PRINTED: 05/17/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTF AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345315	B. WING		C 04/06/2023
	ROVIDER OR SUPPLIER	DN		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	1 0
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	00	
	from 04/03/23 throug FEGS11. The following intakes NC00200204 NC00200421 3 of the 5 complaints Intake NC00200204 immediate jeopardy. Immediate Jeopardy CFR 483.12 at tag Fi K CFR 483.25 at tag Fi K The tags F600 and Fi Quality of Care.	resulted in deficiency. and NC00200421 resulted in was identified at: 600 at a scope and severity 689 at a scope and severity 689 constituted Substandard for F600 began on 03/11/23			
		for F689 began on 02/16/23			
F 600 SS=K	Free from Abuse and	•	F 60	00	4/21/23
	Exploitation The resident has the neglect, misappropria and exploitation as d includes but is not lin corporal punishment	om Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and		TITLE	(X6) DATE

Electronically Signed 04/27/2023

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.

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F 600	\$483.12(a) The facility \$483.12(a) (1) Not us physical abuse, corpinvoluntary seclusion This REQUIREMENT by: Based on staff and robservations, and recto protect two vulners be free from unwanter into personal space that and Resident #2). Resimpaired cognition, however the two vulners be free from unwanter into personal space that and Resident #2). Resimpaired cognition, hown to wander. Or observed by Nurse #1 leaning over her bed shirt near her should apart, and Resident #1 though he was trying mouth. On 3/25/23 Rout for help and when Resident #1 was obsident #1 was obsident #1 was obsident #2 and Resident #2 and	e verbal, mental, sexual, or oral punishment, or is not met as evidenced able female residents right to ed touching and intrusions by Resident #1 (Resident #6 esident #1 was 1 in Resident #6's room with his hands pulling her ers, their faces were inches #1 had his lips pursed as to kiss Resident #6 on her esident #2 was heard calling in staff entered her room erved naked from the waist ent #2's feet. These incidents #1 had a high likelihood of cical injury to the victims.	F 600	F 600 Freedom from Abuse, Neglect, Exploitation Identify those recipients who have suffered, or are likely to suffer, a seric adverse outcome as a result of the noncompliance; and Residents #6 and #2 are the most at r for suffering adverse outcomes based the facility sailure to protect them from the physical abuse and intrusion into their personal space with attempts for inappropriate sexual interactions. Resident #1 is the alleged abuser. All residents are at risk for suffering physical and /or psychosocial harm as result of the deficient practice. Incidents will be reported to the states.	risk I on om		
	from the presence of advancements into the home environment re psychosocial harm we fear, distress, and an	expects to be protected unwanted persons and neir personal space in their esulting in serious ith feelings such as intense xiety. This occurred for 2 of for abuse (Resident #2, and		on 4/4/23. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.			

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		345315	B. WING _		04	C 4/06/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	700/2020	
THE CAR	ROLTON OF LUMBER	TON		1170 LINKHAW ROAD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Resident #1 was four her bed, pulling to be attempting to was removed on 4 and implemented a allegation for IJ rerout of compliance level E (no actual ham minimal harmeducation is complimeted to put into place are effindings included: 1. Resident #1 was 2/1/23 with diagnobehavioral disturbated admission MDS das severely cognitivel physical behaviors of the review period directed at others aperiod. Resident # and locomotion. Hereview period. A Care Plan dated related to Resident #1 will have review period. Goamedications as ord needs, and monito attempt to find an efficiency of the resident and monito attempt to find an efficiency of the review period.	dy (IJ) began on 3/11/23 when bund leaning over Resident #2 her by the shirt and appeared kiss her. Immediate Jeopardy /5/23 when the facility provided and acceptable credible moval. The facility will remain at a lower scope and severity narm with the potential for more that is not IJ) to ensure that eted and monitoring systems effective. Se admitted to the facility on sees that included dementia with ance and anxiety disorder. His ated 2/9/23 indicated he was by impaired. He displayed directed at others 1 to 3 days directed at others 1 to 3 days directed at other to 3 days directed at others 1 to	F	On Tuesday, April 4, 2023 R was relocated to a less populallow for more staff visibility Director of Nursing so (DON) therapy suite, and nursing so This action will diminish wan other resident rooms. Should wandering behavior present would have to cross the centhe presence of the nursing DON soffice, and therapy sold allowing for redirection and in the continue 24 /7 in order to enteresidents are free of adverse related to physical abuse and into their personal spaces. Was previously on 1:1 but was 15 minute checks when the occurred. The monitoring with increased to 24 / 7 the residenting member takes breaks. A full staff mandatory meeting care staff, management staff contracted staff was held on at 3:00 pm in the facility so the corporate Operations, More to make the Corporate Operations, More training session.	ulated hall to from the s) office, tation. Indering into ld the , the resident tral corridor in station, suite thus intervention. Resident #1 lg by a facility ing will issure that all e outcomes ind intrusion The resident as tapered to incidents ill be ent will be ding when the ld for all direct f, and April 4, 2023 ld fining room. Indering the formula to for all direct f, and April 4, 2023 ld fining room. Indering the formula to formula the f		

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THE CAR	ROLTON OF LUMBERTO	N			UMBERTON, NC 28358			
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F 600	Continued From page 3 staff reported Resident #1 was restless, anxious, agitated, and wandering. He was not sleeping. An as needed antianxiety medication was started.		F6	00				
					The DON was responsible for maintain the list of attendees and on-going survended action.			
	15-minute checks 2/1 following an elopeme documentation revea fifteen- minute increm	•			No staff member will be allowed to provide care to residents or otherwise resume normal job roles until they complete the training. Training topics included the following:			
	3:35 PM. Nurse #2 in of March 2023, Resid a common are when assisted living section hand out to him. Resi and twisted her arm be directed him to let go	ephone interview was conducted on 4/3/23 at PM. Nurse #2 indicated that at the beginning arch 2023, Resident #1 was walking through mmon are when another resident (from the sted living section of the facility) reached her I out to him. Resident #1 grabbed her wrist twisted her arm behind her back. Staff sted him to let go and he hit her on the back			 " Monitoring requirements for Resid # 1 to include reporting within 2 hours that allegations of abuse. " Status of survey and interventions in place. " Training on the abuse policy and procedures to ensure full compliance with the procedure of the pro	for put vith		
	other resident was "s called. Nurse #2 adde first physical interacti Resident #1 had beel	dents were separated. The haken", and the police were ed this was Resident #1's on with another resident. In on 1:1 supervision in the tout was agitated having	resident rights consistent with state and federal law, specificating including the resident sight to abuse and proper abuse report the Retraining of facility and constant to ensure awareness of: Abuse definitions, Abuse reporting, Abuse allegation investigations		resident rights consistent with applicab state and federal law, specifically including the resident s right to be free abuse and proper abuse reporting. "Retraining of facility and contracte	e of		
	someone "following" l changed to 15-minute with those.	nim. The supervision was checks, and he did well			staff to ensure awareness of: Abuse definitions, Abuse reporting, Abuse allegation investigations,			
	at 11:00 AM written b	rt dated 3/11/23 (a Saturday) y Nurse #1 indicated that id leaning over Resident #6			Facility Policies Residents right to be free of abuse Protection of all residents at the time of incident occurrence Notification to Administrator and corporations.			
	thrive, cognitive comr	nitted to the facility on ses that included failure to nunication deficit, and nission Minimum Data Set			team of all allegations The facility Administrator and Director of			

