	-	ID HUMAN SERVICES				FORI	M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			E SURVEY PLETED	
			A. BUILDING				
		345325	B. WING				C
		545525	D. WING			11	/09/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				711 SUSAN TART ROAD		
					DUNN, NC 28335		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
PREFIX TAG	, ,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
			1				
F 000	INITIAL COMMENTS	;	F	000			
	A complaint ivestigat	ion survey was conducted					
	from 11/08/22 throug	•					
	ID:#RZWE11.						
	The following intakes						
	NC00192316; NC00193642; NC00194304;						
	-	194567; NC00194649; and					
		(3) of the 21 complaint					
	allegations were substantiated resulting in deficiencies.						
F 583			F	583	3		12/7/22
SS=D	CFR(s): 483.10(h)(1)	-	· · ·	000	, 		12/1/22
	§483.10(h) Privacy a	nd Confidentiality.					
	-	ght to personal privacy and					
		or her personal and medical					
	records.						
	§483.10(h)(l) Persona	al privacy includes					
		edical treatment, written and					
		ations, personal care, visits,					
		ly and resident groups, but					
	this does not require	the facility to provide a					
	private room for each	resident.					
		cility must respect the					
		sonal privacy, including the or her oral (that is, spoken),					
		c communications, including					
		promptly receive unopened					
	mail and other letters						
	materials delivered to	the facility for the resident,					
		ered through a means other					
	than a postal service.						
	\$402 10/h)/2) The	aident has a right to secure					
		sident has a right to secure onal and medical records.					
		he right to refuse the release					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		_	TITLE		(X6) DATE
Electroni	cally Signed						12/02/2022

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/08/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
	345325		B. WING			C 11/09/2022	
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CARROLTON OF DUNN					11 SUSAN TART ROAD JUNN, NC 28335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	Continued From page	e 1	F	583			
	-	ical records except as					
		i)(2) or other applicable					
	federal or state laws.						
	(ii) The facility must a	allow representatives of the					
	Office of the State Lo	ng-Term Care Ombudsman					
		t's medical, social, and					
	administrative record	s in accordance with State					
	law.						
		Γ is not met as evidenced					
	by:				5500		
		iew, observation and staff			F583		
	-	 failed to provide privacy residents (Resident #2) 			Carrolton of Dunn acknowledges rece	vint	
		s' rights when Nurse #1			of the Statement of Deficiencies and	iμι	
		omy care to Resident #2 with			proposes this Plan of Correction to th	e	
	-	etely open to the hallway			extent that the summary of findings is		
		visible from the hall. The			factually correct and in order to maint		
	-	oncept was applied to this			compliance with applicable rules and		
		als have the expectation of			provisions of quality of care of resider	nts.	
	privacy within their ho	ome environment.			The Plan of Correction is submitted a	sa	
					written allegation of compliance.		
	Findings included:						
					Carrolton of Dunn⊡s response to this		
		nitted to the facility on			Statement of Deficiencies does not	6	
	8/24/2022 with respir	atory failure.			denote agreement with the Statemen Deficiencies nor does it constitute an		
	The admission Minim	num Data Set (MDS)			admission that any deficiency is accu	rate	
		24/2022 indicated Resident			Further, Carrolton of Dunn reserves t		
	#2 was comatose, a				right to refute any of the deficiencies		
		a prolonged period) and			this Statement of Deficiencies through		
	received tracheostom				Informal Dispute Resolution, formal		
					appeal procedure and/or any other		
		p.m. Resident #2 was			administrative or legal proceeding.		
		room lying in the bed with					
		the room. Nurse #1 was			Immediate action(s) taken for the		
		n the right side of Resident			resident(s)		
		acheostomy care with the			found to have been affected include:	000	
		Nurse #1 left shoulder			1. Nurse #1 was counseled on 11/7/2		
	completely open to the	ne hallway. The head of			regarding leaving the door open durir	g	

Facility ID: 923073

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 11/09/2022
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 583	Resident #2's bed wa degrees, and she wa residents passing the On 11/7/2022 at 2:06 Nurse #1, she stated care was provided by asked why Resident a during tracheostomy think about closing th On 11/7/2022 at 2:20 Director of Nursing (E present, the DON stat tracheostomy resided privacy was provided	as elevated close to 90 s visible to staff and e doorway. p.m. in an interview with privacy during Resident #2's r closing the door. When #2's door was not closed care, she stated she did not e door. p.m. in an interview with DON) with the Administrator ted residents with d in private rooms, and by closing the door. She door should had been	F 583	 tracheostomy care. Formal re-will be conducted with nurse #1 regar resident privacy on 11/29/22. 2. Administrative staff member in serviced during a staff meet 11/10/22 regarding resident privacy for a residents, including resident #2. Action taken/systems put into reduce the risk of future occurrence include 1. Mandatory in-services for 10 licensed nurses to include Nur be conducted 11/14/22 through 12 In-services included: " Resident Privacy and Confid- " Providing privacy during care tracheostomy care 2. Direct observation of all resi receiving tracheostomy care in Resident #2 will be performed by admin nurses to ensure the licensed nurse is p privacy during tracheostomy care inclu- closing the room door and pulling the priva- 3. Licensed nurses all shifts w 	rding rs were eting on all place to de: 00% of all rse #1 will 2/7/22. entiality e to include idents ncluding uistrative roviding uding acy curtain.

