service Regu	iation			1		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					c		
		HAI 016019	B. WING		1		
		HAL016018	1		1 04/2	0/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		3020 MAF	RKET STREET				
CARTERE	T HOUSE		T, NC 28570				
	OLIMANA DV OT		1	DDOLUBERIO DI ANI OE CORRECTIO			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE	
				DEFICIENCY)			
D 270	Continued From page	. 16	D 270				
D 210	Continued From page	: 10	0270				
	work with physical the	erapy (PT).					
	-PCAs were responsi	ble for checking the					
	resident's location and	d if the resident was					
	breathing.						
	-If the PCA document	ed the resident's location					
	was in the bathroom,	that meant the staff					
	assisted the resident						
	-Completed increased	d supervision check sheets					
		ator in Training (AIT) office.					
		pecified other interventions					
	•	sident had consecutive falls					
	within 72-hour monito						
	-Other interventions v						
	progress notes.	vere decamented in					
	. 0	ımentation in Resident #1's					
		otes of other interventions.					
	-MA were responsible						
	-	oort which initiated an event					
	·	the electronic charting					
	system after a resider						
	•	for reviewing the report and					
	ensuring the fall moni						
		ent to the ER, she was nenting follow up with the					
	PCP and other fall an	- ·					
	interventions.	a injury prevention					
		at other interventions were					
	implemented to reduce	e rans and injury for					
	Resident #1.	for reviewing electronic					
	•	for reviewing electronic					
	incident reports to ens	sure compiete					
	documentation.						
		mentation the PCP was					
		tronic incident report, then					
		P and documented an					
	electronic progress no						
	-The Administrator in						
	responsible for review						
	electronic incident rep	oort and closing the event in					

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the system.

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1141 040040	B. WING		1	
		HAL016018	D. WING		04/2	0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		3020 MA	RKET STREET	·		
CARTERE	T HOUSE					
		NEWPOR	RT, NC 28570			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 270	Continued From page	e 17	D 270			
	linka miliau vuikla klaa AIT	04/20/22 -t 4.54:-:				
		on 04/20/23 at 1:54pm				
	revealed:					
		le for checking a resident's				
	-	or any injuries, sending the				
		needed, contacting the PCP,				
	and initiating the elect					
		le for initiating 72-hour				
	monitoring and super					
	-PCAs were responsi	ble for completing every				
	30-minute checks for	72 hours after a fall.				
	-PCAs were responsi	ble for checking the				
	resident's location and	d any needs the resident				
	might have.					
	-PCAs were expected	d to ensure the resident's				
	call bell was within re-	ach with each 30-minute				
	check.					
	-Resident #1 had a hi	story of confusion and				
	therefore she question					
	·	ed in the resident's EMS				
	report dated 01/21/23	3.				
	•	y the resident was awake at				
	that time.					
		le for monitoring residents				
	every shift for 72 hour					
	•	checking vital signs and				
	checking for bruises a					
	condition.	and any changes in				
		le for contacting the PCP				
		changes in condition.				
		PCP notification form or				
	called the PCP.	Cdandadan loim of				
		acted by phone there would				
		ress note documenting the				
	PCP notification.	1033 Hote documenting the				
	-	c incident reports were				
	•	•				
	available for the RCC					
		nsible for reviewing the				
	electronic incident rep	port and completing the post				

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fall intervention care plan.