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F 600	(MDS) dated 12/28/2 cognitive impairment assistance for bed me Resident #1's Care P was updated on 3/11 supervision due to en uninvited. No new into During an interview of #1 indicated that on 3 she found Resident #1 leaning over her bed shirt near the should apart. When Nurse # at her then back to R shirt with his lips purse to kiss her mouth. Nuresidents' lips touching able to assist with geroom. Resident #6 was assisted her in calling #1 notified Resident #1 Director of Nursing (EDON advised her to f Nurse #1 believed shand attempted kiss in was the first time she touching another resi and out of residents' if Resident #1 was or 3/11/23. Nurse #1 inchim throughout the daneeded. Resident #1 redirected.	2 indicated moderate She required extensive obility and transfers. lan focus area for behaviors /23 to indicate 1:1 stering a resident's room erventions were put in place. n 4/3/23 at 3:20 PM, Nurse ////////////////////////////////////	F	600	Nursing are responsible for the full implementation of the immediate jeopa removal plan. The corporate operation clinical, and compliance team will supp the Administrator and Director of Nursin Date of Removal of Immediate Jeopard April 6, 2023 Since date of IJ removal DON and/or Administrator has completed 100% stateducation on abuse policy and reporting effective 4/10/2023. Social Worker and/or designee will conduct resident abuse interviews with residents weekly x 4 weeks and then monthly x 2 months or until QAPI committee deems compliance. Results of resident audits will be forwarded to the QAPI committee meet monthly x 3 months or until deemed compliance. Any areas of concern will corrected immediately.	s, ort ng. dy: ff g		

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F 600	A telephone interview 2:20 PM with the NA the time of the incides she was assigned to the incident on 3/11/Resident #1 was call and she had not obsother residents. NA susually walked the hattempt to go in other Resident #6 was sleinterview on 4/3/23 at 10:25 AM. 1b. A Progress Note at 10:00 PM written heard Resident #2 c. When she entered, so naked from the wais Resident #2 and tour did not leave the roopolice were called. Resident #2 was add 1/24/23 with diagnosmalnutrition, and cogher admission MDS moderate cognitive in extensive assistance and was dependent.	w was conducted on 4/4/23 at assigned to Resident #1 at ent. NA #5 could not recall if Resident #1 at the time of 23. She indicated that m when she worked with him, erved behaviors directed at #5 revealed Resident #1 alls with her and did not	F	600				
	#2 calling for help. R	noted), she heard Resident lesident #1 was in her room t down, pulling her bedding						

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F 600	Continued From page	e 6	F	600				
	get Resident #1 out of unsuccessful. Nurse assistance. They wer Resident #1 out of th the police.	eet. Nurse #3 attempted to if the room and was #3 retrieved Nurse #4 for ie unsuccessful at getting ie room. Nurse #3 left to call if was conducted on 4/4/23 at						
	12:10 PM. Nurse #3 heard someone callir 300-hall. She arrived Resident #1 had rem and had removed the from the foot of her battempting to hit Resi Nurse #3 when prom naked from the waist Resident #2's feet. R was crying out. Wher to leave, he ignored he clothes out of Reside on her bed. Nurse #3 to call the police and residents. Resident # when the police arrive Nurse #3 revealed the wandering behaviors he was found on and room going through to	revealed that on 3/25/23 she ag out for help on the at Resident #2's room and oved Resident #2's bedding air mattress control box ed. Resident #1 was not dent #2 and gave the box to pted. Resident #1 was down and was rubbing esident#2 was upset and a Nurse #3 told Resident #1 ner. Resident #1 was getting and #2's closet and putting it revealed she left the room Nurse #4 stayed with the 1 was calm in his room ed, so they did not intervene. at Resident #1 had prior. Earlier that evening, ther hall in another resident's heir belongings. Nurse #3 e she had seen him that						
	A progress note date written by Nurse #4 for that after the other nu #1 was pulling clothe and touching her feet plastic spoon with the	d 3/25/23 at 10:00 PM or the same incident added urse left the room, Resident s from Resident #2's closet . Resident #1 grabbed a e handle pointing outward ad Nurse #4 to Resident #2						

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F 600	A written statement fron 3/25/23 at approxicame to the nurse's sassistance. She could 300-hall. Resident #1 down "rummaging" the belongings. Resident #1 was pulling off Rerubbing her feet. Resupset. Resident #1 w to leave the room. Nu Resident #1 continue closet and touching Fulled Resident #1 from A telephone interview 11:00 AM. Nurse #4 is was not working with asked for her assistant redirect him. When Now #2's room, Resident #1 down, pulling things of her feet and legs. Reblankets off Resident out and yelling to get decided to call the poplastic spoon with the tried to get around her Nurse #4 revealed should be after receiving an indicated that Resider in the room by the back police arrived, Resident indicated that Resider in a specific particle with the room by the back police arrived, Reside in indicated that Resider indicated that Residerical support in the room by the back police arrived, Reside in indicated that Residerical support in the room by the back police arrived, Reside in indicated that Residerical support in the room by the back police arrived, Residerical support in the room by the back police arrived, Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical support in the room by the back police arrived that Residerical	pulled Resident #1 out of the his t-shirt. From Nurse #4 revealed that imately 9:30 PM, Nurse #3 station requesting d hear loud voices on the was naked from the waist brough Resident #2's was crying out. Resident sident #2's bedding and ident #2 was getting more was not able to be redirected wise #3 left to call the police. If pulling things from the Resident #2's feet. Nurse #4 form the room. If was conducted on 4/3/23 at indicated that on 3/25/23 she resident #1, but his nurse fince as she was not able to furse #4 arrived at Resident #1 was naked from the waist but of her closet and rubbing sident #1 had pulled the wident #2. Resident #2 was crying him out. The nurses plice. Resident #1 grabbed a see handle sticking out and were to Resident #1 out of the pulled Resident #	Fé	500			

