		ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u>O. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345325	B. WING		0(	C 6/02/2023
NAME OF PI	ROVIDER OR SUPPLIER	I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE CARI	ROLTON OF DUNN			1 SUSAN TART ROAD JNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 6/2/23. The compliance with the r	equirement CFR 483.73, ness. Event ID # NC5111.	F 000			
	survey was conducte 6/2/23. Event ID# RJ The following intakes					
F 561 SS=E	deficiency. Self-Determination	allegations resulted in (3)(8)	F 561			6/30/23
	promote and facilitate through support of re	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules ( waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
	§483.10(f)(3) The res	ident has a right to interact				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE 06/29/2023

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.

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		OATE SURVEY
	CONTRECTION	IDENTIFICATION NOWDER.	A. BUILDIN	IG		
		245205	P. MINC			С
		345325	B. WING			06/02/2023
NAME OF P	ROVIDER 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	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 561	Continued From pag	e 1	F 5	61		
		community and participate in				
		both inside and outside the				
	§483.10(f)(8) The res	-				
		ctivities, including social,				
	-	unity activities that do not				
	-	nts of other residents in the				
	facility.	T is not met as evidenced				
		I is not met as evidenced				
	by: Based on observation	ons, record review, resident		Carrolton of Dunn Nursing	n and	
		nterviews, the facility failed to		Rehabilitation Center ackr		
		ice related to showers for 4		receipt of the Statement o		
		ents reviewed for choices		and proposes this Plan of		
		lent #42, Resident #14, and		the extent that the summa		
	Resident #33).			factually correct and in or		
	,			compliance with applicable		
	Findings included:			provisions of quality of car The Plan of Correction is		
	1. Resident #45 was	admitted to the facility on		written allegation of comp	iance.	
		oses included hemiparesis		Carrolton of Dunn Nursing		
	(partial paralysis on o	one side of the body).		Rehabilitation Center s re	•	
	Dooidont #451	plan initiated on 2/11/2022		Statement of Deficiencies		
		plan initiated on 3/11/2022		denote agreement with the		
		l one person assistance to her clothing on one side of		Deficiencies nor does it co admission that any deficie		
		by assistance with transfers		Further, Carrolton of Dunr	-	
		air. There was no focus for		Rehabilitation Center rese		
		ng addressing baths and		refute any of the deficienc		
	showers on Residen			Statement of Deficiencies		
		- F		Informal Dispute Resolution	0	
	The quarterly Minimu	um Data Set (MDS)		appeal procedure and/or a		
		/14/2023 indicated Resident		administrative or legal pro	•	
	#45 was cognitively i	intact and displayed no			-	
		of care. The MDS further		Tag Cited: F-561		
	indicated Resident #	45 required limited		غ483.10 (f)(1)-(3)(8) □ Se	elf Determination	
		rson with transfers and total		Issue Cited:		
		rson for baths.	1	Choices- Showers		

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. (X3) DATE SI	
	CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
			A. BUILDING	3	с	
		345325	B. WING			2/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		2/2020
				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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 561	Continued From page	e 2	F 56	51		
			1 00	1. Immediate action(s	) taken for the	
	A review of the facility	y's shower schedule		resident(s) found to hav	·	
		45 was scheduled showers		include:		
	on Wednesdays and	Saturdays on the 7a.m. to 3		The facility social worke	r surveyed all	
	p.m. shift.			residents, including Res	sident #45,	
				Resident #42, Resident		
	Nursing documentation			# 33, to determine bathi		
		t received showers as		following the May 30	June 2, 2023,	
	scheduled in the follo	-		DHHS Survey.		
		ere were no showers		N	to settle to a strend	
	documented as giver			Newly admitted resident		
	Saturday. There were	sdays March 9, 2023 and		about their preferences daily living, including ba		
	March 16, 2023.	suays March 9, 2023 and		during the admission pr		
		e were no showers		2. Identification of oth		
	documented as giver			the potential to be affect	•	
	Saturday. There was			accomplished by:		
	documented on Thurs	•		The facility has determine	ned that all	
	May 2023: There	e were no showers		residents in the facility r		
	documented as giver	n on Wednesday and		potential to be affected.		
	Saturday. There was	-				
	documented on Frida	ay, May 19, 2023.		3. Actions taken/syste		
				to reduce the risk of futu	ire occurrence	
		?7 a.m., Resident # 45 was		include:	hy Corrolton	
		motorized wheelchair well		General in-services led	-	
		ersonal clothing in her room. air covering to match her		Facility Management (C staff, the facility Adminis		
	-	ere no foul odors noted.		of Nursing for all staff (ii		
				administrative staff, clin	-	
	In an interview with R	Resident #45 on 5/30/2023 at		contractors), on June 7,		
		d she was scheduled		the Resident s Right of		
		ո. to 3 p.m. shift twice a		Self-Determination, inclu		
	week and had been g	getting one to two showers a		determine when they re		
		was not enough help in the		and other issues identifi	2	
	-	5 stated she wanted a		30- June 2, 2023, DHHS	S Survey.	
		. On 5/31/2023 at 4:15 p.m.,				
		this was her scheduled		The facility administrato	-	
		se Aide (NA) # 2 provided		consultant met with the		
	her a bed bath and d	id not offer to give her a		on June 8, 2023, to disc	cuss the facility⊟s	

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPF OMB NO. 0938	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345325	B. WING		C 06/02/202	23
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
THE CAR	ROLTON OF DUNN			711 SUSAN TART ROAD		
	1			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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMP	X5) PLETIO ATE
F 561	Continued From page	e 3	F 56	1		
<ul> <li>F 561 Continued From page 3 shower. When asked if she ask NA #2 for a shower, she stated she didn't ask for a shower. In a follow up interview with Resident #45 on 6/2/2023 at 1:01 p.m., she stated receiving showers meant a lot to her. Showers made her feel clean and healthy. She stated she want to smell clean and had smelled herself in the past because she had not had a shower.</li> <li>In an interview with NA #2 on 5/31/2023 at 4:20 p.m., she stated she was assigned the 500-hall and Resident #45 on the 300-hall. She said she did not check the shower book before providing Resident #45 a bed bath, and Resident #45 did not ask for a shower. When asked if she had given any assigned showers on 5/31/2023, she explained due to being the only nurse aide assigned to the 500-hall and Resident #45 and had not been able to provide showers to the residents.</li> </ul>		F 56	plan for ensuring that resident preferences regarding activities living, including baths and show Nursing Staff (including all nurse certified nursing assistants) were in-serviced on the Resident□s F Self-Determination, including the determine when they receive a s June 12, 2023, through June 14 the Interim Director of Nursing, Administrator and CFM Corpora The facility shower schedule wa to include residents□ preference regarding baths and showers, in preferences for Resident #45, R #42, Resident #14, and Resider June 18-19, 2023.	ers. es and e Right of e right to shower, , 2023, by te staff. s revised es cluding esident		
	5:40 p.m., she stated scheduled a shower of Saturdays. She said Resident #45 was no Resident #45 had not receive a shower on a #2 was the only nurse 500-hall and Residen 5/31/2023. She expla one nurse aide on the enough time to give F a bed bath was given In an interview with th 6/2/2023 at 2:30 p.m. Resident #45 had not	on Wednesdays and NA #2 had not informed her t given a shower, and t mention to her she did not 5/31/2023. Nurse #2 said NA e aide assigned to work the at #45 on the 300-hall on hined when there was only e assignment, there was not Resident #45 a shower, and		<ul> <li>Resident care plans, including of for Resident #45, Resident #42, #14 and Resident # 33, were readdress activities of daily living, baths and showers June 20 2</li> <li>Nursing staff, including nurses a certified nursing assistants were regarding the new shower scheet documentation expectations and frequencies by the Director of N June 19-22, 2023.</li> <li>How the corrective action(s monitored to ensure the practice recur: The Interim Director of Nursing designee will complete daily aud (4) consecutive weeks beginning 2023, to determine if residents</li> </ul>	Resident vised to including 8, 2023. and educated dules, d auditing ursing ) will be e will not or lits for four g June 20,	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 561 Continued From page 4 F 561 showers were scheduled twice a week and preferences regarding showers are being Resident #45 had received a shower honored. inconsistently when extra staff was available to The facility nurse consultant or other CFM corporate staff will randomly survey assign showers. residents monthly for the next three (3) months to determine if residents 2. Resident #42 was admitted to the facility on preferences regarding showers are being 12/19/2014, and diagnoses included stroke. honored. Survey records will be reviewed by the Resident #42's care plan initiated 11/16/2016 Quality Assurance/ Performance Improvement (QAPI) Committee until included one person providing physical assistance and constant supervision with bathing such time consistent substantial due to impaired mobility. compliance has been achieved as determined by the committee. Audit results will be shared with the A grievance report dated 3/7/2023 stated Resident #42 reported during a Resident Council Resident/Family Group Council for Meeting he had not received a shower, and comment and suggestions. nursing staff were reminded to follow the shower schedule. Corrective action completion date: June 30, 2023. The annual Minimum Data Set (MDS) assessment dated 4/26/2023 indicated Resident #42 was cognitively intact with limited movement to one upper and lower side of the body and required total assistance with bathing. A review of the facility's shower schedule indicated Resident #42 was scheduled showers on Mondays and Thursdays on the 7a.m. to 3 p.m. shift. Nursing documentation for baths revealed Resident #42 had not received showers as scheduled in the following months: March 2023: There were no showers documented given to Resident #42 for the month. April 2023: There were no showers documented given to Resident #42 for the month. May 2023: There were no showers

FORM CMS-2567(02-99) Previous Versions Obsolete

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING			06/	C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		
THE CARI	ROLTON OF DUNN			1 SUSAN TART ROAD JNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 561	observed sitting in a w yellow collared shirt a #42's combed hair did nails were short and do odors noted. In an interview with R 3:46 p.m., he stated h in two weeks. He said him get a bath and wa enough staff to provid had voiced a concern at the Resident Coun- interview with Reside explained that getting made him feel better a shower, he felt like he bed baths. In an interview with N p.m., she explained R showers twice a week nurse aides were una a shower and had be She stated Resident # concern to her about knew Resident #42 lo In an interview with N 12:52 p.m., she expla assigned to Resident months, Resident #42 and not his showers a	Resident #42 for the p.m., Resident #42 was wheelchair wearing a clean and khaki pants. Resident d not appear greasy, and his clean. There were no foul esident #42 on 5/30/2023 at the had received one shower d the nursing staff helped as told there was not le a shower. He stated he about not getting showers cil meetings. In a follow up nt #42 on 6/1/2023, he his two showers a week and if he didn't get a e was still dirty after getting urse #1 on 6/1/2023 at 3:11 Resident #42 was scheduled k, and due to limited staff, ible to provide Resident #42 en providing him bed baths. #42 had not voiced a not getting his shower and wed getting his showers. urse Aide #1 on 6/2/2023 at ined due to one nurse aide #42's hall the last few 2 had received bed baths as scheduled. She recalled	F 561				
	-	ting to provide residents' d and explained she was not					

Facility ID: 923073

If continuation sheet Page 6 of 66

	-						FORM	D: 07/11/2023
STATEMENT (	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345325	B. WING			_		C 02/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	able to complete the s she was the only nurs assigned 19-20 reside p.m. shift. In an interview with th 6/2/2023 at 2:30 p.m. Resident #42 had not showers twice a week assigned to the hall. S provided inconsistent scheduled in the facili nursing staff during a residents their schedu 3. Resident #14 was a 10/10/2020, and diag musculoskeletal impa Resident #14's care p included a focus for a limited mobility and st total assistance of one showering. The quarterly Minimum assessment dated 3/2 #14 was cognitively in to the upper and lowe of the body and requin activities of daily living A review of the facility indicated Resident #1	scheduled showers when be aide on the hall and ents during the 7 a.m. to 3 the Director of Nursing on , she stated she was aware been getting his scheduled a due to not enough staff She explained showers were ly when there was extra staff ty and had reminded the staff meeting to provide uled showers. admitted to the facility on noses included irment. Jaan initiated on 12/29/2020 ctivities of daily living due to rated Resident #14 required e person for bathing and m Data Set (MDS) 24/2023 indicated Resident fact with limited movement er extremities on both sides red total assistance with all g. r's shower schedule 4 was scheduled showers lays on the 3 p.m. to 11 p.m.	F	561				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING		_		C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CARI	ROLTON OF DUNN			11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561		nth of May 2023. 5 a.m., Resident #14 was	F 561				
	leaning toward the lef wearing a gown that v side. His short brown and was uncombed. H	bed with his head down t side. Resident #14 was was wet on the upper left hair did not appear greasy His contracted clean hands					
	computer device that bed table. There were	omach area, as well as a resting up against the over e no foul odors noted while ht #42 during the interview.					
	11:15 a.m., he stated offered on the days so he knew when there w	esident #14 on 5/30/2023 at he would go get a shower if cheduled for a shower and was only one nurse aide ne would not get a shower.					
	Resident #14 stated h In a follow up interview 6/2/2023 at 1:13 p.m.	ne was receiving bed baths. w with Resident #14 on , he explained showers					
	getting showers when the hall. He said he ha	but understood why not one nurse aide assigned to ad not refused any showers staff had not offered to give					
	2:02 p.m., she stated Resident #14 his sche she was the only nurs for the 3:00 p.m. to 11	•					
	the hall, she was unal showers and provide	ing with one nurse aide on ble to complete scheduled bed baths to Resident #14.					
	p.m., she stated Resi	urse #3 on 6/2/2023 at 3:06 dent #14 had not been ce a week as scheduled.					

