DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED
		345255	B. WING			C 8/25/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	ΕΗΔΒΙΙ ΙΤΔΤΙΩΝ		111 HARRILSON STREET		
				CHERRYVILLE, NC 28021		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	survey was conducte 08/11/22. The facility		F 000			
	complaint investigation 08/08/22 through 08/ returned to the facility the extended survey a allegation of IJ remove was changed to 08/22 allegation was substat NC00188008 resulted The facility was notified	site recertification and on survey was conducted on 11/22. The survey team of 008/25/22 to complete and validate the credible ral. Therefore, the exit date 5/22. One (1) of 1 complaint untiated and cited. Intake# d in Immediate Jeopardy. ed on 8/19/22 of Immediate fter management quality				
	(K) CFR 483.55 at tag F7 (K)	884 at a scope and severity 791 at a scope and severity				
	(K)	335 at a scope and severity				
	The tag F684 constitu Care.	ited Substandard Quality of				
		begain on 05/10/22 and was . An extended survey was				
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
	cally Signed					08/11/2022

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.

						RM APPROVE 0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		345255	B. WING		08	C B/25/2022	
	ROVIDER OR SUPPLIER A CARE HEALTH AND R	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	N STREET		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	•		F 00	0			
	(J) The tag F689 constitu Care	uted Substandard Quality of					
	survey was conducte						
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g)	ients	F 64	1		9/14/22	
	resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) asse hospice (Resident #1 required for eating (R Resident #33, Reside Resident #23), oral/d and cognition (Reside for 10 of 18 sampled reviewed. The findings included 1. Resident #14 was 4/28/22 with diagnose non-Hodgkin's lymph the lymphatic system	at accurately reflect the is not met as evidenced iews and staff interviews, the ately code the Minimum assments in the areas of 4), level of assistance atesident #37, Resident #80, ent #9, Resident #51 and ental status (Resident #68) ent #34 and Resident #59) residents whose MDS were : a admitted to the facility on es that included oma (cancer that starts in		The statements included in the pl correction are not an admission at not constitute agreement with the deficiencies herein. The plan of co is completed in the compliance of and federal regulations as outlined remain in compliance with all fede state regulations, the center has to will take the actions set forth in the following plan of correction. The fo plan of correction constitutes the of allegation of compliance. All allego deficiencies cited have been or wit completed by the dates indicated. Residents #33, # 9, #51, #23, #37 #80, were modified on 8/16/2022 accurate coding of eating support MDS. Residents #34 and #59 were mod 9/14/2022 to reflect accurate codin	nd do alleged prrection state d. To eral and aken or e billowing center's ed ill be r, and to reflect on the ified on		

Facility ID: 923063

If continuation sheet Page 2 of 81

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (	CONSTRUCTION	OMB NC (X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>			· /	LETED
							С
		345255	B. WING			08/	25/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			1 HARRILSON STREET		
	1			CH	HERRYVILLE, NC 28021		1
(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) COMPLETIC DATE
F 641	Continued From page	e 2	F 64	11			
		a life expectancy of six			BIMS on the MDS		
		agnosis of non-Hodgkin's			Resident #14 was modified on 8/12/202	22	
		idmitted to hospice care on			to reflect accurate coding of Hospice a	nd	
	5/20/22.	·			6 months or less to live diagnosis on th MDS		
	The admission Minim	um Data Set (MDS)			Resident #68 was modified on 8/12/202	22	
	assessment dated 5/2	23/22 indicated a "No" to a			to reflect accurate dental coding on the	;	
	question which asked	l if Resident #14 had a			MDS		
		lisease that may result in a			All current residents on census as of		
	life expectancy of les				09/13/2022 were audited for the followi	-	
		e was not coded on this			1 Hospice accurate coding for diagnosi	IS	
	MDS.				with life expectancy of less than six		
	An interview with the	MDS Coordinator on 8/11/22			months.; 2 Support provided with eating Dental issues appropriately coded in th		
		she was responsible for			MDS; 4 BIMS completion. These audits		
	coding the prognosis	•			were completed by the Regional MDS	5	
		ssment dated 5/23/22. The			Manager 09/13/2022. Any errors noted	d	
	MDS Coordinator sta	ted she did not code that			were corrected by 9/16/2022.		
	Resident #14 had a li	fe expectancy of less than 6			MDS Coordinator and Social Worker w	ere	
	months because the	Hospice Certification was			educated by the Regional MDS Manag	er	
	not available in the m	edical record when she			on 9/12/2022. This education includes		
		sion MDS assessment, but			accurate coding of Hospice, support		
		ined it from hospice. She			provided with eating, dental assessmen		
		was admitted to hospice on			and BIMS. This education will be includ		
		Ild have coded hospice care			on any new MDS, or Social Services st	att	
	on the admission MD	o assessment.			hired at the time of orientation.		
	An interview with the	Director of Nursing (DON)			The Regional MDS Manager /designee will complete 5 MDS audits weekly for	;	
	on 8/11/22 at 5:08 PM	<b>2</b> , <i>,</i>			accurate coding Hospice, support		
		ave coded hospice care and			provided with eating, dental assessmer	nt,	
		osis according to what the			and BIMS x 4 weeks, then 2 chart audi		
		d indicated in her Hospice			weekly x 4 weeks, then 5 chart audits x		
	Certification. The DC	N stated if the hospice			Month.		
		ocated in the medical record			The Administrator will bring the audit fo		
		linator was completing			MDS accuracy to the Committee month	nly	
		sment then she should have			x 3 months. At that time, the QAPI		
	called and obtained t	he certification from hospice.			committee will evaluate the effectivene		
	0 Decident #07				of the training to determine if continued	1	
	2. Resident #37 was	s admitted to the facility on			auditing is necessary to maintain		

Facility ID: 923063

If continuation sheet Page 3 of 81

				דאם (צא)	D. 0938-039
	IDENTIFICATION NUMBER:	· ,		· · ·	PLETED
					С
	345255	B. WING		08	/25/2022
ROVIDER OR SUPPLIER					
A CARE HEALTH AND R	EHABILITATION				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
Continued From page	e 3	F 641			
			compliance. Date of Completion: 09/14/2022		
assessment dated 7/ required extensive as	1/22 indicated Resident #37 ssistance by two+ persons				
An interview with the MDS Coordinator on 8/11/22 at 3:59 PM revealed Resident #37 was able to feed herself sometimes and at other times, her family member assisted her. The MDS Coordinator stated Resident #37 did not require the assistance of two people with eating and that she had coded the MDS in error. She explained that she based the coding on the documentation made by the nurse aides on what level of assistance required by Resident #37 and she did not catch the error.					
8/11/22 at 5:08 PM re require the assistanc and that the MDS Co verified the documen and made alterations	evealed Resident #37 did not e of two people with eating ordinator should have tation by the nurse aides as necessary in order to				
assessment dated 8/	1/22 indicated Resident #80				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page 7/7/21 with diagnose (difficulty swallowing) The quarterly Minimu assessment dated 7/ required extensive as physical assist with e An interview with the at 3:59 PM revealed feed herself sometim family member assist Coordinator stated R the assistance of two she had coded the M that she based the co made by the nurse at assistance required to not catch the error. An interview with the 8/11/22 at 5:08 PM re require the assistance and that the MDS co- verified the documen and made alterations code the MDS correct 3. Resident #80 was 1/22/21 with diagnos weakness. The quarterly Minimu assessment dated 8/ required supervision	CORRECTION       IDENTIFICATION NUMBER:         345255         ROVIDER OR SUPPLIER         A CARE HEALTH AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3 7/7/21 with diagnoses that included dysphagia (difficulty swallowing).         The quarterly Minimum Data Set (MDS) assessment dated 7/1/22 indicated Resident #37 required extensive assistance by two+ persons physical assist with eating.         An interview with the MDS Coordinator on 8/11/22 at 3:59 PM revealed Resident #37 was able to feed herself sometimes and at other times, her family member assisted her. The MDS Coordinator stated Resident #37 did not require the assistance of two people with eating and that she had coded the MDS in error. She explained that she based the coding on the documentation made by the nurse aides on what level of assistance required by Resident #37 and she did not catch the error.         An interview with the Director of Nursing on 8/11/22 at 5:08 PM revealed Resident #37 did not require the assistance of two people with eating and that the MDS Coordinator should have verified the documentation by the nurse aides and made alterations as necessary in order to code the MDS correctly.         3. Resident #80 was admitted to the facility on 1/22/21 with diagnoses that included muscle weakness.         The quarterly Minimum Data Set (MDS) assessment dated 8/1/22 indicated Resident #80 required supervision from two+ persons physical	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING.         345255       B. WING	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345255       B. WING         ROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, 2IP CODE         A CARE HEALTH AND REHABILITATION       STREET ADDRESS, CITY, STATE, 2IP CODE         ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOW TAG         Continued From page 3 7/7/21 with diagnoses that included dysphagia (difficulty swallowing).       F 641         Continued From page 3 7/7/21 with diagnoses that included MSPhagia (difficulty swallowing).       F 641         Continued From page 3 7/7/21 with diagnoses that included MSPhagia (difficulty swallowing).       F 641         Continued From page 3 7/7/21 with diagnoses that included MSPhagia (difficulty swallowing).       F 641         Continued From page 3 7/7/21 with diagnoses that included MSPhagia (difficulty swallowing).       F 641         Continued From page 3 7/7/21 with diagnoses that included Resident #37 required extensive assistance by two+ persons physical assist with eating.       F 641         An interview with the MDS Coordinator on 8/11/22 at 3:59 PM revealed Resident #37 did not require that she based the coding on the documentation made by the nurse aides on what level of assistance required by Resident #37 did not require the assistance of two people with eating and that the MDS correcity.       N interview with the Director of Nursing on 8/11/22 at 5:08 PM revealed Resident #37 did not require the assistance of two peopl	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       00         ACARE HEALTH AND REHABILITATION       STREET ADDRESS, CITY, STATE, ZP CODE       111 HARRILSON STREET       06         SUMMARY STATUMENT OF DEFICIENCES       IN ORACIONERS PLAN OF CORRECTION       Interview SPLAN OF CORRECTION       06         WIND       SUMMARY STATUMENT OF DEFICIENCES       IN ORACIONERS PLAN OF CORRECTION       Interview SPLAN OF CORRECTION         RECULATORY OR LSC IDENTIFYING INFORMATION       PREPRY       PROVIDERS PLAN OF CORRECTION       EACH CORRECTIVE ACTION SPLAN OF CORRECTION         Continued From page 3       7/7/21 with diagnoses that included dysphagia       F 641       Compliance.         Continued From page 3       F 641       Compliance.       Date of Completion: 09/14/2022         The quarterly Minimum Data Set (MDS)       assessment dated 71/122 indicated Resident #37       required by the assistance of two people with eating and that she had coded the MDS Coordinator on 8/11/22       a1 3:69 PM revealed Resident #37 did not require the assistance of two people with eating and that she had coded the MDS in error. She explained that she based the coding on the documentation made alterations as necessary in order to code the MDS correctly.       An interview with the Director of Nursing on 8/11/22 at 5:08 PM revealed Resident #37 did not require the assistance of two people with eating and that she had coded the MDS correctly.       S. Resident #80 was admitted to the facility on 1/22/21 with diagnoses that included muscle weakness.       S. Resident #80 w

Facility ID: 923063

If continuation sheet Page 4 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/21/2022 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING				C 25/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R			1'	11 HARRILSON STREET		
0,110211				С	HERRYVILLE, NC 28021		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	two people with eating stated that she had con- explained that she had con- explained that she had documentation made level of assistance re- she did not catch the An interview with the 8/11/22 at 5:08 PM re- require the assistance and that the MDS Con- verified the document and made alterations code the MDS correct 4. Resident #33 was a diagnosis that inclue The quarterly Minimu assessment dated 07 #33 required extensive eating from two or mo- An interview with the 08/11/22 at 3:59 PM re- assisted with meals be require the assistance and this had been an based the information assessment from the nurse aides on what I required by Resident the error. An interview with the 08/11/22 at 5:08 PM re- not require the assistance	not require the assistance of g. The MDS Coordinator oded the MDS in error. She ased the coding on the by the nurse aides on what quired by Resident #80 and error. Director of Nursing on evealed Resident #80 did not e of two people with eating ordinator should have tation by the nurse aides as necessary in order to ty. admitted on 01/24/2020 with ded muscle weakness. m Data Set (MDS) 7/01/22 indicated Resident //e physical assistance with ore persons. MDS Coordinator on revealed Resident #33 was by one person and did not e of two people with eating error. She explained she	F	641			

Facility ID: 923063

If continuation sheet Page 5 of 81

		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/21/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING				C /25/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	A CARE HEALTH AND RI			11	11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND RI			С	HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 641	Continued From page verified the document and made alterations MDS accurately. 5. Resident #9 was ac diagnoses that include muscle weakness. The quarterly Minimur assessment dated 05, #9 required supervisio persons physical assi An interview with the 1 08/11/22 at 3:59 PM r able to feed herself ar assistance of two peo Coordinator stated sh error. She explained the documentation may what level of assistan #9 and she had not ca An interview with the 1 08/11/22 at 5:08 PM r require the assistance and said the MDS Co- verified the document	<ul> <li>5</li> <li>ation by the nurse aides as necessary to code the</li> <li>dmitted on 02/28/2019 with ed muscle wasting and</li> <li>m Data Set (MDS) (16/22 indicated Resident on from two or more st with eating.</li> <li>MDS Coordinator on evealed Resident #9 was nd did not require the ple with eating. The MDS in she based the coding on ade by the nurse aides on ce was required by Resident aught the error.</li> <li>Director of Nursing on evealed Resident #9 did not even a did not even a did not even a did not error.</li> </ul>		541		(ALE	
	6. Resident #51 was a 5/01/18.	admitted to the facility on					
	assessment dated 7/1	inimum data set (MDS) 3/22 indicated Resident e assistance of two or more st with eating.					

Facility ID: 923063

If continuation sheet Page 6 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING				C /25/2022
NAME OF PI	ROVIDER OR SUPPLIER	L		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	96	F	641			
	independently with us device. Interventions as needed during eat An interview with Res 02:10 PM revealed R from staff with setting drink, but she can eat An interview with the at 4:18 PM revealed R two-person assistance noted the information reviewed documentat for the level of mealting	esident #51: eats meals se of adaptive equipment include provide assistance ing and drinking. sident #51 on 08/10/22 at esident #51 received help up her tray and opening her t by herself with no issues. MDS Coordinator on 8/11/22 Resident #51 did not require e for eating and she had in error. She stated she tion from nursing assistants me assistance required for not observe Resident #51					
	8/11/22 at 5:12 PM re require two-person ph eating and the MDS s	ector of Nursing (DON) on evealed Resident #51 did not hysical assistance with should reflect correct level of required for the resident.					
	7. Resident #23 was i 8/06/20.	readmitted to the facility on					
	assessment dated 6/0	ninimum data set (MDS) 07/22 indicated Resident re assistance of two or more ist with eating.					
	08/09/22 at 12:10 PM	se Assistant (NA) # dated I revealed Resident #23 ance with her meals. She					

Facility ID: 923063

If continuation sheet Page 7 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/21/2022 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345255	B. WING _				C 25/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			11 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 641	eat. She revealed Re- on her own, but staff y her if needed. Observation on 08/09 #23 sitting at dining ro- member sitting next to able to drink and take own with use of adap An interview with the at 4:18 PM revealed F two-person assistance noted the information reviewed documentat for level of mealtime as Resident #23 but did for mealtime assistan An interview with Dire 8/11/22 at 5:12 PM re require two-person pf eating and the MDS s mealtime assistance of 8. Resident #68 was a 6/13/21 and readmitted a. Review of a quarte assessment dated 5/2 issues or concerns ha Resident #68. b. Review of an admis dated 6/30/22 indicated	d sit at the table with rvise and encourage her to sident #23 was able to eat would assist with feeding //22 at 12:28 PM of Resident for table with one staff or her. Resident #23 was e small bites of food on her tive mealtime equipment. MDS Coordinator on 8/11/22 Resident #23 did not require e for eating and she had in error. She stated she ion from nursing assistants assistance required for not observe Resident #23 ce herself. ector of Nursing (DON) on vealed Resident #23 did not hysical assistance with should reflect correct level of required for the resident. admitted to the facility on ed on 6/23/22. rly minimum data set (MDS) 27/22 indicated no dental	F	541			

Facility ID: 923063

If continuation sheet Page 8 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/21/2022 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345255	B. WING				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	<ul> <li>7/25/22 indicated no had been identified for had been identified for Review of a Physicial revealed Resident #60 Clindamycin (an antik tablet by mouth every dental infection.</li> <li>Review of a Physicial revealed Resident #60 Clindamycin 300 mg hours for 7 days for a Review of a dietary or a new order for a reg due to dental issues.</li> <li>An interview with Ress 8/08/22 at 11:06 AM. having dental issues year after receiving c</li> <li>An observation of Re the interview on 8/08/cheek was observed opened her mouth to red, inflamed, and sw some teeth visible. O chipped.</li> <li>An interview was con PM with Resident #60 an oxycodone tablet of the interview of a dietary of a dietary or a new order for a reg due to dental issues.</li> </ul>	rly MDS assessment dated dental issues or concerns or Resident #68 n order dated 5/10/22 8 was to receive biotic) 300 milligrams (mg) 1 7 8 hours for 7 days for a n order dated 6/09/22 8 was to receive 1 tablet by mouth every 8	F	641			

If continuation sheet Page 9 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345255	B. WING				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
	A CARE HEALTH AND R			1	111 HARRILSON STREET		
CAROLIN				C	CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	be severe when the n when she wakes up in the abscesses inside mouth at the base of through her nose and abscess toward back mouth and jaw cause like she had lock jaw. was the worst pain sh revealed her mouth h chews on the left side and takes small sips of prevent eating and dr worse. Resident #68 dental issues on-goin different times she ha year. She stated nurs Worker told here they dentist who would act out her teeth since las An interview with the at 4:27 PM revealed s information about Res and dental pain on the quarterly MDS assess an error. She stated s dental care from nurs up and assess Reside An interview with the on 8/11/22 at 5:14 PM Resident #68 having and past and present stated the MDS shoul information for Reside	s. She stated the pain could nedication wore off, like in the morning. She revealed the upper right side of her her nose caused pain up into her eye and the of the right side of her d pain through her jawbone Resident #68 stated this he had been through. She urts when she eats, and she e and waits between bites of liquid through straws to inking from making the pain further revealed she had g and believed at least three id abscesses since last ing staff, and the Social were searching for a cept her insurance to take st year. MDS Coordinator on 8/11/22 she should have included sident #68 's broken teeth e admission and two sments and this had been she received information on ing staff but did not follow ent #68 herself. Director of Nursing (DON) A revealed she was aware of missing and broken teeth dental infections. She ld reflect correct dental	F	641			