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F 600	During an interview of revealed she heard y room on 3/25/23 on e Nurse #4 pull Reside t-shirt. She assisted If room. Resident #1 we when the police came nurse and texted the NA #1 indicated that #1 was in and out of was easily directed. If monitored him through the scorted back to his in bed before he was room. A Police Report date indicated an officer reat the facility involving #2. The responding office interview at multiple at Resident #1's Care P was updated on 3/26 resident was wander room rummaging throw No new interventions. An observation was roof Resident #1 in his	elling from Resident #2's evening shift and observed int #1 out of the room by his Resident #1 back to him as calm and resting in bed in the called an off-duty Director of Nursing (DON). It is earlier that night, Resident other residents' rooms but NA #1 indicated all staff ighout the day. If was conducted on 4/4/23 at revealed that prior to the Resident #1 was wandering its' rooms on the 500 hall iteir drawers. Resident #1 was room and was last seen lying found in Resident #2's If a 3/26/23 at 9:30 AM ites is each of the called the resident #1 and focus area for behaviors in items.	F 600		

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F 600	did not respond appr speech was difficult to observation was mad #1 in the DON's offic respond to the quest During a telephone in	with shaving. Resident #1 opriately to questions and o understand. An de later that day of Resident e eating a snack. He did not ioning.	F 60			
	revealed she had be since he was admitted expressed anxiety are and they had been wantianxiety, antidepressed medications. The Me was aware of behavior aggression, and refurindicated around 3/1 refusing medication. was reported to her, antipsychotic medicate would take it. She be improved after the me was doing well when	nd agitation since admission forking to adjust his ressants, and antipsychotic ental Health NP revealed she fors such as wandering, sing medication. She 1/23, Resident #1 was The altercation on 3/11/23 and staff began mixing his tion into a drink and he				
	Nurse Practitioner re Resident #1's behaving agitation and mental working with him. Shows sent to the emer times for combativen at the beginning of Morevealed that both Resident in the second	on 4/4/23 at 2:20 PM, the vealed she was aware of ors of wandering and health services had been e was notified Resident #1 gency department several ess. The first instance was larch. The Nurse Practitioner esident #6 and Resident #2 ould have been seriously stions.				

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F 600	_	e 10 in 4/6/23 at 10:30 AM, the ing the 3/11/23 incident,	F 6	00			
	Resident #1's nurse of him in Resident #6's trying to kiss her. The report when she returned if it noted he was to kiss her. She did not resident interviews. The was frail and he could time of the incident of on 15-minute checks was not aware of white Resident #1 at the time #1 had previously be	called her to report finding room and appeared to be a DON reviewed the incident rned to work but did not as pulling her shirt and trying ot conduct further staff or the DON indicated Resident buld have injured her. At the in 3/11/23, Resident #1 was due to an elopement. She ch NA was assigned to the of the incident. Resident en on 1:1 supervision but ing someone with him all the					
	time. The facility switt with someone assign throughout the day at She was unsure how room without the staff revealed the interven continuing monitoring checks. She was unsuchecks were discontishe was not involved	ched to 15-minute checks ed to monitor him and sign off on a timesheet. he got into Resident #6 ' s f's knowledge. The DON tion for the incident was to g Resident #1 with 15-minute ure why the 15-minute nued on 3/12/23 and states in the decision. She did not ewing other staff or the NA					
	3/25/23 incident that She arrived the follow families of the resident Administrator began The DON revealed st throughout the day at They did not sign off	e was made aware of the night following the incident. wing day and spoke with the nts. She believed the an investigation on 3/26/23. Faff monitored Resident #1 and observed his location. Checks at the time of the The DON revealed the					

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(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 600	During an interview of Administrator revealer resident to resident a March 2023, the resident revealer reviewed in daily clinical reviewed resident reviewed residents were oriented residents were recipied residents. The Administrator was 11:47 AM. The facility provided to jeopardy removal plant lidentify those recipier recipier recipier recipier reviewed. Removed resident reviewed. Removed reviewed. Remo	process in place to monitor effective. In 4/6/23 at 11:30 AM, the d following the initial litercation at the beginning of dents and family members sident #1 was taken to the int for evaluation. The ed the other resident was did did not feel she was realed he was not aware do to be attempting to kissive 3/11/23 incident. No new it into place because the transport aware of the attempted shecks for Resident #1 were not having exit seeking ed the incident reports were call meetings and an put into place. Following the he residents were lent #1 was calm. The facility me incident after Adult is itsed the facility on 3/29/23. The obtained and the facility on 3/29/23 at the following immediate.	F6					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345315	B. WING _			C 04/06/2023
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	,	04/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	suffering adverse out facility's failure to produce and intrusion attempts for inappround Resident #1 is the an All residents are at roor psychosocial hard practice. Incidents were reported the Administrator. Actions taken to alter failure to prevent a soccurring or recurring complete: On Tuesday, April 4 relocated to a less pomore staff visibility from (DON's) office, thereof the action will diminare sident rooms. Sho	ompliance: 2 are the most at risk for a strong tree them from physical into their personal space with priate sexual interactions.	F6	<u> </u>		
	station, DON's office allowing for redirecti On Tuesday, April 4 placed on 1:1 monite member. The monite order to ensure that	e presence of the nursing e, and therapy suite thus on and intervention. , 2023 Resident #1 was oring by a facility staff oring will continue 24/7 in all residents are free of elated to physical abuse and				