Facility ID: 923073

If continuation sheet Page 8 of 66

DEPARTMENT OF HEALTH AN						FORM	D: 07/11/2023
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
	345325	B. WING			_		C 02/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CARROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>were unable to complesive stated Resident #14 h administration was aw residents were not record.</li> <li>In an interview with the 6/2/2023 at 2:30 p.m., Resident #14 was not showers consistently of to the hall Resident #14 pulling the nurse aides showers left the hall willights and bed baths with had reminded the nurse scheduled showers ar available in the facility residents was a priorite</li> <li>4. Resident #33 was a 9/22/2022 with diagno depression and polycy. The quarterly Minimur assessment dated 4/1 #33 was cognitively in behaviors for refusal of one person for bath. A review of the facility indicated Resident #33</li> </ul>	<ul> <li>and nursing aide was</li> <li>#14's hall, the nurse aides</li> <li>et escheduled showers. She ad received bed baths and vare Resident #14 and the ceiving scheduled showers.</li> <li>e Director of Nursing on she stated she was aware receiving his scheduled due to limited staff assigned 14 resided. She stated is from the hall to provide with no one to watch the call vere given. She stated she sing staff to provide nd when extra staff was r, providing showers to the call vere given. She stated she sing staff to provide nd when extra staff was r, providing showers to the call vere given. She stated she sing staff to provide the transfer to the facility on the set that included ystic ovarian syndrome.</li> <li>m Data Set (MDS) /2023 indicated Resident tact and displayed no of care. The MDS further 3 required total assistance is.</li> <li>'s shower schedule 3 had scheduled showers stays on the 7a.m. to 3</li> </ul>	F	561				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING			06/0	C 02/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	E, ZIP CODE	•	
			71'	1 SUSAN TART ROAD			
THE CAR	ROLTON OF DUNN		DL	JNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 561	documented as given Thursdays. There was documented on Frida April 2023: There documented as given Thursdays. There was documented on Satur May 2023: There documented on Satur May 2023: There documented as given Thursdays. There we documented on Frida May 12, 2023. In an interview with R 11:46 a.m., she stated receiving her showers transferred to the 500 weeks ago. Resident shower twice a week, her desire for showers transferred to the 500 weeks ago. Resident shower twice a week, her desire for showers added that she thoug her showers due to th on the halls. Resident clean with some facia interview with Reside PM revealed she had and she was able to s In an interview with N p.m., she stated Resi receiving showers twi She explained that the aides to complete sch Resident #33 had rec that she was aware re showers. Nurse #4 co	wing months: re were no showers on Mondays and s only one shower y, March 3, 2023. e were no showers on Mondays and s only one shower day, April 29, 2023. were no showers on Mondays and re only two showers y, May 5, 2023, and Friday, esident #33 on 5/30/2023 at d she had not been s twice a week since being hall approximately two : #33 stated she wanted a and that staff knew about s instead of bed baths. She ht she was unable to receive there not being enough staff t #33 was observed to be I hair on her chin. A later nt #33 on 6/1/2023 at 1:14 access to her own razor, shave at any time. urse #4 on 6/1/2023 at 1:57 dent #33 had not been ce a week as scheduled. ere were not enough nurse neduled showers. She stated eived bed baths but added	F 561				

Facility ID: 923073

If continuation sheet Page 10 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/11/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345325	B. WING _			_		C 102/2023
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE CARF	ROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561 F 577 SS=C	Resident #33 was not leisure. In an interview with th 6/2/2023 at 2:30 p.m. Resident #33 had not showers twice a week assigned to the hall. S provided inconsistent staff scheduled in the the nursing staff durin residents with their sc Right to Survey Resul CFR(s): 483.10(g)(10) \$483.10(g)(10) The results of the facility conducte surveyors and any pla respect to the facility; (ii) Receive informatio client advocates, and to contact these agen \$483.10(g)(11) The fa (i) Post in a place read and family members a residents, the results	d be a dignity concern if able to shave at her e Director of Nursing on , she stated she was aware been getting his scheduled a due to not enough staff She explained showers were y when there were extra facility and had reminded g a staff meeting to provide heduled showers. Its/Advocate Agency Info )(11) esident has the right to- s of the most recent survey ed by Federal or State an of correction in effect with and on from agencies acting as be afforded the opportunity cies.		577		)EFICIENCY)		6/30/23
	certifications, and con respecting the facility years, and any plan o respect to the facility, to review upon reques	availability of such reports in						

Facility ID: 923073

If continuation sheet Page 11 of 66

ATEMENT	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUUT		CONSTRUCTION	(V2) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · ·	PLETED
			AL DOILDIN				с
		345325	B. WING				02/2023
AME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				71	1 SUSAN TART ROAD		
	OLTON OF DUNN			DI	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 577	Continued From non	- 44					
F 5//	Continued From page		F 5				
	accessible to the pub						
		not make available identifying nplainants or residents.					
		is not met as evidenced					
	by:						
	Based on observatio	ns, resident interviews and			Carrolton of Dunn Nursing and		
	staff interviews, the fa				Rehabilitation Center acknowledges		
	``	47, #42, #45, #59 and #41)			receipt of the Statement of Deficiencies		
		ite inspection results and			and proposes this Plan of Correction to		
	failed to display state accessible to a wheel	-			the extent that the summary of findings factually correct and in order to maintain		
		of 6 residents in attendance			compliance with applicable rules and	1	
	of the Resident Coun				provisions of quality of care of residents	s.	
	-	5			The Plan of Correction is submitted as a		
	The findings included	:			written allegation of compliance.		
					Carrolton of Dunn Nursing and		
		n during a Resident Council			Rehabilitation Center s response to thi	s	
		7, Resident #42, Resident			Statement of Deficiencies does not	£	
		id Resident #41 stated state re not made available for			denote agreement with the Statement on Deficiencies nor does it constitute an	T	
	-	they did not know the			admission that any deficiency is accura	te	
	location of the state in	-			Further, Carrolton of Dunn Nursing and		
					Rehabilitation Center reserves the right	to	
	On 6/1/23 at 10:48 ar	n the state inspection results			refute any of the deficiencies on this		
		acility was observed on the			Statement of Deficiencies through		
		der, with the base of the			Informal Dispute Resolution, formal		
		ed approximately fifty-six			appeal procedure and/or any other		
		in the hallway across from ice. There was no label			administrative or legal proceeding.		
		nspection results binder			Tag Cited: F- 577		
		file holder. The binder was			¿ 483.10 (6-9) Right to Survey Results		
		reading survey results			Issue Cited: State inspection results		
	towards the wall.				were not within reach for all residents.		
					1. Immediate action(s) taken for the		
	On 6/1/23 at 10:50 ar				resident(s) found to have been affected		
		each the State Inspection			include:		
	Results binder while s stated she would be	sitting in her wheelchair and			The facility survey book was lowered to ensure readily accessibility to all		

Facility ID: 923073

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· · /	IG		MPLETED	
		345325	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP CO	06/02/2023		
				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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 577	Continued From page	a 12	F 5	77			
1 011	An interview was con			representatives of residents.			
	the survey inspection	results binder should be		The facility Administrator and			
		ts without assistance. He we the clear file holder		consultant met with the Resident on June 6, 2023, and educat			
		sition so it would be within		on the of the location of the s			
	reach of wheelchair b	oound residents.		notebook.	-		
				2. Identification of other re- the potential to be affected w			
				accomplished by:	43		
				The facility has determined the residents have the potential affected.			
				3. Actions taken/systems p to reduce the risk of future of include:			
				Letters were mailed to every party on June 20, 2023, with regarding where survey resu located.	an update		
				Letters were distributed direct patients on June 20, 2023, p an update on where survey r located. This information is a during the admissions proces	roviding them results are also provided		
				All residents, family member representatives of residents and family members will con access to the survey results.	and guests,		
				General in-services led by C Facility Management (CFM) staff, the facility Administrato of Nursing for all staff (includ	corporate r and Director		

Event ID: RJKF11

Facility ID: 923073

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CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. (C       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SU COMPLET       AMD PLAN OF CORRECTION     345325     B. WING     C       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE	JRVEY
345325 B. WING 06/02	
	2/2023
711 SUSAN TART ROAD	
THE CARROLTON OF DUNN DUNN, NC 28335	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)IDPREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577       Continued From page 13       F 577         administrative staff, clinical staff and contractors), on June 7, 2023, about the location and availability of survey results and other issues identified from the May 30- June 2, 2023, DHHS Survey.         Nursing Staff (including all nurses and certified nursing assistants) were in-serviced about the location and availability of survey results. June 12, 2023, through June 14, 2023, by the Interim Director of Nursing, Administrator and CFM Corporate staff.         4       How the corrective action(s) will be monitored to ensure the practice will not recur: Walking rounds by the Administrator or designee will incorporate a conversation with the residents about the location of survey results. These will occur a minimum of twice weekly for four (4) weeks beginning June 19, 2023. Immediate corrective action, including re-education, will follow as needed. Audits and Survey reconds will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee. Intige compliance has been achieved as determined by the counting. Administent substantial compliance has been achieved as determined by the committee.         Audit results will be shared with the Resident Council for comments and suggestions.         Corrective action completion date: June 30, 2023.	

Event ID: RJKF11

Facility ID: 923073

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/11/2023 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION			SURVEY PLETED
		345325	B. WING			_		02/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585 SS=B	-	(4)	F	585				6/30/23
	grievances to the faci that hears grievances reprisal and without fe reprisal. Such grievan respect to care and tr furnished as well as th furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The resif facility must make pro- resolve grievances the accordance with this p §483.10(j)(3) The faci on how to file a grieva- to the resident. §483.10(j)(4) The faci grievance policy to en of all grievances rega contained in this para provider must give a of to the resident. The g include: (i) Notifying resident in postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance offici- can be filed, that is, h address (mailing and	ident has the right to voice lity or other agency or entity a without discrimination or hear of discrimination or hear which has not been for of staff and of other concerns regarding their LTC dident has the right to and the pompt efforts by the facility to e resident may have, in paragraph. With must make information ance or complaint available lity must establish a heare the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must individually or through clocations throughout the						

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	): 07/11/2023 APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION			LETED
		345325	B. WING			_	( 06/	02/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	ROLTON OF DUNN			71	11 SUSAN TART ROAD			
	KOLION OF DONN			D	UNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	to obtain a written dec grievance; and the co independent entities w be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Grieve responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associated example, the identity of grievances submitted written grievance dec coordinating with state necessary in light of s (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged v abuse, including injuri and/or misappropriation anyone furnishing ser provider, to the admin as required by State Ia (v) Ensuring that all w include the date the g summary statement of the steps taken to inve- summary of the pertin- regarding the resident as to whether the grief	r of the grievance; the right cision regarding his or her ntact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system; ance Official who is being the grievance process, or grievances through to their any necessary investigations ning the confidentiality of all d with grievances, for of the resident for those anonymously, issuing sions to the resident; and e and federal agencies as pecific allegations; ing immediate action to ial violations of any resident violation is being 183.12(c)(1), immediately iolations involving neglect, es of unknown source, on of resident property, by vices on behalf of the istrator of the provider; and	F 5	85				

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CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. (       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SU COMPLE	JRVEY
C 345325 B. WING 06/02	2/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
711 SUSAN TART ROAD	
THE CARROLTON OF DUNN DUNN, NC 28335	
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585       Continued From page 16 taken by the facility as a result of the grievance, and the date the written decision was issued;       F 585         (vi) Taking appropriate corrective action in accordance with the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any or these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grevances for a period of no less than 3 years from the issuance of the grievance decision.       Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose shis Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The quarterly Minimum Assessment Data (MDS) assessment dated 21/14/2023 indicted Resident #45 was cognitively intact.         A review of the grevance reports revealed the following grevances for Resident #45. "On 3/8/2023. Resident #45 voiced concern for having to wait an extended about of time to received incontinent care on 3/5/2023. The grievance report indicated the form was completed by the Director of Nursing (DON) and the concern was investigated by the Don and	