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			231251110		c
		HAL016018	B. WING		04/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CARTERE	T HOUSE		RKET STREET		
			RT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 18	D 270		
	MAs any interventions intervention care plantage of the planta	le for ensuring PCAs were nterventions. Insible for rounding and IAs were performing Inly 3-4 times daily to ensure in for ensuring the fall a process was complete. In with other Administrator the RCC for completing the			
	T	interview with Resident #1's n 04/19/23 at 3:36pm was			
	Attempted telephone interview with Resident #1's Primary Care Provider on 04/20/23 at 10:18am was unsuccessful.				
	Residents #1 who expended to being found unrespended and 14 door resulting in head and emergency room evaluate was detrimental to the of Resident #1 and control of the substitution of th	luations. The facility's failure health, safety and welfare onstitutes a Type B Violation.			
	The facility provided a	a plan of protection in			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		1141 040040	R WING		C
		HAL016018	B. WING		04/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
CARTERE	T HOUSE		(ET STREET , NC 28570		
	CUMMADVCT		, 	DDOVIDEDIS DI AN OF CODDESTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	: 19	D 270		
	accordance with G.S. this violation.	131D-34 on 04/19/23 for			
		DATE FOR THE TYPE B IOT EXCEED JUNE 4,			
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273		
	10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.				
	This Rule is not met a TYPE A2 VIOLATION				
	reviews, the facility fa the primary care prov emergency room eval injuries, obtain a shou	ulder x-ray following a fall as and a urinalysis ordered by			
	The findings are:				
	12/01/23 revealed dia Alzheimer's dementia hypothyroidism, polyr syndrome and ataxia Review of Resident #	, depression, anxiety, neuropathy, restless leg with frequent falls. 1's Resident Register			
	revealed she was adr 07/06/20.	nitted to the facility on			
		t #1's electronic progress at 11:09pm revealed the			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					l c l
		HAL016018	B. WING		04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3020 MAR	ET STREET		
CARTERE	T HOUSE	NEWPORT	NC 28570		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	J (Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 20	D 273		
		was found on the floor and y room (ER) at 9:05pm.			
		/17/23 revealed instructions / care provider (PCP) for			
		1's electronic progress note 5am revealed she had since the fall.			
	dated 01/21/23 at 2:2 -There was document recorded on 02/03/23	tation that the note was			
	dated 01/21/23 at 3:1	1's electronic progress note 5am revealed the PCP and notified she was found on he ER at 2:56am.			
	dated 01/21/23 at 3:1 documentation the Maregarding the residen	1's electronic progress note 8am revealed there was A spoke to the PCP t being sent to the ER after our and complaining of right			
		:1's ER discharge /21/23 revealed instructions r follow up within 2-4 days			
		1's electronic progress note 3am revealed she had since the fall.			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:			E SURVEY PLETED
	HAL016018	B. WING		04	C / 20/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	, ,	
CARTERET HOUSE		RKET STREET RT, NC 28570			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273 Continued From page 21 Review of Resident #1's dated 01/23/23 at 7:38pn increased confusion since Review of Resident #1's dated 01/24/23 at 5:06an increased confusion since Review of Resident #1's dated 01/25/23 at 4:05pn notified she fell without in pressure was a little elevent Review of Resident #1's dated 01/26/23 at 7:35pn increased confusion since Review of Resident #1's dated 02/01/23 at 3:36pn -She fell reaching for a pinch she fell reaching for a pinch she was sent to the ER notified. Review of Resident #1's instructions dated 02/01/25 to contact the PCP for foll (by 02/03/23). Review of Resident #1's instructions dated 02/01/25 at 9:30an -There was documentation recorded on 03/08/23 at 1-There was documentation she fell on 02/28/23 at 9:30an -There was documentation she fell on 02/28/23 at 2:22an Review of Resident #1's dated 03/02/23 at 2:22an	n revealed she had e the fall. electronic progress note n revealed she had e the fall. electronic progress note n revealed her PCP was njury and her blood ated. electronic progress note n revealed she had e the fall. electronic progress note n revealed she had e the fall. electronic progress note n revealed: ecc of candy. g her head and pain in m. and her PCP was ER discharge 23 revealed instructions low up within 1-2 days electronic progress note n revealed: on that the note was 7:15pm. on her PCP was notified 30am. electronic progress note	D 273			

