PRINTED: 06/30/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 00	0	
	conduct a complaint is surveyor was onsite of additional information 6/6/25. The surveyor 6/10/25 to validate crimmediate jeopardy r date was 6/10/25. Ev. The following intakes NC00228836, NC002 NC00230092, and No. NC00229082 resulted One of the eight complete deficiency. Immediate Jeopardy CFR 483.10 at tag 58	emoval. Therefore, the exit ent ID# SEVC11 were investigated: 228877, NC00229082, C00230803. d in immediate jeopardy. plaint allegations resulted in			
	Care. Immediate Jeopardy	uted Substandard Quality of began on 3/21/25 and was			
F 580 SS=J		jury/Decline/Room, etc.)	F 58	0	6/22/25
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident			
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u> </u>	TITLE	(X6) DATE

Electronically Signed 06/25/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING	B. WING		C 06/10/2025		
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	1 00/	10/2023	
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F 580	results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thic clinical complications (C) A need to alter trea need to discontinue treatment due to advecommence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the re	ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or attention of east consequences, or to m of treatment); or sfer or discharge the lity as specified in specified in \$483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or as as specified in paragraph. ecord and periodically mailing and email) and	F	580				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C
NAME OF PI	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE	06/10/2025
				711 SUSAN TART ROAD	
THE CARI	ROLTON OF DUNN			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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 580		e 2 se the composite distinct y the policies that apply to	F 58	0	
	room changes between under §483.15(c)(9).	en its different locations is not met as evidenced			
	Based on record revi staff, therapy staff, ar failed to notify the phy	ew, and interviews with id the Physician the facility /sician when Resident # 3 e in status resulting in a		Immediate action taken for the resider found to have been affected include: The facility failed to notify the physiciar	
	decline observed by r Resident # 3 entered Therapists and Nurse	nultiple staff members. the facility for rehabilitation. Aides revealed Resident # progress in therapy to the		when Resident # 3 showed a significar change in condition. Resident #3 was discharged from the facility on 3/25/25.	nt
	degree that she could short distances with the with a quad cane, toil	feed herself, ambulate herapy in parallel bars or et to the commode, and eds by gestures. Multiple		Identification of other residents having potential to be affected was accomplish by:	
	days prior to a transfe 3 had declined in fund to have symptoms wh	er to the hospital, Resident # ctional status and was noted nich included dizziness, sea, periods of altered		On 6/4/25 and 6/5/25, twenty-four-hour reports (from the electronic medical record) were printed (for daily meetings 3/25/25 to current) and reviewed by the	S
	dry mouth, poor oral i dark stools, and a pos	nge in communication ability, ntake, less urine output, sitive COVID (Coronavirus ysician was not notified of		facility Director of Nursing (DON), Corporate Nurse Consultant, Administrator, and Chief Operations Officer to ensure that the Medical Director	
	the resident's significa multiple days althoug therapy had talked wi	ant change in status for h it was documented that th nursing staff about a		(MD)/Attending Physician was notified appropriately of residents who had a decline in condition and that orders from	
	with the physician or resident was declining	s a plan to communicate DON to determine why the g. The physician reported he ware of the change in		MD visits were implemented appropriately. (The twenty-four report summarizes resident information occurring in the last 24 hours including	all
	aware, the physician seen the resident, pro	. If he had been made reported he would have bbably ordered stat (right		progress notes, vital signs, incident reports, physician progress notes, physician order notes, med administrat	
		d probably sent her back to t #3 was transferred to the 03/25/25. At time of		notes, admissions, discharges, and residents on or returning from leave). There were no additional problems	

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NAME OF P	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP COD		6/10/2025	
TO UNIC OF T	TO VIDER OR GOLF EIER			711 SUSAN TART ROAD	_		
THE CAR	ROLTON OF DUNN			DUNN, NC 28335			
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F 580	Continued From page	e 3	F 58	30			
	hospitalization Reside	ent # 3 was found to be ridual's body has an extreme		identified.			
		on and which can lead to		On 6/5/25 meetings were held	d with the		
		her COVID infection. The		Chief Operating Officer, Chief			
	resident was addition	ally found to have		Officer, Facility Nurse Consul			
	gastrointestinal bleed	ling, which resulted in a		of Nursing, and Facility Admir	nistrator with		
		f 4.0 and required three units		staff members including all lic			
		t was hospitalized in the		(nurses), therapists, certified i			
		The resident's 4/8/25 hospital		assistants, social workers, an			
		noted the resident had		contractors working at the tim			
		/ due to the sepsis. This was sidents reviewed for acute		meeting. Staff members wer opportunity to identify residen	-		
	medical conditions (F			experienced a decline in cond			
	modical conditions (i	toolaont ii o).		3/25/25 through 6/5/25. Nam			
	Immediate jeopardy b	pegan on 3/21/25 when a		documented by the Chief Clin			
	licensed Physical The	erapist identified Resident #		and the Chief Operations Office	cer. Three		
	3 had an overall char	nge in status and the		changes, from earlier in the sa	ame day		
		tified. Immediate Jeopardy		(6/5/25), were brought forward			
	was removed on 6/6/			medical record review revealed			
	-	eptable credible allegation of		three events had been shared			
		emoval. The facility will		physician earlier in the day ar			
	•	ance at a lower scope and		appropriate actions were take			
		education is completed and out in place are effective.		immediately (including one re was sent to the hospital).	sideni inai		
	monitoring systems p	out in place are encouve.		was sent to the nospital).			
	The findings included	i:		The facility has determined th			
				residents have the potential to			
	Record review reveal			when staff members fail to co			
		y on 3/8/25 after being		a decline in a residents condit			
	•	5. Review of Resident # 3's		team members and the physic	cian.		
		y and physical and the pital discharge summary		Actions taken/systems but int	o placo to		
		g information. Prior to		Actions taken/systems put intereduce the risk of future occur	•		
		sident resided independently		include:	TOTICC		
	•	ed to the hospital on 3/3/25		olddo.			
	-	While hospitalized the		All staff members (including li	censed		
		n MRI (Magnetic Resonance		nurses, therapists, certified nu			
		aled multiple acute small		assistants, social workers, an	-		
		in damage from a lack of		contractors) were in-serviced	•		