Facility ID: 923073

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345325	B. WING				C 6/02/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0.01.1010
				7'	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	DUNN, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 585	Continued From page	o 17		585			
1 000				000			
		was no date of resolution on			Tag Citad: E 585		
		and the grievance report on continued. The grievance			Tag Cited: F-585		
	report also indicated	0			¿483.10(j) (1)- (4) - Grievances Issue Cited:		
		ending state investigation.			Failure to Follow Up on Grievances		
		esident #45 voiced concern			1. Immediate action(s) taken for the	<u>_</u>	
		th since February 2023. The			resident(s) found to have been affect		
	DON and Administrat				include:	.00	
		orted on the grievance report			The facility Administrator began prov	idina	
		not receive a shower due			written responses and follow up to al		
		dressing to lower leg.			outstanding grievances during the M		
	-	cated resolution of the			□ June 2, 2023, DHHS Survey.	<b>,</b>	
		ation of Resident #86 on			· · · · · · · · · · · · · · · · · · ·		
	3/7/2023.				Carrolton Facility Management (CFN	I)	
	*On 4/4/2023, a	grievance report for Resident			Corporate staff met with the facility	,	
	#45 voiced a concerr	n for waiting until lunch time			Administrator on June 5, 2023, to dis	cuss	
	to get incontinent car	e and assisted up into her			expectations regarding prompt respo	nse	
	wheelchair. The con	cerns were investigated by			to all grievances and recommendation	ns	
	the DON and Adminis	strator. The grievance report			concerning issues of resident care a	nd life	
	indicated nursing stat	ff would be ins-services on			in the facility.		
	conducting frequent r	rounds and the complainant,					
	Resident #45's sister	was notified of the			The facility nurse consultant and the		
	resolution on 4/5/202	3.			facility administrator met with the Res Council on June 6, 2023, to address	sident	
	There was no eviden	ce of copies of written			grievance follow up and to address a	ny	
	grievance response t #45.	he grievances for Resident			outstanding concerns.		
					2. Identification of other residents h	naving	
		ed 3/20/2023 included			the potential to be affected was		
	discontinuation of the	e unna boot dressing to lower			accomplished by:		
	leg.				The facility has determined that all		
					residents have the potential to be		
		Resident #45 on 5/30/2023 at			affected.		
		ed she was not receiving her					
		and since 3/5/2023 the staff			CFM Corporate staff reviewed all		
	-	er incontinent needs in a			grievances for the past six (6) month		
	more timely manner.				following the May 30-June 2, 2023, E		
					Survey and determined that the facili	•	
	p. Resident #42 was	admitted to the facility on			has addressed outstanding grievance	es.	1

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 585 Continued From page 18 F 585 12/19/2014. 3. Actions taken/systems put into place The annual Minimum Data Set (MDS) to reduce the risk of future occurrence assessment dated 4/26/2023 indicated Resident include: #42 was cognitively intact. The Carrolton Grievance Form was updated on June 1, 2023, to better A review of the grievance reports revealed the facilitate documentation of grievance following grievances for Resident #42: follow up and resolution. \*On 3/7/2023 during resident council meeting Resident #42 voiced a concern for not receiving a The facility social worker was appointed shower. The grievance report indicated the the Grievance Official, responsible for Director of Nursing (DON) investigated and overseeing the grievance process remind ed nursing staff for follow the shower following the May 30-June 2, 2023, DHHS schedule. Resolution was dated 3/7/2023. Survey. \*On 4/3/2023 during resident council meeting Resident #42 voiced a concern for not receiving a General in-services led by Carrolton shower in the past 2-3 weeks. Facility Management (CFM) corporate \*On 5/12/2023, Resident #42 voiced a staff, the facility Administrator and Director concern on the staff attitude when asked to of Nursing for all staff (including administrative staff, clinical staff and change wet linen. The grievance report indicated contractors), on June 7, 2023, to address the DON completed and investigated the concern, and resolution was dated 5/12/2023. Resident Rights concerning Grievances, including Response to Grievances, and There was no evidence of copies of written other issues identified from the May 30grievance response the grievances for Resident June 2, 2023, DHHS Survey. #42. The Director of Nursing, the Social In an interview with Resident #42 on 5/30/2023 at Worker and the Activity Director were 3:36 p.m., Resident #42 stated he had voiced in-serviced on June 8, 2023, by CFM concerns about not receiving showers in the Chief Clinical Officer on Response to resident council meeting and was unsure if the Grievances. concerns had been taken to the Director of Nursing because he had not heard anything and Nursing Staff (including all nurses and still was not getting his scheduled showers. In a certified nursing assistants) were follow up interview, Resident #42 stated he spoke in-serviced on Resident Rights concerning with the Administrator on 5/31/2023 about not Grievances, including Response to getting my showers, but the Administrator didn't Grievances, June 12, 2023, through June say what he was going to do about it. 14, 2023, by the Interim Director of Nursing, Administrator and CFM

FORM CMS-2567(02-99) Previous Versions Obsolete

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		MEDICAID SERVICES					O. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	E SURVEY IPLETED
		345325	B. WING			C 06/02/2023	
	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		5/02/2023
					1 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN				UNN, 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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			ЗE	(X5) COMPLETIO DATE
F 585	Continued From page	<u>, 10</u>		585			
1 303			F 5	585	0		
	In an interview with th				Corporate staff.		
		n., she stated she was			Topics covered in these in-services		
		ig the grievance reports, and			included the following:		
	the greivance reports				A Decident Diritize De		
		or, DON and Administration			A. Resident Rights Regarding		
		d she did not send written			Grievances		
	-	etters after the resolution of			a. Review of Carrolton Policy # 2.3		
	the grievance.				Resident and Family Grievances		
					i. Use of the Grievance Officer		
	In an interview with th				ii. Revised Grievance Form		
		n., he stated since January			iii. Grievance Resolution		
		esponsible for sending the			The facility acciel werken received		
		ponse after resolution of the ning a new Social Worker.			The facility social worker received additional training from a seasoned		
	He stated the DON se				Carrolton social worker on June 13, 20	าวว	
		dents and did not make a			regarding Grievance Resolution.	JZJ,	
		records. In a follow up			regarding Ghevance Resolution.		
		ministrator on 5/31/2023 at			4. How the corrective action(s) will b		
		rsing in-services were held			monitored to ensure the practice will n		
	on 3/31/2023 for negl				recur:	υı	
	incontinent care due f				The facility Administrator will monitor a	511	
		care timely, and there were			grievances and follow up to assure tim		
		staff related to providing			resolution. This will include a weekly a		
		ent care after 3/31/2023. He			for four (4) weeks, beginning June 19,		
		was not given a letter of			2013, of Grievance Resolution using the		
		vances dated 3/6/2023,			Grievance Resolution QI Tool to assur		
		3, and Resident #42 was not			that compliance is maintained.	-	
		ution for the grievances					
	dated 3/7/2023, 4/3/2				Grievances and follow up to all grievar	nces	
		#45 and Resident #42 were			will be audited by the Carrolton Facility		
		1/2023. He said Resident			Management (CFM) Compliance Tean		
		neeting her incontinent			monthly using the Grievance Resolution		
		nner had improved and she			QI Tool to assure that compliance is		
	-	e chair regularly. He stated			maintained. The monitoring will contir	nue	
		eived bed baths regularly,			for three (3) months.		
		ot receiving scheduled			· ·		
	showers and still was	-			Survey records will be reviewed by the	Э	
		t receiving showers on his			Quality Assurance/ Performance		
		nued to be a concern for			Improvement (QAPI) Committee until		

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 093 (X3) DATE SURV COMPLETED	EY	
		345325			C 06/02/2023		
	ROVIDER OR SUPPLIER	545525		TREET ADDRESS, CITY, STATE, ZIP CODE	06/02/20	123	
	ROLTON OF DUNN		7	11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CON	(X5) IPLETIO DATE	
F 585 F 623 SS=B	staff attitudes in provi facility would look at of schedule to adjust wo grievance response v and #42 on 5/31/2023 In an interview with th 6/2/2023 at 2:30 p.m. grievances dated 3/6, 4/4/2023 and Resider 3/7/2023, 4/3/2023 at investigated. She exp in-serviced on negleo care, and staff were r showers as schedule send out letters of wr and nothing had char Resident #45 and #42 limited staffing assign Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans- resident, the facility m (i) Notify the resident representative(s) of th the reasons for the m language and manne facility must send a co representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and	ced no further concerns with ding care. He stated the changing the shower orkload for staff and a written vas given to Resident #45 3. The Director of Nursing on , she stated Resident #45's (2023, 3/7/2023 and nt #45's grievances dated nd 5/12/2023 were blained nursing staff were t and providing incontinent eminded to provide resident d. She stated she did not itten grievance responses nged to consistently provide 2 scheduled showers due to ned to the halls. Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman.	F 585	such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comments and suggestions. Corrective action completion date: J 30, 2023.	une 6/30	/23	

Facility ID: 923073

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CENTER STATEMENT (	MENT OF HEALTH AN	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _				
		345325	B. WING			_	06/	) 02/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	paragraph (c)(5) of thi §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, t discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Contem notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for	is section. of the notice. If in paragraphs (c)(4)(ii) and he notice of transfer or ider this section must be cleast 30 days before the or discharged. de as soon as practicable charge when- riduals in the facility would paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge, )(i)(B) of this section; hefer or discharge is ent's urgent medical needs, )(i)(A) of this section; or cresided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: hefer or discharge; of transfer or discharge; of transfer or discharge; ich the resident is ged; e resident's appeal rights, ddress (mailing and email), or of the entity which ts; and information on how	F	623				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/11/2023 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING			_		C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
THE CAR	ROLTON OF DUNN				1 SUSAN TART ROAD JNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	hearing request; (v) The name, address telephone number of t Long-Term Care Omb (vi) For nursing facility and developmental dis disabilities, the mailing telephone number of t the protection and add developmental disabil C of the Development and Bill of Rights Act of codified at 42 U.S.C. (vii) For nursing facility disorder or related diss email address and tele agency responsible for advocacy of individua established under the for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer of must update the recip as practicable once the becomes available. §483.15(c)(8) Notice i In the case of facility of the administrator of th written notification prior to the State Survey Ag State Long-Term Care the facility, and the recip	s (mailing and email) and the Office of the State oudsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility tients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate	F 6	23				

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CENTER	5 FUR MEDICARE &	MEDICAID SERVICES				<u>VO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDIN	G		C
		345325	B. WING			6/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0/02/2023
				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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	Continued From page	- 22	5.0			
F 023	Continued From page		F 6	23		
	by:	is not met as evidenced				
	-	iew and staff interviews the		Carrolton of Dunn Nursin	a and	
		le written notice of the		Rehabilitation Center ack		
	reason for transfer to	the resident and/or		receipt of the Statement of		
	responsible party (RF	,		and proposes this Plan of		
	(Resident #86) reviev	ved for hospitalization.		the extent that the summa		
				factually correct and in or		
	Findings included:			compliance with applicabl		
	Resident #86 was ad	mitted to the facility on		provisions of quality of car The Plan of Correction is		
	9/9/2022.			written allegation of comp		
				Carrolton of Dunn Nursing		
	The quarterly Minimu	m Data Set (MDS)		Rehabilitation Center Is re		
		8/2023 indicated Resident		Statement of Deficiencies	•	
	#86 was cognitively ir	ntact.		denote agreement with the		
				Deficiencies nor does it co		
		er form dated 3/17/2023 at		admission that any deficie	•	
	3:21 p.m. indicated R			Further, Carrolton of Dunr		
		y tract infection (UTI) on		Rehabilitation Center rese	•	
		sident #86 experienced a		refute any of the deficience		
	resident representativ	atus, the physician and the		Statement of Deficiencies	•	
	-	nt to the hospital for an		appeal procedure and/or a		
	evaluation.			administrative or legal pro		
	A review of Resident	#86's medical record		Tag Cited: F-623		
	revealed no evidence	e that a copy of a written		¿483.15(d) □ Notice of Tr	ansfer	
	notice of reason for tr	ansfer from the facility on		Issue Cited:		
		led to Resident #86 or		Failure to Provide Notifica		
	Resident #86's Repre	esentative.		1. Immediate action(s) t		
		and the public of the state of the		resident(s) found to have	been affected	
		p.m. in a phone interview		include: Resident #86 record was	reviewed for	
		ated she did not provide dent #86's Representative		notification of transfer. Th		
		f reason for discharge on		and/or legal representative		
		harge to the hospital. She		the facility s transfer polic		
		Nursing was responsible for			- , -	
		on to Resident #86 or		2. Identification of other	rogidanta having	

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345325	B. WING			06/	C 02/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
THE CARI	ROLTON OF DUNN								
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	RECTIVE ACTION SHOULD BE COMPL RENCED TO THE APPROPRIATE DA			
F 623	Resident #86's Repre On 6/2/2023 at 1:54 p Director of Nursing, s not receive a written I on 3/17/2023 becaus 4/4/2023 from the Co were to receive a writ explained since 4/4/2 provided nursing edu reason of transfer lett auditing of the discha compliance of resider	e 24 esentative at that time.	F	523	<ul> <li>the potential to be affected was accomplished by:</li> <li>The facility has determined that all residents have the potential to be affected.</li> <li>3. Actions taken/systems put into plat to reduce the risk of future occurrence include:</li> <li>Nursing Staff (including all nurses and certified nursing assistants) were in-serviced on the facility s procedures regarding notification of transfer, June 2023, through June 14, 2023, by the Director of Nursing, Administrator and CFM Corporate staff.</li> <li>The CFM Nurse Consultant in-serviced the social worker on June 14, 2023, addressing the facility s procedures regarding notification of transfer.</li> <li>These in-services covered the following items: <ul> <li>Carrolton Policy 4.5 Transfer and Discharge</li> <li>Transfer/Discharge to Hospital Checklist to include the issuing of the Notice of Transfer</li> </ul> </li> <li>Additional to include the issuing of the Notice of Transfer and Discharge process</li> <li>4. How the corrective action(s) will be monitored to ensure the practice will no recur:</li> <li>The Director of Nursing, or designee, w conduct weekly audits for four (4) consecutive weeks of residents that ha been transferred/discharged using the Transfer/Discharge to Hospital QI Tool</li> </ul>	s 12, 1 g es - e ot vill			