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		1141 040040	B. WING		C
		HAL016018	J		04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3020 MAR	KET STREET		
CARTERE	T HOUSE	NEWPOR1	, NC 28570		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	22	D 273		
<i>D</i> 2.0	Continued From page	, , , ,	52.0		
	Review of Resident #	1's electronic progress note			
	dated 03/19/23 at 9:2	3pm revealed she had			
	increased confusion s	since the fall.			
		with a third shift medication			
	` ,	3 at 9:55pm revealed:			
	-	everything that happened in			
	a notebook.				
	-She did not have her	r notebook and could not			
	remember Resident #	#1's falls on 01/07/23,			
	01/17/23 and 01/21/2	3.			
	-Residents were sent	to the emergency room			
	` ,	falls where the resident			
		nead or complained of pain.			
		er things like a fall mat and			
	concave mattress.				
		out follow up with the PCP			
	because she worked	•			
		sident #1 had increased			
		3 and several other times			
	following falls.				
		nfused for a while then she			
	"snapped out of it".				
		sident #1's life she was more			
	confused.				
		ho she was, where she was			
		n she was at her baseline.			
		used, she would ask the MA			
	-	d thought the MA was her			
	mother.	2 :1 (//// 202			
		Resident #1's PCP was			
	contacted about the	episodes of increased			
	confusion.				
		ng the increased confusion			
	as part of the fall mor				
		ell she either called the			
	PCP's office in the mo	orning before leaving work			
	or faved the PCP's of	fice			

-Faxed notification with the confirmation were

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL016018	B. WING		C 04/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE	3020 MAR	KET STREET			
CARTERE	.1 11003E	NEWPORT	, NC 28570			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
D 273	Continued From page	23	D 273			
	supposed to be filed i	n the resident's chart.				
	revealed: -MAs were responsib resident's PCP when ER following a fallMAs were responsib instructions in the Resident's offices. Telephone interview were member on 04/27/23 -Staff took Resident facility vanHe thought staff tried follow up appointment.	a resident was sent to the le for placing ER discharge sident Care Coordinator's ator's box outside their with Resident #1's family at 4:06pm revealed: #1 to appointments in the				
	Telephone interview of Resident #1's PCP's of revealed: -She had concerns at to the resident missin -The resident was last 12/29/22Historically the reside lady" and at her last of distraughtIt was concerning the to the PCP's office be able to evaluate he orders for her careShe had discussed hat the facility several second remembers of the position of the	with the Office Manager at office on 04/19/23 at 9:40am cout Resident #1's care due g several appointments. It seen in the office on ent was a "well put together visit she looked weak and the resident was not brought excause the PCP needed to the er and write appropriate over concerns with a manager				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL016018	B. WING		04	C J 20/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	1	
CARTER	T HOUSE	3020 MA	RKET STREET			
CARTERE	ET HOUSE	NEWPOR	RT, NC 28570			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 273	sent to the ER on 01/02/01/23 for fallsResident #1 was not following ER visits on 02/01/23. Second telephone int Manager at Resident 04/20/23 at 10:18am -The PCP last saw Re 01/04/23 to write order nurse to provide sacre—HH was still providing when she died on 03/-HH recertification or the staff reported an e 03/11/23There was a note da reported the resident at lunchStaff were instructed there were no further -The office received a liquid diet on 03/16/23-There were no notes	seen for follow up visits 01/17/23, 01/21/23 and erview with the Office #1's PCP's office on revealed: esident #1 at the facility on ers for a home health (HH) all wound care. g services to the resident #20/23. ders were being done when episode of choking on ted 03/11/23 that staff had a cold and was choking to resume her normal diet if	D 273			
	and 02/01/23There were no notes of falls on 01/14/23, 0 02/01/23, 02/14/23, 0 -The PCP's office atte appointment for Resic PCP but the appointm 03/23/23She had reviewed al	in the resident's office chart 1/1/17/23, 01/21/23, 01/25/23, 3/07/23, and 03/16/23. Empted to get an dent #1 to be seen by the nent was scheduled for I notes for Resident #1's were none related to the				
	Interview with the Res (RCC) on 04/20/23 at	sident Care Coordinator : 12:56pm revealed:				