Facility ID: 923073

If continuation sheet Page 3 of 35

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION				
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· · ·	A. BUILDING				
			5.14410	С				
		345325	B. WING		11/09/202			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
THE CARROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPL			
F 583	Continued From page	e 3	F 583	 monitored using the Resident Priv Monitoring tool from 11/28/22 through 12/7/20 areas of concern identified during the mo- will be immediately addressed and nurse providing additional training. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. All residents to include Residen requiring tracheostomy care will be monitored by administrative nurses using the Re Privacy Monitoring tool to ensure all trache care is provided in a private environme room doors closed and privacy curtains in semi⊡private rooms. 2. Monitoring will continue 3 times for 4 weeks, then once weekly for weeks. Any areas of concern identified during monitoring 	22. Any ponitoring s will be e t #2 esident eostomy nt with pulled weekly 4			
				process will be addressed immedi and additional staff training will be con- as needed. The DON will review and the Resident Privacy Monitoring tool v during	ducted			

Event ID: RZWE11

Facility ID: 923073

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			
		345325	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/09/2022	
THE CARROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRID		BE COMPLETIC	
F 583	Continued From page	e 4	F 583	3		
F 655 SS=D	CFR(s): 483.21(a)(1) §483.21 Comprehens Planning §483.21(a) Baseline §483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla (i) Be developed with admission.	sive Person-Centered Care Care Plans cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care.	F 653	 3. The Administrator and/or designed present the findings of the Resident Privacy Monitoring tool to the Quality Assuration and Performance Improvement (QAPI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addrest by implementing changes as necessary include continued frequency of monitoring. 4. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to plan of correction. 	nce ssed , to	

Event ID: RZWE11

Facility ID: 923073

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 11/09/2022	
		345325	B. WING				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD		
					DUNN, NC 28335		1
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 655	 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommediates (F) PASARR recom	ted to- d on admission orders.	F	655		in ts.	

Event ID: RZWE11

Facility ID: 923073

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2022 MAPPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 11/09/2022		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				7	11 SUSAN TART ROAD			
THE CAR	ROLTON OF DUNN			C	DUNN, NC 28335			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 655			F	655	written allegation of compliance.			
F 655	 55 Continued From page 6 1. Resident #1 was admitted on 10/7/2022 with diagnoses including respiratory failure and a tracheostomy. The baseline care plan for Resident #1 initiated on 10/7/2022 revealed no focus for tracheostomy care. The admission Minimum Data Set (MDS) assessment dated 10/14/2022 indicated Resident #1 was cognitively intact and received tracheostomy care and suctioning. On 11/7/2022 at 11:54 a.m. in an interview with the Regional Nurse Consultant, she stated the MDS nurse initiated the baseline plan within forty-eight hours of admission, and tracheostomy care should had been included on the baseline care plan. On 11/8/2022 at 10:04 a.m. in an interview with the MDS Nurse, she stated the baseline care plan was initiated by the Director of Nursing (DON) on 10/7/2022 and did not include tracheostomy care. She stated baseline care plans were not completed due to MDS staff were being pulled 							
	the DON, she stated only be initiated by a initiate the care plan f the MDS nurse was n the baseline care plan triggered in the admis MDS staff frequently	sion assessment. Due to			risk of future occurrence include: 1. Mandatory in-services for 100% of a licensed nurses to include Nurse #1 wi be conducted 11/14/22 through 12/7/22. In-services included: " Resident Privacy and Confidentiality " Providing privacy during care to include	II		

Facility ID: 923073

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 11/09/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	THE CARROLTON OF DUNN		7	11 SUSAN TART ROAD	
			OUNN, NC 28335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 655	Continued From page	<u>a</u> 7	F 655		
	unable to complete ca		1 000	tracheostomy care.	
	10/19/22 with diagnos and muscle weakness Review of Resident #	ses that included dementia		2. The interdisciplinary care plan members (MDS Coordinator, MI Social Worker (SW), Dietary Manager, Director	DS Nurse,
	"Communication to N	ed a document labelled ursing" dated 10/20/22 v which stated Resident #3		Director, DON, and Administrator) and lic nurses were in-serviced on 11/14/2022 Facility Nurse Consultant in regards the	by the
	(MDS) assessment da was assessed as hav	ion Minimum Data Set ated 10/26/22 revealed he ring a moderate cognitive ot have a history of falls.		care plans requirements and the Car Baseline Care Plan Policy.	
	Consultant on 11/7/22 baseline care plan sh	vith the Regional Nurse 2 at 3:06 PM, she stated the ould have reflected the ed by therapy regarding		3. All newly hired MDS Coordina MDS Nurses, Social Workers (S Dietary Managers, Activity Directors, an nurses will be in-serviced during orientation by	SW), d licensed
	on 11/8/22 at 11:30 A	ducted with the MDS Nurse M she reported she did not e care plan for Resident #3.		the ADON/DON regarding base plan requirements and the Carrolton Care	
	Attempts to contact th Resident #3's baselin unsuccessful.			Plan Policy to include care plan residents for tracheostomy care and/or fall pr as	-
	on 11/8/22 at 11:48 at baseline care plan sh	vith the Director of Nursing m she stated Resident #3's ould have reflected his fall MDS nurse was responsible		applicable. How the corrective action(s) will monitored to	be
	for completing the bas items triggered on the Due to the MDS staff	seline care plan based on admission assessment. frequently covering nursing		ensure the practice will not recu 1. 10 % of all new admits will be	e reviewed
	assignments, she sta	ted the MDS staff were		by the administrative nurses to e	ensure

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION			
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
					С		
		345325	B. WING		11/09/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARROLTON OF DUNN				DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO		
F 655	Continued From pag	e 8	F 655				
	unable to complete o			 accuracy and timely completion of base line plans, including addressing tracheostom weekly X 4 weeks and monthly X 1 month the Care Plan Accuracy Monitoring to Areas of concern identified during monitoring will be immediately addressed by DON to include staff retraining and/or base care plan revision. The MDS coordinator or MDS nurred update the care plan during the audit for a identified areas of concerns. 2. The DON will review and initial Plan Accuracy Monitoring tool weeks and monthly X 1 month to ensure completion and that all areas of concerns have addressed. 3. The Administrator and/or design present the findings of the Care Plan curacy Monitoring tool to the Quality Assurement (QAPI) 	y care, n utilizing ol. the the eline se will any the Care ekly X 4 re been nee will lan		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325		B. WING		C 11/09/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2022
THE CAR	THE CARROLTON OF DUNN			11 SUSAN TART ROAD UNN, NC 28335	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 655 F 656 SS=D	CFR(s): 483.21(b)(1)(§483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identifi assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483.2	Comprehensive Care Plan (3) ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive mprehensive care plan must ()- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse	F 655	Any issues, concerns, and/or trend identified will be addressed by implementing changes as necessary, to include continued fre of monitoring. 4. The Administrator and the DON responsible for the implementation corrective actions to include all 100% audits, in-services, and monitoring related to the plan correction.	equency will be n of