Event ID: RJKF11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345325	B. WING				C 02/2023	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARI	ROLTON OF DUNN				711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COM REFERENCED TO THE APPROPRIATE		
F 623 F 625 SS=B	Notice of Bed Hold Pe CFR(s): 483.15(d)(1)( §483.15(d) Notice of I §483.15(d)(1) Notice nursing facility transfe the resident goes on t nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume resi facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi	blicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to int representative that e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any;		623	ensure proper notification of transfer w provided to the resident /legal representative. Audits will begin the w of June 19, 2023. The facility nurse consultant or other C corporate staff will randomly audit five resident records monthly for the next three (3) months to ensure the proper notification of transfer was provided to resident and/or legal representative. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: Jun 30, 2023.	eek FM (5) the	6/30/23	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING _				C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7'	11 SUSAN TART ROAD		
THE CARF	CARROLTON OF DUNN				UNN, NC 28335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TH DEFICIENCY			(X5) COMPLETION DATE
F 625	of this section. §483.15(d)(2) Bed-ho the time of transfer of hospitalization or ther facility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on record revit facility failed to provide writing at the time of to discharged to the hose practice had the potential residents. The findings included Resident #86 was addr 09/09/2022 and was of 3/17/2023. The quarterly Minimut assessment dated 2/8 #86 was cognitively in A review of the transfe 3:21 p.m. indicated R changed in mental star resident #86 was ser evaluation.	d pecified in paragraph (e)(1) Ad notice upon transfer. At a resident for apeutic leave, a nursing to the resident and the re written notice which of the bed-hold policy oh (d)(1) of this section. is not met as evidenced ew and staff interview, the le the bed hold policy in ransfer to 1 of 1 resident spital (Resident #86). This ntial to impact other : mitted to the facility on discharged to the hospital on m Data Set (MDS) 8/2023 indicated Resident ntact. er form dated 3/17/2023 at esident #86 experienced a atus, the physician and the re were notified, and nt to the hospital for an	F	525	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencie and proposes this Plan of Correction to the extent that the summary of findings factually correct and in order to mainta compliance with applicable rules and provisions of quality of care of residen The Plan of Correction is submitted as written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center □s response to th Statement of Deficiencies does not denote agreement with the Statement Deficiencies nor does it constitute an admission that any deficiency is accur. Further, Carrolton of Dunn Nursing an Rehabilitation Center reserves the righ refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-625 ¿483.15(d) □ Notice of Bed Hold Polic	o s is in ts. a a nis of ate. d nt to	

Facility ID: 923073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP 711 SUSAN TART ROAD DUNN, NC 28335			PRINTED: 07/11/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 06/02/2023 IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	Ē	(X5) COMPLETION DATE
F 625	There was no docume was provided to Resid record. On 6/2/2023 at 5:18 p with Nurse #5, she sta not give Resident #86 policy or Resident #86 was discharged to the Director of Nursing wa the bed hold informati representative. Nurse place on Hospice care the hospital. On 6/2/2023 at 1:54 p Director of Nursing, st she was responsible f policy to Resident #86 low in the facility and bed hold policy on 3/1 since Resident #86's in April 2023 of chang information given to re the facility to the hosp been educated on the bed hold policy to give resident representativ the facility had not sta	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 There was no documentation a bed hold policy was provided to Resident #86 in the medical record. On 6/2/2023 at 5:18 p.m. in a phone interview with Nurse #5, she stated on 3/17/2023 she did not give Resident #86 a copy of the bed hold policy or Resident #86's representative when she was discharged to the hospital because the Director of Nursing was responsible for mailing the bed hold information to Resident #86's representative. Nurse #5 said Resident #86 was place on Hospice care at home upon discharge to		625	<ul> <li>and Return Issue Cited:</li> <li>Failure to Provide Notifica</li> <li>1. Immediate action(s) t resident(s) found to have include:</li> <li>Resident #86 s record w notification of Bed Hold.</li> <li>and/or legal representativ the facility s bed hold point</li> <li>2. Identification of other the potential to be affected accomplished by:</li> <li>The facility has determined residents have the potentiant</li> <li>affected.</li> <li>3. Actions taken/system to reduce the risk of futured include:</li> <li>Nursing Staff (including all certified nursing assistant in-serviced on the facility regarding Bed Hold Noticed June 12, 2023, through Jut the Interim Director of Nur Administrator and CFM C</li> <li>The CFM Nurse Consultat the social worker on June addressing Bed Hold Noticed Transfer.</li> <li>These in-services covered items:</li> <li>" Carrolton Policy 4.6 E Upon Transfer</li> <li>" Transfer/Discharge to</li> </ul>	taken for the been affected ras reviewed for The resident re was notified of licy. residents havin d was ed that all ial to be ns put into place e occurrence Il nurses and is) were s procedures e Upon Transfe une 14, 2023, b rsing, corporate staff. ant in-serviced a 14, 2023, ice Upon d the following Bed Hold Notice	- of ng e	

Event ID: RJKF11

Facility ID: 923073

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2023 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING _				C 102/2023
NAME OF PROVIDE	R OR SUPPLIER		- <b>I</b>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
THE CARROLTO				71	1 SUSAN TART ROAD		
				DI	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 640 Encc SS=B CFR §483 requ §483	(s): 483.20(f)(1)- 3.20(f) Automatec irement- 3.20(f)(1) Encodir	g Resident Assessments	F 6		Checklist to include the issuing of the H Hold Notice " The staff member □ s responsibiliti in the Transfer and Discharge process 4. How the corrective action(s) will b monitored to ensure the practice will m recur: The Director of Nursing, or designee, w conduct weekly audits for four (4) consecutive weeks of residents that ha been transferred/discharged using the Transfer/Discharge to Hospital QI Tool ensure proper notification of bed hold w provided to the resident /legal representative. Audits will begin the w of June 19, 2023. The facility nurse consultant or other O corporate staff will randomly audit five resident records monthly for the next three (3) months to ensure the proper notification of bed hold was provided to the resident and/or legal representative Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: Jun 30, 2023.	es e ot will to was reek (5) o e.	6/30/23

Facility ID: 923073

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 07/11/2023 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY LETED
		345325	B. WING			_		C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CARI	ROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	each resident in the fa (i) Admission assessmer (ii) Significant change (iv) Quarterly review a (v) A subset of items of reentry, discharge, and (vi) Background (face is no admission asses §483.20(f)(2) Transmi after a facility complet a facility must be capa CMS System informat contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transmi 14 days after a facility assessment, a facility encoded, accurate, ar the CMS System, incl (i) Admission assessmer (ii) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, an (viii) Background (face	ne following information for acility: nent. ht updates. in status assessments. assessments. upon a resident's transfer, id death. -sheet) information, if there assent. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to its and data dictionaries, dardized edits defined by ittal requirements. Within r completes a resident's must electronically transmit ind complete MDS data to uding the following: nent. it. in status assessment. iton of prior full assessment. iton of prior quarterly upon a resident's transfer, id death. e-sheet) information, for an MDS data on resident that	F	640				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED AND PLAN OF CORRECTION A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 30 F 640 F 640 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interviews the Carrolton of Dunn Nursing and facility failed to transmit and/or complete Rehabilitation Center acknowledges discharge Minimum Data Set (MDS) receipt of the Statement of Deficiencies assessments within the required timeframe for 2 and proposes this Plan of Correction to of 2 residents reviewed for discharge. (Resident the extent that the summary of findings is #38 and Resident #78). factually correct and in order to maintain compliance with applicable rules and The findings included: provisions of quality of care of residents. The Plan of Correction is submitted as a 1. Resident #38 was admitted to the facility on written allegation of compliance. 12/19/22. She was discharged to the community Carrolton of Dunn Nursing and on 1/14/23 based upon record review. Rehabilitation Center s response to this Statement of Deficiencies does not Review of Resident #38's medical record denote agreement with the Statement of revealed her last assessment completed was Deficiencies nor does it constitute an dated 12/26/22, an admission assessment. admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and On 5/31/23 Resident #38's medical record was Rehabilitation Center reserves the right to reviewed and there was no discharge refute any of the deficiencies on this assessment in the record. Statement of Deficiencies through Informal Dispute Resolution, formal During an interview with MDS Nurse #2 on 6/1/23 appeal procedure and/or any other at 1:22 PM she stated Resident #38's discharge administrative or legal proceeding. assessment should have been completed and transmitted. She reported the assessment had Tag Cited: F-640 been overlooked. ¿483.20 (f)(1)-(4) □ Encoding/Transmitting Resident An interview was conducted with the Assessments Administrator on 6/2/23 at 2:24 PM. He stated Issue Cited: Resident 38's MDS assessment dated should Resident Assessment have been completed with the federal 1. Immediate action(s) taken for the timeframes. He stated there had been staff resident(s) found to have been affected

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923073

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 640 Continued From page 31 F 640 turnover in the MDS department which may have include: Resident #38 had a discharge led to the oversight. assessment completed by the MDS nurse 2. Resident #78 was admitted to the facility on on June 2, 2023, and transmitted to the 12/3/22. She was discharged to a local hospital state on June 8, 2023. on 12/4/23 based upon review of her medical Resident # 78 s record was reviewed record. and the delay in assessment completion and transmitted was confirmed. Review of #78's medical record revealed her 2 Identification of other residents having discharge MDS assessment dated 12/4/22 had a the potential to be affected was completion date of 1/9/23. accomplished by: The facility has determined that all During an interview with MDS Nurse #2 on 6/1/23 residents have the potential to be at 1:22 PM she stated Resident #78's discharge affected. assessment dated 12/4/22 should have been completed by 12/18/22. She stated she was not 3. Actions taken/systems put into place employed by the facility at that time so was not to reduce the risk of future occurrence sure the reason it was not completed prior to include: The MDS nurse was replaced with a 12/18/22. seasoned Carrolton MDS nurse following An interview was conducted with the the DHHS survey. Administrator on 6/2/23 at 2:24 PM. He stated Resident 78's MDS assessment dated should General in-services led by Carrolton have been completed with the federal Facility Management (CFM) corporate timeframes. He stated there had been staff staff, the facility Administrator and Director turnover in the MDS department which may have of Nursing for all staff (including led to the oversight. administrative staff, MDS, clinical staff, and contractors), on June 7, 2023, to address Transmitting Resident Assessments, and other issues identified from the May 30- June 2, 2023, DHHS Survey. The facility nurse consultant educated the MDS nurse regarding timelines for completion of MDS and transmission of the assessments on June 8, 2023. The MDS nurse and the Carrolton Facility

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Event ID: RJKF11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C	
		245225				
		345325		B. WING		
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 DEFICIEN	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	(X5) COMPLETIC DATE
F 640	Continued From page		F 64	<ul> <li>Nurse Consultant completed a full transmission of all assessments the ready for export on June 8, 2023.</li> <li>The MDS nurse and the Carrolton Nurse Consultant reviewed all disc from the facility for the last 30 day 6-8-23 to ensure that all discharge assessments were completed and transmitted as per regulation.</li> <li>How the corrective action(s) we monitored to ensure the practice were cur:</li> <li>The MDS nurse will transmit to the weekly and provide the administrat copy of the transmission report for The facility nurse consultant will and discharges from the facility to ensure the Discharge MDS are completed transmitted timely. The audits will weekly for four (4) weeks beginning week of June 19, 2023.</li> <li>Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee usuch time consistent substantial compliance has been achieved as determined by the committee.</li> <li>Corrective action completion date: 30, 2023.</li> </ul>	Facility charges s on vill be vill not e state tor a review. udit all ure that d and occur ig the he ntil	6/30/23
	§483.20(g) Accurac	y of Assessments.				

