STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 06/14/2024

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

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E 000	Initial Comments An unannounced recertification survey was conducted on 06/10/24 through 06/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2GRX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/10/2024 through 06/14/2024. Event ID# 2GRX11. The following intakes were investigated NC00218200,NC00217403, NC00217248, NC00217204, NC00216931,NC00216755,NC00216783 and NC00215354 2 of the 39 complaint allegations resulted in a deficiency.	F 000		
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		7/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/05/2024

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F 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party (RP) and staff interviews, the facility failed to inform the RP of skin tears and bruises for one (1) out of four (4) sampled residents reviewed. (Resident #150)	F 580	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #150 expired at the facility while on Hospice 5/25/24.	

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F 580	Continued From page 2 Findings include: Resident #150 was admitted to the facility on 12/26/2023 with diagnoses that included Alzheimer's disease, hypothyroidism and hypertension. The resident was discharged from the facility on 05/25/2024. The quarterly Minimum Data Set (MDS) dated 04/28/2024 revealed Resident #150 had short-term and long-term memory problems and cognitive skills for daily decision making was severely impaired. A review of Resident# 150 "Skin Observation Tool" dated 12/26/2023 by Nurse #1 revealed the resident was observed with a skin tear on left hand 1st digit. A review of Resident #150 "Skin Observation Tool" dated 03/05/2024 by Nurse #2 revealed the resident was observed with a skin tear on the right cheek. During an interview on 06/13/2024 at 1:29 PM, Nurse #2 indicated that she did not notify the RP on 03/05/2024 about a skin tear on Resident #150's right check. She indicated the facility protocol was to notify the RP about a skin tear and complete an incident report. She also indicated for the future she will make sure she notifies the RP of a skin tear A review of Resident #150 "Skin Observation Tool" dated 04/29/2024 by Nurse #3 revealed the resident was observed with a skin tear on the face. During an interview on 06/13/2024 at 12:45 PM,	F 580	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nurses were in-serviced regarding the facility policy for Notification of Changes, Policy 2.16 by the DON and ADON 6-14-24 through 7-10-24. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/Designee will complete five random weekly audits for four consecutive weeks beginning week of 6/24/24 to ensure compliance with notification of resident changes to the resident□s representative and an incident report is completed if warranted. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 7/10/24	

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F 580	Continued From page 3	F 580		

Nurse #3 indicated she observed the skin tear on Resident # 150 on 04/29/2024 but did not notify the RP. She indicated she did not know the reason why she did not notify the RP of the skin tear. She indicated she had been trained to complete an incident report and notify the RP of any skin tear or bruise on a resident at the facility. She reported moving forward she will make sure the RP is notified of a skin tear and bruise on a resident at the facility

A review of Resident #150 "Skin Observation Tool" dated 05/20/2024 by Nurse # 4 revealed the resident was observed with a bruise on the left knee.

Review of the nursing progress notes between December 2023 and May 2024 revealed no documentation of the RP being made aware of the discovered injuries.

During an interview on 06/13/2024 at 11:00 AM, Resident#150's RP stated she was not notified of the resident's skin tear on left hand 1st digit, right cheek, right face, and a bruise on the resident's knee.

During an interview on 06/13/2024 at 11:42 AM, Assistant Director of Nursing (ADON) indicated she was not aware of the reason the staff failed to notify the RP about the Resident #150's skin tears and a bruise. She indicated the staff at the facility was expected to notify the RP about a change in the condition of a resident and document in the progress notes that the RP was notified. She indicated moving forward the staff will call the RP and document that the RP had been notified of the skin tear or a bruise on a resident.