Facility ID: 923063

If continuation sheet Page 10 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/21/2022 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING _				C / <b>25/2022</b>
	ROVIDER OR SUPPLIER A CARE HEALTH AND R	EHABILITATION		1'	TREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	(MDS) dated 6/25/22 speech and sometim Brief Interview for Me structured interview a assessment noted sh it had been left blank for Mental Status had An interview conduct (SW) on 8/11/22 at 5 completed the BIMS admission MDS asses Resident #34 answer her ability, but her an sense. The SW state was incomplete and it The SW stated the re BIMS assessment sh and not left blank. An interview conduct Nursing (DON) and th 8/11/22 at 5:15 PM re assessment should h left blank.	ssion Minimum Data Set revealed she had clear es understood others. The ental Status (BIMS, a	F	541			
	(MDS) dated 7/19/22 clear speech and usu Brief Interview for Me structured interview a assessment noted th						

Facility ID: 923063

If continuation sheet Page 11 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/21/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY PLETED
		345255	B. WING _				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION			1 HARRILSON STREET HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page for Mental Status had	e 11 I been completed instead.	F	641			
F 657 SS=D	(SW) on 8/11/22 at 5: completed the BIMS admission MDS asse Resident #59 answer not understand their s interviewed staff inste- resident interview for should have been col An interview conducte Nursing (DON) and th 8/11/22 at 5:15 PM re- assessment should h left blank. Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive a- (ii) Prepared by an in- includes but is not lim (A) The attending phy (B) A registered nurse- resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac- the resident and the r An explanation must medical record if the	(i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the	F	657			9/12/22

If continuation sheet Page 12 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		C 08/25/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
	A CARE HEALTH AND R			111 HARRILSON STREET	
CAROLIN	A CARE HEALTH AND R			CHERRYVILLE, NC 28021	
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 657	disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on record rev resident and staff inte update care plans to 1 resident reviewed for #68). The findings include: Resident #68 was ad 06/13/21 and readmit included type 2 diabe stage renal failure. Review of a quarterly assessment dated 05 assessment dated 05 as	e development of the e staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced iew, observation, and erviews, the facility failed to reflect dental issues for 1 of or dental care (Resident mitted to the facility on tted on 06/23/22. Diagnosis etes, heart failure and end T minimum data set (MDS) 5/27/22, an admission MDS 5/30/22, and a quarterly MDS 5/30/22, all indicated no terns had been identified for re plans dated 05/27/22,	F 657	The statements included in the pla correction are not an admission an not constitute agreement with the a deficiencies herein. The plan of col is completed in the compliance of s and federal regulations as outlined remain in compliance with all feder state regulations, the center has ta will take the actions set forth in the following plan of correction. The fo plan of correction constitutes the co- allegation of compliance. All allege deficiencies cited have been or will completed by the dates indicated. All current residents on census as 08/10/2022 were assessed by Dire Nursing and Unit Manager for any concerns. Care plans for residents dental concerns were updated on 8/21/2022 MDS Coordinator was educated by	d do alleged rrection state . To al and ken or llowing enter's d be of ctor of dental with
	interventions for dent Review of an in-hous revealed Resident #6 dentist for a routine d	e dental note dated 04/28/22 i8 was seen by the facility		<ul> <li>Regional MDS Manager on 9/12/20</li> <li>This education includes accurate of planning and updates related to de concerns. This education will be informed and new MDS staff hired at the orientation.</li> <li>The Regional MDS Manager /designation</li> </ul>	are ntal cluded time of

Facility ID: 923063

If continuation sheet Page 13 of 81

	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
					с
		345255	B. WING		08/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021	
(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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 657	Continued From page 13 extractions due to all teeth being root tips, covered with tissue, and requiring surgery. Review of a nursing progress note dated 05/10/22 revealed a new order for Resident #68 to receive Clindamycin (an antibiotic) 300		F 657	will complete 5 care plans audits to validate that dental concerns a addressed in the plan of care x 4 then 2 chart audits weekly x 4 we 5 chart audit x 1 month	ire weeks, eks, then
m fo R 00 c c 1 d d R r e s c R d i d t T	milligrams (mg) 1 tab for a dental abscess. Review of a nursing p 06/09/22 revealed ne consult for teeth extra	let by mouth every 8 hours		The Administrator will bring the au dental care plan to Committee mo months. At that time, the QAPI or will evaluate the effectiveness of t training to determine if continued is necessary to maintain compliar Date of completion: 09/12/2022	onthly x 3 ommittee he auditing
	revealed Resident #6 scheduled dental visi Resident #68 had pre oral surgeon for extra Resident #68 as havi disease (the result of of the gums and bone	eviously been referred to an actions and described ng "severe periodontal infections and inflammation e that surround and support calculus (plaque) buildup". ed Resident #68 had			
	08/08/22 at 11:06 AM been having dental is last year after receiving treatments. An observation of Re the interview on 08/00 cheek was observed opened her mouth to red, inflamed, and sw	sident #68 was conducted on I. She revealed she had sues and infections since ing chemotherapy sident #68 was made during 8/22 at 11:06 AM. Her right as slightly swollen. She reveal gums which were vollen with only the tips of ther teeth were broken and			

If continuation sheet Page 14 of 81

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345255	B. WING		C 08/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/23/2022
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021	
(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 APPROPR DEFICIENCY)	BE COMPLÉTIO
F 657	An interview with the 08/11/22 at 04:27 PM should have had a ca include dental infection surgery recommendation	MDS Coordinator on revealed Resident #68 re plan for dental care to ons and treatment, oral tions, and missing or broken	F 65	7	
	having a care plan fo her part. She stated s				
F 677 SS=D	on 08/11/22 at 05:14 of Resident #68 havir and past and present past year. She stated should reflect goals for ADL Care Provided for	or Dependent Residents	F 67	7	9/1/22
	out activities of daily l services to maintain g personal and oral hyg This REQUIREMENT by:	is not met as evidenced			
	and staff interviews, t nail care to 1 of 6 res	iew, observations, resident he facility failed to provide idents (Resident #80) ce with activities of daily		The statements included in the plan of correction are not an admission and d not constitute agreement with the aller deficiencies herein. The plan of correct is completed in the compliance of stat and federal regulations as outlined. To	o ged ction e
	The findings included			remain in compliance with all federal a state regulations, the center has taken	and
		mitted to the facility on es that included generalized		will take the actions set forth in the following plan of correction. The follow	

Event ID: OE2V11

Facility ID: 923063

If continuation sheet Page 15 of 81

			0/02 100			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY
			A. BUILDING	·		С
		345255	B. WING			)8/25/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		)0/2J/2022
				111 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 677	Continued From page	e 15	F 67	7		
				allegation of compliance.	All alleged	
	-	blan dated 7/26/22 indicated		deficiencies cited have be		
		ADL (activities of daily living)		completed by the dates in		
		e deficit related to decreased		On 08/12/2022 Resident		
	• •	nails long and polished and		fingernails cleaned and tri		
		t nails short. Interventions e resident to allow staff to		her request by the Licens Nurse (LPN).	ed Practical	
		and monitor fingernails for		On 8/18/22, 100% of all ir	house	
	cleanliness and need	5		residents were observed		
				deficits to include cleanlin		
	The quarterly Minimu	m Data Set (MDS)		filing needs by the license		
	assessment dated 8/	1/22 indicated Resident #80		certified nursing assistant	s on each unit.	
	was severely cognitiv			Any resident who had lon		
	rejection of care beha			jagged nails, were correct		
		sistance with personal		based on the resident pre	ference at that	
	hygiene.			time. Education was initiated or	2 8/12/22 by	
	An observation and ir	nterview of Resident #80		Director of Nursing (DON)	•	
		at 11:08 AM. Resident #80's		all current nursing departr		
		erved being at least a half		including certified nursing		
	inch longer than the t	ips of her fingers and there		medication aides, license	d practical	
		cked edges. Resident #80		nurses, and registered nu		
		ed her fingernails trimmed		and trimming nails per res		
		e supposed to trim them		choice. All residents will I		
	today.			trimmed and cleaned bas		
	A second observation	n of Resident #80 on 8/9/22		observation and resident showers and as needed.	-	
		her sitting in her wheelchair		included asking the reside		
		er bed. Her fingernails were		observation regarding nai		
		than the tips of her fingers.		regardless of past refusal		
		she had asked the staff to		department staff member	who did not	
	clip her fingernails, bu	ut they didn't do it.		receive this education by		
				allowed to work until com		
		Resident #80 on 8/10/22 at		education will be included	I in the new hire	
		r eating breakfast with her		orientation.	aiatratia -	
		a fork. Her fingernails		The DON or Nurse Admin		
		f inch longer than the tips of		designee will audit 10 res fingernails weekly times 4		
	her fingers.			resident observations week		

Facility ID: 923063

If continuation sheet Page 16 of 81

		MEDICAID SERVICES				0.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING			~
		345255	B. WING		C 08/25/2022	
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2022
				111 HARRILSON STREET		
AROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021		
(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 AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 677	Continued From page	e 16	F 67	7		
1 011		of Resident #80 on 8/11/22	FUT	weeks, and then 3 resident obse	arvations	
		her lying in bed. Her		weekly times 4 weeks.		
		to be long and had jagged		The DON or Nurse Administratio	'n	
		Resident #80 stated she		designee will bring the audit res	ults to the	
		e day before and she wanted		Quality Assurance Committee m		
		aff never did, and no one had		times 3 consecutive months. The		
	offered to trim her fin	gernalls.		Assurance committee will evalua		
	An interview with Nu	rse Aide (NA) #4 on 8/11/22		effectiveness of the above plan a make additional interventions ba		
		d she gave Resident #80 a		the audits to ensure continued		
		nd she noticed that her		compliance.		
	fingernails were long	and needed to be trimmed.		Completion date is 9/1/22.		
		nt #80 would not let the staff				
	cut her fingernails in the past, but she didn't ask her on 8/10/22 if she could cut her fingernails.					
		dication Aide (MA) #1 on				
		revealed she had noticed				
		nails when she gave her ning but Resident #80				
		cut her fingernails and she				
		have them trimmed. MA #1				
		Resident #80 if she could				
	cut her fingernails thi	s morning.				
	A follow-up interview	with MA #1 on 8/11/22 at				
		esident #80 let her trim her				
		ated she noticed the jagged				
	and cracked edges a	nd that Resident #80's				
		thin, and they broke once				
	she started cutting th	em.				
	An interview with the	Director of Nursing on				
		evealed staff should still offer				
	to trim Resident #80'	s fingernails even though				
	she had refused nail	care in the past.				
F 684			F 68	4		9/1/22
SS=K	CFR(s): 483.25					

Facility ID: 923063

If continuation sheet Page 17 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		C 08/25/2022
NAME OF PI	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	
				111 HARRILSON STREET	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 684	Continued From page	e 17	F 684	4	
	applies to all treatment facility residents. Base assessment of a reside that residents received accordance with profe practice, the compret care plan, and the residents residents REQUIREMENT by: Based on observatio Practitioner (NP), fact interviews, the facility well-being by not pro- prevent oral abscesse and chewing difficulty (Resident #68). On 1 in-house dentist who pain due to a tooth in made for outside den were recommended. ordered the next day Resident #68 was see who wrote a referral f extraction of all remain was seen by an oral se plan was to remove a during two appointment which she asked to d when her Medicaid w Resident #68's diet of diet with mechanical physician orders were dental abscess. From Resident #68 reporter to 7 (on a scale of 1-1 pain). Antibiotics were	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices. is not met as evidenced ns, record reviews, Nurse ility staff, and resident failed to ensure resident's viding care and services to es, unresolved dental pain of or 1 of 1 resident 10/19/21 was seen by the noted Resident #68 was in fection and referral was tal treatment and antibiotics		The statements included in the pla correction are not an admission an- not constitute agreement with the a deficiencies herein. The plan of cor- is completed in the compliance of s and federal regulations as outlined. remain in compliance with all feder state regulations, the center has ta- will take the actions set forth in the following plan of correction. The fol plan of correction constitutes the ce allegation of compliance. All allege deficiencies cited have been or will completed by the dates indicated. On 8/10/22, the Director of Nursing performed an oral evaluation on Re #68. Resident #68 saw an oral sur on 8-15-22 and is scheduled for ora surgery on 8-25-22. On 8-10-22, Nursing Management and Unit Coordinators) completed a audit of all in-house residents to ide those with complaints of dental pair audit included an observation of the cavity for abnormalities of the teeth redness, odor, or signs and sympto infection. The physician was notifie	d do lleged rrection state . To al and ken or lowing enter's d be (DON) esident geon al (DON, an entify n. This e oral b, poms of

Facility ID: 923063

If continuation sheet Page 18 of 81

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · /	G	. ,	IPLETED
						С
		345255	B. WING		08	8/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET		
				CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 18	F 68	34		
		n 06/09/22 through 06/15/22,		any abnormalities, new	orders for dental	
		d pain level ranging from 5		referrals were obtained		
		10 with 10 being the worst		consult recommendation		
		ident #68 diet order was		implemented, including	pain	
	changed to regular di	iet with chopped meat. On		management.		
		3 was seen by the NP who		By 8/11/22, Director of N		
		ss. This infection required 14		Development Coordinat		
		d oxycodone for the pain.		Licensed Nurses to com		
		8/11/22, Resident #68		observations for red swo	-	
	reported a pain level			and/or other teeth abnor		
	Resident #68 oral sur			admission, during routin residents that complain		
	appointment was scheduled on 08/10/22 (after the survey started) for 08/15/22.			is the responsibility of th	-	
				report any oral abnorma		
	Immediate jeopardy k	began on 05/10/22 when		the Licensed Nurse. It is		
		ated for a tooth abscess and		of the Licensed Nurse to		
	the facility failed to ob	otain dental services for		abnormalities and pain t	to the Unit	
		extraction of all remaining		Coordinators. Unit Coor		
		jeopardy was removed on		responsible for notifying		
	8/12/22 when the fac			Physician/Nurse Practiti		
	-	Illegation for immediate		off shifts it is the respon	-	
		he facility remains out of		Nurses to notify the Phy		
		r scope and severity level of		Practitioner of any abno obtain new orders for tre		
		th the potential for more than not immediate jeopardy) to		interventions including p		
		d monitoring systems put into		and dietary consultation	•	
	place are effective.	a monitoring by storie pat into		Nursing staff will not be		
	F			next shift prior to receivi		
	Findings included:			and all new hires will red		
				education during orienta	ation process. On	
		mitted to the facility on		8/10/22, the Unit Coordi		
		nitted on 06/23/22 with		Licensed Nurses were r		
		Type 2 Diabetes, end stage		responsibility by the Dire		
	renal failure, heart dis	-		and Staff Development	Coordinator during	
	female genital organs	ary and overlapping sites of		this education. By 8/11/22, the Director	of Nursing will	
	remaie genital organs	anu icit kiulicy.		educate Licensed Nurse		
	Review of admission	minimum data set (MDS)		process for communicat		
		aled Resident #68 was coded		orders for oral cavity		

Facility ID: 923063

If continuation sheet Page 19 of 81

						<u>3 NO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		DATE SURVEY COMPLETED	
		345255	B. WING			C 08/25/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	00/23/2022	
				111 HARRILSON STREET			
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From page	e 19	F 68	4			
		or concerns with oral care		observations/abnormaliti	es, treatments		
				and interventions including			
		68's revised care plans		management, and dietar	y consults if		
	revealed no approach	n for oral care.		needed, to the Unit Coor			
	Review of in-house d	ental note dated 10/19/21		off hours the Licensed N orders, which will pull inte			
		8 was in pain due to tooth		Report-Orders" and will b	• •		
		was made for outside dental		Daily Clinical Meeting by	•		
	treatment and recomi	mended antibiotics such as		Coordinators.			
		milligrams) 1 tablet every 8		By 8/11/22, Nursing Man	-		
		Clindamycin 300 MG 1 tablet		(Director of Nursing, Unit			
	overall health condition	days if appropriate due to		will educate the Nurse Ai cavity observations for re			
		511.		odor, and/or other teeth			
	Review of nursing pro	ogress note dated 10/20/21		admission, during routine			
		itioner (NP) evaluated		residents that complain o			
		to tooth infection with new		difficulty chewing. Issues			
		oxicillin 50 milligrams (MG)		reported to the Licensed			
		lays. Resident #68 is her on and is aware of new		Coordinator for follow-up will be reported to the Lic			
	orders.			Unit Coordinator for follo			
				Aides will not be able to	•		
		order dated 10/20/21 for		shift prior to receiving the			
		tablet by mouth every 8 am) for tooth infection.		all new hires will receive during orientation proces			
		ntal note dated 11/21/21		The Director of Nursing V			
		8 required oral surgery for		staff will work without rec	•		
		aining teeth. The outside		training. Any new hires, i			
		a referral for Resident #68 surgeon for teeth extraction		agency staff, will receive to the start of their shift.	education prior		
		g broken and all root tips with		On 8/10/22, the Regiona	I Clinical		
	tissue covering the te			Manager educated the D			
	5			Nursing, Unit Coordinato			
		on note dated 12/07/21		Worker, and the Adminis			
		ove all upper and lower teeth		clinical morning meeting			
		ng two appointments using		review the "Facility Activi			
	wait until January 202	er, the resident requested to		-Orders" to include any r	elenais (orders)		