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		345315	B. WING		C 04/06/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	04/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 600	was previously on 15-minute checks with a monitoring will resident will be more when the staff memperson will be assigned. A full staff mandato staff, management be held on April 4, 2 dining room. The facility Adminis Managing Director, Clinical Nurse Consistent of attendees and No staff member with the total staff member with the tota	bersonal spaces. The resident :1 but was tapered to when the incidents occurred. be increased to 24/7 the nitored at all times, including ther takes breaks. A backup and to the 1:1 caregiver. Ty meeting for all direct care staff, and contracted staff will 2023 at 3:00 pm in the facility's attrator and members of the VP Property, and Corporate sultant will conduct the training asponsible for maintaining the don-going survey education. If be allowed to provide care rwise resume normal job roles the training. Include the following: ments for Resident # 1 to sion at all times - with back up. Ind interventions put in place. The use policy and procedures to note with resident rights licable state and federal law, go the resident's right to be free r abuse reporting. Ty and contracted staff and environmental services) to	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345315	B. WING		C 04/06/2023	
	ROVIDER OR SUPPLIER)N		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	, 0.1.00.2020	
(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 COMPLETION	
F 600	-Abuse allegation inv -Facility Policies -Residents right to be -Protection of all residuccurrence -Notification to Admin of all allegations The facility Administrate responsible for the immediate jeopardy roperations, clinical, a support the Administra	estigations	F 60			
F 689 SS=K	recent training on abuabuse, reporting, and involved. Education resheets were reviewed with a 1:1 sitter. The 4/5/23 was validated. Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The reas free of accident has \$483.25(d)(2)Each resupervision and assist accidents.	rerification on 4/6/23. With staff revealed they had use that included types of a protecting residents naterials and staff signature d. Resident #1 was observed facility's IJ removal date of ards/Supervision/Devices (2)	F 68	39	4/21/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG	С		
		345315	B. WING				06/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	DOLTON OF LUMBERT	ON		11	170 LINKHAW ROAD		
THE CAR	ROLTON OF LUMBERT	ON		L	UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag by:	ge 15 on, staff interviews, Nurse	F	689	F 689 FREE of accident hazards,		
	Practitioner interview	v, and record review, the			supervision, and devises		
	facility failed to provious to prevent accidents with severe cognitive awareness, and knot exit seeking, wande rooms, and physical resident reviewed for Resident #1 exited twithout staff's knowl miles away from the likelihood of resulting #1. On 3/11/23 Resing Nurse #1 in Resident bed with his hands pushoulder, their faces Resident #1 had his trying to kiss Resided 3/25/23 Resident #2	ide the necessary supervision for a resident (Resident #1) e impairment, poor safety wn behaviors that included ring into other residents' aggression for 1 of 1 r accidents. On 2/16/23 he facility unsupervised and edge and was found 1.7 facility. This had a high g in serious harm to Resident dent #1 was observed by at #6's room leaning over her bulling her shirt near her were inches apart, and lips pursed as though he was nt #6 on her mouth. On			Identify those recipients who have suffered, or are likely to suffer, a seriou adverse outcome as a result of the noncompliance; and Resident # 1 is at risk for suffering adverse outcomes based on the facility failure to provide supervision of a resid with severe cognitive impairment, poor safety awareness, and behaviors including wandering and physically aggressive behaviors to prevent an unsupervised exit and resident to resid altercations. Resident #1 exited the facility with the assistance of another resident □s family member, who walked behind a desk ar	r□s ent ent	
	help and when staff entered her room Resident #1 was observed naked from the waist down rubbing Resident #2's feet. These incidents initiated by Resident #1 had a high likelihood of causing serious physical injury to the victims. Resident #2 and Resident #6 did not have the cognitive ability to express an adverse outcome. A reasonable person expects to be protected from the presence of unwanted persons and advancements into their personal space in their home environment resulting in serious psychosocial harm with feelings such as intense fear, distress, and anxiety. Immediate Jeopardy (IJ) began on 2/16/23 when Resident #1 exited the facility unsupervised and without staff's knowledge. Immediate Jeopardy was removed on 4/5/23 when the facility provided				pressed the door release button. Residents #6, and #2 are the most at refor suffering adverse outcomes based the facility failure to supervise and prevention accidents and hazards. All residents are at risk for suffering physical and / or psychosocial harm. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.	sk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED C	
			D 14/11/0				
		345315	B. WING		0-	4/06/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CAR	ROLTON OF LUMBERTO	M.		1170 LINKHAW ROAD			
THE CAR	ROLION OF LUMBERIO	JN .		LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 16	F 68	9			
	out of compliance at a level E (no actual har than minimal harm the education is complete put into place are effect Findings included: 1a. Resident #1 was 2/1/23 with diagnoses behavioral disturbance. A nursing progress no Nurse #6 indicated R going from room to restating someone was	val. The facility will remain a lower scope and severity m with the potential for more at is not IJ) to ensure that ed, and monitoring systems ective. admitted to the facility on a that included dementia with the eand anxiety disorder. the dated 2/3/23 written by esident #1 was anxious and from and to the front exit a coming to pick him up.		A device cover (screamer cover) placed over the release button of the unsupervised exit incident of 2-16-23. It is a device with a hind that has to be opened to access lock release. Opening the device in a piercing alarm that alerts stamembers audibly that the button accessed. In addition to the release button, keypads on all exit doors that all staff exit when the proper code in The access code was changed of 2-16-23. Staff members were not aware of the access code changes staff members are the only person access the keypad. There is also keypad for releasing the door locon the wall to the immediate right door.	on the day occurred ged lid the mag e results aff has been there are ow for s entered. On made ge and ons that o a ck that is		
	elopement related to impaired safety award behavior. Goals included through the maintained by offering for wandering, monitors tructural activities. Resident #1's admissed (MDS) dated 2/9/23 in cognitively impaired behaviors directed at not directed at others of the review period, independent for walking the maintained of the safety and the safety are the safety as	disorientation to place, eness, and wandering ded Resident #1's safety will the review period. distract resident from gidiversions, identify pattern or location, and provide sion Minimum Data Set andicated he was severely He displayed physical others and other behaviors and wandered 4 to 6 days Resident #1 was		On 2-16-23 the resident was pla 1:1 supervision because prior to he had never eloped before. Cowith his attending physician / Nu Practitioner resulted in a change resident smedication that stabil mood and behaviors. Education regarding not allowing residents to exit the building was to all staff members (employed a contracted housekeeping, dietar environmental services and ther contract staff). The facility does not have contract	this date, insultation rse in the lized his grovided and y, apy		