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING				C 09/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				7	711 SUSAN TART ROAD		
	ROLTON OF DUNN			1	DUNN, NC 28335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	 (iii) Any specialized services provide as a result of recommendations. If a findings of the PASAF rationale in the residet (iv)In consultation with resident's representation (A) The resident's goad desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. §483.21(b)(3) The set by the facility, as outlic care plan, must- (iii) Be culturally-composite facility failed to develor individualized care pear a resident receiving to the facility for the section for 2 of 10 residents receiving the facility failed to develor individualized care pears. Findings included: 1. Resident #1 was and diagnoses including receiving the facility for the facility for the facility for the facility for the section. 	ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate use. In the comprehensive care in accordance with the in paragraph (c) of this rvices provided or arranged ined by the comprehensive petent and trauma-informed.	F	656	Carrolton of Dunn acknowledges rece of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to mainta compliance with applicable rules and provisions of quality of care of residem The Plan of Correction is submitted as written allegation of compliance. Carrolton of Dunn □s response to this Statement of Deficiencies does not	in ts. a	
						of	

Facility ID: 923073

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING	B. WING			C 109/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7.	11 SUSAN TART ROAD		
THE CARF					UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F	656	Deficiencies nor does it constitute an	- 4 -	
	The admission Minimum Data Set (MDS) assessment dated 10/14/2022 indicated Resident #1 was cognitively intact and received tracheostomy care and suctioning. The comprehensive care plan dated 10/21/2022 for Resident #1 revealed no focus for				admission that any deficiency is accura Further, Carrolton of Dunn reserves the right to refute any of the deficiencies of this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	е	
	the Regional Nurse C tracheostomy care sh the comprehensive ca	ould had been included on are plan.			F656 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident #1 was discharged from th facility on 10/28/2022.	е	
	the MDS Nurse, she s comprehensive care p 10/21/2022 and did no care. She stated due	olan was completed on ot include tracheostomy to MDS staff working weekly, comprehensive			2. Resident #3 comprehensive care pla was revised to reflect fall precautions of 11/7/2022 by the Minimum Data Set (MDS) nurse.		
	On 11/8/2022 at 11:48 the DON, she stated to responsible for complicate plans. Due to MI nursing assignments, were unable to compliant 2. Resident #3 was a 10/19/22 with diagnost and muscle weakness Review of Resident # 10/20/22 revealed not	B p.m. in an interview with the MDS nurse was eting the comprehensive DS staff frequently covering she stated the MDS staff ete care plans. admitted to the facility on ses that included dementia s. 3's care plan dated			Action taken/systems put into place to reduce the risk of future occurrence include: 1. A 100% audit of all comprehensive of plans was initiated on 11/11/2022 by th corporate nurse consultant, to ensure accuracy of comprehensive care plans, including addressing tracheostomy care and fall precautions applicable will be completed by 12/7/20 Any deficient care plans will be immediately	ie s as	
		ursing" dated 10/20/22 which stated Resident #3			addressed by the Director of Nursing (DON) and/ or the Assistant Director of Nursing		

Facility ID: 923073

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 11/09/2022	
		345325					
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				71	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	(MDS) assessment da was assessed as hav impairment. He did n During an interview w Consultant on 11/7/22 care plan should have completed by therapy risk. An interview was con- on 11/8/22 at 11:30 A #3's care plan should She reported she add plan on 11/8/22. The unable to complete co- due to MDS staff bein complete nursing task On 11/8/2022 at 11:48 the DON, she stated to responsible for compl care plans. Due to MI	ion Minimum Data Set ated 10/26/22 revealed he ing a moderate cognitive ot have a history of falls. At 3:06 PM, she stated the ereflected the assessment regarding Resident #3's fall ducted with the MDS Nurse M she reported Resident have included his fall risk. led his fall risk to his care MDS Nurse stated she was omprehensive care plans ig pulled to the floor to ks weekly. B p.m. in an interview with the MDS nurse was eting the comprehensive DS staff frequently covering she stated the MDS staff	F	656	 (ADON) to include additional staff training regardin accurate completion of comprehensive care plans and the Carrolton Comprehensive Care Plan Policy and/or revision of the comprehensive care plan to reflect tracheostomy care and/or fall precautions. 2. An in-service for the interdisciplinary care plan team members (Dietary manager, MDS Nurse, Social Services Director, Activit Director, Director of Nursing (DON) and Administrator) and all licensed nurses be initiated by the Facility Nurse Consulta on 11/14/2022 regarding requirements for accurately and timely completion of a comprehensicare plan for each resident to include tracheostomy care, to be completed by 12/7/2022. Any licensed nurses not receiving the in-service during this time will be educated on the in-service prior to working their next scheduled sl by the DON. All newly hired IDT care plan team 	e , ies d will nt sive	
					members and licensed nurses will receive the in-serv during	ice	

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Facility ID: 923073

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED FORM APPROVED OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345325	B. WING		11/09/2022
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CARE	OLTON OF DUNN			711 SUSAN TART ROAD	
				DUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 656	Continued From pag	e 13	F 65	 orientation by the Facility Nurse Consultant and/ or the DON. How the corrective action(s) with monitored to ensure the practice will not rected a structure the practice will not rected and the practice will be immediately reflect the resident to include tracheostomy care and timely completion utilizing the prevised immediately preserves and the prevised immediately by the previ	II be ur: lans will be monthly x rses and/or blans the Care team the care DON for ed during ial the Care weekly x 4 npliance
				3. The Administrator and/or des present the findings of the Care	