Facility ID: 923063

If continuation sheet Page 20 of 81

	OF DEFICIENCIES	MEDICAID SERVICES			ONSTRUCTION	(X3) DATE	0.0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		JNSTRUCTION		PLETED
			A. BUILDING	·			c
		345255	B. WING			C	
	ROVIDER OR SUPPLIER	0.0200	STREET ADDRESS, CITY, STATE, ZIP CODE			08/25/2022	
					HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			ERRYVILLE, NC 28021		
			I		PROVIDER'S PLAN OF CORRECTION		0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIOI DATE
F 684	Continued From page	e 20	F 68	4			
	take effect.				physician orders, pain, and infections.		
					This review identifies any new pain,		
	Per telephone intervi	ew with Transportation			dietary concerns, and resolution of		
		/22 at 03:19 PM revealed			infections/abscesses. The Unit		
		irgeon practice in January			Coordinators were notified during this		
	2022 to make Reside			education that they are responsible to			
		ted and the oral surgeon the extractions had retired.			print, review, and bring the "Facility ac	tivity	
		o took over the practice			Report-Orders" to Clinical Morning Meeting. Attendees of the Clinical Mor	nina	
		e until August 2022 and did			Meeting are Director of Nursing,	ming	
	not accept Medicaid.				Administrator, Staff Development		
					Coordinator, Social Worker, and Unit		
	Review of dietary ord	Review of dietary order dated 03/27/22 revealed			Coordinators.		
		diet with mechanical soft					
	meat.			-	The DON or designee will audit the de	ntal	
					referral log 3 times a week times 4 we		
		view was conducted on			then 2 times a week times 4 weeks, a	nd	
		l revealed she was familiar		1	then weekly times 4 weeks.		
		d her on-going dental		.			
		peech and occupational			The DON will bring the results of this a	audit	
		orking with Resident #68 ing to accommodate her diet			to three consecutive monthly Quality		
		r her dental issues. She			Assurance Committee meetings. The Quality Assurance committee will eval		
		8 goes back and forth with			the effectiveness of the above plan an		
		s are easiest for her to eat			will make additional interventions base		
		her mouth and teeth are			on the audits to ensure continued		
	•	Pirector stated that she lets			compliance.		
	-	eds something chopped or					
		enough for her to eat as is,			Date of Compliance 09-01-22		
	they go by her prefer						
		regular diet with chopped					
		likes things soft and lots of					
		rent dental issues. She not recall a discussion					
		eting of not being able to find					
		t #68 teeth extractions who					
		nce but does not recall the					
	-	or which staff member was					
	discussing the matter						

Facility ID: 923063

If continuation sheet Page 21 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/21/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345255	B. WING _			-		C 25/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
CAROLIN	A CARE HEALTH AND RI	EHABILITATION			11 HARRILSON STREET HERRYVILLE, NC 2802	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	21	F 6	84				
	revealed Resident #6 for routine dental visit could not perform extr house due to all teeth had completely cover procedure would need #68 had been referred and the attached refe recommendations in of to proceed with the tre provider that accepts was recommended th resident's Medicaid pr dental offices. There was no docume staff or the Social Wo a list of oral surgeons in-house dentist. The any documentation of surgeon practices to i #68 Medicaid. Review of nursing pro- revealed new orders for Clindamycin 300 MG	d to be surgical. Resident d out for dental treatment, rral provided dentist's case the resident would like eatment plan through a their current coverage. It						
	300 MG 1 tablet by m 8AM, 4PM) for 7 days Resident #68 had bee	8 to receive Clindamycin outh every 8 hours (12AM, s for dental infection. en ordered Acetaminophen nouth every 4 hours as						

If continuation sheet Page 22 of 81

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · · ·	E SURVEY	
OVIDER OR SUPPLIER			G	COM	IPLETED	
OVIDER OR SUPPLIER					С	
OVIDER OR SUPPLIER	345255	B. WING		08	08/25/2022	
			STREET ADDRESS, CITY, STATE, ZIP CODE			
CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021			
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
		F 68	84			
received Clindamycin hours (12AM, 8AM, 4 on 05/10/22 and endi #68 received Acetami tooth pain at a level o being the worst pain) tooth pain at a level o and 03:59 PM, and to	a 300 MG 1 tablet every 8 PM) as ordered beginning ng on 05/16/22. Resident inophen 325 MG related to of 6 on a scale of 1 to 10 (ten on 05/10/22 at 01:06 PM, of 7 on 05/12/22 at 05:42 AM both pain at a level of 7 on					
revealed an order for	a consult for oral surgery for					
revealed new orders teeth extractions, Clir mouth every 8 hours	for oral surgery consult for ndamycin 300 MG 1 tablet by for 7 days for dental					
revealed Resident #6 300 MG 1 tablet by m	8 to receive Clindamycin outh every 8 hours (5AM,					
(MAR) for June 2022 received Acetaminopl pain at a level of 5 on being the worst pain) and 04:09 PM, tooth J 06/12/22 at 03:43 PM	revealed Resident #68 hen 325 MG related to tooth a scale of 1 to 10 (ten on 06/10/22 at 12:53 AM pain at a level of 7 on 1, and tooth pain at a level of					
	Review of medication (MAR) for May 2022 received Clindamycin hours (12AM, 8AM, 4 on 05/10/22 and endi #68 received Acetam tooth pain at a level of being the worst pain) tooth pain at a level of and 03:59 PM, and to 05/13/22 at 04:02 AW effective results. Review of Physician of revealed an order for teeth extractions for F Review of nursing pro- revealed new orders teeth extractions, Clin mouth every 8 hours abscess. Resident #6 300 MG 1 tablet by m 1PM, 9PM) for 7 days Review of medication (MAR) for June 2022 received Acetaminop pain at a level of 5 on being the worst pain) and 04:09 PM, tooth 06/12/22 at 03:43 PM 5 on 06/15/22 at 11:3 Review of in-house d	Continued From page 22 Review of medication administration record (MAR) for May 2022 revealed Resident #68 received Clindamycin 300 MG 1 tablet every 8 hours (12AM, 8AM, 4PM) as ordered beginning on 05/10/22 and ending on 05/16/22. Resident #68 received Acetaminophen 325 MG related to tooth pain at a level of 6 on a scale of 1 to 10 (ten being the worst pain) on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/12/22 at 05:42 AM and 03:59 PM, and tooth pain at a level of 7 on 05/13/22 at 04:02 AM and 12:30 PM all with effective results. Review of Physician order dated 06/07/22 revealed an order for a consult for oral surgery for teeth extractions for Resident #68. Review of nursing progress note dated 06/09/22 revealed new orders for oral surgery consult for teeth extractions, Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental infection. Review of medication administration record (MAR) for June 2022 revealed Resident #68 received Acetaminophen 325 MG related to tooth pain at a level of 5 on a scale of 1 to 10 (ten being the worst pain) on 06/10/22 at 12:53 AM and 04:09 PM, tooth pain at a level of 7 on 06/12/22 at 03:43 PM, and tooth pain at a level of 5 on 06/15/22 at 11:38 AM and 06:50 PM. Review of in-house dental note dated 06/28/22 revealed Resident #68 was seen again for a	Review of medication administration record (MAR) for May 2022 revealed Resident #68 received Clindamycin 300 MG 1 tablet every 8 hours (12AM, 8AM, 4PM) as ordered beginning on 05/10/22 and ending on 05/16/22. Resident #68 received Acetaminophen 325 MG related to tooth pain at a level of 6 on a scale of 1 to 10 (ten being the worst pain) on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/12/22 at 03:42 AM and 03:59 PM, and tooth pain at a level of 7 on 05/13/22 at 04:02 AM and 12:30 PM all with effective results. Review of Physician order dated 06/07/22 revealed an order for a consult for oral surgery for teeth extractions for Resident #68. Review of nursing progress note dated 06/09/22 revealed new orders for oral surgery consult for teeth extractions, Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for dental abscess. Resident #68 was made aware. Review of Physician order dated 06/09/22 revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental infection. Review of medication administration record (MAR) for June 2022 revealed Resident #68 received Acetaminophen 325 MG related to tooth pain at a level of 5 on a scale of 1 to 10 (ten being the worst pain) on 06/10/22 at 12:53 AM and 04:09 PM, tooth pain at a level of 7 on 06/12/22 at 03:43 PM, and tooth pain at a level of 5 on 06/15/22 at 11:38 AM and 06:50 PM. Review of in-house dental note dated 06/28/22	Continued From page 22       F 684         Review of medication administration record       (MAR) for May 2022 revealed Resident #68         received Clindamycin 300 MG 1 tablet every 8       hours (12AM, 8AM, 4PM) as ordered beginning         on 05/10/22 and ending on 05/16/22. Resident       #68 received Acetaminophen 325 MG related to         tooth pain at a level of 6 on a scale of 1 to 10 (ten being the worst pain) on 05/10/22 at 01:06 PM,       tooth pain at a level of 7 on 05/12/22 at 05:42 AM         and 03:59 PM, and tooth pain at a level of 7 on 05/13/22 at 04:02 AM and 12:30 PM all with       effective results.         Review of Physician order dated 06/07/22       revealed new orders for oral surgery consult for teeth extractions for Resident #68.         Review of nursing progress note dated 06/09/22       revealed new orders for oral surgery consult for teeth extractions, Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for a dental infection.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental infection.         Review of medication administration record (MAR) for June 2022 revealed Resident #68       received Acetaminophen 325 MG related to tooth pain at a level of 5 on a scale of 1 to 10 (ten being the worst pain) on 06/10/22 at 12:53 AM         and 04:09 PM, tooth pain at a level of 7 on 06/12/22 at 03:43 PM, and tooth pain at a level of 5 on 06/15/22 at 11:38 AM and 06:50 PM. </td <td>Continued From page 22       F 684         Review of medication administration record       (MAR) for May 2002 revealed Resident #68         received Clindamycin 300 MG 1 tablet every 8       hours (12AM, 8AM, 4PM) as ordered beginning         no 05/10/22 and ending no 05/16/22. Resident       #68         #68 received Acetaminophen 325 MG related to       to to to pain at a level of 6 on a scale of 1 to 10 (ten being the worst pain) on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/10/22 at 01:06 PM, and 03:59 PM, and tooth pain at a level of 7 on 05/13/22 at 04:02 AM and 12:30 PM all with effective results.         Review of Physician order dated 06/07/22       revealed new orders for oral surgery consult for teeth extractions, Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a clental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a cale of 1 to 10 (ten being the worst pain) on 06/10</td>	Continued From page 22       F 684         Review of medication administration record       (MAR) for May 2002 revealed Resident #68         received Clindamycin 300 MG 1 tablet every 8       hours (12AM, 8AM, 4PM) as ordered beginning         no 05/10/22 and ending no 05/16/22. Resident       #68         #68 received Acetaminophen 325 MG related to       to to to pain at a level of 6 on a scale of 1 to 10 (ten being the worst pain) on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/10/22 at 01:06 PM, tooth pain at a level of 7 on 05/10/22 at 01:06 PM, and 03:59 PM, and tooth pain at a level of 7 on 05/13/22 at 04:02 AM and 12:30 PM all with effective results.         Review of Physician order dated 06/07/22       revealed new orders for oral surgery consult for teeth extractions, Clindamycin 300 MG 1 tablet by mouth every 8 hours for 7 days for dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental abscess. Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a dental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a clental absces.         Review of Physician order dated 06/09/22       revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (5AM, 1PM, 9PM) for 7 days for a cale of 1 to 10 (ten being the worst pain) on 06/10	

Facility ID: 923063

If continuation sheet Page 23 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/21/2022 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345255	B. WING			0	C 8/25/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	A CARE HEALTH AND R				111 HARRILSON STREET		
CAROLINA	A CARE HEALTH AND R	ENABLINATION			CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 684	indicated Resident #6 referred to an oral su described Resident # periodontal disease ( inflammation of the g and support the teeth buildup". It was noted abscess present toda a month ago. Review of dietary ord new order for regular Review of quarterly m dated 07/25/22 revea cognitively intact. Res having no issues or c dental issues. Review of nursing pro- revealed request for I (NP) for complaint of is swollen. NP evalua physician order on 07 consults for extraction Review of Physician of revealed oral surgery extraction of teeth for Resident #68 was red urinary tract infection 08/03/22. Review of physician of antibiotic Clindamycir	he in-house dental note 88 he previously been rgeon for extractions and 68 as having "severe the result of infections and ums and bone that surround 1) with heavy calculus 1 there was no dental by though one was detected er dated 07/08/22 revealed diet with chopped meat. hinimum data set (MDS) led Resident #68 to be sident #68 was coded as oncerns with oral care or bgress note dated 07/26/22 Physician/ Nurse Practitioner pain of right-side jaw, area ted on 07/28/22. Received 7/28/22 for oral surgery n of teeth for dentures. brder dated 07/28/22 consult for Resident #68 for dentures. ceiving antibiotics for a which was completed on brder dated 08/04/22 for n 300 MG 1 tablet by mouth	F	684			
	08/03/22. Review of physician of antibiotic Clindamycir every 8 hours (7PM, 5	order dated 08/04/22 for					

Facility ID: 923063

If continuation sheet Page 24 of 81

		MEDICAID SERVICES					O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION		· · ·	E SURVEY IPLETED
			A. DOILDIN	<u> </u>			С
		345255	B. WING			08	3/25/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, C	CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON ST CHERRYVILLE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 24	F 6	34			
	hours PRN for pain a	nd Ibuprofen 400 MG 1 es daily (7PM, 3AM, 11AM)					
	Nursing progress not AM revealed Resider medication related to Result was effective.						
	Review of Physician of Ibuprofen 200 MG 2 t daily (5AM, 1PM, 9PI						
	AM revealed Resider	e dated 08/10/22 at 11:58 ht #68 was administered pain jaw pain at a level of 8.					
	antibiotic Clindamycir hours (7PM, 3AM, 11 abscess, Oxycodone	order dated 8/11/22 for n 300 MG 1 tablet every 8 AM) for 7 days for dental 5-325 MG every 6 hours uprofen 200 MG 2 tablets by or pain.					
	(MAR) for August 202 received Oxycodone every 6 hours PRN for AM for pain level of 7 9:20 PM for pain leve dental pain, 08/05/22 7 with effective result with effective result a	a administration record 22 revealed Resident #68 5-325 MG 1 tablet by mouth or pain on 08/04/22 at 11:44 with effective result and el of 7 with effective result for at 4:21 AM for pain level of , 11:14 AM for pain level of 9 nd 09:09 PM for pain level of for dental pain, 08/08/22 at					
	11:59 AM for pain lev and 9:12 PM for pain results for dental pair	rel of 6 with effective results level of 9 with effective n, 08/10/22 at 3:51 AM for fective results and 11:58 AM					

If continuation sheet Page 25 of 81

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/21/2022 MAPPROVED D. 0938-0391	
STATEMENT OF D AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMP	SURVEY PLETED		
		345255	B. WING			C 08/25/2022		
NAME OF PROV	IDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLINA C.	ARE HEALTH AND RE	HABILITATION			11 HARRILSON STREET CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
wi pa 8 y 7 y lev Re co sit #0 op sw sv ar he re las ar of re loo Mi Ar 08 sh rig 8- co sv sv ar he re ar ar sh at de ar ar sh sv sv ar sv sv ar sv sv ar sv sv ar ar ar ar ar ar ar ar ar ar ar ar ar	ain, and on 08/11/22 with effective results with effective results vel of 7 with effective esident #68 observa onducted on 08/08/22 tting up in her wheel 58 right cheek was s bened her mouth to r wollen and only tips of wollen gums, other v nd chipped. Residen er mouth is painful an eceiving an antibiotic evealed she has been st year after she recond this is her third infine saw the in-house pout her dental issue entist was not able to hor teeth removed to evealed the facility sta oking for an oral sur- ledicaid. In interview was condo 3/10/22 at 1:57 PM do he had an abscess of ght side of her mouth 10 days ago. She st off foods and liquids bservation of Reside ad gums swollen ove	th effective results for dental at 3:53 AM for pain level of s, 10:23 AM for pain level of s and 08:39 PM for pain e results for dental pain. tion and interview was 2 at 11:06 AM revealed her chair in her room. Resident lightly swollen, and she reveal gums were red and of teeth were visible from isible teeth were broken t #68 stated the abscess in nd she was currently and pain medication. She n having dental issues since eived chemo treatments, fection. Resident #68 stated dentist several months ago as and was told the in-house o treat her, so she saw ecommended she have all by an oral surgeon. She aff was supposed to be geon who will take her	F	684				

Facility ID: 923063

If continuation sheet Page 26 of 81

		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED	
						С	
		345255	B. WING		0	08/25/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE .		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET			
				CHERRYVILLE, NC 28021			
(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 ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	<u>- 26</u>	F 68	4			
1 001		cted on 08/11/22 at 02:08 PM	F 00	4			
		vealed she received her					
		ween breakfast and lunch					
	•	her abscesses at lunch					
		fens, so her pain scale right					
		ated her pain usually stays					
		dications and 9 when she is					
		dications have worn off. She ses inside the upper right					
		base of nose caused pain up					
	through her nose and						
		of right side of mouth and					
		ugh her jawbone like she					
	had lock jaw. Reside	nt #68 stated this was the					
	-	een through. She revealed					
		n she eats, and she chews					
		aits between bites and takes					
		rough straws to prevent om making the pain worse.					
		revealed she has had dental					
		believes at least three					
		as had abscesses since last					
		sing staff, and the Social					
		edly searching for a dentist					
		r Medicaid to take out her					
	teeth since last year.						
	An interview was con	ducted with Nursing					
		0/22 at 07:15 AM revealed					
		M with Resident #68 and					
		care and current dental					
		esident #68 was able to					
	-	care and staff provided					
	-	Resident #68 informed her					
		ses in her mouth and would					
		ion stating that her mouth stated when Resident #68					
	-						
	Complains or being in	pain or is requesting pain					