Division of Health Service Regulation

STATE FORM 6899 KONM11 If continuation sheet 25 of 37

DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	≣TED
					ے ا	
		1101.040049	B. WING		04/0	
		HAL016018			04/2	0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		3020 MAR!	KET STREET			
CARTERE	T HOUSE		, NC 28570			
	OLUMBA DV OT		.	DDOV/DEDIO DI ANI OF CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		ı
D 273	Continued From page	25	D 273			
DZIO	Continued From page) 25	DZIS			
	-She was responsible	e for ensuring residents had				1
	follow up and referral	appointments.				ı
	-MA were responsible	for completing an				ı
	electronic incident rep	port which initiated an event				ı .
		the electronic charting				ı !
	system after a resider					ı
		ent to the ER, she was				ı
	responsible for docun	nenting follow up with the				ı
	PCP and other fall an					ı
	interventions.	, , ,				ı
	-She documented in t	the resident's electronic				ı
	progress notes the da	ate of follow up				ı
	appointments and tra					ı
		onic progress note dated				ı
		l late entry because she				ı
		23/23 for a fall that occurred				ı
	on 03/16/23.					
		e fall because the MA on				ı
	duty at the time of the resident's PCP.	e fall did not contact the				
	-She contacted Resid	dent #1's PCP on 03/16/23 at				ı
	3:55pm regarding the	resident's fall.				ı
		responsible for contacting				ı
	the PCP after a fall.					1
	-She was responsible	e for reviewing electronic				1
	incident reports to en	sure complete				1
	documentation.					1
	-If there was no docu	mentation the PCP was				1
	contacted on the elec	tronic incident report, then				1
	she contacted the PC	CP and documented an				1
	electronic progress no	ote.				1
	-The Administrator in	Training (AIT) was				1
	responsible for review	ving the completed				1
	electronic incident rep	port and closing the event in				1
	the system.	-				1
	-MAs were responsib	le for putting ER discharge				1
	instructions in her offi					1
	-She was responsible	e for giving appointments to				1
	the transporter for sch					1

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-There was an electronic calendar to track

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILBING.		
		HAL016018	B. WING		C 04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CARTERE	T HOUSE	3020 MAR	KET STREET		
CARTERE		NEWPOR [*]	Γ, NC 28570		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	26	D 273		
D 273	resident appointments -She did not know if F appointments schedu ER visits on 01/17/23 -The staff documentir fall monitoring were re PCPShe did not know if F contacted regarding in 01/18/23, 01/21/23, 0 03/01/23, 03/02/23 ar -She did not review p between January and -She started weekly re documentation beginn Interview with the Adr on 04/20/23 at 1:54pr -ER discharge instruct RCC's boxThe RCC reviewed of gave a copy to the tra -The transportation per scheduling the appoint appointment on the cap rogress noteThe RCC had access calendar to track follo appointmentsThe process was bro Resident #1Resident #1 should h appointments with he visitShe was responsible	Resident #1 had follow up led with her PCP following, 01/21/23 and 02/01/23. In increased confusion with responsible for contacting the resident #1's PCP was increased confusion on 1/23/23, 01/24/23, 01/26/23, and 03/19/23. Reviews of post fall documentation in March 2023. Reviews of post fall phing in April 2023. Reviews were placed in the revealed: Resident was responsible for alternation person. Rerson was responsible for alternation and in an electronic rest to the appointment wup and referral resident and not followed with	D 2/3		
		t #1's provider notification			

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-The resident complained of right shoulder pain