<u> </u>	o i oi i inebior ii ie a	T CELLATORS				1	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	_			c
		345315	B. WING			04/	06/2023
NAME OF PI	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF LUMBERTO	DN			170 LINKHAW ROAD UMBERTON, NC 28358		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
F 689	Continued From page	e 17	F	689			
	indicated Resident #			000	nursing stoff		
	wandering.	i was at high risk tol			nursing staff. The facility administrator conducted the		
	wandening.				training and letters to the families of	-	
	Δn Event Report date	ed 2/16/23 completed by the			current patients.		
		d the following Elopement			A letter was provided to all family		
	timeline:	a the fellowing Elepenions			members regarding the same. A letter		
	-start time 12:38 PM				was also added to the admission pack		
	-12:50 PM: The nurse	e noticed Resident #1 was			to educate future residents and familie	•	
	not in his room. She	proceeded to the front lobby			about the importance of NOT allowing		
	area and resident wa			residents to exit the facility. This was			
	administrator was no			done on 2/16/23.			
	-12:52 PM: Code Ora	ange [announced over the					
	speaker to indicate a			On Tuesday, April 4, 2023 Resident #			
	called.				was relocated to a less populated hall	to	
		#1's Responsible Party,			allow for more staff visibility from the		
	physician, and the po				Director of Nursing □s (DON □s) office,		
		ched inside and outside the			therapy suite, and nursing station.		
	facility.	11 was found by a stoff			This action will diminish wandering into		
	member (Receptionis	1 was found by a staff			This action will diminish wandering into other resident rooms and protect all	,	
	The report indicated t				residents within the facility. Should the	1	
	reviewed the security				wandering behavior present, the reside		
		ened the door and let			would have to cross the central corrido		
	Resident #1 walk out				the presence of the nursing station, DO		
					office, and therapy suite thus allowing		
	During an interview o	on 4/4/23 at 10:00 AM, the			redirection and intervention and for		
	Administrator indicate	ed they did not have access			supervision to prevent further occurren	ce.	
	to the security footag	e and corporate reviewed					
	the footage and provi				On Tuesday, April 4, 2023 Resident #1		
	information and timel	ine.			was placed on 1:1 monitoring by a faci	lity	
					staff member. The monitoring will		
	A police report dated				continue 24 /7 in order to ensure that a		
		eported to the facility in			residents are free of abuse and intrusion	on	
	reference to a missin				into their personal spaces. A back up		
		left the facility at 12:38 PM.			staff member will be identified to cover		
	As the officer was filli	•			breaks to ensure that the resident is		
		ne Administrator stating she			monitored and supervised 24/7.		
		t #1. Resident #1 was			A & JI - 4 - 55	4	
	returned to the facility	/ sate and unharmed.			A full staff mandatory meeting for all di	rect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345315	B WING	B. WING			С	
NAME OF D	20//050 00 01/001/50	343313	D. WING	0.	TREET ARRESTS OF THE TIP CORE	04	/06/2023	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARE	ROLTON OF LUMBERTO	ON .		1	170 LINKHAW ROAD			
1112 07 11 11	(021011 01 20111 DEIX10			L	UMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 18	F	689				
		be reached for interview.			care staff, management staff, and staff was held on April 4, 2023 at 3:00 pm in the facility s dining room. The facility	า		
	_	on 4/3/23 at 2:20 PM, Nurse			Administrator, Managing Director, VP			
		arrived to Resident #1's			Property, and Corporate Nurse Consu	ııanı		
		und 1:00 PM and noticed he			conducted the training session.			
	was gone. She searched the facility and could not							
	find him. She notified the Administrator, and he paged overhead to look for him. Management				The DON will be accompatible for			
					The DON will be responsible for			
		for him by car. Nurse #6			maintaining the list of attendees and			
		ent #1 previously wandered			on-going survey education.			
	_	d would walk to the front			NI4-ff			
		cated that the front door was			No staff member will be allowed to			
		unlocked by pushing a			provide care to residents or otherwise resume normal job roles until they			
	button behind the rec	ceptionist's desk.			complete the training.			
	A tolophono intorviou	www.vwas.conducted.on 4/4/23 at			Complete the training.			
	-	tionist indicated that she was			Training topics will include the followin	a.		
		ent #1 left the facility. She			Training topics will include the following	y.		
		nt #1 was in the front lobby			" Resident supervision to prevent			
		lunch break. The staff			accidents			
		s off the lobby covered door			" Redirection of patients with			
		one. The Receptionist			inappropriate behaviors including			
		ed a red button on the wall			protection of resident □s rooms and			
	behind her desk to ur	nlock the door for visitors,			personal spaces.			
		went behind her desk to			" The phrase PROTECT & REPOR	Т		
	_	et out of the front door. When			was highlighted as the mantra for the			
		er lunch break, staff was			educational session.			
	searching for Reside				" Elopements			
		esident #1 in a parking lot of			" Monitoring requirements for Resid	lent		
		got into her car with her.			# 1 (1:1 and 24/7 with breaks also			
	Resident #1 was not	alert and oriented and			covered).			
	attempted to exit the	car while she was driving.			" Immediate Jeopardy was discusse	ed,		
	The Receptionist add	led that Resident #1 had to			defined, and the steps taken for IJ			
	cross a very busy, da	angerous road to get to his			removal was reviewed.			
	location.				" Retraining of facility and contracte			
					staff (therapy, dietary, and environmer	ntal		
		ed the temperature for			services) to ensure awareness of:			
	2/16/23 at 12:35 PM	was approximately 72			Resident Supervision			