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) MILL	דופי ר	CONSTRUCTION	OMB NC	0. 0938-039
				(X2) MULTIPLE CONSTRUCTION A. BUILDING			LETED
		345325	B. WING				C 02/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CARROLTON OF DUNN					11 SUSAN TART ROAD UNN, NC 28335		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	<b>`</b>	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO DATE
F 641	Continued From page	e 33	F	641			
	The assessment mus	st accurately reflect the					
	resident's status.	T is not met as evidenced					
	by:						
	-	view, observation and staff			Carrolton of Dunn Nursing and		
	interviews, the facility			Rehabilitation Center acknowledges			
	-	ndwelling catheter (Resident			receipt of the Statement of Deficiencie		
		nedication use (Resident and a diagnosis for anxiety			and proposes this Plan of Correction to the extent that the summary of findings		
		of 21 residents whose			factually correct and in order to mainta		
	. ,	MDS) assessments were			compliance with applicable rules and		
	reviewed.				provisions of quality of care of resident	ts.	
					The Plan of Correction is submitted as	а	
	Finding included:				written allegation of compliance.		
	1 Resident #61 was	admitted to the facility on			Carrolton of Dunn Nursing and Rehabilitation Center⊡s response to th	nie	
		oses included obstructive			Statement of Deficiencies does not	115	
	reflux uropathy and r				denote agreement with the Statement Deficiencies nor does it constitute an	of	
	The annual Minimum	n Data Set (MDS)			admission that any deficiency is accurate	ate.	
	assessment dated 3/	13/2023 indicated Resident			Further, Carrolton of Dunn Nursing and	d	
		gnitively impaired. The MDS			Rehabilitation Center reserves the righ	nt to	
		dent #61 had an indwelling			refute any of the deficiencies on this		
	catheter, and urinary rated.	elimination was marked not			Statement of Deficiencies through Informal Dispute Resolution, formal		
					appeal procedure and/or any other		
	Resident #61's care	plan last revised on			administrative or legal proceeding.		
		, he resident had an indwelling					
	catheter due to a neu	urogenic bladder.			Tag Cited: F-641		
	0 5/00/2000				¿483.20 (g) □ Accuracy of Assessmen	nts	
		I p.m., Resident #61 was			Issue Cited:		
	observed with an Ind	welling urinary catheter.			Accuracy of Assessments 1. Immediate action(s) taken for the		
	On 6/1/2023 at 10.48	3 a.m. in an interview with the			resident(s) found to have been affecte	d	
		e #1, she stated Resident			include:		
	, #61 had always had				Resident #61 MDS was modified by th	e	
	catheter. In reviewing	g Resident #61's annual			MDS nurse on June 8, 2023, reflect th		
		3, she stated the MDS was			indwelling urinary catheter.		
	not marked for an inc	dwelling catheter for			Resident #55 MDS was modified by th	e	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIDI	E CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING		
					с	
		345325	B. WING		06/02/202	23
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CARROLTON OF DUNN				711 SUSAN TART ROAD		
	ROLION 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPI	X5) PLETIO ATE
F 641	Continued From page	e 34	F 64 <sup>2</sup>			
		ed nursing documentation	1 04	MDS nurse on June8, 2023, to re	flect a	
		61 had an indwelling catheter		contraindication for dose reduction		
		larch 2023 and not marking		antipsychotic medication.		
	-	r for elimination on the MDS		Resident #54 MDS was modified		
	was an oversight.			MDS nurse on June8, 2023, to re		
	On 6/4/2022 at 40.55			resident⊡s routine use of antipsy	chotic	
		a.m. in an interview with the ted the facility's full time		Resident #33 MDS was modified	by the	
	MDS nurse had beer	-		MDS nurse on June 8, 2023, to re		
		#1 and the Assistant		diagnosis of anxiety.		
	Director of Nursing (A	ADON) had been helping to		2. Identification of other resider	its having	
	conduct MDS assess	ments as needed. He		the potential to be affected was		
	explained the facility			accomplished by:		
		Ill of 2022 and audits for		The facility has determined that a residents have the potential to be		
	improvement of MDS	d he was unsure how the		affected.		
		or Resident #61 was missed				
	•	onduct another audit for the		3. Actions taken/systems put in	to place	
	accuracy of MDS ass			to reduce the risk of future occurr	ence	
		admitted to the facility on		include:	-	
	10/4/21 with diagnos			The MDS nurse was replaced wit		
	post-traumatic stress	disorder.		seasoned Carrolton MDS nurse f the DHHS survey.	bilowing	
	A progress note date	d 2/22/23 revealed a gradual		the Drin o survey.		
		an antipsychotic medication		General in-services led by Carrol	ton	
	was contraindicated.			Facility Management (CFM) corp	orate	
				staff, the facility Administrator and	d Director	
		erly Minimum Data Set		of Nursing for all staff (including	o	
		ated 4/19/23 indicated a ction of an antipsychotic		administrative staff, including MD clinical staff, and contractors), on		
	medication was not c			2023, to address Accuracy of		
				Assessments, and other issues in	lentified	
	During an interview w	vith MDS Nurse #2 on 6/1/23		from the May 30- June 2, 2023, E		
	at 1:22 PM she state	d Resident #55's		Survey.		
		ave been coded to reflect a				
		adual dose reduction for an		The facility nurse consultant educ		
		tion. She reported there		MDS nurse regarding the accurat completion of MDS assessments		
	was some conjusion	about this and thought the		L completion of MDS assessments		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/11/2023 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 06/0	, )2/2023	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C	ODE			
THE CARF	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 641	Continued From page 35 lookback period. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated Resident #55's MDS assessment dated should have been coded accurately to reflect the contraindication of a gradual dosage reduction of antipsychotic medication. He stated there had been staff turnover in the MDS department which may have led to the error.		F 641 The Nursing consultant, DON and nur managers completed a 100% review of the MDS coding June 16  June 27, 2023, to ensure that all appropriate its for resident care and services were captured on the MDS. Any coding err noted in the assessment have been modified by the MDS nurse.					
	12/26/17 with diagnost Review of Resident # revealed an order dat prescribed Risperidor antipsychotic medicat Review of Resident # Administration Record revealed she received daily. Resident #54's quarte (MDS) assessment da received an antipsych lookback period. The revealed she did not t medication. During an interview w at 1:22 PM she stated	sident #54 was admitted to the facility on 17 with diagnoses that included dementia. w of Resident #54's medication orders ed an order dated 4/13/21 which ibed Risperidone .5 milligrams (an ychotic medication) twice a day. w of Resident #54's Medication istration Records for April and May 2023 ed she received antipsychotic medication ent #54's quarterly Minimum Data Set assessment dated 5/4/23 revealed she ed an antipsychotic 7 days of the 7-day ack period. The assessment further ed she did not take antipsychotic ation. g an interview with MDS Nurse #2 on 6/1/23 2 PM she stated Resident #54's sment should have been coded to reflect		<ul> <li>4. How the corrective act monitored to ensure the prarecur:</li> <li>The facility nurse consultar three (3) newly completed assessments per week for to check for assessment ac audits will beginning the we 2023.</li> <li>Audit records will be review Quality Assurance/ Perform Improvement (QAPI) Comr such time consistent substac compliance has been achied determined by the committee Corrective action completion 30, 2023.</li> </ul>	actice will no mt will audit MDS four (4) week couracy. The eek of June 1 wed by the mance mittee until antial eved as ee.	t ks ∋ 19,		
	her routine use of an She reported it was a An interview was cond	antipsychotic medication. n oversight.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2023 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING		_		C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	ATE, 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 656 SS=B	have been coded acc an antipsychotic medi had been staff turnove which may have led to 4. Resident #33 was 9/22/23 Review of Resident # revealed an order dat Ativan .5 milligrams a Resident #33's quarte (MDS) assessment da received an antianxie lookback period. The revealed Resident #3 anxiety disorder. During an interview w at 3:04 PM she stated assessment should have her diagnosis of anxie oversight. An interview was com Administrator on 6/2/2 Resident #33's MDS a been coded accurated anxiety disorder. He s turnover in the MDS of led to the error. Develop/Implement C CFR(s): 483.21(b)(1)(0 §483.21(b) Comprehe §483.21(b) Comprehe	assessment dated should urately to reflect her use of ication. He stated there er in the MDS department o the error. admitted to the facility on 33's medication orders ed 9/26/22 which prescribed t bedtime for anxiety. erly Minimum Data Set ated 3/14/23 revealed she ty 7 days of the 7-day assessment further 3 was not coded as having ith MDS Nurse #1 on 6/1/23 d Resident #33's ave been coded to reflect ety. She stated it was an ducted with the 23 at 2:24 PM. He stated assessment should have y to reflect her diagnosis of stated there had been staff department which may have comprehensive Care Plan (3)	F 64	1			6/30/23

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/11/2023 APPROVED 0: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING		_	( 06/	) 02/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			7'	11 SUSAN TART ROAD			
THE CARP	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 PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 656	Continued From page care plan for each res resident rights set fort §483.10(c)(3), that inc objectives and timefra medical, nursing, and needs that are identifi assessment. The corr describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that v under §483.24, §483. provided due to the re- under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section.	a 37 ident, consistent with the h at §483.10(c)(2) and cludes measurable imes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must - re to be furnished to attain nt'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 ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the sed and any referrals to a and/or other appropriate se. In the comprehensive care n accordance with the a in paragraph (c) of this	F 656				
		vices provided or arranged					

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		MEDICAID SERVICES					<u>VO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
		345325	B. WING				C 6/02/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				7	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	OUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 656	Continued From pag	e 38	F	656			
				000			
	care plan, must-	lined by the comprehensive					
	• •	petent and trauma-informed.					
		T is not met as evidenced					
	by:						
	-	view and staff interviews, the			Carrolton of Dunn Nursing and		
		lop and implement an			Rehabilitation Center acknowledges		
		erson centered care plan in			receipt of the Statement of Deficienc	ies	
		of Daily Living (ADL) and			and proposes this Plan of Correction		
		residents reviewed for			the extent that the summary of findin		
	-	plans (Resident #45,			factually correct and in order to main	-	
	Resident #88).				compliance with applicable rules and		
					provisions of quality of care of reside		
	Findings included:				The Plan of Correction is submitted a		
					written allegation of compliance.	10 4	
	1 Resident #45 was	admitted to the facility on			Carrolton of Dunn Nursing and		
		oses included hemiparesis			Rehabilitation Center s response to	this	
	-	one side of the body).			Statement of Deficiencies does not	uno	
					denote agreement with the Statemer	nt of	
	The resident care ou	ide in Resident #45's care			Deficiencies nor does it constitute an		
		22 did not included a focus			admission that any deficiency is accu		
	•	#45's care plan did not			Further, Carrolton of Dunn Nursing a		
	-	DL addressing Resident			Rehabilitation Center reserves the rig		
	#45's need for assist	-			refute any of the deficiencies on this	,	
					Statement of Deficiencies through		
	The annual Minimum	n Data Set (MDS)			Informal Dispute Resolution, formal		
		1/9/2022 indicated Resident			appeal procedure and/or any other		
		ntact, had limited movement			administrative or legal proceeding.		
		er extremity on one side of					
		d total assistance of one			Tag Cited: F-656		
		The MDS assessment also			¿483.21(b)(1)□ Comprehensive Res	ident	
		on as a concern for care			Centered Care Plans		
		was marked to address in			Issue Cited:		
		plan on the MDS. The			Develop/Implement Comprehensive	Care	
		sment dated 2/14/2023			Plan .		
		45 remained cognitively			1. Immediate action(s) taken for the	e	
		ovement to the upper and			resident(s) found to have been affect		
		ne side of the body and			include:		
		ince of one person with			Resident #45⊡s care plan was upda	hod	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DOILDIN		с
		345325	B. WING		06/02/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	PCODE
THE CARI	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 C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 656	Continued From page	2 39	F 6	56	
	bathing. In an interview with A	ssistant Director of Nursing at 11:13 a.m., she stated		on June 23, 2023, by the reflect ADLs including bar preferences.	
	she and the MDS Nu the residents, and ca quarterly or when the	rse completed care plans for re plans were updated re was a significant change.		Resident #88 was discha facility on March 9, 2023	3.
	stated there was no for baths and showers or	ent #45 's care plan she ocus area that included n the care plan for Resident on the quarterly MDS		<ul> <li>Identification of other</li> <li>the potential to be affected</li> <li>accomplished by:</li> <li>The facility has determined</li> </ul>	ed was
	assessment dated 2/ <sup>,</sup> plan needed to includ	1/2023, Resident #45's care led total assistance of one could not explain why it		residents have the potent affected.	
	was not included on t	he care plan.		3. Actions taken/system to reduce the risk of futur	
	required assistance w	, she stated Resident #45 vith bathing and showering een included in her care plan.		include: The facility MDS nurse is FMLA and has been repla seasoned Carrolton MDS	aced with a
	She stated the full tim	he MDS Nurse #2 had been leave, and the ADON had		A 100% audit was complete	
	plans.	ompleting and updating care		Facility Management nurs and facility administrative 16, 2023, to ensure that a	e nurses on June all areas of care
	2/15/2023 for rehabili surgery. Resident #88	admitted to the facility on tation services following 8 was discharged on ility back to the community.		and treatment have been comprehensive care plan be deficient were correcte 27, 2023.	Areas found to
	Resident #88's care p not include a discharg	olan initiated 2/16/2023 did ge plan.		Carrolton General in-serv Carrolton Facility Manage corporate staff, the facility	ement (CFM)
	2/22/2023 indicated F	um Data Set (MDS) dated Resident #88 was cognitively ed to be discharged to the		and Director of Nursing for (including administrative nurses, clinical staff, and	or all staff staff, MDS contractors), on
	community. A social service note	dated 2/22/2023 initiated an		June 7, 2023, to address Care Plans, and other iss from the May 30- June 2,	sues identified

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 40 F 656 expected discharge for Resident #88 to the Survey. community in a month or less. How the corrective action(s) will be 4. In an interview with the Assistant Director of monitored to ensure the practice will not Nursing (ADON) on 6/2/2023 at 11:19 a.m., she recur: stated Resident #88's goal for discharge to the The facility nurse consultant or other CFM community was discussed in morning meetings, corporate staff will audit three (3) care plans a week for the next four (4) weeks, and his care plan should had included a discharge goal to communicate the plan for beginning June 19, 2023, based on the discharge. She said she helped with MDS MDS assessment schedule. assessments and care plans with the MDS Nurse #2 on family medical leave and did not know why Audit records will be reviewed by the a discharge goal was not included in Resident Quality Assurance/ Performance #88's care plan. She further stated she was not Improvement (QAPI) Committee until sure if the social worker or the MDS nurse was such time consistent substantial responsible for entering the discharge goal on the compliance has been achieved as care plan. determined by the committee. In an interview with the Social Worker on Corrective action completion date: June 06/02/23 at 11:33 a.m., she stated she placed 30, 2023. Resident #88 discharge plan in a note on the electric medical record and stated MDS nurse conducted the care plan for Resident #88. In an interview with the Director of Nursing on 6/2/2023 at 2:19 p.m., she explained the Social Worker, who was a new graduate in social services to the facility, conducted the initial discharge review and should had entered a discharge plan on the care plan for Resident #88. F 657 Care Plan Timing and Revision F 657 6/30/23 SS=E CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-(i) Developed within 7 days after completion of the comprehensive assessment.