If continuation sheet Page 27 of 81

		MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY LETED
	CONTROLOTION	BENTI IGATION NUMBER.	A. BUILDING	<u> </u>		
			B		0	2
		345255	B. WING			25/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	A CARE HEALTH AND R			111 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND N			CHERRYVILLE, NC 28021		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE
F 684	Continued From page 27		F 68	34		
		nister any medication.				
	An interview was cor	nducted with Nurse #4 on				
	08/10/22 at 03:25 PM which revealed he was					
		t #68 and her dental issues.				
	He stated he observe					
		de and she informed him				
		her mouth. He stated he told				
		r (NP) about Resident #68 ' s				
	abscess in her mouth	on the right side and having				
		rrently receiving antibiotics,				
		ibuprofen for the abscess				
		vere supposedly looking for				
	an oral surgeon to re					
	. ,	nterview was conducted on				
		I which revealed he was				
		t #68 and had been working				
		ral surgeon since November				
		ident #68 was referred to an				
		n November 2021 and he				
		al surgeon referral. He 88 was sent out to oral				
		r 2021 and a plan was				
	-	al surgeon to extract her				
		ntments. The SW stated in				
		ansportation aide called the				
		dule the two appointments				
	and the oral surgeon	••				
	•	have an opening until August				
		ept Medicaid. He revealed				
		en by the in-house dentist in				
	-	ecommended to have all				
		eferred to a dental clinic. The				
		ted the dental clinic in June				
		s of the referral for Resident d they had not received the				

Facility ID: 923063

If continuation sheet Page 28 of 81

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY MPLETED
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING	G		
			D 14/11/0			С
		345255	B. WING			8/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
CAROLIN	A CARE HEALTH AND R	REHABILITATION		111 HARRILSON STREET		
				CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 004						
F 684			F 68	34		
		I clinic again in July 2022 to				
		tus of the referral and was				
		had been denied due to the				
		iding oral surgery and not The SW stated he had not				
		mpts made to contact dental				
		nt #68 to be seen by an oral				
		d he contacted an oral				
		b takes Medicaid on 08/10/22				
		pointment scheduled on				
	08/15/22 for Residen	-				
		cted on 08/11/22 at 11:41 AM				
		er (NP) which revealed she sident #68 and her dental				
		october 2021 Resident #68				
		al pain and had some broken				
		fection which required				
		aled Resident #68 was seen				
		and outside dentist who				
	-	eth to be extracted by an oral				
	surgeon. The NP rev	ealed she was told Resident				
	#68 teeth extraction	supposedly fell through due				
		and the SW was working on				
		on who would accept				
		Resident #68 had been on				
		t October for a dental				
		st May for a dental abscess				
		sident #68 mouth, and was iotic, pain medication and				
		cesses on right side of				
		elling of right side of her face.				
	-	elt it had taken too long and				
		ern to the Director of Nursing				
	-	ple times over the past year				
		was being worked on. She				
	revealed the dental is	ssues had affected Resident				
	-	had expressed concerns to				
	the DON and SW ab	aut the a double links ation	1			

Facility ID: 923063

If continuation sheet Page 29 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 09/21/2022 ORM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) [	DATE SURVEY COMPLETED	
		345255	B. WING			C 08/25/2022		
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				111	HARRILSON STREET			
CAROLIN	A CARE HEALTH AND R	ERABILITATION		СН	ERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	NP stated she spoke about her concerns a move the referral pro- medical director orde on 07/28/22. The NP knowledge of an oral consult taking this lon The Director of Nursin Nurse Consultant inte 08/11/22 at 06:30 PM was aware of the nee referred for oral surge SW had been working practice in getting Re surgery services but I that would accept Me facility had not contact for a list of oral surge accept Medicaid. The spoken with Resident her dental referral but severe pain the reside mouth due to her teel The facility was notifie 08/19/22 at 04:39 PM F 684 Identify those recipier are likely to suffer, a s a result of the noncor On 11/23/2021, a refe surgeon was received dental service for Res	lent due to heart issues. The with the medical director nd asked he get involved to cess along. She stated the red a consult for oral surgery revealed she had no surgery consult or any ing to be completed. Ing (DON) and Regional erview was conducted on I which revealed the DON ed for Resident #68 to be ery services. She stated the g with the in-house dental sident #68 seen for oral has trouble finding a practice edicaid. She revealed the cted Medicaid or corporate on providers that would a DON stated she had t #68 multiple times about t was not aware of the ent was having with her th and current abscess. ed of immediate jeopardy on the serious adverse outcome as inpliance erral to an outside oral d from the facility contracted sident #68 related to need h due to broken, decayed	F	684				

Facility ID: 923063

If continuation sheet Page 30 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 09/21/2022 DRM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) D	ATE SURVEY OMPLETED	
		345255	B. WING			C 08/25/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE	•		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			HARRILSON STREET ERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	schedule an oral surg Resident #68 who ex pain, difficulty eating, antibiotics affecting of saw oral surgeon on a for oral surgery on 8/2 On 8/10/22, the Direct performed an oral eva Resident #68 exhibite mucous membrane. N Resident #68 verbaliz Resident #68 verbaliz Resident #68 stated s eating related to oral On 8/10/22, Nursing I Nursing, and Unit Cot audit of all current in- those with complaints included an observati abnormalities of the to and symptoms of infer notified of any abnorr dental referrals were consult recommendat including pain manag Specify the action the process or system fai adverse outcome fror when the action will b By 8/11/22, Director of Development Coordir Nurses to complete o red swollen gums, od abnormalities on adm and with residents that	geon appointment for perienced unresolved tooth and abscesses requiring verall well-being. Resident 8/15/20022 and is scheduled 25/2022. Ator of Nursing (DON) aluation on Resident #68. ed slight redness to the No overt swelling of gums. zed no pain at the time. she has had no issues with pain. Management (Director of ordinators) completed an house residents to identify s of dental pain. This audit ion of the oral cavity for eeth, redness, odor, or signs action. The Physician was malities, new orders for obtained and any dietary tions were implemented, ement. e entity will take to alter the fure to prevent a serious m occurring or recurring, and be complete	F	684				

Facility ID: 923063

If continuation sheet Page 31 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/21/2022 RM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345255	B. WING			C 08/25/2022		
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				111	HARRILSON STREET			
CAROLIN	A CARE HEALTH AND R	ERABILITATION		СН	ERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 684	Nurse. It is the respon Nurse to report any o the Unit Coordinators responsible for notifyi Practitioner. Regardir responsibility of Licer Physician or Nurse P abnormalities and obt treatments and interv management, and die Nursing staff will not B shift prior to receiving hires will receive this process. On 8/10/22, Licensed Nurses wer responsibility by the D Development Coordir By 8/11/22, the Direct Licensed Nurses rega communicating new p cavity observations/a interventions includin- dietary consults if nee Coordinators. During Nurses will input order "Facility Activity Repo brought to the Daily C Coordinators. By 8/11/22, Nursing M Nursing, Unit Coordir Nurse Aides to report red swollen gums, od abnormalities on adm	s and pain to the Licensed nsibility of the Licensed ral abnormalities and pain to a Unit Coordinators are ing the Physician/Nurse ng off shifts it is the need Nurses to notify the ractitioner of any tain new orders for entions including pain etary consults if needed. be able to start their next the education, and all new education during orientation the Unit Coordinators and e notified of this Director of Nursing and Staff nator during this education. tor of Nursing will educate arding the process for ohysician orders for oral bnormalities, treatments and g pain management, and eded, to the Unit off hours the Licensed ers, which will pull into ort-Orders" and will be Clinical Meeting by the Unit	F	684				

Facility ID: 923063

If continuation sheet Page 32 of 81

	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI II TI	PLE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	`,	IG	(X3) DATE S COMPL	
					с	
		345255	B. WING			5/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				111 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021		
(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) COMPLETIO DATE
F 684	Continued From page	e 32	F 6	84		
		<i>v</i> -up. Issues identified will be				
	reported to the Licen					
		<i>y</i> -up. Nurse Aides will not be				
	able to start their nex	t shift prior to receiving the				
		w hires will receive this				
	education during orie	ntation process.				
	The process is as fol	lows:				
		and Nurse Aides will				
		observations for red swollen				
	•	er teeth abnormalities on utine care, and with residents				
		th pain, and/or difficulty				
	-	identified will be reported to				
		Unit Coordinator. The Unit				
		ponsible for notifying the				
		ctitioner; regarding off shifts				
		of Licensed Nurses to notify se Practitioner of any oral				
		bnormalities and new orders				
		terventions including pain				
		etary consults if needed				
	2. Any dental recor					
	-	Practitioner will be entered				
	-	ses or Unit Coordinators. nators will print, review, and				
		ivity Report - Orders" to				
		ervices referral (orders) to				
		and Social Services Director				
		cal Morning Meeting. During				
	Clinical Morning mee	-				
		cility Activity Report -Orders"				
	to include any referra	otes, physician orders, pain,				
		eview identifies any new				
	pain, dietary concern					
	infections/abscesses					
		ng will ensure no staff will	1			

Facility ID: 923063

If continuation sheet Page 33 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 09/21/2022 ORM APPROVED 3 NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		DNSTRUCTION	(X3) [	DATE SURVEY COMPLETED	
		345255	B. WING			C 08/25/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	A CARE HEALTH AND R			111	HARRILSON STREET			
CAROLIN	A CARE REALIN AND R	ERABILITATION		CHE	ERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	hires, including nursine education prior to the On 8/10/22, the Regine educated the Director Coordinators, Social Administrator regardi process to review the -Orders" to include and dental services, program pain, and infections. In we pain, dietary com- infections/abscesses notified during this ed- responsible to print, r activity Report-Orders Meeting. Attendees of Meeting are Director Staff Development Co- and Unit Coordinators Effective 8/11/22, the Administrator will be a implementation of this removal for this allego Alleged Date of IJ Ref On 8/25/22 the credite immediate jeopardy r the removal date of 0 The audit tools comp 08/10/22 were review notified with dental see in house dentist a	g this education. Any new ng agency staff will receive start of their shift. onal Clinical Manager r of Nursing, Unit Worker, and the ng clinical morning meeting "Facility Activity Report ny referrals (orders) for ress notes, physician orders, This review identifies any cerns, and resolution of . The Unit Coordinators were lucation that they are eview, and bring the "Facility s" to Clinical Morning of Nursing, Administrator, cordinator, Social Worker, s. Director of Nursing and responsible to ensure s immediate jeopardy ed non-compliance. moval: 8/12/2022 ble allegation for the emoval was validated and 8/12/22 was confirmed.	F	584				
	Z(02.00) Bravieus Versiene Obs							

If continuation sheet Page 34 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/21/2022 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345255	B. WING				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			11 HARRILSON STREET HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	process to review the -Orders" to include and dental services, progr pain, and infections. new pain, dietary com infections/abscesses. Interviews with nurse Unit Coordinators review education on identifying condition including m coming from mouth, b gums, any abnormal eating and reporting the and the medical provi- also provided to all nut contacts the Nurse P any reports of dental orders and referrals, Coordinator so appoint Interviews with the Uni- they had also receive any new orders or reference scheduling appointment facility report to review meeting. Director of Nursing (Direvealed she educate and referral process, assistants are respon- care every shift and a	r of Nursing, Unit Worker, and the ng clinical morning meeting "Facility Activity Report hy referrals (orders) for ress notes, physician orders, This review identifies any ocerns, and resolution of s, nursing assistants and realed they received ing any changes in resident outh pain, abnormal odor broken teeth, bleeding areas in mouth, difficulty these changes to the nurses iders. Oral care handout was ursing staff. Nursing staff ractitioner or Physician with issues, enters any new and informs the Unit ntments can be scheduled. hit Coordinators confirmed ad education on reviewing ferrals for dental issues and ents. They will inform the f the new order or referral t was made and complete a w during daily clinical	F	684			

Facility ID: 923063

If continuation sheet Page 35 of 81

	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
	345255	B. WING				C 25/2022	
PLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
TH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021				
DEFICIENC	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE	
en obser f was res dental iss ator, Nur ental con- ers or ref notify Unit ordinator s s and co daily clir vas respo tal appoi ct when t dent Haz .25(d)(1) Accidents nust ensu 1) The res cident ha 2)Each re and assis REMENT ecord rev interview e manne supervis (32). The floor dur he reside I and dia one) frac	ved to notify nursing. ponsible for assessing uses and pain and inform the se Practitioner or Physician cerns. Nursing will also input errals related to dental coordinator. She revealed schedules all dental mpletes a tracking form that nical meeting. The DON nsible for keeping a master ntments that was reconciled he resident appointment ne outcome. ards/Supervision/Devices (2)						
	CARE & CARE &	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345255	CARE & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL' A. BUILDI         345255       B. WING         PPLIER       TH AND REHABILITATION         JMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)       ID PREFI TAG         irom page 35       F         irotify Unit Coordinator. She revealed         <	CARE & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLI         IDENTIFICATION NUMBER:       A.BUILDING         345255       B. WING         37PLIER       ID         IMMARY STATEMENT OF DEFICIENCIES       ID         DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)       ID         Irom page 35       F 684         en observed to notify nursing.       ID         f was responsible for assessing dental issues and pain and inform the nator, Nurse Practitioner or Physician ental concerns. Nursing will also input lers or referrals related to dental notify Unit Coordinator. She revealed ordinator schedules all dental ts and completes a tracking form that o daily clinical meeting. The DON vas responsible for keeping a master ttal appointments that was reconciled ct when the resident appointment ted and the outcome.       F 689         dent Hazards/Supervision/Devices       F 689         .25(d)(1)(2)       Accidents.         Accidents.       .25(d)(1)(2)         Accident sistence devices to prevent       REMENT is not met as evidenced         acord review, staff and Nurse interviews, the facility failed to provide fe manner for 1 of 2 residents supervision to prevent accidents         132). The resident fell out of a raised e floor during incontinence care which the resident being transported to the al and diagnosed with distal femoral one) fracture, proximal tibial (lower	CARE & MEDICAID SERVICES         i       (x1) PROVIDERSUPPLERCIAL DENTFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING	CARE & MEDICAID SERVICES     OMB NC       i     (X1) PROVIDENSUPPLETENCIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING     (X3) DATE (X3) DATE A BUILDING       i     345255     IR     INING     (X3) DATE (X3) DATE	

Facility ID: 923063

If continuation sheet Page 36 of 81

		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/21/2022 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345255	B. WING					C 25/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
				11	11 HARRILSON STREET			
CAROLIN	A CARE HEALTH AND RI	EHABILITATION		С	HERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 689	Continued From page	36	F	689				
	The findings included	:						
	Resident # 132 was a 05/30/18 and readmit diagnoses included ca stroke, muscle weakn with splint and type II The quarterly Minimut assessment dated 02 #132 was moderately required extensive as accomplish activities of include bed mobility, of personal hygiene. The (CAA) summary indic risk for falls due to mu use, impaired mobility limited range of motio extremities.	dmitted to the facility on ted on 08/20/20. Here erebral vascular accident or ess, left hand contracture diabetes mellitus. m Data Set (MDS) /16/22 indicated Resident cognitively impaired and sistance of 2 staff to of daily living (ADL) to dressing, toileting, and e Care Area Assessment ated Resident #132 was at uscle weakness, medication or and incontinence and n in her bilateral lower						
	at 3:30 AM when Res the bed rail and fell or was assisted back inte lift. Pain medication a administered for comp #132 continued to cor requested to be sent to Medical Services (EM #132's responsible pair requested the residen closest to the family. round and equally rea to light being shined - with light and larger w	to the hospital. Emergency S) was notified, Resident irty (RP) was notified and t be sent out to the hospital The resident's pupils were ictive to light (pupils reaction pupils will become smaller						

Facility ID: 923063

If continuation sheet Page 37 of 81

	S FOR MEDICARE &		0.00			O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345255	B. WING		0	B/25/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		5/25/2022
				111 HARRILSON STREET	-	
CAROLINA	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COL	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
F 689	Continued From page	e 37	F 68	39		
		d the resident had no head	1.00			
		2's respirations were regular				
		staff remained with the				
		rived to transport her to the				
	hospital emergency r	oom (ER).				
	Nursing Assistant (N/ 03/10/2022 indicated	A) #1's statement dated				
		M Resident #132 activated				
		point NA #1 entered the				
	•	it requested to be changed.				
		o get a towel, washcloths,				
	and brief, then wet th	e washcloths before				
	-	ide. NA #1 turned the				
		window onto her left side as				
		rail with her right arm. At an cleaning her bottom but				
		e a bowel movement while				
		IA #1 turned away from the				
		ief and cream for her bottom				
	from the chair in her	room at the end of the bed				
		l from the bed which had				
		h during care onto the floor.				
		o notify her nurse and one of				
		the room to assess the ith lifting the resident via				
	mechanical lift back i					
	An interview on 09/10	0/22 at 6:58 AM with Nursing				
		licated she was changing				
		when she fell from the bed				
		tated she had raised the bed				
	-	vided peri care to Resident				
		e and turned her onto her left				
		dow to clean her bottom. NA				
		e was a paper pad on top of				
	the resident's air mat	tress and under her bottom.				1
	NIA #1 overlained at a	began cleaning Resident				

Facility ID: 923063

If continuation sheet Page 38 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/21/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345255	B. WING					C <b>25/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIF	CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE	CTION SHOULD B D THE APPROPRIA		(X5) COMPLETION DATE
F 689	#1 further explained s resident and walked a the clean brief to put of Resident #132 slipped floor. NA #1 said she the brief and did not s her moaning and noti- with her head at the fa- indicated she left the the nurse and when s resident was moaning #132 stated her left left hurting. NA #1 furthe Nurse #2 came into th assessed the residen room to contact the p the responsible party Nurse #2 assessed th with NA #2, NA #3, ar Resident #132 back in mechanical lift. Resides for evaluation and treas Nurse #1's statement she was notified at ap 03/10/22 that Resider onto the floor during in performed by Nursing #1 stated when she e was on the floor on th her head at the foot o stated Nurse #2 was resident when she en	finally had her clean. NA she turned away from the approximately 6 feet to get on the resident when d off the bed and onto the turned back around with see the resident but heard ced she was on the floor bot of the bed. NA #1 room immediately to go get the returned to the room the g "oh, oh" and Resident g and left shoulder were r indicated Nurse #1 and he room and Nurse #2 t while Nurse #1 left the hysician on call and notify (RP) of the resident's fall. he resident and NA #1 along nd Nurse #2 assisted nto the bed with the dent #132 requested to be nd Nurse #2 called EMS and sferred to a local hospital ER atment. dated 03/10/22 revealed proximately 3:30 AM on nt #132 had fallen out of bed ncontinence care being p Assistant (NA) #1. Nurse ntered the room the resident e left side of the bed with f the bed. She further in the room assessing the	F	689				