AND PLAN OF CORRECTION IDEN	IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
					С		
	345315	B. WING			04/	06/2023	
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON			11	TREET ADDRESS, CITY, STATE, ZIP CODE 170 LINKHAW ROAD UMBERTON, NC 28358			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
degrees Fahrenheit (wundergmaps indicated the distance hand the parking lot where Reswas 1.7 miles and was an estwalk. An observation was made 4/4 the suspected route Resident street from the facility to the Tlimit was 45 miles per hour. Ttwo-lane road with very few sditches on both sides of the recame to a T-intersection with Resident #1 had to cross the There were few sidewalks and to cross to get to his final local During an interview on 4/6/23 previous Director of Nursing (Resident #1 left the facility affirmember allowed him out the facility but she was not avout the front door prior. The pindicated that anyone with dewas at risk for elopement and Planned for elopement risk. During an interview on 4/6/23 Administrator indicated that Ridisplay exit seeking behaviors building unsupervised on 2/16 PM. A visitor opened the door behind the receptionist's deskincident, the facility provided asking them not to let resident The Administrator indicated hexit seeking behavior prior to	Detween the facility sident #1 was found timated 33-minute #/23 at 4:30 PM of at #1 took down the F-intersection. Speed The facility was off a idewalks and large load. The street a four-lane road. If the four-lane road idemany parking lots ation. ### at 9:35 AM, the **(DON)** indicated that the another family front door. Prior to lide wander around load ware if he tried to get were in the tried to get was not aware of the facility around 12:38 around 12:38 around 12:38 around 12:38 around 12:38 around the letters to all families arts out the front door. It is not aware of the format ware of the format ware of the format ware of the facility and the letters to all families arts out the front door. It is not aware of the format ware of the facility and the faci	F	689	Elopements The facility Administrator and Director of Nursing will be responsible for full implementation of the facility plan of correction for the immediate jeopardy removal. They will be assisted by the corporate compliance, operations, and clinical team members. Date of Removal of Immediate Jeopard April 6, 2023 Since date of IJ removal DON and/or Administrator has completed 100% stateducation on abuse policy, reporting, a elopements (risks) effective 4/10/2023. Social Worker and/or designee will conduct resident abuse interviews with residents weekly x 4 weeks and then monthly x 2 months or until QAPI committee deems compliance. DON and/or Administrator will audit residents risk for wandering x 4 weeks and then monthly x 2months or until QAPI committee deems compliance. Results of resident audits will be forwarded to the QAPI committee meet monthly x 3 months or until deemed compliance. Any areas of concern will is corrected immediately.	dy: ff nd 2		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345315		B. WING		04/06/2023	
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	1 0.00.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 689	Continued From pag	e 20	F 689			
	2/1/23 with diagnose behavioral disturban A Psychiatry Initial C staff reported Reside agitated, and wande as needed antianxie: His admission MDS was severely cognitiphysical behaviors dof the review period directed at others 4 to period. Resident #1 and locomotion. He wreview period.	admitted to the facility on as that included dementia with one and anxiety disorder. Consult dated 2/2/23 indicated ant #1 was restless, anxious, ring. He was not sleeping. An ty was started. dated 2/9/23 indicated he wely impaired. He displayed irected at others 1 to 3 days and other behaviors not so 6 days of the review was independent for walking wandered 4 to 6 days of the				
	related to Resident # combativeness towa into other residents' Resident #1 will have review period. Interv medications as orde needs, and monitor lattempt to find an un	t1's episodes of rds staff, pacing, and going rooms. Goals included e fewer behaviors through the entions included administer red, anticipate resident's behavioral episodes and derlying cause.				
	15-minute checks 2/ following an elopeme indicating they were #1 at that time.	ated Resident #1 was on 16/23 through 3/12/23 ent. Staff signed a sheet assigned to monitor Resident				
	3:35 PM. Nurse #2 ir	w was conducted on 4/3/23 at ndicated that at the beginning dent #1 was walking through				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345315	B. WING _			C 04/06/2023	
	ROVIDER OR SUPPLIER	DN	•	STREET ADDRESS, CITY, STATE, ZIP CODI 1170 LINKHAW ROAD LUMBERTON, NC 28358	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 689	assisted living section hand out to him. Resident wisted her arm directed him to let go of the head. The resident was "scalled. Nurse #2 addirst physical interact Resident #1 had been past for an elopement someone "following" changed to 15-minut with those. An Incident Report of written by Nurse #1 was found leaning or Resident #6's admissindicated she had mimpairment. During an interview of #1 indicated that on #1 in Resident #6's with his hands pulling and their faces inches his attention, he look Resident #6, pulling pursed as though her Nurse #1 did not obstouching. A Nurse Ai with getting Resident #6 was crysher in calling her farm notified Resident #6 Director of Nursing (another resident (from the on of the facility) reached her sident #1 grabbed her wrist behind her back. Staff of and he hit her on the back idents were separated. The shaken", and the police were led this was Resident #1's ion with another resident. It is non 1:1 supervision in the not but was agitated having him. The supervision was the checks, and he did well were Resident #6 in her bed. Sion MDS dated 12/28/22 orderate cognitive on 4/3/23 at 3:20 PM, Nurse 3/11/23, she found Resident room leaning over her bed go her shirt near the shoulder the sapart. When Nurse #1 got the set was trying to kiss her mouth. Serve the residents' lips de (NA) was able to assist	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345315	B. WING _			C 04/06/2023
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP COD 1170 LINKHAW ROAD LUMBERTON, NC 28358	•	04/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689		he put the pulling of the shirt	F	689		
	was the first time she touching another resand out of residents' that staff monitored intervened as neede able to be redirected	n her incident report. That he had seen Resident #1 hident, but he did wander in rooms. Nurse #1 indicated him throughout the day and hid. Resident #1 was usually hide Nurse #1 was unsure if hide 15-minute checks at that				
	15-minute check off	ated NA #5 had signed the sheet for 3/11/23 from 11:00 time the incident occurred).				
	2:20 PM with NA #5 Resident #1 at the ti NA #5 could not reca Resident #1 at the ti She indicated that R she worked with him behaviors directed a revealed Resident #	w was conducted on 4/4/23 at who was assigned to me of the 3/11/23 incident. all if she was assigned to me of the incident on 3/11/23. esident #1 was calm when and she had not observed to ther residents. NA #5 1 usually walked the halls attempt to go in other				
		eping during attempts to at 10:00 AM and at 4/5/23 at				
	DON revealed follow Resident #1's nurse him in Resident #6's trying to kiss her. Th report when she retu	on 4/6/23 at 10:30 AM, the ving the 3/11/23 incident, called her to report finding room and appeared to be e DON reviewed the incident urned to work but did not vas pulling her shirt and trying				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345315	B. WING _			C 04/06/2023	