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMILE	ILD
		HAL016018	B. WING		04/20)/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE		KET STREET			
		NEWPOR1	, NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	27	D 273			
	following a fall earlier -There was a notation with the facility's fax r	n for a right shoulder x-ray				
		1's imaging order dated order for a right shoulder				
	dated 02/20/23 at 5:1	1's electronic progress note 7am revealed her primary vas notified she was found n on 02/20/23.				
		1's electronic progress note 1pm revealed she had arm				
	dated 02/20/23 at 10:	1's electronic progress note 30pm revealed her PCP ation of shoulder pain since				
		1's electronic progress note 8pm revealed her PCP was with an injury.				
		1's electronic progress was no documentation of a				
	notes revealed there	1's electronic progress was no documentation an cheduled, or completed.				
	on 04/20/23 at 11:34a -She remembered se shoulder x-ray for Res	eing the order for the sident #1. at happened; she thought				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL016018	B. WING		C 04/20/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 04/20/2023
CARTERE	T HOUSE		KET STREET		
		NEWPORT	, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 28	D 273		
	-Usually, when a residust sent a faxed notif	dent refused something MAs ication to the PCP.			
	Second telephone int Manager at Resident 04/20/23 at 10:18am	#1's PCP's office on			
	-Staff reported on 02/ shoulder pain following	20/23 Resident #1 had ng a fall on 02/19/23.			
	-A shoulder x-ray was ordered and faxed to the local hospital's imaging department on 02/21/23.				
	-The order was faxed -There was no x-ray r record.	to the facility. result in the resident's office			
		d not have an x-ray result, so ne.			
	(RCC) on 04/20/23 at	sident Care Coordinator : 12:56pm revealed it was ned with Resident #1's order ated 02/21/23.			
	Interview with the Adr	ministrator in Training (AIT)			
	on 04/20/23 at 1:54pr -The MA notified the I shoulder pain.	PCP of Resident #1 having			
		der to the imaging center. ify staff of the x-ray order.			
	transport calendar.	erson reported that she did			
	not take Resident #1	for an x-ray. g why Resident #1 did not			
		t #1's physician order dated order for urinalysis, culture			
	Upon request on 04/1	8/23, 04/19/23 and			