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/202 MAPPROVE D. 0938-039	
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING				C 1 <b>02/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 657	<ul> <li>includes but is not lin</li> <li>(A) The attending phy</li> <li>(B) A registered nursi resident.</li> <li>(C) A nurse aide with resident.</li> <li>(D) A member of food</li> <li>(E) To the extent practice the resident and their resident and their resident and their medical record if the and their resident region to practicable for the resident's care plan.</li> <li>(F) Other appropriated disciplines as determined or as requested by the (iii)Reviewed and revite am after each assessments.</li> <li>This REQUIREMENT by:</li> <li>Based on record revistaff interviews, the figuraterly care plan minesident #45, Resident and 2) revise a resider with new fall prevention and the prevention of the prevention</li></ul>	terdisciplinary team, that hited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in hined by the resident's needs he resident. rised by the interdisciplinary assment, including both the	F	657	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficienc and proposes this Plan of Correction the extent that the summary of findin factually correct and in order to main compliance with applicable rules and provisions of quality of care of reside The Plan of Correction is submitted a	to gs is tain nts.		
	3/9/2022, and diagno	as admitted to the facility on oses included Diabetes esis (partial paralysis			written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center⊡s response to Statement of Deficiencies does not denote agreement with the Statemer Deficiencies nor does it constitute an	nt of		

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 657 Continued From page 42 F 657 restricted to one side of the body). admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and The quarterly Minimum Data Set (MDS) Rehabilitation Center reserves the right to assessment dated 2/14/2023 indicated Resident refute any of the deficiencies on this #45 was cognitively intact. Statement of Deficiencies through Informal Dispute Resolution, formal A review of Resident #45's electronic medical appeal procedure and/or any other record revealed documentation of the last care administrative or legal proceeding. plan meeting was on 10/4/2022 that occurred by phone with Resident #45 and a family member. Tag Cited: F-657 ¿483.21(b)(2)(i)-(iii) Comprehensive **Resident Centered Care Plans** A review of Resident #45's care plan indicated on 5/16/2023 the resident care guide related to Issue Cited: Resident #45's diet was revised, and a new focus Care Plan Timing and Revision area was created for allergies. Resident #45's 1. Immediate action(s) taken for the care plan was further updated on 5/26/2023 to resident(s) found to have been affected include restorative care for splint application include: assistance of the left hand and wrist. The facility interdisciplinary team scheduled care plan meetings with In an interview with Resident #45 on 5/30/2023 at residents #45 (June 20, 2023), #42 (June 10:39 a.m., she stated the facility had not 21, 2023) and #77 (June 21, 2023) scheduled and conduct quarterly care plan between June 2- 23, 2023. meetings with her. 2. Identification of other residents having the potential to be affected was b. Resident #42 was admitted to the facility on accomplished by: The facility has determined that all 12/19/2014, and diagnoses included stroke with hemiparesis (paralysis to one side of the body). residents have the potential to be affected. The annual Minimum Data Set (MDS) assessment dated 4/26/2023 indicated Resident Actions taken/systems put into place 3. to reduce the risk of future occurrence #42 was cognitively intact. include: A review of Resident #42's electronic medical The facility MDS nurse is currently on record revealed documentation of the last care FMLA and has been replaced with a seasoned Carrolton MDS nurse. plan meeting was on 3/29/2022. A review of Resident #42's care plan indicated A 100% audit was completed June 16, revision of all current goals occurred on 5/7/2023, 2023, by the MDS nurse to determine

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 657 Continued From page 43 F 657 and new focuses for advance directives, Diabetes care plan needs for the next three (3) Mellitus, coronary heart disease, hypothyroidism months. A calendar was created for the facility social worker to use for invitations. and gastroesophageal reflex disease were initiated on 5/15/2023. General in-services led by Carrolton In an interview with Resident #42 on 5/30/2023 at Facility Management (CFM) corporate 3:46 p.m., he stated the facility was not staff, the facility Administrator and Director conducting quarterly care plan meetings with him. of Nursing for all staff (including administrative staff, clinical staff, and contractors), on June 7, 2023, to address c. Resident #77 was admitted to the facility on Care Plan Timing and Revision, and other 9/19/2022, and diagnoses included ischemic issues identified from the May 30- June 2, stroke. 2023, DHHS Survey. The quarterly Minimum Data Set (MDS) The facility social worker was educated by assessment dated 4/7/2023 indicated Resident a seasoned Carrolton social worker on #77 was severely cognitively impaired and was June 13, 2023, regarding invitations to fully dependent on staff for all activities of daily care plan meetings, who should attend living. the care plan meetings and the timeframes of care plans based on the A review of Resident #77's electronic medical MDS calendar. record revealed documentation of the last care 4. How the corrective action(s) will be plan meeting was on 9/21/2022. monitored to ensure the practice will not A review of Resident #77's care plan indicated recur. new focuses for diabetes mellitus, bed mobility, The facility administrator will monitor the cognitive function, communication, tube feeding, care plan schedule daily in the morning falls, and swallowing difficulties, were meetings to ensure they are scheduled implemented on multiple dates in November and completed as per the calendar. This 2023, as well as new focuses of bed rails, daily monitoring will begin on June 19, hypertension, gastroesophageal reflux disease, 2023, and continue for four (4) weeks. stroke, resident needs, and pressure ulcers on multiple dates in April 2023. The facility nurse consultant or other CFM corporate staff will audit the care plan schedule weekly for the four (4) weeks In an interview with the Social Worker on and monthly for three (3) months to 5/31/2023 at 4:11 p.m. she stated she started monitor compliance. employment with the facility in January 2023. She Audit records will be reviewed by the explained she scheduled and conducted resident Quality Assurance/ Performance

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		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP (	06/02/2023
				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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 657	Continued From page	e 44	F 65	57	
	care plan meetings w to the facility and for changes as needed. informed to schedule meetings quarterly w and had not schedule	continued From page 44 are plan meetings within 72 hours of admission o the facility and for residents with significant hanges as needed. She said she had not been iformed to schedule and conduct care plan neetings quarterly with the MDS assessments nd had not scheduled quarterly care plan neetings for the residents.		Improvement (QAPI) Com such time consistent subst compliance has been achi- determined by the committ Corrective action completio 30, 2023.	antial eved as tee.
	at 4:25 p.m., she stat meetings coincided w quarterly, and the So when quarterly MDS	vith the MDS assessments cial Worker would know assessments were occurring Social Worker components			
	shared upcoming and assessments in the m Social Worker was re and conducting reside other interdisciplinary explained since Augu three different Social facility and may have	n., he stated MDS Nurse #2 d significant change MDS norning meetings, and the esponsible for scheduling ent care plan meetings with v team members. He ist 2022 there had been Workers employed at the contributed to quarterly care nducted with cognitive			
	2. Resident #77 was 9/19/2022.	admitted to the facility on			
	#77 was severely cog	Im Data Set (MDS) 7/2023 indicated Resident gnitively impaired and was aff for all activities of daily			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/11/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMF	SURVEY PLETED
		345325	B. WING			_		C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE CARF	ROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page living.	÷ 45	F	657				
	#77 had a fall on 5/7/2 report for the fall on 5 mat was placed in the the incident. The incid 5/9/23 revealed that th the time of Resident # Resident #77 was obs on 6/1/2023. A fall ma side of the resident's A review of Resident # that her care plan had include the use of a fa An interview was cont with Nurse #5, who st Resident #77 often. S interventions following incident report. She a completed a 24 hour	served resting in her room at was in place on the right bed. #77's care plan revealed I not been updated to all mat. ducted on 6/1/23 at 2:45 PM						
F 690 SS=D	with MDS Nurse 1#, w #77's care plan should include the use of a fa implementation on 5/7 not sure why the care explained it must have Bowel/Bladder Incont	7/23. She stated she was plan was not updated and e been an oversight. inence, Catheter, UTI -(3)	F	690				6/30/23

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345325	B. WING				C 02/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 690	§483.25(e)(1) The factor resident who is contin- admission receives see maintain continence us condition is or become not possible to maintain see the second second resident who enter incontinence, based of comprehensive assesses ensure that- (i) A resident who enter indwelling catheter is resident's clinical come catheterization was nerve that catheter is assessed for removal as possible unless that catheter is receives appropriate the prevent urinary tract in continence, based of comprehensive assesses ensure that a resident who enter indwelling catheter or is assessed for removal prevent urinary tract in continence to the externation of the externating of the externation of the externation of the externa	cility must ensure that tent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's asment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced ew, observations and staff	F	690	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/11/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 06/02/2023
NAME OF P	ROVIDER 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 690	Continued From page	e 47	F 690		
F 090	of 1 resident reviewer (Resident #61). Finding included: Resident #61 was ad 5/2/2020, and diagno uropathy. Resident #61's care p included a focus for a elimination due to an interventions included tubing was secured w strap) to prevent tens Physician orders date indwelling urinary cat related to obstructive	d for urinary catheter mitted to the facility on ses included obstructive	F 690	the extent that the summary of fine factually correct and in order to ma compliance with applicable rules a provisions of quality of care of res The Plan of Correction is submitte written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center⊡s response Statement of Deficiencies does no denote agreement with the Statem Deficiencies nor does it constitute admission that any deficiency is a Further, Carrolton of Dunn Nursing Rehabilitation Center reserves the refute any of the deficiencies on th Statement of Deficiencies through Informal Dispute Resolution, forma appeal procedure and/or any othe administrative or legal proceeding	aintain and idents. ed as a to this ot nent of an ccurate. g and e right to his al
	(leg strap) was in play The annual Minimum assessment dated 3/ #61 was severely cog limited mobility to one body. The MDS asse use of an indwelling of elimination. A review of May 2023 Record (TAR) indicat indwelling urinary cat checked daily to ensu device (leg strap) was On 6/1/2023 at 7:36 a device observed on F	ce. Data Set (MDS) 13/2023 indicated Resident gnitively impaired and had e upper and lower side of the essment did not indicate the catheter for urinary B Treatment Administration ed Resident #61 had an heter, and nursing staff ure Resident #61's anchoring		<ul> <li>Tag Cited: F-690 ¿483.25 Quality of Care Issue Cited: Bowel/Bladder Incontinence, Cath UTI- No Leg Strap <ol> <li>Immediate action(s) taken for resident(s) found to have been aff include: </li> <li>A stabilization device (leg strap) w applied to Resident s #61 s indv urinary catheter to prevent kinking catheter and excessive tension or catheter which can lead to urethra and tears on June 1, 2023, during DHHS recertification of other resident the potential to be affected was</li> </ol></li></ul>	the fected vas velling g of the h the al trauma the