Event ID: RZWE11

Facility ID: 923073

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE COMF	SURVEY	
	345325		B. WING			C	
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/	09/2022	
				711 SUSAN TART ROAD			
THE CAR	ROLTON OF DUNN			DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
	Respiratory/Tracheos	e 14 stomy Care and Suctioning	F 650	 Accuracy Monitoring tool to the Quality Assiand Performance Improvement (QAPI Committee monthly for 3 months. Any issues, concerns, and/or trendidentified will be addressed by implementing chas necessary, to include continued for of monitoring. 4. The Administrator and the DON responsible for the implementation corrective actions to include all 100% audits in-services, and monitoring related to the plan correction. 	l) nds nanges requency V will be n of	12/7/22	
SS=D	The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compre- care plan, the resider and 483.65 of this sul- This REQUIREMENT by: Based on record revi	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. is not met as evidenced iew and staff interviews, the de tracheostomy care as		Carrolton of Dunn acknowledges of the Statement of Deficiencies a proposes this Plan of Correction t	and		

Event ID: RZWE11

Facility ID: 923073

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	ΓIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED	
		345325	B. WING			C 11/09/2022		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARROLTON OF DUNN				D	DUNN, NC 28335			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
					DEFICIENCY)			
F 695	15		F	695				
	reviewed for tracheos	tomy care. (Resident #1)			extent that the summary of findings is			
	<u>-</u>				factually correct and in order to mainta	in		
	Findings included:				compliance with applicable rules and provisions of quality of care of resident	•		
	Resident #1 was adm	nitted to the facility on			The Plan of Correction is submitted as			
		oses including respiratory			written allegation of compliance.			
	failure and tracheosto							
					Carrolton of Dunn⊡s response to this			
		ed 10/7/2022 stated to			Statement of Deficiencies does not			
		ne inner cannula of the			denote agreement with the Statement	tc		
	occlusion and to char	rery shift and as needed for			Deficiencies nor does it constitute an admission that any deficiency is accura	ate		
	dressing every shift.				Further, Carrolton of Dunn reserves the			
	5,				right to refute any of the deficiencies or			
		um Data Set (MDS) dated			this Statement of Deficiencies through			
		Resident #1 was cognitively			Informal Dispute Resolution, formal			
		ing oxygen, suctioning and			appeal procedure and/or any other			
	tracheostomy care.				administrative or legal proceeding.			
	There was not a focus	s for tracheostomy care			F695			
	included on the care	-						
					Immediate action(s) taken for the			
		edication Administration			resident(s)			
		ed tracheostomy care was erformed on 10/11/2022.			found to have been affected include:			
	not documented as p				1. Resident #1 was discharged from th	e		
	On 11/8/2022 at 9:19	a.m. in a phone interview			facility on 10/28/22.	-		
	with Nurse #3, she sta							
		m tracheostomy care to			2. On 11/28/22, Nurse #3 was counsel	əd		
		/2022 during the 7:00 p.m.			and educated on the proper way to			
		e stated she suctioned I did not change the inner			administer			
	cannula of the trache				tracheostomy care as ordered by the physician;			
	tracheostomy dressin				appropriate and accurate documentation	on		
	physician.	<u> </u>			on the			
					EMAR (electronic medical administration	on		
		p.m. in an interview with the			record).			
		he stated Nurse #3 should						
	nave performed trach	eostomy care for Resident			3. All licensed nurses were educated o	n		

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	-	ND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345325	B. WING		11/09/2022			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				711 SUSAN TART ROAD				
THE CAR	ROLTON OF DUNN			DUNN, NC 28335				
(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 COMPLETIC			
F 695	Continued From pag #1 as prescribed by		F 69		y the ocument inistration and will be ork until of the ocument inistrate are checklist ill receive ures for e. or the DON ace to lude: or will initial of the ocument initial			
			WF11	counseled and educated on the way to administer tracheostomy care as by				

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345325	B. WING		C 11/09/2022	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				711 SUSAN TART ROAD		
THE CARR	OLTON OF DUNN			DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETIO ATE
F 695	Continued From page	e 17	F 69		electronic mies were rve the d intact e were no tiated on ey of orders, ion, inner ange on 12/6/22. ucated on histering by the document hinistration 2 and will be vork until	
				competence on tracheostomy		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345325		B. WING		C 11/09/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD		
				DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 695	Continued From page	e 18	F 69	 5 utilizing the Tracheostomy Care Validation Cheby 12/6/22. 7. New clinical staff members will reducation on the proper procedure administering tracheostomy care. Orientation will be completed by th and / or ADON. Nurses will not be allowed to work they have completed the in-service training. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Utilizing the Tracheostomy Care Validation Checklist, tracheostomy for all trach patients will be observed and monitored to ensure that tracheostomy care is p in a private environment utilizing prope technique per MD order. This will occur 3 x per w four weeks. Areas of concern will be addressed immediately by the ADON / DON and nurses wi receive immediate education to correct bef and technique. 	eceive s for e DON until care rovided r eek for d	

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Facility ID: 923073

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345325	B. WING _			C 11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER		[ST	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2022
THE CAR	THE CARROLTON OF DUNN			71	11 SUSAN TART ROAD		
				D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	≥ 19	F	595	 Utilizing the Tracheostomy Care Validation Checklist, beginning the fifth week, monitoring will continue once weekly fo weeks. Any areas of concern identified durin the monitoring process will be addresse immediately and additional staff training will be conducted as needed. The DON and Administrator will revie and initial the Resident Privacy Monitor tool weekly during the monitoring proce The DON and/or designee will prese the findings of the to the Administrator a Quality Assurance and Performance Improvement (QAPI) Committee month for 3 months. All issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued 	er 4 ed ew ring ess. nt and	
F 726 SS=D	Competent Nursing S CFR(s): 483.35(a)(3)		F7	726	frequency of monitoring.		12/7/22
	the appropriate comp provide nursing and r resident safety and a	vices e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial					