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04/20/23, results of a urinalysis for Resident #1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL016018	B. WING		C 04/20	/2023
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	04/20	1/2023
			KET STREET	11, 211 6001		
CARTERE	T HOUSE	NEWPORT	NC 28570			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	29	D 273			
	was not provided for r	review.				
	Telephone interview of Resident #1's PCP's of 10:18am revealed the on 03/08/23 and there #1's office chart. Interview with the Residence (RCC) on 04/20/23 at -Urinalysis orders were the specimen. If the MA was not about that shift, they were recommunicating the tathe specimen was collected aboratory. She did not know if the urinalysis got lost on a weekend shift. There was no definite.	with the Office Manager at office on 04/20/23 at e PCP ordered a urinalysis e was no result in Resident sident Care Coordinator 12:56pm revealed: re given to MAs to collect the to collect the specimen on esponsible for sk to the oncoming MA until lected. In the order for Resident #1's				
	on 04/20/23 at 1:54pr -The RCC received P communicated the ore	CP orders for urinalysis and				
	laboratory to pick up to -On review of what has urinalysis order, she to the RCC on the labora-Normally, the RCC wwas a laboratory resurshed did not have a re-	he specimen. appened with Resident #1's cound the MA should include atory pick up request. vas not notified until there It.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _		
		HAL016018	B. WING		C 04/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CARTERE	T HOUSE		KET STREET T, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page 30		D 273		
	•	20/23, the January, February sport calendar was not			
		interview with Resident #1's n 04/19/23 at 3:36pm was			
		interview with Resident #1's er on 04/20/23 at 10:18am			
	[Refer to Tag 270, 10 Personal Care & Sup	A NCAC 13F .0901(b) ervision]			
	The facility failed to ensure follow up with the primary care provider (PCP) for Resident #1 following three emergency room evaluations for falls with injuries, obtain a shoulder x-ray following a fall as ordered by the PCP and a urinalysis ordered by the PCP. The facility's failure to follow up with Resident #1's PCP resulted in continued falls without care coordination and demonstrated substantial risk of serious injury and neglect of Resident #1 which constitutes a Type A2 Violation.				
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 04/19/23 for			
		DATE FOR THE TYPE A2 NOT EXCEED MAY 20,			
D 338	10A NCAC 13F .0909	Resident Rights	D 338		
	10A NCAC 13F .0909 An adult care home s	Resident Rights hall assure that the rights of			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED	
		HAL016018	B. WING		0	C 4/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
CARTERE	ET HOUSE	3020 MA	RKET STREET			
CARTER	-1 11003L	NEWPO	RT, NC 28570			
(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 IE APPROPRIATE	(X5) COMPLETE DATE
D 338	all residents guaranted Declaration of Resideration of Residerand may be exercised. This Rule is not met TYPE B VIOLATION. Based on observation reviews, the facility for response to Residen admitted to the facility assistance in identifical administered to him. The findings are: Review of Resident #03/08/24 revealed diffibrillation, congestive coronary heart diseat hypertension, hyperlice lower extremity edent interview with Resider revealed: -He was trying to figures taking. -He knew the names when he was at home each pill was. -He did not recognize the medication aide (or He did not know when he was those when he was at home each pill was.	eed under G.S. 131D-21, ents' Rights, are maintained d without hindrance. as evidenced by: ns, interviews and record ailed to ensure a reasonable t #4's who was newly y and requested staff cation of medications #4's current FL-2 dated agnoses included atrial e heart failure, anxiety, se, diabetes mellitus, pidemia, depression, and na. ent #4 on 04/18/23 at 9:35am are out what medications he of some of his medications. It is taking his medications are because he knew what the the tablets and capsules (MA) left him with.	D 338			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SI COMPLE	
			_		l c	
		HAL016018	B. WING		_	0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE	3020 MAR	KET STREET			
CARTERE	.1 11003E	NEWPORT	Γ, NC 28570			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page 32		D 338			
	O4/18/23 at 9:39am re -The MA told the reside provider was just in the questionsThe MA walked out of moment later with a vicupThe resident said to what I am taking." -The MA took the meand capsulesThe MA said to the retake these because I -The MA left the room cartThe PCP was comin roomThe MA told the PCF his medications and sthat he refused. Interview with the MA revealed: -She could not review with him because she she could not review medication with the pack (MDP) because was taking them forEach medication coushe did not know what being used forReviewing the medical of the PCP.	dent the primary care he room to answer his of the room and returned a white liquid in a medicine the MA, "I just want to know dication cup with the tablets esident, "I am just going to cannot leave them." h and went to the medication g out of another resident's P Resident #4 was not taking she was going to document A on 04/18/23 at 9:41am W Resident #4's medications				
	Second iterview with	Resident #4 on 04/18/23 at				

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-No one had gone over what medication each pill

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING		С
		HAL016018	B. WING		04/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓΕ, ZIP CODE	
CARTERE	T HOUSE	3020 MA	RKET STREET		
OAKTEKE		NEWPOI	RT, NC 28570		
(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 CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLETE
D 338	Continued From page	e 33	D 338		
	wasThe tablets and caps the ones he took at he. He just wanted to kn capsule were. Interview with the PC revealed: -She had just reviewed medications with him. He was confused owinsurance would not pis used to treat opioid.	sules looked different from ome. ow what each tablet and P on 04/18/23 at 9:48am ed Resident #4's er one medication his pay for, Symproic. (Symprioc linduced constipation.) iscuss concerns related to			
	3:20pm revealed: -He took his morning went over a list of who was in the medication -All he asked was for each tablet and capsuneededThat morning he was not knowing what was -He was also experieneeded to move his boundaried to him, and he linterview with the Adron 04/19/23 at 12:41pour -It was her understant confused about what prescribed for.	someone to tell him what ule were and that was all he s upset and frustrated from s going on. ncing constipation and lowels. lement, someone came and felt much better. ministrator in Training (AIT) om revealed: ding Resident #4 was his medications were ted to discuss what each			

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identification of each medication.