Facility ID: 923073

### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 48 F 690 tubing. The urinary catheter tubing was observed accomplished by: exiting from underneath the adult brief and laying The administrative nursing team observed across the upper right thigh area unsecured. all residents with urinary catheters on June 1, 2023, and found no other On 6/1/2023 at 7:36 a.m. in an interview with residents without stabilization straps. Nurse Aide (NA) #1. she stated anchoring devices (leg straps) were used to prevent The facility has determined that 100% of movement and pulling of the catheter. She residents with indwelling urinary catheters explained Resident #61's anchoring device (leg have the potential to be affected. strap) was not attached because Resident #61 3. Actions taken/systems put into place to reduce the risk of future occurrence would unstrap the anchoring device. Therefore, the anchoring device (leg strap) was not applied include: as ordered. She further stated at times Resident The procedure for Indwelling Catheter #61 would pull on the urinary catheter tubing. Care was revised June 8, 2023, to include the use of stabilization devices for On 6/1/2023 at 7:55 a.m. in an interview with indwelling catheters. Nurse #1, she stated Resident #61 was to have an anchoring device (leg strap) to attach the All direct care nursing staff, including urinary catheter tubing and was unsure why nurses and certified nursing assistants Resident #61's anchoring device was not (CNAs) were in-serviced regarding the attached for the urinary catheter tubing. At 7:57 facility procedure for Indwelling Catheter am on 6/1/2023 when NA #1 informed Nurse #1 Care and the facility procedure for Catheter Insertion and Removal on June Resident #61 needed an anchoring device (leg 12, 2023, through June 14, 2023, by the strap), Nurse #1 stated she would get an anchoring device for Resident #61. Director of Nursing (DON) and Carrolton Facility Management (CFM) corporate On 6/1/2023 at 11:02 a.m., in an interview with clinical staff. Chief Clinical Officer, she stated an anchoring device (leg strap) should have been applied to How the corrective action(s) will be 4. monitored to ensure the practice will not Resident #61 with the urinary catheter tubing attached to secure the urinary catheter in place. recur: The DON, RN Supervisor or designee will complete weekly audits on all residents with indwelling urinary catheters for four (4) consecutive weeks beginning June 19, 2023, monitoring compliance with the use of stabilization devices on residents with indwelling catheters.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 07/11/20 RM APPROVE IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345325	B. WING		0	C 6/02/2023
NAME OF P	ROVIDER OR SUPPLIER	I	5	STREET ADDRESS, CITY, STATE, ZIP COI		
THE CAR	ROLTON OF DUNN			11 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 690	Continued From page	9 49	F 690	Audit records will be reviewe Management/Quality Assura Committee until such time co substantial compliance has b achieved as determined by th committee.	nce onsistent oeen	
F 695 SS=D		stomy Care and Suctioning	F 695	Corrective action completion 30, 2023.	date: June	6/30/23
	The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compreher care plan, the resider and 483.65 of this sure this REQUIREMENT by: Based on observation interviews, the facility the use of oxygen for for oxygen use (Resident #74 was ad 10/20/22 with diagnost respiratory failure, ple obstructive pulmonar A review of the March	d tracheal suctioning. ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. T is not met as evidenced ns, record reviews, and staff failed to follow orders for 1 of 3 residents reviewed dent #74). E mitted to the facility on ses that included acute eural effusion, and chronic y disease. h 2023 active physician rder for oxygen continuously		Carrolton of Dunn Nursing a Rehabilitation Center acknow receipt of the Statement of D and proposes this Plan of Co the extent that the summary factually correct and in order compliance with applicable re provisions of quality of care of The Plan of Correction is sut written allegation of compliar Carrolton of Dunn Nursing an Rehabilitation Center s resp Statement of Deficiencies do denote agreement with the S Deficiencies nor does it cons	vledges reficiencies orrection to of findings is to maintain ules and of residents. omitted as a nce. nd oonse to this res not otatement of	

Event ID: RJKF11

Facility ID: 923073

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 50 F 695 admission that any deficiency is accurate. A quarterly Minimum Data Set (MDS) Further, Carrolton of Dunn Nursing and assessment dated 4/25/23 indicated Resident Rehabilitation Center reserves the right to #74 was coded as receiving oxygen therapy. The refute any of the deficiencies on this MDS further revealed that Resident #74's Statement of Deficiencies through cognition was moderately impaired. Informal Dispute Resolution, formal appeal procedure and/or any other Resident #74's care plan dated 3/10/23 included administrative or legal proceeding. a focus area for potential for altered respiratory status/difficulty breathing related to acute Tag Cited: F-695 respiratory failure. The interventions included ¿483.25(i)□ Respiratory/Tracheostomy administering oxygen as ordered. Care and Suctioning Issue Cited: On 5/30/23 at 11:52 AM, Resident #74 was O2 at Wrong Liter Flow observed sitting in bed and indicated she was 1. Immediate action(s) taken for the dependent on oxygen via nasal cannula. The resident(s) found to have been affected oxygen regulator on the concentrator was set at include: 3.0 liters per minute when viewed horizontally at The oxygen liter flow for Resident #74 was corrected to 2 liters as ordered on eve level. June 1, 2023, during the DHHS During subsequent observations made on recertification survey. 5/31/23 at 2:47 PM and 6/1/23 at 11:36 AM Resident #74 was receiving oxygen via nasal 2. Identification of other residents having cannula at 3.0 liters per minute when viewed the potential to be affected was horizontally at eye level. accomplished by: The administrative nursing team observed An observation was made with Nurse #1 of all residents with oxygen on June 8, 2023, Resident #74's oxygen concentrator on 6/1/23 at and June 12, 2023, and all residents now 4:47 PM, followed by an interview. Nurse #1 have the correct liter flow. confirmed the oxygen regulator on the concentrator was set at 3 liters when viewed The facility has determined that all (100%) horizontally at eye level. Nurse #1 checked residents identified with the use of oxygen Resident #74's order for oxygen and stated it have the potential to be affected. should have been set to 2.0 liters per minute. Nurse #1 adjusted the flow to administer 2 liters 3. Actions taken/systems put into place to reduce the risk of future occurrence of oxygen as ordered. Nurse #1 stated that oxygen rates were checked throughout the day include: and should only be adjusted by nurses. All direct care nursing staff, including nurses were in-serviced regarding the

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						NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		DATE SURVEY
			A. DOILDING			С
		345325	B. WING			06/02/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	00/02/2023
				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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 695			F 69		aon	
	on 6/1/23 at 4:53 PM,	vith the Chief Clinical Officer , she indicated it was her en to be delivered at the		facility procedure for Oxy Administration Care on J through June 14, 2023, b Nursing (DON) and Carro Management (CFM) corp staff.	une 12, 2023, by the Director of olton Facility	
				<ul> <li>4. How the corrective a monitored to ensure the precur:</li> <li>The DON, RN Superviso complete weekly audits of with oxygen for four (4) c weeks beginning June 19 monitoring compliance w oxygen liter flow for all reoxygen.</li> </ul>	practice will not r or designee will on all residents onsecutive 9, 2023, ith the ordered	
				Audit records will be revie Management/Quality Ass Committee until such tim substantial compliance h achieved as determined committee.	surance e consistent as been by the	
				Corrective action comple 30, 2023.	tion date: June	
F 725 SS=E	0		F 72			6/30/23
	the appropriate comp provide nursing and r resident safety and at practicable physical, i well-being of each res	Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care				

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-					FORM	07/11/2023 APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI	SURVEY LETED
	345325	B. WING		_		C 02/2023
ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
		7'	11 SUSAN TART ROAD			
ROLION OF DUNN		D	UNN, NC 28335			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	( EACH CORRECTIVE ACTION SHOULD BE COMPLE			(X5) COMPLETION DATE
Continued From page	: 52	F 725				
diagnoses of the facili	ty's resident population in					
by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers	of each of the following a 24-hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and connel, including but not					
paragraph (e) of this s designate a licensed in nurse on each tour of This REQUIREMENT by: Based on observation interviews and staff in provide sufficient nurse dependent residents in (Resident #45, Reside Resident #33). The findings included This tag is cross-refer F561 Based on obser resident interviews an failed to honor resider showers for 4 of 5 dep for choices (Resident	section, the facility must nurse to serve as a charge duty. is not met as evidenced ns, record reviews, resident terviews, the facility failed to se staff to ensure 4 of 4 received scheduled showers ent #42, Resident #14, and : renced to: vations, record review, id staff interviews, the facility nts' choice related to bendent residents reviewed #45, Resident #42,		Rehabilitation Center receipt of the Stater and proposes this F the extent that the s factually correct and compliance with app provisions of quality The Plan of Correct written allegation of Carrolton of Dunn N Rehabilitation Center Statement of Deficient denote agreement of Deficiencies nor door admission that any	er acknowledges ment of Deficiencies Plan of Correction to summary of findings d in order to maintai plicable rules and of care of residents ion is submitted as compliance. Jursing and er s response to the encies does not with the Statement of es it constitute an deficiency is accura	is n a is of te.	
F	S FOR MEDICARE & I DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ROLTON OF DUNN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page and considering the n diagnoses of the facili accordance with the fa at §483.70(e). §483.35(a)(1) The face by sufficient numbers types of personnel on nursing care to all ress resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this se designate a licensed in nurse on each tour of This REQUIREMENT by: Based on observation interviews and staff in provide sufficient nurse dependent residents in (Resident #45, Reside Resident #33). The findings included This tag is cross-refer F561 Based on obser	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345325         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 52         and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: <ul> <li>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</li> <li>(ii) Other nursing personnel, including but not limited to nurse aides.</li> <li>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observations, record reviews, resident interviews and staff interviews, the facility failed to provide sufficient nurse staff to ensure 4 of 4 dependent residents received scheduled showers (Resident #45, Resident #42, Resident #14, and</li></ul>	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER       (P2) MULTIPLE CONSTRUCTION A BUILDING         SUMDER OR SUPPLIER       345325       E. WING         ROLTON OF DUNN       STREET ADDRESS, CITY, STI 711 SUSAN TART ROAD DUNN, NC 28335         SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREPIX (RACH CORREC CROSS-REFEREN (EACH OCAREC CROSS-REFEREN (EACH CORREC CROSS-REFEREN (EACH CORREC CROSS-REFEREN (I) Cher number, acuity and diagnoses of the facility resident paragraph (e) of this section, licensed nurses, and (I) Other nursing personnel, including but not limited to nurse aides.       F 725         \$483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duly.       Carrolton of Dunn I Rehabilitation Cent Resident #45, Resident #42, Resident #14, and Resident #33).       Carrolton of Dunn I Rehabilitation Cent the extent that the s factualiy correct and compliance with ap provisions of quality	MENT OF HEALTH AND HUMAN SERVICES         SP OR MEDICARE & MEDICARD SERVICES         SUMMARY SMTEMENT OF DEFICIENCY         SOUTOR OF DUNN         SECONFORM STREEMENT OF DEFICIENCY         REGULTORY OR LSC DENTIFYING INFORMATION)         PREFX         REGULATORY OR LSC DENTIFYING INFORMATION)         Continued From page 52         and considering the number, acuity and diagnoses of the facility assessment required at \$483.70(e).         \$443.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:         (I) Other nursing personnel, including but not limited to nurse aides.         \$483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurses; and (II) Other nursing personnel, including but not limited to nurse aides.         \$483.35(a)(2) Except when waived under paragraph (e) of this section, the facility failed to provide sufficient nurse staff thereviews, the facility failed to provide sufficient nurse staff the onsure 4 of 4 dependent residents received scheduled showers (Resident #43, Resident #14, and Rehabilitation Center: sresponsed interviews and staff interviews, the facility failed to honor resi	MENT OF HEALTH AND HUMAN SERVICES OMB NO SFOR MEDICARE & MEDICALD SERVICES OMB NO PERCENCIPS (1) PROVIDER/SUPPLEACUA DEVIFICATION MUMBER 4 BULDING 345325 B (2) PROVIDER OR SUPPLER ROUDER OR SUPPLE

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Facility ID: 923073

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		MEDICAID SERVICES					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				TE SURVEY MPLETED
							С
		345325	B. WING			0	6/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	ROLTON OF DUNN				1 SUSAN TART ROAD JNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 725	Continued From page	<u>- 53</u>	É -	725			
	In an interview with N 12:52 p.m., she state nurse aide assigned to informed the nursing aware scheduled sho administered to the re- administrative staff he- times on the halls but showers. In an interview with D 6/2/2023 at 2:30 p.m. asked the Corporate staff to help with the st told "no". She said sl and extra staffing pos and the Corporate Of the strict payroll. She was approved for the Friday evening they v work. She stated new periods of time after of Administration staff w nursing aides to help shower schedules an changed to help cover more help to conduct residents were not co as scheduled, but sho	lurse Aide #1 on 6/2/2023 at d she had been the only to a hall for months. She had staff and administration was wers were not being esidents. She stated elped pass meal trays at t did not help with resident			refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-725 ¿483.35 (a)(1)(2) □ Sufficient Nursing Staff Issue Cited: Sufficient nursing staff to provide show 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility implemented the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. " Changes were made to schedulin practices to maximize staff availability efficiency. " The staffing coordinator was changed. " Additional facility staff were sche- to ensure adequate staffing levels and provide the necessary resident care. 2. Identification of other residents h the potential to be affected was accomplished by: The facility has determined that all	wers ed ng and duled d to	
					affected. 3. Actions taken/systems put into pl to reduce the risk of future occurrence include: All facility staffing practices and patter were reviewed. An all-staff meeting (including	9	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · ·	LE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		345325	B. WING		0	6/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	∋ 54	F 72	<ul> <li>administrative staff, clinical state contractors), was held on June facilitated by Carrolton Facility Management (CFM) corporate facility Administrator and Direct Nursing to address facility staft and procedures as well as sur from the May 30- June 2, 2023 Survey. All-staff meetings will monthly to provide updates to well as to receive staff feedback input.</li> <li>The Carrolton Facility Manage Director of Human Resources meetings with part-time staff nd discuss incentives to convert the employment. Two (2) staff meetings with status.</li> <li>The facility has actively been results. This converted from part-time to full status.</li> <li>The facility has actively been results. The staff members have been added to the scheduled for orientation. Receifforts continue and additional have been scheduled for intermode coversight of staffing and a Correct Facility Nurse Consultant has</li> </ul>	e 7, 2023, e staff, the ctor of fing policies vey findings 3, DHHS be held staff, as ck and ement held nembers to o full-time embers have il-time recruiting 3) new een hired f members fule or cruitment candidates view. daily porate provided	
				facility visits five (5) days a we (3) weeks. Corporate Facility Consultant visits will continue weekly for at least three (3) me	Nurse at least	