Facility ID: 923073

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	-	D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI F	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
				_		(c
		345325	B. WING			11/	09/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN			7	11 SUSAN TART ROAD		
				D	DUNN, NC 28335		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page	20	F	726			
	- 15	sident, as determined by		120			
		and individual plans of care					
	and considering the n	umber, acuity and					
		ity's resident population in					
		acility assessment required					
	at §483.70(e).						
	§483.35(a)(3) The fac	cility must ensure that					
		the specific competencies					
		ary to care for residents'					
	needs, as identified th						
	assessments, and de	scribed in the plan of care.					
	8483 35(a)(4) Providi	ng care includes but is not					
		evaluating, planning and					
	-	t care plans and responding					
	to resident's needs.						
	S400 05(a) Drafiaiana						
	§483.35(c) Proficienc	y of nurse aldes. Ire that nurse aides are able					
	to demonstrate comp						
	techniques necessary						
	needs, as identified th						
		scribed in the plan of care.					
		is not met as evidenced					
	by: Record on record rovi	ow and staff interviewe the			Corrolton of Dunn ocknowlodges ross	int	
		ew and staff interviews, the te nursing staff and verify			Carrolton of Dunn acknowledges rece of the Statement of Deficiencies and	ιρι	
		e respiratory care needs for			proposes this Plan of Correction to the		
	1 of 2 residents (Resi				extent that the summary of findings is		
	tracheostomy care.				factually correct and in order to mainta	in	
					compliance with applicable rules and		
	Findings included:				provisions of quality of care of resident		
	Resident #1 was adm	uitted to the facility on			The Plan of Correction is submitted as	а	
	Resident #1 was adm	bses of respiratory failure			written allegation of compliance.		
	and tracheostomy.				Carrolton of Dunn⊡s response to this		
					Statement of Deficiencies does not		
	Physician orders date	ed 10/7/2022 revealed to			denote agreement with the Statement	of	

Facility ID: 923073

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		ND HUMAN SERVICES				FOF	ED: 12/08/2022 RM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION		IO. 0938-0391 E SURVEY
AND PLAN OF CORRECTION			A. BUILDING			COMPLETED	
		345325	B. WING			1	C 1/ 09/2022
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/09/2022
					SUSAN TART ROAD		
THE CARI	ROLTON OF DUNN				INN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 726	Continued From non	- 01		~			
F 720	Continued From page		F 72	26			
	0	he inner cannula of the			Deficiencies nor does it constitute an	-	
	-	very shift and as needed for			admission that any deficiency is acc Further, Carrolton of Dunn reserves		
	dressing every shift.	nge the tracheostomy			right to refute any of the deficiencies		
	areasing every shint.				this Statement of Deficiencies through		
	A review of October 2	2022 Medication			Informal Dispute Resolution, formal	J.,	
	Administration Recor				appeal procedure and/or any other		
	documentation of trac provided to Resident	cheostomy care was			administrative or legal proceeding.		
					F726		
		ational classes revealed					
		ersonnel provided classes on			Immediate action(s) taken for the		
		nd 9/2/2022 and attendees			resident(s) found to have been affected include	:	
		#4 and Nurse #5 that			1. Desident #1 was discharged from	the e	
		ident #1. Education class Iled Nurse #1 and Nurse #3,			1. Resident #1 was discharged from facility on 10/28/2022.	lne	
		ostomy care to resident #1,					
	attended the tracheos				Action taken/systems put into place reduce	to	
		lurse #1 on 11/7/2022 at she had worked with			the risk of future occurrence include:	:	
	tracheostomy resider	nts prior to her employment had received training on			1. On 11/14/22, A contracted Respire Therapist completed training and	atory	
		ostomy care and attended a			completion of		
		ass on tracheostomy care at			the tracheostomy care skills validation	on/	
	the facility.				competency check off with return		
	In a phone interview	with Nurse #4 or 11/7/2022			demonstration	ina	
	•	with Nurse #4 on 11/7/2022 ed she did not receive			to include all licensed nurses, includ Nurse #	ing	
	-	aining from the facility at			4 and Nurse #5.		
	-	ed when she was assigned to					
		ed a registered nurse to			2. On 11/14/2022, an in-service was		
		perform tracheostomy care.			initiated with all license nurses, by a contracted		
	In a phone interview	with Nurse #5 on 11/8/2022			Respiratory Therapist on providing		
	at 8:58 a.m., she stat	ed she had been employed			tracheostomy		
		months. She stated she did			care as ordered by the physician. The	ne	
	not recall tracheostor	ny care as part of orientation			in-service		

Facility ID: 923073

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325			` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		B. WING		1	C 11/09/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
	ROLTON OF DUNN			711 SUSAN TART ROAD		
				DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 726			F 7		4: 414	
		e tracheostomy care class to having a scheduled		also addressed the expecta documentation must be pre- Medication Administration R after	sent on the	
	at 9:19 a.m., she stat	with Nurse #3 on 11/8/2022 ed the facility started vith tracheostomy tubes in		The in-service will be compl 12/7/2022.		
	the last four months. one class on tracheo	She stated she attended stomy care and did not		No licensed nurse will be all until		
	part-time.	ass. She stated she worked		receiving the in-service and successful return demonstra tracheostomy		
		8 a.m. in an interview with ng (DON), she stated the staff development		care skills validation. All newly hired licensed nur complete the	ses will	
	corporate level. She	ation was conducted at the stated orientation of new Tuesday, and corporate		tracheostomy care in-servic successful return demonstra tracheostomy		
	personnel came to th employees on their c	e facility to checkoff the new ompetencies. In a follow-up 22 at 12:30 p.m. with the		care skills validation during process as provided by the Therapist		
	DON, she stated the for the staff on trache	facility had provided classes ostomy care, and there		and/or the Director of Nursin Assistant Director of Nursin		
	the nursing staff.	es for tracheostomy care for		How the corrective action(s) monitored to	-	
		p.m. in an interview with the strator present, the DON had attended the		ensure the practice will not 1. 10% of licensed nurses to		
	increase of residents	eld on 9/2/2022 and with the with tracheostomy tubes in g staff should have had a		Nurse #4 and Nurse #5 will be mo competency in providing tra		
		f on tracheostomy care.		care by the ADON, treatment nurse, resource	-	
				nurses utilizing the Tracheo Validation Checklist weekly then	-	