	ROVIDER OR SUPPLIER	DN .		STREET ADDRESS, CITY, STATE, ZIP COL 1170 LINKHAW ROAD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	resident interviews. #6 was frail and he could time of the incident of on 15-minute checks was not aware of white Resident #1 at the time explained that Reside on one to one (1:1) so agitated having some of the facility switched someone assigned to day and sign off on a how he got into Resident #1 with 15-minute why the 15-minute why the 15-minute why the 15-minute with interviewing other Resident #1 at the time. During an interview of Administrator revealer Resident #1 at the time. During an interview of Administrator was not kiss. The 15-minute of discontinued due to repeat the following the provious resident #1 and a previous res	ot conduct further staff or The DON indicated Resident ould have injured her. At the in 3/11/23, Resident #1 was due to an elopement. She is children to the incident. The DON ent #1 had previously been upervision but became eone with him all the time. It to 15-minute checks with it is monitor him throughout the timesheet. She was unsure indent #6 without staff's in revealed the intervention in continuing monitoring minute checks. She was inute checks were 1/23 and states she was not on. She did not follow up er staff or the NA assigned to the intervention in the intervention in the checks were 1/23 and states she was not on. She did not follow up er staff or the NA assigned to the intervention in	F6	89			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345315	B. WING _			C 04/06/2023		
	NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON			STREET ADDRESS, CITY, STATE, ZII 1170 LINKHAW ROAD LUMBERTON, NC 28358	P CODE	1 04/00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BI O THE APPROPRIA	DATE		
F 689	heard Resident #2 ca When she entered, s naked from the waist Resident #2 and toud did not leave the roo police were called. A progress note date written by Nurse #4 f that after the other no #1 was pulling clother and touching her fee plastic spoon with the and tried to get aroun in her bed. Nurse #4 room backwards by I Resident #2's admiss indicated she had me impairment. A written statement f on 3/25/23 around ap #3 came to the nurse assistance. She coul 300 hall. Resident #7 down "rummaging" to belongings. Resident #1 was pulling off Resident #1 to leave the room. No Resident #1 continue closet and touching I pulled Resident #1 fr A telephone interview 11:00 AM. Nurse #4	alling out from her room. The observed Resident #1 It down pulling the covers off ching her feet. Resident #1 Im when prompted. The It down pulling the covers off ching her feet. Resident #1 Im when prompted. The It down pulling the covers off ching her feet. Resident #1 Im when prompted. The It down prompted at the room, Resident was from Resident #2's closet the resident #1 grabbed at the handle pointing outward and Nurse #4 to Resident #2 It pulled Resident #1 out of the his t-shirt. It was in MDS dated 1/31/23 to derate cognitive It was naked from the waist provided the rough Resident #2's the rough Resident #2's the the rough Resident #2's the deduct was getting more was not able to be redirected curse #3 left to call the police. The red pulling things from the Resident #2's feet. Nurse #4	F6	889				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		245245	B. WING				
		345315	D. WING _		•	4/06/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
THE CAR	ROLTON OF LUMBE	RTON		1170 LINKHAW ROAD			
				LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From p	page 25	F	889			
	asked for her assiredirect him. Whe #2's room, Reside down, pulling thin her feet and legs. blankets off Reside out and yelling to decided to call the plastic spoon with tried to get around Nurse #4 revealed the room by the beat after receiving indicated that Resided and out of other receivally be redirect 15-minute checks	istance as she was not able to in Nurse #4 arrived at Resident ent #1 was naked from the waist gs out of her closet and rubbing Resident #1 had pulled the lent #2. Resident #2 was crying get him out. The nurses e police. Resident #1 grabbed a the handle sticking out and do her to Resident #2 in her bed. It is to the handle sticking out and the pulled Resident #1 out of ack of his t-shirt. When the sident #1 was resting calmly in ganxiety medication. Nurse #4 sident #1 frequently wandered in the sidents' rooms but could the seidents' rooms but could the steel Resident #1 was not on that the time of the incident.					
	A written statemer on 3/25/23, she help. Resident #1 the waist down, prouching her feet. Resident #1 out of unsuccessful. Nurassistance. They Resident #1 out of the police. A telephone interval: 10 PM. Nurse heard someone cat Resident #2's removed Resident removed the air memoved the air memoved.	nt from Nurse #3 indicated that eard Resident #2 calling for was in her room naked from ulling her bedding off and Nurse #3 attempted to get of the room and was rese #3 retrieved Nurse #4 for were unsuccessful at getting of the room. Nurse #3 left to call view was conducted on 4/4/23 at #3 revealed that on 3/25/23 she alling out for help. She arrived oom and Resident #1 had t #2's bedding and had nattress control box from the esident #1 was not attempting					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		345315	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	343313	B. Willo	STREET ADDRESS, CITY, STATE, ZIP (4/06/2023	
	ROLTON OF LUMBER	RTON		1170 LINKHAW ROAD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	when prompted. R waist down and wa Resident#2 was u Nurse #3 told Res her. Resident #1 v Resident #2's clos Nurse #3 revealed police and Nurse # Resident #1 was o police arrived, so t revealed that Resi behaviors prior. Ea found on another h going through thei revealed that last t resting in bed. During an interview revealed she hear room and observe of the room by his #1 back to his room resting in bed whe texted the Director indicated that earli in and out of other easily directed. Na him throughout the A telephone interv 12:10 PM, Nurse # incident on 3/25/25 in and out of reside their drawers. Res his room and was was found in Reside	and gave the box to Nurse #3 desident #1 was naked from the as rubbing Resident #2's feet. pset and was crying out. When ident #1 to leave, he ignored was getting clothes out of et and putting it on her bed. I she left the room to call the #4 stayed with the residents. calm in his room when the they did not intervene. Nurse #3 dent #1 had wandering arlier that evening, he was hall in another resident's room or belongings. Nurse #3 time she had seen him he was W on 4/3/23 at 11:40 AM, NA #1 d yelling from Resident #2's d Nurse #4 pull Resident #1 out t-shirt. She assisted Resident m. Resident #1 was calm and on the police came. NA #1 of Nursing (DON). NA #1 er that night, Resident #1 was residents' rooms but was A #1 indicated all staff monitored e day. iew was conducted on 4/4/23 at #5 revealed that prior to the 3, Resident #1 was wandering ents' rooms and going through ident #1 was escorted back to last seen lying in bed before he	F	689			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345315	B. WING _			C 04/06/2023	
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON				STREET ADDRESS, CITY, STATE, ZIP 1170 LINKHAW ROAD LUMBERTON, NC 28358	•	04/00/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pag	e 27	F 6	689			
		esponded to an assault call g Resident #1 and Resident					
	The responding offic interview at multiple	er could not be reached for attempts.					
	DON indicated she v 3/25/23 incident that arrived the following families of the reside monitored Resident observed his location checks at the time of The DON revealed to	on 4/6/23 at 10:30 AM the was made aware of the following the incident. She day and spoke with the ents. The DON revealed staff #1 throughout the day and n. They did not sign off the incident or following. The facility did not have a monitor if interventions were					