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	š		
		345325	B. WING		C 06/02/2023
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00,02,2020
THE CARI	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 725 F 847 SS=D	CFR(s): 483.70(n)(2) §483.70(n) Binding A	Arbitration Agreements (i)(ii)(3)-(5)	F 72	<ul> <li>4. How the corrective action(s) will b monitored to ensure the practice will n recur: The Director of Nursing (DON) or designee will complete daily audits for (4) consecutive weeks beginning June 2023, to determine if residents preferences regarding showers are be honored. The DON or designee will also conduct random call light audits weekly for four weeks, then three (3) times a week for minimum of three (3) months beginning June 19, 2023.</li> <li>The Administrator and corporate consultant audit staffing sheets daily. Audits will continue daily for a minimum three (3) months.</li> <li>Audit records will be reviewed by the Quality Assessment/Performance Improvement Committee until such tim consistent substantial compliance has been achieved as determined by the committee.</li> <li>Audit results will be shared with the Resident/Family Group Council for comment and suggestions.</li> <li>Corrective action completion date: Jun 30, 2023.</li> </ul>	ot four 21, ing tt (4) a g m of
		o ask a resident or his or her			

Facility ID: 923073

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			06/	C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
THE CARI	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 847	binding arbitration, the of the requirements in §483.70(n)(1) The fac resident or his or her agreement for binding admission to, or as a receive care at, the fa inform the resident or his or her right not to condition of admission continue to receive ca §483.70(n)(2) The fac (i) The agreement is e his or her representat that he or she underst language the resident representative underst (ii) The resident or his acknowledges that he agreement; §483.70(n)(3) The agr grant the resident or h right to rescind the ag days of signing it. §483.70(n) (4) The agr state that neither the n representative is require for binding arbitration to, or as a requirement at, the facility. §483.70(n) (5) The agr	er into an agreement for e facility must comply with all this section.	F 84	47			

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	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MILL T		ONSTRUCTION		D. 0938-039 E SURVEY
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:					<b>N</b> 7	PLETED	
		A. BUILDING			с		
		345325	B. WING				/02/2023
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
	ROLTON OF DUNN				SUSAN TART ROAD NN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 847	Continued From page	e 57	F 8	347			
		se from communicating with					
		l officials, including but not					
		l state surveyors, other					
		n department employees,					
		the Office of the State budsman, in accordance					
	with §483.10(k).						
	This REQUIREMENT						
	by:						
	-	iew, resident, resident			Carrolton of Dunn Nursing and		
	representative and st			Rehabilitation Center acknowledges			
	-	rbitration agreement to the			receipt of the Statement of Deficiencies		
		epresentative prior to having nent and to ensure they			and proposes this Plan of Correction to the extent that the summary of findings		
		e resident/representative that			factually correct and in order to mainta		
		nt was not required as a			compliance with applicable rules and		
		n. This occurred for 2 of 3			provisions of quality of care of resident	s.	
	residents (Resident #	9 and Resident #45)			The Plan of Correction is submitted as		
	reviewed for arbitration	on.			written allegation of compliance.		
					Carrolton of Dunn Nursing and		
	Findings included:				Rehabilitation Center s response to th	nis	
	Boviow of the facility'	s "Arbitration Agreement"			Statement of Deficiencies does not	of	
		revealed documentation			denote agreement with the Statement Deficiencies nor does it constitute an	01	
	that the resident and/				admission that any deficiency is accura	ate.	
		wledged they had read and			Further, Carrolton of Dunn Nursing and		
	understood the agree				Rehabilitation Center reserves the righ		
	•	adequately explained to			refute any of the deficiencies on this		
	them in plain languag	Je.			Statement of Deficiencies through		
	a Resident #0 was a	dmitted to the facility on			Informal Dispute Resolution, formal		
	a. Resident #9 was a 3/24/23.	dmitted to the facility on			appeal procedure and/or any other administrative or legal proceeding.		
		9's arbitration agreement			administrative of logal proceeding.		
		's representative had signed			Tag Cited: F-847		
	the agreement on 3/2				زغ483.70(n)(2)(i)(ii)(3)-(5) Binding		
					Arbitration Agreements		
		ion Minimum Data Set			Issue Cited: Arbitration agreements no	t	
	(MDS) assessment d was cognitively intact	ated 3/31/23 revealed she			explained		
	was cognitivaly intact		1				

Facility ID: 923073

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 847 Continued From page 58 F 847 1. Immediate action(s) taken for the An interview was conducted with Resident #9 on resident(s) found to have been affected 6/2/23 at 2:00 PM who stated her responsible include: party completed her admission paperwork. Arbitration agreements for Resident #9 and Resident #45 were reviewed. The A telephone interview occurred with Resident #9's resident and/or legal representative was representative on 6/2/23 at 2:25 PM. The resident notified of the facility s arbitration policy representative stated the arbitration agreement and given the opportunity to cancel the had been explained to her and she understood agreement. the concept. She added she believed signing the 2. Identification of other residents having the potential to be affected was agreement was a condition of admission. accomplished by: b. Resident #45 was admitted to the facility on The facility has determined that all 3/9/22 residents admitted since the hiring of the Review of Resident #45's arbitration agreement current Admission Ds Coordinator (July revealed the resident had signed the agreement 2021) have the potential to be affected. on 3/9/22. Actions taken/systems put into place 3. to reduce the risk of future occurrence Resident #45's most recent Minimum Data Set include: The facility Administrator in-serviced the (MDS) assessment dated 5/17/23, a quarterly Admission Coordinator on June 19, 2023, assessment revealed she was cognitively intact. regarding Binding Arbitration Agreements. An interview was conducted with Resident #45 on 6/2/23 at 2:17 PM. She stated she did not recall This education included: signing the agreement and reported there were Carrolton Policy 17.13 Binding so many papers to sign during the admission Arbitration Agreements, emphasizing 2 process she did not understand them all. (d): Explicitly state that neither the resident An interview was conducted with the Admissions nor his or her representative us required Coordinator on 6/2/23 at 2:40 PM. She stated to sign an agreement for binding she reads each section of the arbitration arbitration as a condition of admission to, agreement and asked residents or their or as a requirement to continue to receive representatives to sign during the admissions care at, the facility. process. The Admissions Coordinator stated she asked the resident or their representative if Letters were sent to every resident/legal they had any questions. When asked about representative, including Resident #9 and explaining the agreement was not a condition of Resident # 45, on June 20, 2023, to admission the Admissions Coordinator replied it educate arbitration agreements including was at the top of the form and she went over the that arbitration agreements are not a

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# FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 847 Continued From page 59 F 847 information. She reported she did not explicitly condition of admission. Resident letters explain the form was not a requirement of were distributed directly to all residents in admission. the facility and representative letters were mailed on June 20, 2023. The Administrator was interviewed on 6/2/23 at 3:26 PM. The Administrator stated he expected On June 23, 2023, a follow up memo was the arbitration agreement to be explained to the sent to all residents and legal resident and/or the resident representative in a representatives/responsible party, language they can understand. The providing instructions for rescinding Administrator stated prior to the Admissions binding arbitration agreements that may have been completed without the proper Coordinator's hire he was reviewing the arbitration agreement with residents. He stated education. that most residents refused to sign the agreement. The Administrator continued and How the corrective action(s) will be 4. stated he believed the Admissions Coordinator monitored to ensure the practice will not was not explaining that signing the agreement recur: was not a requirement for admission in a way The facility Administrator will review all residents and their representatives understood. arbitration agreements signed in June and for the next three (3) months and will make follow up calls to residents/legal representatives to ensure that they understand what they have agreed to, including that the arbitration agreement is not a condition of admission. The administrator will bring information regarding signed arbitration agreements to the Quality Assurance/Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023. F 867 **QAPI/QAA** Improvement Activities F 867 6/30/23 SS=D CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/11/2023 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345325	B. WING		_		C 02/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE CARROLTON OF DUNN				11 SUSAN TART ROAD DUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impre §483.75(c)(2) Facility systems to identify, co information from all de not limited to the facili §483.70(e) and includ will be used to develo indicators. §483.75(c)(3) Facility and evaluation of perf including the methodo gystematically identify analyze and use data adverse events in the	eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will v, report, track, investigate, and information relating to facility, including how the ta to develop activities to	F 867				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 07/11/2023 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345325	B. WING			_		C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CARI	ROLTON OF DUNN				11 SUSAN TART ROAD UNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	§483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance improvements are real §483.75(d)(2) The fac implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance imple ensure that improvem §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive	eystematic analysis and ility must take actions improvement and, after ctions, measure its success, it to ensure that alized and sustained. ility will develop and dressing: a systematic approach to causes of problems ems; lop corrective actions that fect change at the systems y of care, quality of life, or Il monitor the effectiveness provement activities to tents are sustained. activities. ility must set priorities for its ment activities that focus on a, or problem-prone areas; a, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. hance improvement hedical errors and adverse	F	867				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345325	B. WING			C 06/02/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			6	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	62	F	867			
	§483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sec §483.75(g) Quality as §483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to mak This REQUIREMENT by: Based on record revi	a of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). Is must include at least t focuses on high risk or identified through the data s described in paragraphs tion. Issessment and assurance. Ality assessment and reports to the facility's esignated person(s) ming body regarding its oplementation of the QAPI ler paragraphs (a) through e committee must: Isseent appropriate plans of tified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on			Carrolton of Dunn Nursing and Rehabilitation Center acknowledges		
	committee had previo	naintain implemented tor interventions that the susly put in place following of 11/9/22. The deficiency is			receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings factually correct and in order to maintai	is	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345325 B. WING 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD THE CARROLTON OF DUNN DUNN, NC 28335 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 867 Continued From page 63 F 867 in the area of respiratory care (F695). The compliance with applicable rules and continued failure during two federal surveys provisions of quality of care of residents. showed a pattern of the facility's inability to The Plan of Correction is submitted as a sustain an effective Quality Assurance Program. written allegation of compliance. Carrolton of Dunn Nursing and Findings included: Rehabilitation Center s response to this Statement of Deficiencies does not This tag is cross referenced to: denote agreement with the Statement of Deficiencies nor does it constitute an F695: Based on observations, record reviews, admission that any deficiency is accurate. and staff interviews, the facility failed to follow Further, Carrolton of Dunn Nursing and orders for the use of oxygen for 1 of 3 residents Rehabilitation Center reserves the right to reviewed for oxygen use (Resident #74). refute any of the deficiencies on this Statement of Deficiencies through During the complaint survey of 11/9/22 the facility Informal Dispute Resolution, formal was cited at F695 for failing to provide appeal procedure and/or any other tracheostomy care for 1 of 2 residents reviewed administrative or legal proceeding. for tracheostomy care. Tag Cited: F 867 ¿ 483.75(c)(d)¿(g)(2)(i)(ii) QAPI/QAA An interview with the Administrator was Improvement Activities conducted on 6/2/23 at 3:40 PM. The Issue Cited: Administrator stated the facility had some # Recited deficiencies (F 695) turnover in staff which contributed to the repeat 1. Immediate action(s) taken for the citation. resident(s) found to have been affected include: Carrolton Facility Management team members held a series of meetings with the facility administrative team to discuss survey findings and develop the respective plans of correction, including the plan of correction for F 695, Respiratory Care. These meetings included but were not limited to: June 5, 2023 June 7, 2023 June 12, 2023

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					PRINTED: 07/11/2023 FORM APPROVED
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345325	B. WING		C 06/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	711 SUSAN TART ROAD	
	ROLTON OF DUNN		1	DUNN, NC 28335	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 867	Continued From page	. 64	F 867	<ul> <li>June 19, 2023</li> <li>June 20, 2023</li> <li>June 28, 2021</li> <li>Identification of other residents to be affected was accomplished by: The facility has determined that residents have the potential to affected.</li> <li>Actions taken/systems put to reduce the risk of future occilinclude: Detailed plans of correction, all monitoring tools have been der and executed to address all su findings including the repeat decited (F 695 Respiratory Care))</li> <li>The facility administrator met w facility administrative team to g regarding the plan of correction 19, 2023.</li> <li>All areas of deficient practice h added to the facilities QAPI plabe reviewed in the QAPI meeting scheduled for June 28, 2023.</li> <li>Facility administrative staff will in-serviced by the facility Nurse Consultant or designee on Jun during the QAPI meeting. This will cover implementation, mon revisions of action plans and p achieve and sustain compliance 4. How the corrective action(monitored to ensure the practice recur: The facility Administrator will enterpresent the practice of the practice of the plan of action plans and p achieve and sustain compliance 4. How the corrective action(monitored to ensure the practice of the practice of the practice of the practice of the plans and p achieve and sustain compliance 4. How the corrective action(monitored to ensure the practice of the pract</li></ul>	t all be into place urrence ong with veloped rvey eficiency with the give updates n on June ave been an and will ng be e 28, 2023, in-service itoring and rocesses to re. s) will be ce will not

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	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345325	B. WING		C 06/02/2023
NAME OF F	ROVIDER OR SUPPLIER	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	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 COMPLETION
F 867	Continued From pag	e 65	F 867		monthly ly be and QAPI and plan Corporate ty QAPI action tial

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