Facility ID: 923063

If continuation sheet Page 39 of 81

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDIN			С
		345255	B. WING		0	8/25/2022
NAME OF PI	ROVIDER OR SUPPLIER	·	_ <b>·</b> [	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET		
				CHERRYVILLE, NC 28021		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	a 30	F 6	80		
1 003	Nursing Assistant (N		FO	09		
	<b>U</b> (	M that Resident #132 had				
	•••	nto the floor. Nurse #1 said				
	when she went into the	ne resident's room, Resident				
	#132 was lying in the	floor with her head at the				
		er feet at the head of the				
		d Nurse #2 was already in				
	U	he resident, so she left the				
		all provider and responsible nem of the fall and get				
	,	end her out to the hospital				
	• •	d treatment. Nurse #1				
	indicated initially Res	ident #132 had not				
		ut once they moved her back				
		plaining of left leg pain and				
		they medicated her, and				
		ported her to the hospital ER atment. Nurse #1 further				
		ovided one on one education				
		esident's care Kardex and				
		soned nursing assistant and				
		o have another person in the				
	-	providing Resident #132's				
		urse #1 stated because of				
	Resident #132's fall,					
	assist with bed mobil	equired to have a 2-person ity.				
	Nurse #2's statement	t dated 03/10/22 revealed				
		lursing Assistant (NA) #1 at				
	•	M on 03/10/22 that Resident				
		f bed. Nurse #2 stated				
		e room the resident was				
		r back in the floor beside of				
		132 requested to get out of her bed. Nurse #2 further				
		the resident, and her pupils				
		nd reactive to light and				

Facility ID: 923063

If continuation sheet Page 40 of 81

	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	E SURVEY
	CONTECTION	IDENTIFICATION NOWDER.	A. BUILDING	<u> </u>		
			5 11/11/0			С
		345255	B. WING			8/25/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	A CARE HEALTH AND R			111 HARRILSON STREET		
0,				CHERRYVILLE, NC 28021		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pag	e 40	E			
1 003			F 68	59		
		, she had no respiratory				
	distress and her rang	ge of motion to all 4 In her normal limits. The				
		g her head and NA #1 stated				
		e resident hit her head.				
		o visible injuries noted so				
		ck to bed via mechanical lift				
		of NA #1, NA #2, and NA #3.				
		sident #132 requested pain				
		given pain medication as				
		132 then became adamant				
		ospital ER, so EMS was				
		esident sent to the hospital				
	ER for evaluation and	•				
	A phone interview on	n 08/10/22 at 7:12 PM with				
	Nurse #2 revealed N	ursing Assistant (NA) #1				
		y of Resident #132's fall.				
	Nurse #2 stated whe	n she went into the room the				
	resident was lying or	her back with her head at				
	the foot of the bed.	Nurse #2 said initially				
		aughing and talking with				
		lifted to bed she started				
		n her left shoulder. Nurse #2				
		d assessed Resident #132				
		er back to bed and did not				
		shorter than the other or				
	•	t said her feet were naturally				
		se #2 indicated Nurse #1				
		ler and because the resident				
		pain, they decided to send				
		al ER for evaluation and				
	treatment. Nurse #2					
		ould have known to have				
		her while toileting a total care				
		urther stated now if a				
	resident is on an air i	-				
	0	bed mobility. Nurse #2				

Facility ID: 923063

If continuation sheet Page 41 of 81

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/21/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345255	B. WING					C 25/2022
NAME OF PF	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A CARE HEALTH AND RI	EHABILITATION			11 HARRILSON STREET HERRYVILLE, NC 2802	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	An interview on 08/11 Director of Rehabilitat familiar with Resident provided occupationa her. The Director of F was aware of the resis said because of her fa all residents on air ma assist with bed mobilit A review of the hospit revealed Resident #13 hospital on 03/10/22 a facility on 03/31/22. H included displaced clo closed proximal tibial displaced closed fract Resident #132 was pl non-weight bearing to sling was applied to th pain was difficult to m stay due to her blood was taken off all antih accomplished pain co discharged from the h another facility with no extremity and under F had prior to hospital a An interview on 08/11 Nurse Practitioner (NH notified of Resident # stated she had been to resident and she had NP further stated Res	Resident #132 on 03/10/22. /22 at 9:32 AM with the ion revealed she was #132, and they had I therapy (OT) treatment to Rehabilitation stated she dents fall on 03/10/22 and all the facility now required attresses have a 2-person ty and toileting. al discharge summary 32 was admitted to the and discharged to another Her admitting diagnoses bed distal femur fracture, fracture and 2-part ure of the humerus. aced on bedrest with the left extremity and a he left arm. The resident's anage during her hospital pressure being low, so she ypertensives and eventually ntrol. Resident #132 was ospital on 03/31/22 to on-weight bearing to the left Palliative Care (which she dmission). /22 at 4:35 PM with the P) revealed she had been 132's fall at the facility. She old staff were changing the fallen out of the bed. The ident #132 had hemiplegia	F	689				
		previous stroke and could h holding on with her left						

Facility ID: 923063

If continuation sheet Page 42 of 81

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING				C /25/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
F 689	with her right side. The resident may have been right hand holding onto been assessed by nut assistance with bed in would have expected the room assisting the An interview on 08/11 Director of Nursing (D #132 had been assess assistance with bed in stated she would have been 2 staff members care. She stated it was #1's first night off ories stated she was not aver resident was inside he provided additional or Nurse #1 on the night The facility was notified past non-compliance The facility provided to allegation of complain of 03/11/22. The facility's corrective the accident to prevent the fall by a licensed of ER for further evaluat 2. The Director of Ref 100% audit of all resid appropriate bed mobility in the second state of the second state of the second the second state of the second the second state of the second the second state of the second state appropriate bed mobility of the second state of the second the second state of the second state of th	ossibly held onto a bedrail he NP indicated although the en able to assist with her to the bedrail if she had rsing staff as needing 2-staff nobility and toileting she there to have been 2 staff in e resident. /22 at 5:37 PM with the ON) revealed Resident used as needing 2-person nobility and transfers and e expected there to have is in the room providing her as Nursing Assistant (NA) intation and NA #1 had ware the care Kardex for the er closet, so NA #1 was ne on one education by to f the incident. ed of Immediate Jeopardy at on 08/19/22 at 5:08 PM. he following credible nee with a compliance date e actions implemented after in a reoccurrence included is immediately assessed after nurse and transported to the	F	689			
	in comparison to the r	-					

Facility ID: 923063

If continuation sheet Page 43 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/21/2022 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTIO		(X3) DA	TE SURVEY MPLETED
		345255	B. WING _			0	C 8/25/2022
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRES	S, CITY, STATE, ZIP CODE		
	A CARE HEALTH AND R			111 HARRILSON	STREET		
CAROLIN	A CARE HEALTH AND R	ERABILITATION		CHERRYVILLE	, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORR CH CORRECTIVE ACTION SI S-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	resident that required referred to therapy. 3. On 03/11/22, educ department (active nu find bed mobility statu each resident in alert (POC). Any nursing required education pr education was added orientation. 4. Therapy staff and I reviewed any bed mo morning meeting five 5. When a resident has it was documented or and in the residents of (EMR). 6. The weekend man nursing supervisor of nurses regarding any status and reported to 7. DON and/or design weekly observations resident's bed mobility Any non-compliance education provided a 8. The frequency of w 10 residents reviewed ensure bed mobility F 5 residents reviewed ensure bed mobility F 9. The Administrator Assurance/Performar committee analyzed for Manager for immedia	I further evaluation was ation was given to all nursing urses and NAs) of where to us of one or two person for s section of point of care staff on leave received the for to their first shift. The I to the nursing staff DON and/or designee obility changes during times a week. ad a change in bed mobility in the nursing 24-hour report electronic medical record ager on duty or weekend obtained report from the or changes in resident mobility of the DON. nee conducted random for 12 weeks and validated y status was being followed. was addressed, and further s needed. weekly observations was: d/observed for weeks 1-4 to POC alerts. observed for weeks 9-12 to POC alerts.	F 6	89			

Facility ID: 923063

If continuation sheet Page 44 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FC	FED: 09/21/2022 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ISTRUCTION		ATE SURVEY DMPLETED
		345255	B. WING _				C 08/25/2022
NAME OF P	ROVIDER OR SUPPLIER	l	- 1	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			ARRILSON STREET RRYVILLE, NC 28021		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689 F 732 SS=C	QAPI committee will a bove plan and make recommendations for audits to ensure cont Allegation of complian On 08/11/22 the facili validated by the follow the facility were revie completed according nurses and nursing a where to find bed mo section of POC. The "transfers, bed mobili content included: 1. Proper transfers, b find alerts for each re 2. If resident requires assist with care, utiliz Director of Nursing (IC Coordinator (SDC)/As (ADON) was respons were trained on proper The corrective action completed as of 03/1 Posted Nurse Staffing CFR(s): 483.35(g)(1) §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followir basis: (i) Facility name. (ii) The current date. (iii) The total number	ntinued compliance. 10. The continue to evaluate the a additional interventions based on the inued compliance. Ince (AOC) date: 03/11/222. ty's Plan of Correction was wing: audits conducted by wed and were found to be to the plan of correction. All ssistants were educated on bility status in the alerts training topic was ty and alerts" and the ed mobility and where to sident. air mattress or is not able to e 2-person assist for ADLs. DON)/Staff Development ssistant Director of Nursing ible for ensuring all staff er care to prevent falls. plan was validated to be 1/22. g Information -(4)	F 6				9/1/22

Event ID: OE2V11

Facility ID: 923063

If continuation sheet Page 45 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING _		C 08/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 732	unlicensed nursing st resident care per shif (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must per specified in paragrap daily basis at the beg (ii) Data must be post (A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fac posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on observatio interviews, the facility daily nurse staffing in of the recertification s correct census numb	aff directly responsible for t: s. I nurses or licensed a defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. accerse to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to ty standard. data retention acility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ms, record review and staff f failed to post the correct formation for 1 out of 4 days survey and failed to post the er for 4 out of 4 days of the t 8 through 11, 2022).	F 7	The statements include correction are not an ad not constitute agreemen deficiencies herein. The is completed in the com and federal regulations remain in compliance w state regulations, the ce will take the actions set	Imission and do at with the alleged plan of correction pliance of state as outlined. To ith all federal and enter has taken or

Facility ID: 923063

If continuation sheet Page 46 of 81

		MEDICAID SERVICES	0			<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		PLETED
		345255	B. WING			C /25/2022
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				111 HARRILSON STREET		
AROLIN	A CARE HEALTH AND R	REHABILITATION		CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE
F 732	Continued From pag	e 46	F 73	32		
	- 15	during the recertification		following plan of correction	on The following	
		at 8:10 AM and 4:45 PM		plan of correction constitu		
	revealed the posted			allegation of compliance.		
		d 8/08/2022 for the previous		deficiencies cited have be	-	
	day.			completed by the dates in	ndicated.	
	Observations made of	during the recertification		The daily staffing sheet f	or the week of	
	-	at 10:55 AM, 8/09/2022 at		08/08/2022 through 08/1		
		M, 8/10/2022 at 8:50 AM, and		corrected on 8/11/22 by t		
	08/11/2022 at 2:00 P			Nursing (DON)to ensure		
	information for the ce	ensus number for the facility.		census was accurate for	•	
	On 0/11/2022 at 2:40			The daily staffing sheets		
		B PM an interview was staffing Coordinator (SC) who		August 7 were audited or DON for accuracy of cent	-	
		he scheduling of the nursing		identified concerns were	•	
		stated she was responsible		8/11/22.		
		ting the daily nurse staffing		Education on the daily sta	affing sheet and	
	hours with the censu			changes per shift was pro		
	completed the daily r	nurse staffing information a		08/12/2022 by Administra	ator, DON, or	
		and would make changes as		Designee to Nursing Adm		
		or the census number. The		education was also provi		
	-	d the daily nurse staffing on		Licensed Nurses and the	-	
		tside of the nursing station		duty to provide accurate		
		nalls in the mornings and		on the daily staffing shee	-	
		orking one of the nurses on e. She revealed the incorrect		licensed nurse or the Nur Administration who did no	•	
		e daily nurse staffing		service by 09-01-22 will r		
	information was an e			work until the in service h		
		daily census number for the		completed. This education		
		d the posting on 8/09/2022		implemented in the new I		
	of the previous day d	laily nurse staffing was an		The facility has adopted a	a new process of	
		date and information should		having members of Nursi	-	
	be posted each day.			Administration complete		
				sheet at the start of each		
		cted with Director of Nursing		member of Nursing Admi		
		at 5:33 PM revealed the SC		present at time of shift ch		
		printing off the daily nurse		designated licensed nurs	e in the facility	
	She stated the SC w	nd posting it in the facility.		will complete. The administrator or DON	l will audit 5 daily	
	information a week a			staffing sheets for accura		

Facility ID: 923063

						3 NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · · ·	DATE SURVEY
						С
		345255	B. WING			08/25/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	PRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 732	Continued From page	e 47	F 73	32		
		ect the daily census in the		first four weeks, 3 daily staffing	g sheets a	
		nanges. She revealed she		week from weeks five through		
		aily nurse staffing information		daily staffing sheets a week for	r weeks	
		was the previous day nor		nine through twelve.	roport all	
		ensus was not correct. She e staffing information should		The Administrator or DON will audit findings to the Quality As		
		te and number of hours and		Committee monthly for three of		
	the correct census nu			months. The Quality Assurance		
				Committee will evaluate the effective		
				of the above plan and will mak		
				interventions based on the au ensure continued compliance.	dits to	
				Completion date is 09/01/2022	)	
F 761	Label/Store Drugs ar	nd Biologicals	F 76			9/1/22
SS=E						
		of Drugs and Biologicals				
		s used in the facility must be				
	professional principle	e with currently accepted				
	appropriate accessor					
	instructions, and the					
	applicable.					
	§483.45(h) Storage c	of Drugs and Biologicals				
	§483.45(h)(1) In acco	ordance with State and				
		ility must store all drugs and				
		compartments under proper				
	personnel to have ac	, and permit only authorized ccess to the keys.				
	§483.45(h)(2) The fa	cility must provide separately				
		affixed compartments for				
	storage of controlled	drugs listed in Schedule II of				
		Drug Abuse Prevention and				
		and other drugs subject to the facility uses single unit				
	abuse, except when	the facility uses single unit				

If continuation sheet Page 48 of 81

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	). 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /				LETED
							0
		345255	B. WING			08/	25/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				1	11 HARRILSON STREET		
CARULIN	A CARE HEALTH AND R	ERABILITATION		С	CHERRYVILLE, NC 28021		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 761	Continued From page	e /8	F 7	761			
1 701				01			
		ution systems in which the					
		nimal and a missing dose can					
	be readily detected.	Γ is not met as evidenced					
	by:	ו וא חטר חופר מא פעועפווטפע					
		ons and staff interviews, the			The statements included in the plan of	F	
		erate an unopened insulin			correction are not an admission and do		
		ulin vials and discard expired			not constitute agreement with the alleg	-	
		e for use in 3 of 5 medication			deficiencies herein. The plan of correct		
	carts (Medication Ca	rt 2, Medication Cart 4, and			is completed in the compliance of state		
	Medication Cart 1).				and federal regulations as outlined. To		
	,				remain in compliance with all federal a		
	The findings included			state regulations, the center has taken	or		
					will take the actions set forth in the		
		f Medication Cart 2 with			following plan of correction. The follow	-	
		at 10:28 AM revealed an			plan of correction constitutes the cente	r⊔s	
		ed vial of Insulin detemir			allegation of compliance. All alleged		
	with Resident #36's r	ne top drawer and labeled			deficiencies cited have been or will be completed by the dates indicated.		
		ich indicated it was sent to			On 8/11/22, the Nurses on the medicat	ion	
					carts, removed the undated,		
	•	the facility on 8/8/22. Insulin detemir is a long-acting insulin used to treat diabetes.			unrefrigerated insulin, and expired mag	nic	
					mouthwash. The Director of Nursing a		
	An interview with Nur	rse #3 on 8/11/22 at 10:35			the Nurse Administrative team audited		
		n't know who placed the			medication carts and medication room		
		ulin detemir in the medication			for expired and undated medications.	Any	
	cart but whoever did	it probably did not realize			items found to be affected were remov	ed	
	that Resident #36 ha	d another vial in the			immediately and discarded.		
		was available. Nurse #3			On 8/16/22, the pharmacy nurse		
		I have been kept in the			consultant and consulting pharmacist		
		y to be opened and used			audited 100% of medication carts and		
		good for 42 days after being			medication storage rooms for expired a		
		tion. Nurse #3 further stated			undated medications. Any items found		
		insulin because she didn't			be out of date or undated, were remove	ed	
	-	was scheduled to be given			and discarded.		
	only at bedtime.				On 8/11/22, the Director of Nurses (DC		
	b An observation -	f Madication Cart 4 with			initiated education to all Licensed Nurs	es	
		_				rina	
		f Medication Cart 4 with ) #1on 8/11/22 at 10:38 AM			and Medication Aides on dating medications, insulin storage and check	ling	

Facility ID: 923063

If continuation sheet Page 49 of 81

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 TE SURVEY	
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· · /	i	) ´co	MPLETED	
						С	
		345255	B. WING		(	8/25/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021			
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 761	Continued From page	e 49	F 76	1			
	revealed an opened a detemir labeled with I opened and undated Resident #14's name insulin product used f An interview with MA revealed Nurse #4 wa insulins from Medicat have anything to do w medication cart. MA and verified that both An interview with Nur AM revealed he hadre insulins in Medication the insulin vials that w stated both insulins s when they were open was only good for 42 while Admelog was g opened. c. An observation of Nurse #4 on 8/11/22 bottle of Magic Mouth date of 7/17/22 and a (milliliters) left in the the There was another bo with an expiration dat approximately 75 ml Magic Mouthwash we Resident #37. Magic mouth-rinse mixture u mouth and throat sore	and undated vial of Insulin Resident #4's name and an vial of Admelog labeled with . Admelog is a short-acting to help control blood sugar. #1 on 8/11/22 at 10:38 AM as assigned to give all the tion Cart 4, and she did not with the insulins on the #1 checked both insulin vials did not have an open date. se #4 on 8/11/22 at 11:09 of gotten around to giving the a Cart 4 and had not seen were undated. Nurse #4 hould have been dated ned because Insulin detemir days after it was opened ood for 28 days after being Medication Cart 1 with at 11:01 AM revealed a hwash with an expiration upproximately 150 ml bottle available for use. ottle of Magic Mouthwash te of 8/3/22 and left for use. Both bottles of ere labeled as belonging to Mouthwash is a used to relieve pain from es.		<ul> <li>expirations of medications. Add education on these topics was taught by the Nurse Administra Any licensed nurse or medicati who did not complete this educ 8/30/22 will not be allowed to w complete. This education will b in the new hire orientation. The DON and/or Nurse Admini audit 5 medication carts/storag weekly times 4 weeks, then 3 r carts/storage rooms weekly tim weeks then 1 medication cart/s room weekly times 4 weeks. The DON will report the finding audits to the Quality Assurance Committee for 3 consecutive m The Quality Assurance Commi evaluate the effectiveness of th plan and will make additional in based on the audits to ensure compliance. Completion date is 09/01/2022</li> </ul>	being tion team. on aide cation by vork until be included stration will e rooms nedication nes 4 storage s of these enorths. ttee will ne above nterventions continued		
		rse #4 on 8/11/22 at 11:06 not sure why the expired thwash had not been					