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		HAL016018	B. WING		04/20/2023	
		11112010010			1 04/20/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CARTERE	T HOUSE	3020 MA	RKET STREET			
OAKTEKE	THOUSE	NEWPOR	RT, NC 28570			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	INIAIL 5/112	
D 338	Continued From page 34		D 338			
	Interview with anothe	r resident on 04/18/23 at				
	8:55am revealed:					
		th the staff being "short" to				
	him when he asked a					
	-It was not all the staf	ff; some were very nice.				
	-They act like they do	not have time to take care				
	of us.					
		n at different times about				
		e given on certain days for				
		give them since they were				
	not given every day.					
		ministrator on 04/19/23 at				
	12:41pm revealed:	to identify modications being				
	administered.	to identify medications being				
		of each tablet or capsule on				
	the MDP for the purpo					
	medication.	eee or racharying and				
		to listen to a resident's				
	request to clearly idea					
		the MA to help Resident #4				
	recognize the tablets	and capsules he was taking				
	rather than marking a	all his morning medications				
	as refused.					
		ations such as amlodipine				
	(antihypertensive), Ci					
	extremity blood flow p					
	(antidepressant), Eliq					
	isosorbide (cardiac m					
	(diabetes medication)	, .				
		etoprolol (cardiovascular				
	medication), rosuvast					
		prostone (bowel medication)				
	were important to tak	e as ordered by the PCP.				
	[Pefer to Tog 250 40	A NCAC 13F .1004(a)				
	Medication Administra					
	modiodion Administr	auonj	1	1		

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	or perior Noiro		(VO) MILITIDI E	CONCEDUCTION	LVO BATE OUBVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
					С
		HAL016018	B. WING		04/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE	
CARTERE	T HOUSE		KET STREET		
		NEWPOR	Γ, NC 28570		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGOLATORI ORT	100 IDENTIFY TING IN GRAWATION	TAG	DEFICIENCY)	UAIL
D 338	Continued From page	e 35	D 338		
	The facility failed to e	nsure a reasonable			
	response to Resident				
	admitted to the facility	_			
	assistance in identific	•			
		The facility's failure resulted			
		ns of constipation and delay			
		used for cardiovascular			
	•	sion which was detrimental			
	• •	and welfare of Resident #4			
	and constitutes a Typ				
	,				
	The facility provided a plan of protection in				
	accordance with G.S.	. 131D-34 on 04/19/23 for			
	this violation.				
		OIC REVIEW	FNDS HE	RE THANKS TBN	
P-050	10A NCAC 13F .1004			THE THINKING TEN	
	Administration	.(2)			
	, tarrimion and the				
	10A NCAC 13F .1004	- Medication Administration			
	(a) An adult care hor	ne shall assure that the			
		nistration of medications,			
		prescription, and treatments			
	by staff are in accorda				
	-	sed prescribing practitioner			
		in the resident's record; and			
		on and the facility's policies			
	and procedures.	• •			
	·				
	This Rule is not met	as evidenced by:			
D-366	10A NCAC 13F .1004	l (i) Medication	D-366		
	Administration	• •			
	10A NCAC 13F .1004	l-Medication Administration			
		he administration on the			
		ation record shall be by the			
	staff person who adm	ninisters the medication			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL016018		B. WING			C 04/20/2023		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CARTERET HOUSE 3020 MARKET STREET							
NEWPORT, NC 28570							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETE DATE		
D 366	Continued From page 36		D 366				
		dent and observation of the ig the medication and prior of another resident's ting is prohibited.					

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