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F 580	Continued From page		F 580			
	stroke with right-sided speech. The discharg Resident # 3 needed	t was diagnosed with a d weakness and slurred ling physician further noted to be evaluated as an blood loss and further		the Chief Operating Officer and Chier Clinical Officer regarding the importation of notifying the physician and other to members of decline immediately.	nce	
	gastrointestinal worku primary care physicia on anticoagulant med The resident's 3/8/25	up would be deferred to the n. She was also discharged lications due to her stroke. discharge summary also d benign hypertension.		The Lead Therapist in serviced all the team members on 6/5/25 regarding communicating to the physician and other team members of significant change. Agendas for both meetings included the following:		
	which noted the resid	record revealed an te on 3/8/25 at 3:08 PM ent had a right sided deficit, ented to self, and denied any		Survey findings related to failure to notifying the physician of resident changes;		
	Resident # 3 was a fu	erapy, and Physical Therapy		Change identification- all residents w reported change in condition must be assessed by a nurse immediately. Assessment findings indicating declir the need for emergent physician intervention will be immediately calle	ne or	
	3/10/25 Resident # 3 physical therapy. PT following information session on 3/10/25. S Resident # 3 to go fro	regarding the treatment		the Physician and documented in the medical record. Other changes identification must be communicated to the physic before the shift ends. Calls to physic and family members must be document as notifications are completed.	iified ian ians	
	good balance and wit and bilateral lower ex resident was able to t PT # 1 and an Occup PT # 1 helped Reside with a quad cane and trial with the quad car device for individuals	h bilateral upper extremities tremities supported. The ransfer to the toilet with both ational Therapist present. ent # 3 with trials of transfers the future plan was to do a ne or hemiwalker (a mobility who have limited use of one transfers and ambulation		Effective communication among the interdisciplinary team (including 100% facility team members and contractor This communication includes but is n limited to: -Nursing assistants and therapists reporting changes to nurses promptly -Nurses reporting changes in condition physicians timely	rs). ot	

		IDENITIEICATION NITIMBED:		LE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
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F 580	Continued From page	2.5	F 58	0			
1 000	Continued From page	= 0	F 30				
	A 15 (d)			-Apprising the Physician, Direct			
	According to the reco			Nursing, and Administrator of	significant		
		n the facility physician while		changes immediately	M/ATOLL		
		at the facility on 3/11/25.		-Implementation of a STOP &			
		ysician's progress note, the		program for both nursing and t			
	physician included fu	•		teams to communicate identificate	ed change.		
	thrombocytosis (eleva	ease of the heart muscle),		The Director of Nursing contin	uod		
		d cholesterol or fats), and		education every shift until 100			
	aphasia (loss of ability to express speech clearly			members and contractors were			
	or understand). There			mombere and confidence work	o oddodiod.		
	documentation that the			New staff members will be edu	icated by		
	resident while she resided at the facility.			the Director of Nursing (DON),	•		
				Director of Nursing (ADON), U			
	On 3/11/25 ST (Spee	ch Therapist) # 1		Manager, or Facility Nurse Co			
	documented the follow	wing in a speech therapy		during the orientation process.			
	progress note, "Pt as	sessed with her lunch meal.					
	Pt [patient] alert and	sitting up in her wheelchair.		On 6/9/25, Carrolton Facility M	lanagement		
		If with her left hand for the		corporate employees, includin	•		
		ther noted Resident # 1		Operating Officer, Chief Clinic			
	consumed 40 percen			and Facility Nurse Consultant,			
	_	want any more and that she		therapy leaders, including the			
		r teeth with intermittent		Lead, Clinical Specialists, and			
		Γhe ST also noted Resident		Director. The following issues			
	# 3 was receptive to e	education.		for resolution were discussed	during this		
	On 3/12/25 Dhysical	Therapy Assistant (PTA) # 1		meeting:			
	_	treatment modalities in a		The need to see thereby deau	montation in		
	•	ress note. One included that		The need to see therapy docu real-time:	mentation in		
		un in the parallel bars, and		real-time.			
		to complete the length of		-Carrolton Facility managemer	nt requested		
		minimal assistance two		an upgrade to allow therapy no			
	times while resting in			visible in the electronic medica			
				-Therapy notes will be brought			
	On 3/14/25 PTA # 1 c	documented in a therapy		morning clinical meeting the d			
		session of 3/13/25 the		care provision and reviewed b			
	. •	She (PTA # 1) instructed		and Therapy Lead.	-		
		se of the hemiwalker and		.,			
		sident required minimal to		Documentation Issues (timelin	ess and		