	AM, the Mental Heal revealed she had be since he was admitted expressed anxiety and they had been wantianxiety, antidepromedications. The Mewas aware of behaving aggression, and refu	nd agitation since admission					
	Nurse Practitioner re Resident #1's behav agitation and mental working with him. Sh	on 4/4/23 at 2:20 PM, the evealed she was aware of iors of wandering and health services had been se was notified Resident #1 regency department several					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345315	B. WING _			C I/ 06/2023
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358		04	106/2023
(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 CORRECT ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	at the beginning of M arm of another reside the assisted living set. Nurse Practitioner revand Resident #2 were been seriously injured was not aware of interactions. During an interview of Administrator he indicated were reviewed in dail appropriate plan was incident on 3/25/23, to separated, and Resident protective Services were staff statements were	ess. The first instance was arch when he twisted the ent (a resident who resided in ction of the facility). The wealed that both Resident #6 every frail and could have do by the interactions. The NP erventions regarding the ent 4/6/23 at 11:30 AM the cated the incident reports y clinical meetings and an put into place. Following the he residents were lent #1 was calm. The facility he incident after Adult isited the facility on 3/29/23. The obtained and are interviewed on if they	F6	889		
	The Administrator wa jeopardy on 4/4/23 at	s notified of immediate 11:47 AM.				
		the following immediate n with an alleged removal				
		nts who have suffered, or serious adverse outcome as npliance:				
	outcomes based on t	c for suffering adverse he facility's failure to provide lent with severe cognitive				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	COMPLETED		
		345315	B. WING _			C 04/06/2023	
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358		04/00/2023	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689	aggressive behaviors exit and resident to resident to resident to resident to resident to resident #1 exited the of another resident's behind a desk and pubutton. Residents #6 and #2 suffering adverse our failure to supervise a and hazards. All residents are at ri or psychosocial harm. Actions taken to alter failure to prevent a soccurring or recurring complete. A device cover (screathe release button or exit incident occurred a hinged lid that has mag lock release. Oppiercing alarm that a that the button has but in addition to the release keypads on all exit dwhen the proper cod code was changed owere made aware of and staff members a access the keypad.	ety awareness, and vandering and physically is to prevent an unsupervised esident altercations. The facility with the assistance family member, who walked ressed the door release are the most at risk for toomes based on the facility and prevent from accidents sk for suffering physical and / h. The process or system erious adverse outcome from g, and when the action will be amer cover) was placed over in the day the unsupervised d - 2-16-23. It is a device with to be opened to access the bening the device results in a lerts staff members audibly	F 6	89			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345315	B. WING _			C 04/06/2023	
	NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON			STREET ADDRESS, CITY, STATE, ZIP COD 1170 LINKHAW ROAD LUMBERTON, NC 28358	•	0.410012020	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	supervision because never eloped before Attending Physician in a change in the restabilized his mood Education regarding the building was pro (employed and contenvironmental servistaff). The facility does not staff. The facility administ and letters to the far A letter was provide regarding the same the admission packer residents and familie NOT allowing resided was done on 2/16/2 On Tuesday, April 4 relocated to a less pamore staff visibility for the residents and familie was done on 2/16/2	dent was placed on 1:1 e prior to this date, he had . Consultation with his / Nurse Practitioner resulted esident 's medication that and behaviors. I not allowing residents to exit vided to all staff members racted housekeeping, dietary, ces and therapy contract Thave contracted nursing rator conducted the training milies of current patients. Id to all family members A letter was also added to age to educate future es about the importance of ents to exit the facility. This	F	BEFICIENCY)			
	resident rooms and facility. Should the v the resident would h corridor in the prese	nish wandering into other protect all residents within the vandering behavior present, ave to cross the central nce of the nursing station, rapy suite thus allowing for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345315		B. WING				C (06/2023	
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON				1170	EET ADDRESS, CITY, STATE, ZIP CODE D LINKHAW ROAD MBERTON, NC 28358	1 04/	00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	On Tuesday, April 4, 2 placed on 1:1 monitor member. The monitor order to ensure that a abuse and intrusion ir back up staff member breaks to ensure that and supervised 24/7. A full staff mandatory staff, management staff, management staff, management staff, management staff, room. The facility Adri Director, Vice Preside Corporate Nurse Contraining session. The DON will be resplist of attendees and of the complete them. Training topics will incomplete them. Training topics will incomplete them. Resident supervision. Redirection of patier behaviors including personal staff. The phrase "PROTE highlighted as the masession. Elopements	ention and for supervision to ence. 2023 Resident #1 was ring by a facility staff ing will continue 24 /7 in II residents are free of noto their personal spaces. A rivill be identified to cover the resident is monitored meeting for all direct care aff, and staff will be held on om in the facility's dining ministrator, Managing ent (VP) of Property, and sultant conducted the consible for maintaining the on-going survey education. The allowed to provide care rise resume normal job roles the training. Solude the following: The to prevent accidents into with inappropriate rotection of resident 's spaces. ECT & REPORT" was intra for the educational	F	589				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		345315	B. WING _			C 04/06/2023		
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF LUMBERTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358				
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 689	and the steps taken for Retraining of facility (therapy, dietary, and ensure awareness of Resident Supervision Elopements The facility Administrativill be responsible for facility plan of correct jeopardy removal. The corporate compliance team members. The credible allegation validated by on-site volunterviews conducted recent training on elopmonitoring. The adminiallowing residents out the device cover at the observed and the recuse. Keypads were of Education materials as were reviewed. Residents.	was discussed, defined, or IJ removal was reviewed. and contracted staff environmental services) to ator and Director of Nursing full implementation of the ion for the immediate ey will be assisted by the ey, operations, and clinical on of IJ removal was erification on 4/6/23. With staff revealed they had pements and resident ession packet letter on not at the facility was reviewed. The reception desk was eptionist was interviewed on observed on all exit doors. Ind staff signature sheets ent #1 was observed with a doom. The facility's IJ removal	F	889				