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Facility ID: 923073

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325		B. WING		C 11/09/2022
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CAR	THE CARROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 726	Continued From page	23	F 72	6	
				 2. This skills validation will verify th " tracheostomy care is performed p order and policy and procedure, " assessments have been complet protocol, " documentation is completed on th and " the tracheostomy site is clean an free. Areas of concern identified during audit will be addressed immediately by the ADON/DON to include MD notification, assessment affected resident, and/or providing additionation retraining. 3. The administrator and/or design present the findings of the Tracheo Care Validation Checklist to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI Committee will review the audit results monthly for months and review the Tracheostomy Care Val Checklist to determine trends and/ issues that may need further interventions put place and to determine the need for further frequency of monitoring. 	eer MD ed per he MAR d odor the nt of al eee will ostomy r 3 idation or

Event ID: RZWE11

Facility ID: 923073

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 11/09/2022
IAME OF PI	ROVIDER OR SUPPLIER	l	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
HE CARI	ROLTON OF DUNN			11 SUSAN TART ROAD JUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLÉTIC
F 726	Continued From page	≥ 24	F 726	4. The administrator and DON w responsible for the implementati corrective actions to include all 100% audit services, and monitoring related to the pla correction.	on of s, in
F 745 SS=E	CFR(s): 483.40(d) §483.40(d) The facilit medically-related soc maintain the highest p and psychosocial wel	y Related Social Service y must provide ial services to attain or practicable physical, mental I-being of each resident.	F 745		12/7/22
	physician interviews, an appointment with a nose and throat docto physician for a reside (Resident #1) and co appointments and tra neurologist for a reside	nt with a tracheostomy ordinate follow up nsportation with the dent after craniotomy surgery 2 residents reviewed for		Carrolton of Dunn acknowledge of the Statement of Deficiencies proposes this Plan of Correction extent that the summary of findir factually correct and in order to r compliance with applicable rules provisions of quality of care of re The Plan of Correction is submit written allegation of compliance.	and to the ngs is maintain and esidents. ted as a
	10/7/2022 with diagno failure. The admission Minim 10/14/2022 indicated	dmitted to the facility on oses including respiratory um Data Set (MDS) dated Resident #1 was cognitively ing tracheostomy care.		Carrolton of Dunn □s response to Statement of Deficiencies does in denote agreement with the State Deficiencies nor does it constitut admission that any deficiency is Further, Carrolton of Dunn reser right to refute any of the deficien this Statement of Deficiencies the Informal Dispute Resolution, for appeal procedure and/or any oth administrative or legal proceedir	not ement of te an accurate. ves the cies on rough mal ner

Event ID: RZWE11

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/08/2022 A APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		345325	B. WING				/09/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD UNN, NC 28335		
(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	Continued From page	e 25	F	745			
	order to arrange for a	in appointment for Resident gologist on 10/24/2022.		1 10	F745		
	Emergency Room for tracheostomy. In an interview with th 8:33 a.m., she stated communicated reside needed to be schedu written note and was requesting her to mal appointment for Resid In an interview with N 8:58 a.m., she stated scheduling the otolary because the order was she gave the Director the order on the morr appointment could be In an interview with th 12:05 p.m., he stated see the otolaryngolog proceed in decannula tracheostomy in the r not know why the app scheduled. He stated working on a planned	was discharged to the possible decannulation of the Scheduler on 11/8/2022 at the nursing staff ent appointments that led verbally or left her a unable to recall anyone ke an otolaryngologist dent #1. Jurse #5 on 11/8/2022 at there was no way to yngologist appointment as written on a weekend, and of Nursing (DON) a copy of ning of 10/24/2022 so the e scheduled. The Physician on 11/8/2022 at the wanted Resident #1 to gist for guidance on how to ation of Resident #1's nursing home setting and did pointment was not the knew the DON was d discharge for Resident #1 y facility as well, and the			Immediate Action Taken for the resident(s) found to have been affected: The facility will provide medically relat social services to attain and maintain Highest practicable physical, mental, and psychosocial well-being of each patient. 1. Resident # 1 has an appointment w Vidant Neurology on December 13, 2 His mother (responsible party) and sis will accompany him to the appointment. Actions taken to reduce the risk of fut occurrence include the following: 1. An in-service regarding timely follow of ordered appointments to include ensuring a date and time for appointment is scheduled, documentation of RR refusals is prese in the progress note, and that the RR or representative from the facility accompanies the patient 2. The scheduler has been counseled	the vith 022. ster ure w up ent	
	discontinued. In an interview with th Administrator present	ne DON with the t on 11/8/2022 at 2:46 p.m.,			notifying the DON, SW, and other care team meml of issues regarding appointments (ex.	pers	
		ngologist appointment was			delays,		