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F 580	Continued From page 4 . An attempt to contact Nurse#1 was unsuccessful. An attempt to contact Nurse #4 was unsuccessful. During an interview on 06/13/2024 at 2:14 PM, the Director of Nursing reported it was his expectation that residents or their RP be notified of skin tears and bruises. He reported the staff at the facility had been trained to notify the RP of any skin tear or bruises. During an interview on 06/13/2024 at 3:00 PM, Administrator reported he did not know the reason for the staff not notifying the RP of the skin tears and a bruise on Resident #150. He indicated his expectation was that RP be notified of skin tears and bruises. He reported the staff would be in serviced in reference to notifying RP of a skin tear or bruise.	F 580		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		7/10/24

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F 645	Continued From page 5	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

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F 645	Continued From page 6 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to apply for a Preadmission Screening and Resident Review (PASRR) Level II screening for 1 of 5 residents reviewed for PASRR Level II screenings (Resident #4). The findings included: A review of the PASRR level I determination letter dated 11/04/2023 revealed a PASRR number already existed for Resident #4. Resident #4 was admitted to the facility on 12/13/2023 with diagnoses including bipolar disorder 12/13/2023. A physician's order dated 12/13/2023 revealed an order for risperidone (antipsychotic medication) extended-release subcutaneous injection (used to administer medications between skin and muscle) 120 milligrams (mg) one time a day every 28 days for psychosis. The admission Minimum Data Set (MDS) dated 12/19/2023 had Resident #4 coded as cognitively	F 645	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 4 had a Level II PASARR request made on 6-12-24 utilizing the NC MUST portal. Additional information was provided on 6-29-24 (MD Progress Note) detailing her diagnoses and medications. The screening remains in "manual review" and we are awaiting the final decision for LEVEL II determination. 2. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be negatively impacted by failure to provide diagnoses and medications on PASARR determination requests. An audit of all residents was completed on Friday, June 29 by the facility social worker and the admission coordinator. All PASRRs that required additional follow-up	

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F 645	Continued From page 7 intact and was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #4 used psychotropic medication related to bipolar disorder. The care plan dated 02/07/2024 had focus of the resident at risk for adverse reaction related to psychotropics. An interview with the Social Worker (SW) was conducted on 06/12/2024 at 10:07 AM. The SW explained that if a newly admitted resident had a PASRR level I at admission and had a psych diagnosis or psych medications, that was her cue to apply for a PASRR level II screening. The SW also stated Resident #4 was admitted on 12/13/2023 with a diagnosis of bipolar disorder and a PASRR level II was not submitted and she did not know why it was not completed. It must have been an oversite. An interview with the Administrator was conducted on 06/12/2024 at 10:35 AM. The Administrator explained that Resident #4 came in with a completed PASRR level I and she should have been screened for a PASRR level II when she was admitted due to her diagnosis of bipolar disorder. The Administrator also stated the SW was the person responsible for this task and in the future, they will have training and a 2nd SW so an issue like this will not happen again.	F 645	including expirations, or addition of diagnoses and medications were updated immediately. All residents in the facility have current PASRR determination requests submitted on their behalf. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Social Worker was re-educated on the PASRR regulations and requirements on June 14, 2024. Education was completed by the facility Administrator. Current PASRRs for all patients in the facility were printed and placed in a large notebook in the Social Worker's office. A worksheet is now utilized in the front of the notebook detailing the date of admission, time of PASRR Request, and final determination for LEVEL I or II is printed. Level II PASRR determinations are flagged by the Social Worker and resubmitted with requested information immediately upon receipt within 48 hours of admission to the facility. All determinations that include special parameters, shorter time frames, or any follow-up outside of a LEVEL I PASRR are documented and calendared with the date certain. The Social Worker is updating the PASRR notebook on a weekly basis with all new admissions. The MDS Coordinator and Admitting Nurse will notify the Social Worker of any changes in residents' diagnoses that would prompt a LEVEL II PASARR	

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F 645	Continued From page 8	F 645	screening. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The corporate nurse consultant will review all new PASRR determinations on a weekly basis for the next four weeks beginning the week of 7/8/24 to ensure accuracy of PASRR requests and information submission. Then audits will be completed one time per month times two months until substantial compliance is achieved. Items missing will be immediately identified and returned to the Social Worker for completion and resubmission. The corporate nurse consultant will review the PASRR notebook as part of the audits to ensure that the notebook is maintained with accurate and current information. Audit will include validating that the log and calendar are updated with new facility admissions. Corrective action completion date: July 10, 2024.	