Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0501	A. BUILDING: ______ B. WING ______	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF FAYETTEVILLE	2461 LEGION ROAD FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS The survey team entered the facility on 02/17/24 to conduct a complaint survey and exited on 02/19/24. The survey team returned to the facility on 02/28/24 to obtain additional information and exited on 02/29/24. Therefore, the exit date was changed to 02/29/24. This state licensure deficiency was cited in addition to deficiencies related to the federal regulations. Event ID # IFJM11.	L 000		
L 022	.2202(C) ADMISSIONS 10A-13D.2202 (c) Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnoses, and other information necessary to formalize the initial plan of care. This Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain current medication administration records, physician orders, labs, a physician progress note, and history and physical, within 48 hours of admission to assist in the formulation an initial plan of care for 1 of 3 residents (Resident #1). The findings included: Resident #1 was admitted into the facility on 1/2/24 with diagnoses of protein malnutrition, muscle wasting/atrophy, paranoid schizophrenia, anxiety, and peripheral vascular disease, protein calorie malnutrition, and muscle weakness. A review of Resident #1's medical record admission paperwork received by the admitting	L 022	1. Immediate action(s) taken for the resident(s) found to have been affected include: LNHA contacted the Medical Director of Resident #1's previous facility to request additional historical medical records. Additional medical records were not available. 2. Identification of other residents having the potential to be affected was accomplished by: All residents admitted to the facility have the potential to be affected. 3. Actions taken/systems put into place	3/28/24

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/24

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L 022	Continued From page 1 facility on 1/2/24 from the discharging facility revealed the most recent medication list included the last dose of aripiprazole 5 mg, aspirin-dipyridamole 25-200 mg, carvedilol 12.5 mg, Vitamin D3 10 mcg, clonazepam 0.5 mg, ferrous gluconate 324 mg, hydrocodone-acetaminophen 5-325, levothyroxine 125 mcg, megestrol 400 mg/10 mL suspension, mexiletine 250 mg, pantoprazole 40 mg were administered on 11/18/23, atorvastatin 20 mg and finasteride 5 mg were administered on 11/17/23, the latest physician progress from the former primary care provider was dated 8/24/23, a psychiatry progress noted dated 9/12/23, an after visit summary from an outside consultant included a medication list and progress noted dated 9/20/23, and the face sheet from discharging facility. A review of Resident #1's admission skin assessment dated 1/2/24 noted a pressure wound to his right hip. There was not any paperwork provided by the discharging facility regarding what treatment was being done to the area. A review of Resident #1's admission Minimum Data Set dated 1/9/24 noted he was severely cognitively impaired, had one stage 4 pressure area present on admission and noted no pressure ulcer care, applications of nonsurgical dressings, or applications of ointments or medications. It further noted that he had no behaviors, rejected care 1-3 days, had received both antipsychotic and antianxiety medications, had limited range of motion in his bilateral lower extremities. A review of Resident #1's medical record revealed a base line care plan had not been	L 022	to reduce the risk of future occurrence include: The Admission Director and the Admission Nurse were educated on 3/20/2024 by Nursing Home Administrator regarding medical information needed on new admissions. New admissions will be reviewed by Interdisciplinary team members in the daily clinical meeting to identify if additional medical information is needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Corporate Clinical Team will monitor the clinical meeting minutes weekly for 4 weeks and monthly for 2 months to ensure compliance. Results will be taken to QAPI to deem compliance. Corrective action completion date: 3/28/24.	

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L 022	Continued From page 2 developed within 48 hours of admission. A review of Resident #1's undated care plan revealed the comprehensive care plan was started 7 days after the comprehensive assessment was completed, however it was not completed. An interview was conducted with the Chief Executive Officer on 2/28/24 at 10:00 AM who revealed that the prior nursing home was in a rush to discharge residents due to closing, and when the facility called the prior facility, they were told that the records were no longer available. She stated that they did what they could with the information they had by having Speech, Physical, and Occupational therapies see the resident within two days, the Medical Director saw him within one week, and staff who had taken care of Resident #1 at the prior facility assisted the resident based on prior knowledge of him. She further stated that when a resident is admitted the facility expects to receive current physician orders, current history and physical, current medication administration record, a current treatment administration record, and last assessment, along with any other pertinent information.	L 022		