Facility ID: 923073

If continuation sheet Page 26 of 35

	-	D HUMAN SERVICES MEDICAID SERVICES			F	ITED: 12/08/2022 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) [DATE SURVEY OMPLETED
		345325	B. WING		_	C 11/09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
	ROLTON OF DUNN			711 SUSAN TART ROAD		
	CETON OF BONN			DUNN, NC 28335		
(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 CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page	26	F 74	45		
	not made for Residen	t #1, and the facility was nty-four hour respiratory and		timeliness, and fam	ily follow up).	
	#1 for decannulation. family and physician of the family declined the appointment and a pla Emergency Room wa for decannulation of th 2. Resident #5 was a 7/22/22 with diagnose hypertension and left opening into the skull The admission Minim 7/29/22 indicated Res cognitive impairment. Review of a note date Director of Nursing (D neurologist's office wh not be seen if his gua him to his follow-up a An interview was con- Scheduler on 11/8/22 she had attempted to his family members w scheduler stated if far to attend the appointment.	anned discharge to an s scheduled for Resident #1 he tracheostomy. Idmitted to the facility on es that included parietal craniotomy (surgical). um Data Set (MDS) dated sident #5 had significant ed 7/29/22 revealed the DON) spoke with staff at the no stated Resident #5 could rdian could not accompany		residents including Resident i Manager and the Resource N The audit will be co with any identified areas immediately addressed by DON re-scheduling appointments and/o staff training. 4. All upcoming app reviewed by the Dir designee) weekly x 8 weeks, f month, utilizing the Resider Monitoring tool	es for ordered (14/2022 for 100% of #1 by the RN Unit Nurse. ompleted on 11/18/2022 s of concern to include or providing additional pointments will be rector of Nursing (or then monthly x 1	
	notified the DON som scheduling appointme Resident #5 had not b since admission. During an interview w 3:15 PM she reported been difficulties with F	etimes of her difficulty ents. The scheduler verified been seen by his neurologist with the DON on 11/8/22 at I she was aware there had Resident #5 attending		scheduled timely. Areas of concern id monitoring will be immediately add include re schedul and/or providing additional staff train	Iressed by DON to ing appointments ning.	
	scheduled neurology	appointments. She stated		How the corrective	action will be	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2022 MAPPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		LETED
		345325	B. WING _			(11/	C 09/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CARF	ROLTON OF DUNN				11 SUSAN TART ROAD UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745 F 842 SS=B	he was made aware of #5's transportation on expectation is resident appointments. During an interview w 11/8/22 at 3:45 PM he doing well and had no from not being seen b Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a con agrees not to use or of	een explored. ducted with the /22 at 3:20 PM who stated of the issue with Resident 11/7/22. He indicated his its attend outside medical ith the Medical Director on e stated Resident #5 was of had any adverse effects by his neurologist. entifiable Information 483.70(i)(1)-(5) at-identifiable information. elease information that is o the public. lease information that is o an agent only in intract under which the agent lisclose the information		342	monitored: 1. The DON will review and initial the Resident Appointment Monitoring tool weekly for 4 weeks then monthly x 1 month for compliance with timely follow up of scheduled appointments, ensuring cancellations are addressed w follow □ up re-scheduling, if applicable. 2. The Administrator and/or the DON w present the findings of the Resident Appointment Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Issues, concerns, and/or trends identified will be addressed by implementing changes ar necessary, to include continued frequent of monitoring.	ill e ed s	12/7/22
	resident-identifiable to accordance with a con agrees not to use or c	o an agent only in ntract under which the agent					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345325	B. WING			11/	09/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	to do so. §483.70(i) Medical re §483.70(i)(1) In accord professional standard must maintain medicat that are- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The fact all information contain regardless of the form records, except whene (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to he by and in compliance §483.70(i)(3) The fact record information ag unauthorized use. §483.70(i)(4) Medical for-	cords. rdance with accepted Is and practices, the facility al records on each resident ented; e; and ganized ility must keep confidential ned in the resident's records, n or storage method of the release is- ir their resident permitted by applicable law; yment, or health care ted by and in compliance	F	342			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 11/09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
				711 SUSAN TART ROAD	
THE CARROLTON OF DUNN				DUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 842	Continued From page	e 20	F 84	12	
1 042			F O	42	
		ne date of discharge when			
	there is no requireme				
	legal age under State	ars after a resident reaches			
	logal age under State				
	\$483.70(i)(5) The me	edical record must contain-			
		ion to identify the resident;			
		sident's assessments;			
		ive plan of care and services			
	provided;				
	(iv) The results of any	y preadmission screening			
	and resident review e				
	determinations condu				
		e's, and other licensed			
	professional's progre				
		logy and other diagnostic			
		equired under §483.50.			
		Γ is not met as evidenced			
	by:	ious and staff interviews the		Correlton of Dunn colum	ovuladaga ragaint
		view and staff interviews, the		Carrolton of Dunn ackno	-
	facility failed to docur	Resident #1) and wound care		of the Statement of Defic proposes this Plan of Co	
		ered by the physician for 2 of		extent that the summary	
	,	for identifiable information		factually correct and in o	
	on resident records.			compliance with applical	
				provisions of quality of c	
	Findings included:			The Plan of Correction is	
				written allegation of com	pliance.
	1. Resident #1 was a	admitted to the facility on			
		oses including respiratory		Carrolton of Dunn⊡s res	
	failure and tracheost	omy.		Statement of Deficiencie	
				denote agreement with t	
		ed 10/7/2022 stated to		Deficiencies nor does it of	
		he inner cannula of the		admission that any defic	-
		very shift and as needed for		Further, Carrolton of Dur	
		nge the tracheostomy		right to refute any of the	
	dressing every shift.			this Statement of Deficie	-
	The educir -is a Ad			Informal Dispute Resolut	
	i ne admission Minim	num Data Set (MDS) dated		appeal procedure and/or	r any other