If continuation sheet Page 50 of 81

	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		с
		345255	B. WING	08/25/2022	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
			111	I HARRILSON STREET	
	A CARE HEALTH AND	REHADILITATION	CH	IERRYVILLE, NC 28021	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLET
F 761	Continued From pag	ge 50	F 761		
		edication cart and that he had			
		out of the medication cart but			
	had just not gotten a	around to doing it.			
	An interview with the Director of Nursing (DON) on 8/11/22 at 5:08 PM revealed the insulins				
		the refrigerator until ready to			
		be dated when opened. The			
		ired bottles of Magic			
		nave been taken off the			
		n they expired. The DON			
		I the nurses who were on the			
		re responsible for checking t. The medication aides were			
		ecking all the medications			
		s so they should make sure			
	all insulins were dat	ed and not expired.			
F 791 SS=K			F 791		9/1/22
	§483.55 Dental Ser	vices			
		sist residents in obtaining			
	,	emergency dental care.			
	S400 EE(h) Numerie e				
	§483.55(b) Nursing The facility-				
	§483.55(b)(1) Must	provide or obtain from an			
		accordance with §483.70(g)			
	of this part, the follo	wing dental services to meet			
	the needs of each re				
		ervices (to the extent covered			
	under the State plar (ii) Emergency dent				
		if necessary or if requested,			
	assist the resident-				
	(i) In making appoin				

Event ID: OE2V11

Facility ID: 923063

If continuation sheet Page 51 of 81

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 09/21/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/25/2022	
		345255	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	A CARE HEALTH AND R			11	11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R			С	HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 791	dental services locati §483.55(b)(3) Must p residents with lost or dental services. If a r 3 days, the facility mu what they did to ensu and drink adequately services and the exter led to the delay; §483.55(b)(4) Must h circumstances when	ansportation to and from the ons; romptly, within 3 days, refer damaged dentures for eferral does not occur within ust provide documentation of ire the resident could still eat while awaiting dental muating circumstances that ave a policy identifying those the loss or damage of	F	791			
	charge a resident for dentures determined policy to be the facilit §483.55(b)(5) Must a eligible and wish to p reimbursement of der medical expense und This REQUIREMENT by:	ssist residents who are articipate to apply for ntal services as an incurred ler the State plan. is not met as evidenced			On 8/10/22, the Director of Nursing		
	Nurse Practitioner (N facility staff, and resid failed to obtain dental surgeon for teeth extr seen by a dentist on referral for an oral su remaining teeth. Resi oral surgeon on 12/07 remove all upper and appointments using m asked to defer until Ja Medicaid would take	ns, record reviews, and P), Dental Clinic Manager, dent interviews, the facility I services from an oral ractions. Resident #68 was 11/21/21 who wrote a rgeon for extraction of all ident #68 was seen by an 7/21 and the plan was to lower teeth during two itrous oxide which she anuary 2022 when her effect. When the oral contacted in January 2022 it			On 8/10/22, the Director of Nursing (DON) performed an oral evaluation Resident #68. Resident #68 exhibite slight redness to the mucous membr No overt swelling of gums. Resident verbalized no pain at the time. Resid #68 stated she has had no issues wi eating related to oral pain. On 8/10/22, Nursing Management (Director of Nursing and Unit Coordinators) completed a review of current in-house residents' medical records to identify any outstanding	d ane. #68 ent th	

Facility ID: 923063

If continuation sheet Page 52 of 81

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) D	NO. 0938-03	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	C	OMPLETED	
						С	
		345255	B. WING			08/25/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
	A CARE HEALTH AND R			111 HARRILSON STREET			
0/11/02/11				CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIC DATE	
F 791	Continued From page	e 52	F 79	91			
		nat the current oral surgeon		referrals for dental care a	nd ensure these		
		aid. The in-house dentist		have been completed. As			
		als to an oral surgeon for		dental visit status, includir			
	extractions on 4/28/22	5		visit, follow up recommen			
		ctitioner wrote orders for oral		validation of scheduled ap			
	-	extraction of teeth on 6/7/22		applicable).	•		
	and 7/28/22. The del	ay in services led to					
		tions, unresolved pain, and		By 8/11/22, the Director o	•		
-		dent #68 oral surgeon		educate Licensed Nurses			
		nent was scheduled on		process for communicatin			
		rvey started) for 08/15/22.		orders for dental services	-		
		e occurred for 1 of 1 resident		Coordinators. The Directo	•		
	reviewed for dental se	ervices (Resident #68).		Unit Coordinators, and So			
	Immediate iconardy k	A = A = A = A = A = A = A = A = A = A =		be responsible for reviewi	-		
		began on 05/10/22 when ated for a second tooth		dentist visit notes for reco referrals, and notify MD a			
		ity failed to obtain dental		orders. On 8/11/22 The R			
		ction of all remaining teeth.		Coordinator educated the	•		
		rdy was removed on 8/12/22		Nursing, Unit Coordinator			
		emented an acceptable		Worker of the process.	o, and ocolar		
	credible allegation for	-		The DON or designee will	audit the dental		
		remains out of compliance		referral log 3 times a wee			
	-	severity level of E (no actual		then 2 times a week times			
		al for more than minimal		then weekly times 4 week			
		ediate jeopardy) to ensure					
	education and monito	oring systems put into place		The DON will bring the re-			
	are effective.			to three consecutive mon			
				Assurance Committee me			
	Findings included:			Quality Assurance commi			
				the effectiveness of the al	-		
		mitted to the facility on		will make additional interv			
		nitted on 06/23/22 with		on the audits to ensure co	nunuea		
		Type 2 Diabetes, end stage		compliance.			
	renal failure, heart dis neoplasm of right ova	-		Completion date is 09/01/	2022		
	Review of admission	minimum data set (MDS)					
		led Resident #68 was coded					
	as having no issues c	or concerns with oral care					

Facility ID: 923063

If continuation sheet Page 53 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345255	B. WING			C 08/25/2022	
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			11 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 791	Continued From page	<del>9</del> 53	F	791			
	revealed Resident #6 infection and referral treatment and recomm Amoxicillin 500 MG (r hours for 10 days or 0 every 8 hours for 10 do overall health condition Review of nursing pro- revealed Nurse Pract Resident #68 related order as follows: Amo- by mouth daily for 7 do own responsible perso order. Review of Physician of Amoxicillin 500 MG 1 hours (2pm, 10pm, 6a Review of outside den revealed Resident #6 extractions of all rema dental practice wrote Resident #68 to be set teeth extraction due to all root tips with tissue Review of oral surgeor revealed plan to remo- for Resident #68 durin nitrous oxide; however wait until January 202 take effect.	ogress note dated 10/20/21 itioner (NP) evaluated to tooth infection with new oxicillin 50 milligrams (MG) lays. Resident #68 is her on and is aware of new order dated 10/20/21 for tablet by mouth every 8 am). Intal note dated 11/21/21 8 required oral surgery for aining teeth. The outside a referral for een by an oral surgeon for o the teeth being broken and					

If continuation sheet Page 54 of 81

		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · · ·	E SURVEY IPLETED	
		345255	B. WING		C 08/25/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD			
CAROLIN	A CARE HEALTH AND R	EHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021				
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 791	the oral surgeon prace make Resident #68 at teeth extracted and the agreed to do the extr surgeon who took ow anyone until August 2 Medicaid. Review of in-house do revealed Resident #66 for routine dental visit in house dentist could Resident #68 due to tissue had completely procedure would need #68 had been referred and the attached refer recommendations in to proceed with the tr provider that accepts was recommended the resident's current inst accepted dental office There was no documer record as to whether Worker contacted Mes surgeons as recommendent dentist. The facility co documentation of any practices to inquire if Medicaid. Review of nursing pro-	/22 at 03:19 PM, she called ctice in January 2022 to an appointment to have her he oral surgeon who had actions had retired. The oral er the practice could not see 2022 and did not accept dental note for 04/28/22 visit 88 was seen by facility dentist t. Facility dental note stated d not perform extractions for all teeth being root tips and y covered her teeth and the ed to be surgical. Resident do out for dental treatment, erral provided dentist's case the resident would like reatment plan through a their current coverage. It he facility contact the urance provider for a list of es. uentation in the medical the staff or the Social edicaid for a list of oral ended by the in-house build not produce any yone contacting oral surgeon they took Resident #68	F 791				

Facility ID: 923063

If continuation sheet Page 55 of 81

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345255	B. WING		С
	ROVIDER OR SUPPLIER	545255	D. WING	STREET ADDRESS, CITY, STATE, ZIP COI	08/25/2022
				111 HARRILSON STREET	
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID       JCH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       GULATORY OR LSC IDENTIFYING INFORMATION)     TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 791	Continued From page	e 55	F 79	1	
	Review of Physician order dated 05/10/22 revealed Resident #68 to receive Clindamycin 300 MG 1 tablet by mouth every 8 hours (12AM, 8AM, 4PM) for 7 days.				
	-	I 05/27/22 revealed Resident aving no issues or concerns			
		order dated 06/07/22 oral surgery consult for Resident #68.			
	revealed new orders	-			
	revealed Resident #6	order dated 06/09/22 88 to receive Clindamycin nouth every 8 hours (5AM, s.			
	revealed Resident #6 routine scheduled de dental note indicated been referred to an o and described Reside periodontal disease ( inflammation of the g and support the teeth buildup". It was noted	lental note dated 06/28/22 58 was seen again for a ntal visit. The in-house Resident #68 had previously oral surgeon for extractions ent #68 as having "severe the result of infections and ums and bone that surround h) with heavy calculus d there was no dental ay though one was detected			

Facility ID: 923063

If continuation sheet Page 56 of 81

						D. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G		E SURVEY PLETED	
				<u> </u>		с	
		345255	B. WING			/25/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021				
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 791	Continued From page	e 56	F 79	91			
		ded as having no issues or					
	Review of quarterly Minimum Data Set (MDS) dated 07/25/22 revealed Resident #68 to be cognitively intact. Resident #68 was coded as having no issues or concerns with oral care or dental issues.						
	revealed request for I (NP) for complaint of swollen. NP evaluate physician order on 07	ogress note dated 07/26/22 Physician/ Nurse Practitioner right-side jaw pain area is d on 07/28/22. Received 7/28/22 for oral surgery n of teeth for dentures.					
	Review of Physician of Physician of revealed an oral surg for extraction of teeth	ery consult for Resident #68					
	new orders by Medica	te dated 07/28/22 revealed al Director for oral surgeon of teeth for dentures for					
		ceiving antibiotic therapy for on and received the last dose					
	antibiotic Clindamycir every 8 hours (7PM, dental abscess, Oxyc hours PRN for pain a	order dated 08/04/22 for n 300 MG 1 tablet by mouth 3AM, 11AM) for 7 days for codone 5-325MG every 6 nd Ibuprofen 400 MG 1 daily (7PM, 3AM, 11AM) for					
		order dated 08/08/22 for ablets by mouth 3x ' s daily					

Facility ID: 923063

If continuation sheet Page 57 of 81

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVI	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	)
					С	
		345255	B. WING		08/25/20	)22
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	A CARE HEALTH AND R		1	11 HARRILSON STREET		
OANOLIN			c	HERRYVILLE, NC 28021		
(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 COM	(X5) IPLETION DATE
F 791	Continued From pag	e 57	F 791			
	(5AM, 1PM, 9PM) for					
	Review of nursing progress note dated 08/08/22 revealed new order received from nurse practitioner (NP) to begin Ibuprofen 200 MG 2 tablet by mouth 3x's daily. Orders processed and Resident #68 was made aware of new orders.					
	antibiotic Clindamyci hours (7PM, 3AM, 11 abscess, Oxycodone	order dated 8/11/22 for n 300 MG 1 tablet every 8 AM) for 7 days for dental s 5-325 MG every 6 hours uprofen 200 MG 2 tablets by pain.				
	conducted on 08/08/2 sitting up in her whee #68 right cheek was opened her mouth to inflamed and swollen visible from swollen g were broken and chip the abscesses in her was currently receivin medication. She reve dental issues since la chemo treatments, a infection. Resident # in-house dentist seve dental issues and wa was not able to treat dentist who recomment teeth removed by an the facility staff told her	ation and interview was 22 at 11:06 AM revealed her elchair in her room. Resident slightly swollen, and she reveal gums were red, and only tips of teeth were gums, other visible teeth oped. Resident #68 stated mouth were painful and she ng an antibiotic and pain ealed she had been having ast year after she received nd this was her third 68 stated she saw the eral months ago about her is told the in-house dentist her, so she saw another ended she have all of her oral surgeon. She revealed uer they were looking for an uld take her Medicaid.				

Facility ID: 923063

If continuation sheet Page 58 of 81

		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	i			
						С	
		345255	B. WING		0	8/25/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
				111 HARRILSON STREET			
CARULIN	A CARE HEALTH AND F	ERABILITATION		CHERRYVILLE, NC 28021			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE	
F 791	Continued From pag	e 58	F 79	1			
1 751			F /9				
		t #68 and her dental issues.					
	He stated he observe						
		de and she informed him					
		her mouth. He stated he told					
		r (NP) about Resident #68 ' s					
		on the right side and having					
	abscess in her mouth						
		irrently receiving antibiotics,					
á		ibuprofen for the abscess					
	-	vere supposedly looking for					
	an oral surgeon to re	move her teeth.					
	Social worker (SM/)	nterview week conducted on					
	. ,	nterview was conducted on					
		/I which revealed he was It #68 and had been working					
		ral surgeon since November					
		ident #68 was referred to an					
		in November 2021 and he					
		al surgeon referral. He					
		58 was sent out to oral					
		r 2021 and a plan was					
		al surgeon to extract her					
		ntments. The SW stated in					
		ansportation aide called the					
		dule the two appointments					
	and the oral surgeon						
		have an opening until August					
		cept Medicaid. He revealed					
		en by the in-house dentist in					
		ecommended to have all					
		referred to a dental clinic. The					
	SW stated he contac	ted the referred dental clinic					
		he status of the referral for					
	Resident #68 and wa	as informed they had not					
		and it had to be faxed. He					
	revealed he spoke w	ith the dental clinic again in					
	-	about the status of the					
		rmed the referral had been					
		ntal clinic not providing oral					

Facility ID: 923063

If continuation sheet Page 59 of 81

	OF DEFICIENCIES	MEDICAID SERVICES				IO. 0938-039		
		IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION IG		IPLETED		
			7			С		
		345255	B. WING		0	8/25/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET				
				CHERRYVILLE, NC 28021				
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 791	Continued From page	e 59	F7	01				
		pting Medicaid. The SW		51				
	stated he had not documented the attempts							
		al practices for Resident #68						
	to be seen by an oral	surgeon.						
	A telephone interview	v was conducted with the						
		er on 08/11/22 at 09:48 AM						
		linic received a referral on						
	-	gery for Resident #68. She						
	referral and denied it	ic director reviewed the						
		and they did not perform						
		ealed this was the only						
		he clinic for Resident #68.						
		hager revealed the facility he dental clinic on 08/10/22						
		e referral for Resident #68						
		to the clinic not being able						
	to perform oral surge	-						
	Linit coordinator inter	view was conducted on						
	-	1 which revealed she was						
		dental issues with Resident						
		ental clinic herself sometime						
		h someone about oral						
		esident #68. She stated she						
	not been reviewed ye	was in the basket and had						
		nformation received from the						
	dental clinic. The Uni	t Coordinator revealed she						
		make a note of her call to the						
		no knowledge of the name						
	or the dental clinic en	nployee she spoke with.						
	Telephone interview	conducted with						
	Transportation Coord	linator on 08/11/22 at 03:19						
		s familiar with Resident #68						
	and had transported in November 2021. S	her to a dental appointment						

Facility ID: 923063

If continuation sheet Page 60 of 81

	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI II (Y2)	LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
					С	
		345255	B. WING		0	8/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	A CARE HEALTH AND R			111 HARRILSON STREET		
OANOEIN				CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE	
F 791	Continued From page	e 60	F 79	1		
		rgeon in December 2021	1.70			
		a plan with Resident #68 to				
	-	d she asked to wait until she				
		d at the first of the year. The				
	Transportation Coord					
		on's office in January 2022 to				
		68 appointment and the oral				
		and his replacement did not e stated she called a few				
	-	s in January 2022, but none				
	of the offices accepte	-				
	Transportation Coord	linator revealed she				
		inic in July, and they would				
		She further revealed she				
		nter notes into electronic				
		er supervisor and the Social es she called in January and				
	July.					
		cted on 08/11/22 at 11:41 AM				
		er (NP) which revealed she				
		sident #68 and her dental ctober 2021 Resident #68				
		al pain and had some broken				
		fection which required				
		aled Resident #68 was seen				
	by both an in-house a	and outside dentist who				
		th to be extracted by an oral				
		ealed she was told Resident				
		supposedly fell through the				
		nce issues and the SW was n oral surgeon who would				
		e stated Resident #68 had				
	-	erapy last October for a				
		his past May for a dental				
	abscess on the left si	ide of Resident #68 mouth,				
	and was currently on	-				
		ofen due to abscesses on nd slight swelling of right side				
	I right side of mouth a	ad alight avalling of right aida				

If continuation sheet Page 61 of 81

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FOF	ED: 09/21/2023 RM APPROVEI IO. 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345255	B. WING		0	C 8/25/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				111 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		CHERRYVILLE, NC 28021		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 791	too long and has exp Director of Nursing (E over the past year an being worked on. She had affected Residen expressed concerns the dental infection ca to heart issues. The N Medical Director about he get involved to mo along. She stated the consult for oral surge revealed she had no surgery consult or an be completed. The Director of Nursin Nurse Consultant inte 08/11/22 at 06:30 PM was aware of the need referred for oral surge SW had been working practice in getting Re surgery services but I that would accept Me facility had not contact for a list of oral surge accept Medicaid. The spoken with Resident her dental referral but severe pain the resid mouth due to her teel The facility was notifie 08/19/22 at 04:39 PM	stated she felt it had taken ressed concern to the DON) and SW multiple times d kept being told it was e revealed the dental issues it #68's eating and she had to the DON and SW about ausing harm to resident due NP stated she spoke with the ut her concerns and asked ove the referral process e Medical Director ordered a ry on 07/28/22. The NP knowledge of an oral y consult taking this long to ng (DON) and Regional erview was conducted on I which revealed the DON ed for Resident #68 to be ery services. She stated the g with the in-house dental sident #68 seen for oral has trouble finding a practice edicaid. She revealed the cted Medicaid or corporate on providers that would e DON stated she had t #68 multiple times about t was not aware of the ent was having with her th and current abscesses.	F 79			

Facility ID: 923063

If continuation sheet Page 62 of 81

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FO	ED: 09/21/202 RM APPROVE NO. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		TE SURVEY MPLETED
		345255	B. WING			c	C )8/25/2022
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION			HARRILSON STREET ERRYVILLE, NC 28021		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 791	Continued From page 62		F	791			
	are likely to suffer, a a result of the noncor On 11/23/2021, a refe surgeon was received dental service for Res need for extractions of decayed teeth and m multiple attempts to s An appointment was with an oral surgeon surgeon recommende upper teeth. However	erral to an outside oral d from the facility contracted sident #68 related to the of teeth due to broken, outh pain. The facility made achedule this appointment. scheduled for the resident on 12/7/21. The oral ed extraction of lower and r, Resident #68 requested to					
	wait until January 2022 when dental insurand would take effect. In January 2022, the transportation aide proceeded to schedule at appointment however attempts were unsuccessful. Resident #68 was seen by the facility contracted dentist on 4/28/22 and 6/2 with a referral to an oral surgeon for extraction On 7/28/22, the facility received an order from medical director to refer Resident #1 to an oral surgeon for teeth extractions and dentures. facility failed to schedule the oral surgeon	January 2022, the roceeded to schedule an r attempts were ent #68 was seen by the htist on 4/28/22 and 6/28/22 ral surgeon for extractions. ty received an order from the fer Resident #1 to an oral ractions and dentures. The fulle the oral surgeon					
	antibiotics. Resident 8/15/2022 and is sch 8/25/2022.	in and abscesses requiring saw oral surgeon on eduled for oral surgery on					
	performed an oral ev Resident #68 exhibite mucous membrane. I Resident #68 verbaliz	ctor of Nursing (DON) aluation on Resident #68. ed slight redness to the No overt swelling of gums. zed no pain at the time. she has had no issues with pain.					

Facility ID: 923063

If continuation sheet Page 63 of 81

DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         NAME OF PROVIDER OR SUPPLIER       345255         NAME OF PROVIDER OR SUPPLIER       CAROLINA CARE HEALTH AND REHABILITATION				FORM	M APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345255	B. WING				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 791	Continued From page On 8/10/22, Nursing I Nursing and Unit Coor review of all current in records to identify any dental care and ensur completed. As well, to including the last den recommended and va appointments (as app Specify the action the process or system fai adverse outcome fror when the action will b By 8/11/22, the Direct Licensed Nurses rega communicating new p services to the Unit C The Director of Nursin Social Worker will be in-house dentist visit referrals, and notify M On 8/11/22 The Regio educated the Director	A 63 Management (Director of ordinators) completed a h-house residents ' medical y outstanding referrals for re these have been o identify dental visit status, tal visit, follow up alidation of scheduled blicable). e entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete for of Nursing will educate arding the process for ohysician orders for dental oordinators. ng, Unit Coordinators, and responsible for reviewing notes for recommendations, ID and obtain any orders. onal Clinical Coordinator of Nursing, Unit cial Worker of the process.		791	DEFICIENCY)	AIE	
	<ol> <li>A licensed nurse inputs the orders for a</li> <li>The Unit Coordin bring the "Facility Action include new dental set</li> </ol>	receives the referral and a referral. lator will print, review, and ivity Report - Orders" to ervices referrals (orders) to and Social Services Director al Morning Meeting.					

Facility ID: 923063

If continuation sheet Page 64 of 81

	S FOR MEDICARE &					O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	E CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345255	B. WING			
	ROVIDER OR SUPPLIER	545255		STREET ADDRESS, CITY, STATE, ZIP COL		3/25/2022
	ROVIDER OR SOFFLIER			111 HARRILSON STREET	JE	
CAROLIN	A CARE HEALTH AND F	REHABILITATION		CHERRYVILLE, NC 28021		
				,		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 791	Continued From page 64		F 79	1		
		rs will communicate with	1.10			
	Director of Nursing if					
	appointment daily					
		sing will write the information				
		esidents receiving dental				
	-	daily; Director of Nursing will				
	reconcile this log dai	ly by validating any outside or				
		pintments. When the Director				
		ilable the Social Worker will				
	-	ling in and updated the				
		/22 the Regional Clinical				
	-	he Director or Nursing and				
		e responsibility for the Master				
	log and the new refe	concile this log daily by				
	validating any outsid					
	appointments that ha					
		ing will ensure no staff will				
		ng this education. Any new				
		ing agency staff will receive				
	education prior to the					
	On 8/10/22 the Regi	ional Clinical Manager				
	educated the Directo					
	Coordinators, Social	Worker, and the				
	Administrator regard	ing the new referral process				
	and their responsibili	ities on the referral process				
		y Activity Report -Orders" to				
		(orders) for dental services				
		orders. During this education				
		s were notified that they were				
		ng, reviewing, and bringing				
		Report- Orders" to Clinical				
		he Director of Nursing, Unit ocial Worker will review the				
		ort - Orders" during the daily				
		eting. Additionally, new				
	-	ang. Auditionally, new				
	admissione will be re	eviewed to identify residents				

Facility ID: 923063

If continuation sheet Page 65 of 81

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FO	ED: 09/21/2022 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345255	B. WING			C	C 8/25/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION			HARRILSON STREET ERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 791	orders completed. Or Clinical Manager edu the responsibility for t process. The Director Coordinators, and Sc documentation daily t appointments and in- to ensure dental serv the dental provider an implemented. Effective 8/11/22, the Administrator will be implementation of this removal for this alleg. Alleged Date of IJ Re On 8/25/22 the credit immediate jeopardy r the removal date of 0 The audit tools comp 08/10/22 were review notified of results fror identified with dental see in house dentist a On 08/10/22, the Reg provided education w Director of Nursing, U Worker on regarding and their responsibilit to review the "Facility include any referrals and pain medication of the Unit Coordinators	es are scheduled and these n 8/10/22 the Regional cated the Social Worker on the log and the new referral r of Nursing, Unit bicial Worker will review from outside dental house dental appointments ice recommendations from nd physician are Director of Nursing and responsible to ensure s immediate jeopardy ed non-compliance. emoval: 8/12/2022 Die allegation for the emoval was validated and 8/12/22 was confirmed. Leted by the facility on yed. The physician was n the audits and residents needs were scheduled to and oral surgeon gional Clinical Manager	F	791			

Facility ID: 923063

If continuation sheet Page 66 of 81

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	IPLETED		
					С			
		345255	B. WING			8/25/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE			
CAROLIN	A CARE HEALTH AND R	REHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021				
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
F 791	Continued From page	e 66	F 79	91				
		Report- Orders" to Clinical						
	Morning Meeting. The Director of Nursing, Unit							
	-	cial Worker will review the						
		ort - Orders" during the daily						
		eting. Additionally, new viewed to identify residents						
		for dental services to						
		es are scheduled and these						
		ne Director of Nursing, Unit						
		ocial Worker will review						
	documentation daily	rom outside dental -house dental appointments						
		vice recommendations from						
	the dental provider an implemented.	nd physician are						
	A review of the Denta	0						
	1 · ·	aled residents with dental ed to see the in-house dentist						
		xtractions depending on what						
	issue was indentified							
		es, nursing assistants and						
	Unit Coordinators rev	-						
		ing any changes in resident						
		outh pain, abnormal odor broken teeth, bleeding						
	•	areas in mouth, difficulty						
	eating and reporting	these changes to the nurses						
		iders. Oral care handout was						
		ursing staff. Nursing staff						
		ractitioner or Physician with issues, enters any new						
	orders and referrals,							
		intments can be scheduled.						
	Interviews with the U	nit Coordinators revealed						
	-	ducation on reviewing any						
	I new orders or referra	als for dental issues and	1					

Facility ID: 923063

If continuation sheet Page 67 of 81

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 09/21/20 FORM APPROVE OMB NO. 0938-039		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345255	B. WING			25/2022
NAME OF PF	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLINA	A CARE HEALTH AND R	EHABILITATION	с	HERRYVILLE, NC 28021		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIOI DATE
F 791	F 791 Continued From page 67 scheduling appointments. They will inform the Director of Nursing of the new order or referral and if an appointment was made and complete a facility report to review during daily clinical meeting.		F 791			
F 835 SS=K	nursing staff on oral of She stated nursing as performing oral care and looking for any d difficulty chewing, pa notify nursing. Nursin assessing resident for inform the Unit Coord Physician about any also input any new or dental issues and not revealed the Unit Coord appointments and co is brought to daily clir stated she was respond list of all dental appoin daily to reflect when the was completed and the Administration CFR(s): 483.70		F 835			9/1/22
	enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by:	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial		On 8/10/22, the Regional Clinical		
		P), Dental Clinic Manager,		Manager and the Regional Director of		

Event ID: OE2V11

Facility ID: 923063

If continuation sheet Page 68 of 81

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
			A. BOILDING	°		с	
		345255	B. WING			08	0/25/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				111	HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		СН	IERRYVILLE, NC 28021		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 835	Continued From page	- 6 <b>9</b>		25			
1 000			F 83	35	On another and use to all the Aldreinistructure	_	
		erviews Administration failed and oversight to facility staff			Operations educated the Administrator (NHA), Director of Nurses (DON), Unit		
		rrals for extractions were			Coordinator and Nurse Supervisor on		
	scheduled for Reside			facility's revised process for managing			
		the dentist and ordered by the Physician. The			in-house and outside dental services.		
		to have an effective process			On 8/10/22, the Regional Director of		
		rdisciplinary team and			Operations re-educated the NHA on th	ne	
		ensure needed care and			requirements of F835.		
	services were provide	ed for 1 of 1 sampled					
	resident (Resident #6	68).			On 8/10/22, the Regional Director of		
					Operations and Regional Clinical Mana		
		began on 05/10/22 when the			educated the NHA and DON regarding		
	-	systems in place to obtain			process for the Daily Stand-Up meetin		
		esident #68 for the extraction			where the Interdisciplinary Team (IDT)		
	-	. The immediate jeopardy			which includes Administration, Nursing	],	
	was removed on 8/11	ptable credible allegation for			Social Services, Dietary and Therapy Services will meet and review to identi	fv	
	-	emoval. The facility remains			and outstanding consultations of denta	-	
		a lower scope and severity			referrals. This education included the		
		narm with the potential for			Stand Down meeting where follow up i		
		arm that is not immediate			validated on previously identified issue		
		ducation and monitoring					
	systems put into plac	e are effective.			The Regional Director of Operations a	nd	
					Regional Clinical Manager will provide		
	Findings included:				onsite support and validation for the		
					Administrator and Director of Nursing		
	This tag is cross refe	rred to F684 and 791.			weekly. A random observation of key		
					facility meetings to include the daily ID		
		servations, record reviews,			meeting and weekly Risk meeting will		
		P), facility staff, and resident			conducted by the Regional Director of		
		r failed to ensure resident's viding care and services to			Operations and Regional Clinical Mana to provide ongoing validation, support,	•	
		es, unresolved dental pain			and education.		
	and chewing difficulty						
		10/19/21 was seen by the			Date of Completion: 9-01-22		
		noted Resident #68 was in					
		fection and referral was					
		tal treatment and antibiotics					
	were recommended	The antibiotics were					

Facility ID: 923063

If continuation sheet Page 69 of 81

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY IPLETED
						С
		345255	B. WING		08	3/25/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP COD	E	
	A CARE HEALTH AND F		1	11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND I		C	CHERRYVILLE, NC 28021		
(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 COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 835 Continued From page 69		e 69	F 835			
-		by the Nurse Practitioner.				
	Resident #68 was se	en by a dentist on 11/21/21				
who wrote a referral	for an oral surgeon for					
	extraction of all remaining teeth was seen by an oral surgeon of plan was to remove all upper a					
		•				
		ents using nitrous oxide				
	which she asked to c	lefer until January 2022				
		vould take effect. On 3/27/22				
		order was changed to regular soft meat. On 05/10/22				
		re written for antibiotics for a				
		m 5/10/22 through 5/13/22,				
		ed a pain level ranging from 6				
		10 with 10 being the worst				
		re prescribed on 6/9/22 for a				
		n 06/09/22 through 06/15/22, ed pain level ranging from 5				
		10 with 10 being the worst				
		sident #68 diet order was				
	• •	liet with chopped meat. On				
		8 was seen by the NP who				
		ess. This infection required 14				
		nd oxycodone for the pain. 8/11/22, Resident #68				
	reported a pain level					
	Resident #68 oral su					
		neduled on 08/10/22 (after				
	the survey started) for	or 08/15/22.				
	F 791 - Based on ob	servations, record reviews,				
	and Nurse Practition	er (NP), Dental Clinic				
		f, and resident interviews,				
		btain dental services from an				
		h extractions. Resident #68 st on 11/21/21 who wrote a				
		irgeon for extraction of all				

Facility ID: 923063

If continuation sheet Page 70 of 81

CENTER STATEMENT (	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	\G			PLETED
		345255	B. WING _				C / <b>25/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20,2022
				11	11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND RI	EHABILITATION		С	HERRYVILLE, NC 28021		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	remove all upper and appointments using n asked to defer until Ja Medicaid would take of surgeon 's office was it was communicated surgeon did not accept dentist recommended for extractions on 4/28 Physician/Nurse Prace surgery consults for e and 7/28/22. The delive repeated dental infect difficulty eating. Reside consultation appointm 08/10/22 (after the su The deficient practice reviewed for dental set Facility administration jeopardy on 08/19/22 The facility provided to Identify those recipient are likely to suffer, a set a result of the noncom The Administration fat and oversight to the fat dental referral/consult were no effective syste consults with an oral set with recommendation lack of effective syste	7/21 and the plan was to lower teeth during two itrous oxide which she anuary 2022 when her effect. When the oral contacted in January 2022 that the current oral of Medicaid. The in-house referrals to an oral surgeon 8/22 and 6/28/22. The titioner wrote orders for oral xtraction of teeth on 6/7/22 ay in services led to tions, unresolved pain, and dent #68 oral surgeon nent was scheduled on rvey started) for 08/15/22. occurred for 1 of 1 resident ervices (Resident #68).	F	335			