Facility ID: 923073

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		MEDICAID SERVICES	I				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED
		345325	B. WING				C 11/09/2022
NAME OF PR	ROVIDER OR SUPPLIER	·		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
THE CARF	ROLTON OF DUNN				1 SUSAN TART ROAD JNN, NC 28335		
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page	e 30	F 84	42			
-	10/14/2022 revealed	Resident #1 was cognitively ving oxygen, suctioning and		12	administrative or legal proceeding.		
	tracheostomy care.				F842		
	The October 2022 M Record (MAR) reveal	edication Administration			Immediate action(s) taken for the resident(s)		
	tracheostomy tube ar	nd tracheostomy care was performed on 10/8/2022 and			found to have been affected include:		
		00 p.m. to 7:00 a.m. shift.			1. Resident #1 was discharged from t facility on 10/28/2022.	the	
	Nursing documentation	on dated 10/21/2022			,		
		I was sent to the Emergency			2. On 11/7/2022, Resident #6 sacral		
		ue to the family's concerns			wound was assessed with documenta	ation	
		be dislodgement. Nursing			in the		
		er revealed, Resident #1			electronic medical record (eMAR) to		
	-	y on 10/22/2022 at 1:15 a.m.			include wound care on the electronic Treatme	ant	
	Emergency Room vis	re was provided during the sit.			Administration Record (eTAR).	ent	
	-	with Nurse #4 on 11/7/2022 ted she provided suctioning			3. On 11/28/22, Nurse #3 was in-serv on the Carrolton Tracheostomy Care	viced	
	and tracheostomy ca				Policy and		
	· · · · ·	ht she had documented			providing tracheostomy care as order	red	
		my care. On 10/21/2022, she			by the	- Cu	
		ed in the nurses notes			physician and documenting on the		
	Resident #1 was sen	t to the Emergency Room,			electronic		
	and tracheostomy ca	re was provided while she			medication administration record (eM	IAR)	
	was at the Emergence	cy Room.			after care is provided.		
	In a phone interview	with Nurse #3 on 11/8/2022					
	-	ted tracheostomy care was			4. On 11/28/22, Nurse #4 was in-serv	viced	
		0/11/2022 because she did			on providing wound care and		
	not have time to prov	rided tracheostomy care to			documenting on		
	•	ne 7:00 p.m. to 7:00 a.m.			the electronic Treatment Administration	on	
		did provide suctioning once			Record		
	to Resident #1 on 10 p.m. to 7:00 a.m. shif	/11/2022 during the 7:00 ft.			(eTAR) after providing wound care.		
	In an interview with th	he Director of Nursing on			5. Administrative staff members were in serviced during a staff meeting or		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DA	TE SURVEY
		345325	B. WING				C 11/09/2022
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				7	11 SUSAN TART ROAD		
THE CARR	OLTON OF DUNN			D	DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	document tracheostor physician on the MAR care for Resident #1. 2. Resident #6 was a 10/11/2021 with a diag The quarterly Minimur assessment dated 6/1 #6 was cognitively int pressure ulcer. Physician orders date order to clean the pre sacrum with wound cl silver alginate to wour dressing daily on the 9/15/2022 to clean sc normal saline and app seven days on the da A review of the Septe Administration Record care was not docume by the physician on 9/ 9/15/2022, 9/16/2022 In an interview with th 11/8/2022 at 2:46 p.m should be provided as and documented on the the care for Resident In an interview with N 3:08 p.m., she stated not present to perform assigned to Resident	n., she stated nurses should my care as ordered by the R after completion of the admitted to the facility on gnoses of pressure ulcer. m Data Set (MDS) 17/2022 indicated Resident act and had an unhealed ed 6/14/2022 revealed an ssure ulcer wound to the eanser, apply collagen and nd bed and cover with foam day shift and an order dated ar to the sacrum with oly a foam dressing daily for y shift. mber 2022 Treatment d (TAR) revealed wound nted as provided as ordered (4/2022, 9/8/2022, , 9/17/2022 and 9/18/2022. the Director of Nursing on h., she stated wound care is ordered by the physician the TAR after completion of #6. urse #2 on 11/8/2022 at when the wound nurse was	F	842	 11/10/22 regarding documentation, including: Action taken/systems put into place to reduce the risk of future occurrence include: 1. A 100% audit of all eMARs and eT for the last 3 months was initiated on 11/25/2022 by the resource nurse to identify omissions to documentation to include tracheostor care and wound care. The audit will be comple by 12/7/2022. Areas of concern identified during the audit will be immediately addressed to ADON/DON to include providing additional training and assessment of the reside affected. 2. New Policy Addition: Carrolton Pol 17.13 Documentation in the Medical Record was added to outline the company sexpectations regarding timely and accurate documentation of identifiable information in the medical record. 3. 100% in-service for all licensed nu was initiated on 11/29/2022 by administrative nurses. The in-service will be compleid by 	ARs ny ted d y the ent cy #	

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2022 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	LETED
		345325	B. WING		11/0))9/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	stated wound care wa on 9/4/2022, 9/8/2022 9/17/2022 and 9/18/2 documented on the T nursing staff divided v the day and night shift verbally communicate	a 32 as provided to Resident #6 2, 9/15/2022, 9/16/2022, 2022 and should have been AR. She stated when the wound care tasks between ft staff, the night shift staff ed the wound care was got to document wound care	F 842	 12/7/2022 and will include: "Carrolton Policy # 17.13 Doct in the Medical Record "Completing tracheostomy car ordered by the physician to include doct on the eMAR after care is provide "Providing wound care as orded include documenting on the electronic wound care is provided. "Policy Review Test 4. All newly hired licensed nurse receive the in-service during of the ADON/DON or Staff Developm personnel. How the corrective action(s) with monitored to ensure the practice will not rec 1. 10% of eMARs to include all with tracheostomies will be mo the administrative nurses weekly x then monthly x 2 months, utilizing the Documentation Monitoring tool concern identified during the mo process will be addressed immediately ADON/ DON to include providing addit training. The DON will review and signal 	re as cumenting d. ered to eTAR after ses will rientation by nent ill be ur: I residents initored by a 4 weeks, ne Care I. Areas of nonitoring by the tional staff	

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	5 FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILT	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
				С	
		345325	B. WING		11/09/2022
NAME OF P	ROVIDER OR SUPPLIER			ZIP CODE	
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIN TO THE APPROPRIATE DATE DIENCY)
F 842	Continued From pag	e 33	F 8	 42 42 42 43. 10% of eTARs to inclusion weeks, then monthly x 2 month 3. 10% of eTARs to inclus #6, will be monitored by nurses weekly x 4 weeks, then months, utilizing the Care Documentation to ensure document care is present on the resident concern identified during process will be address the ADON/DON and/or the include providing additional difference and the ADON/DON and/or the include providing additional difference are the ADON/DON and/or the include providing additional difference are been addressed the ADON/DON and/or the include providing additional difference are and the addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON/DON and/or the include providing additional difference are addressed the ADON difference are addressed the	ring tool weekly x 4 h. lude Resident y administrative n monthly x 2 mentation htation of wound t eTAR. Areas of hg the monitoring sed immediately by resource nurses to ional staff training. r and sign the lonitoring tool x 2 months. hd/or designee s of the Care ring tool to the irance (QA) ommittee will
				6. The Executive QA C review the Care Docum Monitoring tool to determine trend may need further interv determine the need for further mo	nentation s and/or issues that ventions and

Event ID: RZWE11

Facility ID: 923073

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 345325 B. WING 11/09/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335 711 SUSAN TART ROAD DUNN, NC 28335 512			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/202 // APPROVEI). 0938-039
Image: Name of PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE CARROLTON OF DUNN STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE F 842 Continued From page 34 F 842 7. The administrator and DON will be responsible for the implementation of corrective actions to include all audits, in-services, and monitoring related to the 7. The administrator and DON will be	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
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Event ID: RZWE11

Facility ID: 923073

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