If continuation sheet Page 71 of 81

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
	345255	B. WING		0	C 3/25/2022
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
A CARE HEALTH AND R	EHABILITATION				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Specify the action the process or system fa adverse outcome from when the action will b On 8/10/22, the Regi the Regional Director Administrator (NHA), Unit Coordinator and facility 's revised pro and outside dental se On 8/10/22, the Regi re-educated the NHA F835. On 8/10/22, the Regi and Regional Clinical and DON regarding t Stand-Up meeting wh Team (IDT) which inc Nursing, Social Servi Services will meet an outstanding consultate education included the where follow up is var identified issues. The Regional Director Regional Clinical Man support and validatio Director of Nursing w observation of key fa daily IDT meeting and	e entity will take to alter the ilure to prevent a serious m occurring or recurring, and be complete onal Clinical Manager and r of Operations educated the Director of Nurses (DON), Nurse Supervisor on the cess for managing in-house ervices. onal Director of Operations on the requirements of onal Director of Operations I Manager educated the NHA he process for the Daily here the Interdisciplinary cludes Administration, ices, Dietary and Therapy ad review to identify and tions of dental referrals. This he daily Stand Down meeting lidated on previously or of Operations and nager will provide onsite n for the Administrator and reekly. A random cility meetings to include the d weekly Risk meeting will	F 83			
	Continued From pag Summary ST (EACH DEFICIENCIES CORRECTION A CARE HEALTH AND R SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag Specify the action the process or system fa adverse outcome fro when the action will th On 8/10/22, the Regi the Regional Director Administrator (NHA), Unit Coordinator and facility ' s revised pro and outside dental se On 8/10/22, the Regi re-educated the NHA F835. On 8/10/22, the Regi and Regional Clinica and DON regarding th Stand-Up meeting will ream (IDT) which into Nursing, Social Servi Services will meet an outstanding consulta education included th where follow up is va identified issues. The Regional Director Regional Clinical Ma support and validatio Director of Nursing w observation of key fa daily IDT meeting an be conducted by the	DF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:       345255         ROVIDER OR SUPPLIER       345255         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 71       Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete         On 8/10/22, the Regional Clinical Manager and the Regional Director of Operations educated the Administrator (NHA), Director of Nurses (DON), Unit Coordinator and Nurse Supervisor on the facility 's revised process for managing in-house and outside dental services. On 8/10/22, the Regional Director of Operations re-educated the NHA on the requirements of F835.         On 8/10/22, the Regional Director of Operations and Regional Clinical Manager educated the NHA and DON regarding the process for the Daily Stand-Up meeting where the Interdisciplinary Team (IDT) which includes Administration, Nursing, Social Services, Dietary and Therapy Services will meet and review to identify and outstanding consultations of dental referrals. This education included the daily Stand Down meeting where follow up is validated on previously identified issues.         The Regional Director of Operations and Regional Clinical Manager will provide onsite support and validation for the Administrator and Director of Nursing weekly. A random observation of key facility meetings to include the daily IDT meeting and weekly Risk meeting will be conducted by the Regional Director of	OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING         345255       B. WING         ROVIDER OR SUPPLIER       A CARE HEALTH AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 71       F 835         Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete       F 835         On 8/10/22, the Regional Clinical Manager and the Regional Director of Operations educated the Administrator (NHA), Director of Nurses (DON), Unit Coordinator and Nurse Supervisor on the facility 's revised process for managing in-house and outside dental services. On 8/10/22, the Regional Director of Operations re-educated the NHA on the requirements of F835.       ON 8/10/22, the Regional Director of Operations re-educated the NHA on the requirements of F835.         On N 10/22, the Regional Director of Operations and Regional Clinical Manager educated the NHA and DON regarding the process for the Daily Stand-Up meeting where the Interdisciplinary Team (IDT) which includes Administration, Nursing, Social Services, Dietary and Therapy Services will meet and review to identify and outstanding consultations of dental referrals. This education included the daily Stand Down meeting where follow up is validated on previously identified issues.         The Regional Director of Operations and Regional Clinical Manager will provide onsite support and validation for the Administrator and Director of Nursing weekly.	De DEFICIENCIES CORRECTION       (M1) PROVIDERUSUPPLIERUCLIA IDENTIFICATION NUMBER:       (A2) MULTIPLE CONSTRUCTION A BUILDING         345255         STREET ADDRESS, CITY, STATE, ZIP COD 111 HARRILSON STREET CHERRYVILLE, NC 28021         COVIDER OR SUPPLIER         A CARE HEALTH AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 71         F 835         Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete         On 8/10/22, the Regional Clinical Manager and the Regional Director of Operations educated the Administrator (NHA), Director of Nurses (DON), Unit Coordinator and Nurse Supervisor on the facility 's revised process for managing in-house and outside dental services.         On 8/10/22, the Regional Director of Operations re-educated the NHA on the requirements of F835.         On 8/10/22, the Regional Director of Operations re-educated the NHA on the requirements of F835.         ON 8/10/22, the Regional Director of Operations re-educated the Almager educated the NHA and DON regarding the process for the Daily Stand-Up meeting where the Interdisciplinary Services will meet and review to identify and outstanding consultations of dental referrals. This education included the daily Stand Down meeting where follow up is validated on previously identified issues. </td <td>CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COM         345255       B. WING       00         ROWDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       111 HARRILSON STREET         A CARE HEALTH AND REHABILITATION       PREPX       PROVIDERS OR SUPPLIER       PREPX         SUMMARY STATEMENT OF DEPCIFIENCES       D       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Second Participation of DEPCIFICURATION       PREPX       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Continued From page 71       F 835       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Continued From page 71       F 835       PREPX       PREPX&lt;</td>	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COM         345255       B. WING       00         ROWDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       111 HARRILSON STREET         A CARE HEALTH AND REHABILITATION       PREPX       PROVIDERS OR SUPPLIER       PREPX         SUMMARY STATEMENT OF DEPCIFIENCES       D       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Second Participation of DEPCIFICURATION       PREPX       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Continued From page 71       F 835       PREPX       PROVIDERS CITY, STATE, ZIP CODE       111 HARRILSON STREET         Continued From page 71       F 835       PREPX       PREPX<

If continuation sheet Page 72 of 81

						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
			A. DOILDING			С
		345255	B. WING		0	8/25/2022
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CO		•	
CAROLINA CARE HEALTH AND REHABILITATION				111 HARRILSON STREET CHERRYVILLE, NC 28021		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	Continued From page	e 72	F 83	35		
	immediate jeopardy r non-compliance.	e implementation of this removal for this alleged				
	Alleged Date of IJ Removal: 8/11/2022 On 8/25/22 the credible allegation for the					
		removal was validated and 08/11/22 was confirmed.				
	A root cause analysis was completed by the Regional Director of Operations which identified the following root causes for the IJ concerns identified at the survey: failure to provide leadership and oversight to the facility staff to ensure that dental referral/consults were completed and no effective systems to manage referrals/ consults.					
	08/10/22 were review notified of results from	leted by the facility on ved. The physician was m the audits and residents needs were scheduled to and oral surgeon				
	Regional Director of education with the Ac Nursing on identifying jeopardy cited and di components of the re	gional Clinical Manager and Operations provided dministrator and Director of g issues with immediate scussed with them the egulations for F-684, F-791, cation also included QA				
	(Quality Assurance) r morning stand-up, cli	roles and responsibilities, inical stand-up, dental follow-ups, correction plans				
	they received educat	es and nurse aides revealed ion on identifying any condition including mouth				

Facility ID: 923063

If continuation sheet Page 73 of 81

CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES and PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILDING		C
	345255		B. WING		08/25/2022
	ROVIDER OR SUPPLIER A CARE HEALTH AND F	REHABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE	
	1			CHERRYVILLE, NC 28021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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)	
F 835	Continued From pag	e 73	F 835		
	pain, abnormal odor coming from mouth, broken teeth, bleeding gums, any abnormal areas in mouth, difficulty eating and reporting these changes to the nurses and the medical providers. Oral care handout was also provided to all nursing staff.				
F 867 SS=E	Improvement) meetin 08/22/22 with the foll attendance: Regiona Administrator, Directo Director. They discu morning stand-up, cli referral process and and monitoring proces QAPI/QAA Improvem	owing key personnel in al Clinical Manager, or of Nursing, and Medical ssed weekly risk meetings, inical stand-up, dental follow-ups, correction plans esses. nent Activities	F 867		9/15/22
	§483.75(g) Quality a	ssessment and assurance.			
	assurance committee (ii) Develop and impl action to correct iden This REQUIREMEN by: Based on observation and staff interviews, Assessment and Ass failed to maintain imp monitor the intervent into place. This was the areas of Accurac Plan Timing and Rev cited on the 08/12/21 survey and Infection	ement appropriate plans of tified quality deficiencies; Γ is not met as evidenced ons, record reviews, resident,		The facility □s Quality Assurance Committee failed to maintain implemen procedures and monitor the interventio the facility put into place following the recertification survey on 8/12/21 in the areas of Accuracy of Assessments, Ca Plan Timing and Revision, and Infection Control. Infection Control was cited in addition on the 9/22/20 recertification survey. A plan of Correction for F641, F657 and	ns re n

Event ID: OE2V11

Facility ID: 923063

If continuation sheet Page 74 of 81

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · · ·	OATE SURVEY
		345255	B. WING			C 08/25/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		00,20,2022
				111 HARRILSON STREET		
CAROLINA CARE HEALTH AND REHABILITATION				CHERRYVILLE, NC 28021		
(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)	SHOULD BE	(X5) COMPLETIC DATE
F 867	Continued From pag	e 74	F 86	37		
1 007			FOU			
		<ul> <li>These areas were cited recertification survey with an</li> </ul>		F880 cited during the annual s 8/12/21 and F880 for annual s	•	
	0	. The continued failure of the		9/22/20 were submitted to CM	•	
		ee federal surveys showed a		accepted with follow up and re		
		s inability to sustain an		compliance visits.		
		essment and Assurance		Plans of correction were put in	nto place at	
	Program.			the time of each deficiency cit		
				plan of correction included mo		
	The findings included	1:		tools, and review of monitoring		
				during monthly Quality Assura		
	This citation is cross	referred to:		Committee meetings for a def		
				of time. Monitoring of each pla	an of	
	1. F641: Based on re	cord reviews and staff		correction was presented to the	ne Quality	
		/ failed to accurately code		Assurance Committee and no	further	
		et (MDS) assessments in		issues were identified through		
		(Resident #14), level of		monitoring period and were di		
	-	or eating (Resident #37,		The Administrator initiated an		
	Resident #80, Reside			all administrative staff on 09/1		
		esident #23), oral/dental		regarding Quality Assurance F		
		) and cognition (Resident		Improvement processes includ	•	
		9) for 10 of 18 sampled		identifying and prioritizing qua		
	residents whose MD	S were reviewed.		deficiencies, systemically ana		
	During the recertifies	tion survey completed an		causes of systemic quality de		
	-	tion survey completed on vas cited for not accurately		developing, and implementing action or performance improve		
		essment reviewed for the		activities, and monitoring and		
		eflect prognosis for 1 of 1		the effectiveness of corrective		
		hospice and the number of		action/performance improvem		
	falls for 1 of 3 resider	•		activities. This in-service inclu		
				ensuring accuracy of audits, e		
	2. F657: Based on re	cord review, observation,		audits when appropriate, and		
		ff interviews, the facility failed		corrective action/performance	•	
		to reflect dental issues for 1		improvement activities to eval		
		d for dental care (Resident		effectiveness of each plan and		
	#68).			necessary. All newly hired ad	ministrative	
				staff will receive the appropria	te education	
	During the recertifica	tion survey completed on		during orientation. No Adminis	strative staff	
		ailed to revise a resident's		will work until they have received		
	care plan to reflect th	a level of assistance		appropriate education.		

Facility ID: 923063

If continuation sheet Page 75 of 81

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				OMB	RM APPROVI NO. 0938-03	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED		
		345255	B. WING			C 08/25/2022		
NAME OF PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE				
	A CARE HEALTH AND F			111 HARR	RILSON STREET			
OANOEIN				CHERRY	VILLE, NC 28021			
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 867	Continued From pag	e 75	F 8	67				
		when repositioning in bed for						
	1 of 3 residents revie			The	QAPI Committee will review	the		
		, , ,			pliance audits for F641, F657			
		ecord reviews, observation			) to evaluate continued comp committee will make	bliance.		
	and staff interviews, implement their infect			mmendations if any noncom	nliance is			
	Centers for Disease			tified and reevaluate the plan				
	(CDC) recommended		corre	ection for possible revisions.	This			
		#5) failed to change gloves			ess will continue until the fac	•		
		giene during incontinence			eved three months of consist	ent		
	for infection control.	nts (Resident #37) reviewed		comp	pliance.			
				The	Administrator will be respons	sible for		
	During the recertifica	ation survey completed on			lan of correction.			
	-	was cited for not placing an						
		nt on enhanced droplet according to CDC guidance,		Date	of Compliance: 09/15/2022			
		rsonal protective equipment						
		iging PPE between rooms						
	and nurses not clear	ning glucometers after use						
	according to the mar	nufacture's						
	recommendations.							
	During the recertifica	ation survey completed on						
		was cited for staff working on						
	the isolation unit for	staff not performing hand						
		ing and after exiting a						
		not disposing of used gloves earing face mask on the						
		ot wearing PPE correctly on						
		I staff failing to follow CDC						
	guidance and their o	wn policy and procedure for						
	-	cting resident care equipment						
	after use on the isola	ation unit.						
	An interview with the	Director of Nursing (DON)						
	who was also the Inf	ection Preventionist on						
		evealed they were constantly						
	educating staff on inf	fection control procedures						

If continuation sheet Page 76 of 81

ALEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY		
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUILDING	COM	PLETED			
					С			
		345255	B. WING		08	/25/2022		
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE				
CAROLINA CARE HEALTH AND REHABILITATION				111 HARRILSON STREET CHERRYVILLE, NC 28021				
(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 867	Continued From page	76	F 867					
1 007		re training on infection	F 007					
		ures. She stated they						
	• •	udits of infection control						
		ous procedures and more						
	education on principles of infection control across all staff members and include all aspects in the							
	orientation process for	or new hires.						
	A phone interview on	08/11/22 at 6:04 PM with						
		ealed their implemented						
		eld strong and they had had						
	· ·	ns and it was difficult for one						
	person to keep up wit	th the workload. He						
		n the process of recruiting						
		perience to help with the						
	taking a more proacti	urther explained he would be						
		e stand-up meeting held						
		ator stated he would continue						
		inistrative team to discuss						
	concerns and look at	ways to resolve them in the						
	best interest of the re							
	indicated they would							
		g for the MDS position to kload on one person and						
	-	e in educating staff on						
	infection control princ							
F 880	Infection Prevention &	& Control	F 880			9/20/22		
SS=D	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)						
	§483.80 Infection Co	ntrol						
	-	blish and maintain an						
	infection prevention a							
	designed to provide a							
		nent and to help prevent the						
	nevelopment and trar	nsmission of communicable	1			1		

Facility ID: 923063

If continuation sheet Page 77 of 81

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345255	B. WING			08/25/2022		
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLIN	A CARE HEALTH AND R	EHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
F 880	<ul> <li>§483.80(a) Infection program.</li> <li>The facility must estat and control program (a minimum, the follow</li> <li>§483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visite providing services uncertain and communicable distaff, volunteers for the procedures for the probut are not limited to:</li> <li>(i) A system of surveil possible communicable diseases reported;</li> <li>(ii) When and to whom communicable diseases reported;</li> <li>(iii) Standard and trant to be followed to prev (iv)When and how isom resident; including but (A) The type and durated depending upon the init involved, and</li> <li>(B) A requirement that least restrictive possible circumstances.</li> <li>(v) The circumstances</li> </ul>	brevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be ensmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the obe for the resident under the s under which the facility ees with a communicable	F	880				

Facility ID: 923063

If continuation sheet Page 78 of 81

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/21/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
	345255		B. WING		C 08/25/2022		
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
CAROLINA CARE HEALTH AND REHABILITATION			111 HARRILSON STREET CHERRYVILLE, NC 28021				
(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 COMPLETION		
F 880	contact with residents contact will transmit t (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on record rev interviews, the facility infection control polic Disease Control and recommended praction member (Nurse Aide and perform hand hysic care on 1 of 3 resider for infection control. The findings included The Centers for Disea (CDC) guidance entit Healthcare Settings," indicated the following gloves and perform h care, if moving from v a clean body site on t	s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of view. to an annual review of its ir program, as necessary. is not met as evidenced iews, observation and staff failed to implement their ies and the Centers for Prevention (CDC) ces when 1 of 1 staff #5) failed to change gloves giene during incontinence nts (Resident #37) reviewed : ase Control and Prevention led, "Hand Hygiene in last reviewed on 1/8/21 g information: Change and hygiene during patient vork on a soiled body site to	F 880	The statements included in the plan correction are not an admission and on not constitute agreement with the alled deficiencies herein. The plan of corre is completed in the compliance of sta and federal regulations as outlined. T remain in compliance with all federal state regulations, the center has take will take the actions set forth in the following plan of correction. The follow plan of correction constitutes the cent allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. NA#5 was educated on 8-9-22 by the Director of Nursing (DON) regarding handwashing/Hand Hygiene, specific moving from a contaminated surface non-contaminated surface. On 08/30/2022, the DON initiated	do eged ction te o and n or wing ter⊡s e ally		

Facility ID: 923063

If continuation sheet Page 79 of 81

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUILDING	G	C	
		345255	B. WING		08/25/2	022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CAROLINA CARE HEALTH AND REHABILITATION				111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CO O THE APPROPRIATE	(X5) MPLETIO DATE
F 880	Continued From page	e 79	F 88	30		
	occurs. The facility's infection "Handwashing/Hand 2015 indicated the fol alcohol-based hand r alcohol; or, alternative non-antimicrobial) an situations: h. Before body site to a clean b care; i. After contact v An observation of inc Aide (NA) #5 on Resi 8/9/22 at 10:53 AM. hand sanitizer to both gloves on before star proceeded to unfaste turned her towards he #37 held on to the sid stool off Resident #37 disposable wipe using hand supported Reside removing her gloves, Resident #37's drawe of moisture barrier cro left hand, and applied #37's buttocks with he new brief underneath then rolled her onto h wipe her front perinea wipe using her left ha brief, replaced Reside re-adjusted her bed. plastic bag and remov	a control policy entitled, Hygiene," revised in August llowing statements: Use an ub containing at least 62% ely, soap (antimicrobial or d water for the following moving from a contaminated ody site during resident with blood or bodily fluids. ontinence care by Nurse dent #37 was made on NA #5 was observed using n hands prior to putting ting the procedure. NA #5 n Resident #37's brief and er right side. While Resident der rail, NA #5 started to clean 7's buttocks with a g her left hand while the right dent #37's back. Without NA #5 reached into er with her right hand for a jar eam, opened the lid with her a the cream to Resident er left hand. She placed a Resident #37's bottom and er back and proceeded to al area with a disposable ind. She fastened the new ent #37's covers and NA #5 placed the trash in a ved gloves from both hands. ish and then used hand		education on all Nursing certified nursing assistar aides, licensed practical registered nurses were e appropriate hand hygien include contaminated surfact completed hand hygiene Any members of nursing complete this education by 09/20/2022, will not b until complete. This edu washing observation will the new hire orientation. The Staff Development C and Unit Managers will c members on hand hygie incontinence care weekly then 5 staff members we weeks then 2 staff memb 4 weeks. The DON will bring the re audits to the Quality Ass Committee monthly time months. The Quality Ass committee will evaluate t of the above plan and wi interventions based on tt ensure continued compli Date of Compliance: 09/2	ats, medication nurses, and educated on e processes, to rfaces to ces. The DON observations. staff who did not and observation e allowed to work cation and hand be included in Coordinator, DON observe 10 staff ne during y times 4 weeks weekly times 4 bers weekly times esults of these urance s 3 consecutive surance the effectiveness Il make additional ne audits to ance.	
		ls. #5 on 8/9/22 at 2:15 PM				

If continuation sheet Page 80 of 81

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/21/2022 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345255	B. WING		_	C 08/2	; 25/2022
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAROLIN	A CARE HEALTH AND R	EHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 280	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	BPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	revealed she normally to back but if the resid movement, she would off the buttocks first. should have changed for the barrier cream i wiping Resident #37's stated this was what s do when doing incont forgot to change her g in between touching of surfaces. An interview with the who was also the Infe 8/11/22 at 2:43 PM re started doing incontin perineal area and the have never reached in contaminated gloves, off her gloves and wa touching between dirt DON stated she need	y did perineal care from front dent had a bowel d wipe the bowel movement NA #5 stated she probably her gloves prior to reaching in the drawer and before s front perineal area. NA #5 she had been educated to inence care and she just gloves and do hand hygiene contaminated and clean Director of Nursing (DON) ection Preventionist on evealed NA #5 should have ence care from the front n to the back. She should	F 8	80			

If continuation sheet Page 81 of 81