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F 580	Continued From pag		F 58			
	support her right upp deficits. The resident	to impulsivity, the need to er extremity, and balance was documented as walking hemi walker and the quad		-Education plan for clinical staff nurses and therapists as well as		
	cane on 3/13/25. The as needing minimal a	e resident was documented assistance for transfers on /13/25. The resident had		nursing assistants). -Therapy notes will be brought to morning clinical meeting the data	to the	
	declined wheelchair	mobility because she (the ocus on transfers and gait.		care provision and reviewed by and Therapy Lead.	•	
		sion MDS (Minimum Data ted 3/14/25 coded the		Ways to improve communicatio	n:	
	resident as having unclear speech and was moderately cognitively impaired. She was			-Nametags to clearly identify me		
		bstantial to maximum ing, dressing, and hygiene.		-Utilization of the Stop and Wate warning tool -Increased interdisciplinary clini	-	
	for the session of 3/1	in a therapy progress note 4/25 the following A #1) had instructed the		meetings (morning and afternoon- Nursing will attend rehabilitation meetings weekly for the next for	n team	
		er use of the quad cane t using it properly. The		weeks.	. ,	
		rticipated in bean bag m sitting to standing, and ball		Following the meeting with them Carrolton Facility Management employees, including the Chief Officer, Chief Clinical Officer, ar	corporate Operating	
	for the session of 3/1 minimal assistance to	d in a therapy progress note 7/25 Resident # 3 needed to transfer to the left and that th a Nurse Aide (NA) to allow		Nurse Consultant, met with the administrator and the DON to d issues and corrective action pla	iscuss	
	_	toileted by the Nurse Aide.		On 6/9/25, the therapy Clinical in-serviced all therapy teams	Specialist	
	ST #1 documented in a speech therapy progress note for the session of 3/17/25 the following information. "Pt [patient] participated with			(company-wide), including the I therapy team (licensed therapis assistants, and rehabilitation aid	its,	
	completion and simp	tasks for simple phrase le responsive naming tasks		the following topics:		
		ted. Pt completed tasks with min to mod [minimal to		-Documentation timeliness, -Documentation accuracy, inclu	ding the	

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		245205	B WING			С	
		345325	B. WING _			06	/10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 580	Continued From page	e 7	F 5	580			
	moderate] verbal cue functional phrases ou fluency. Pt approxima reading simple phrase [pt wearing glasses foup in her wheelchair further noted she ediswallowing recomme was able to participat minimal improvement Review of weight recorded Resident # 3's weight pounds, which indicated	ing. Pt read simple It loud with improved It			importance of including clinically releval and factual content in daily notes, -Effective communication with nursing staff to ensure immediate physician notification, -Reporting a change in condition, including utilization of the Stop and Walearly warning tool. The Therapy Lead or Clinical Specialis provided in-service training to any staff members who had not received it before they returned to work. The Therapy Lewill educate all new rehabilitation staff members during orientation.	itch t f	
	ST # 1 documented in note for the session of information. Resident speaking) but she par common pictured iter given minimal to mod was approximately 75 session the resident's suddenly started to the grabbed her face. The nursing. The resident with minimal assistant drink through a straw	n a speech therapy progress of 3/18/25 the following # 3 was dysarthric (difficulty rticipated with naming ns with 75 % accuracy when erate cueing. Her speech 5 % intelligible. During the stright side of her face witch and Resident # 3 e physician was notified via was able to brush her teeth ce. The resident was able to without signs of aspiration.			The therapy staff began use of the Sto and Watch early warning tool on 6/11/2 On 6/11/25, the facility Stop and Watch form was revised by the Chief Clinical Officer and sent to the print shop for triplicate carbon copies. The facility macopies of the form until the triplicate carbon copy form was available. 6/13/25 through 6/21/25, the facility Director of Nursing /Facility Nurse Consultant in-serviced all certified nurs assistants on the following topics: -Effective communication with nursing	25. n ade	
	reported the following part of Resident # 3's feeding herself. It was considered she was of the will to do good. So plate to help with mea	ed on 6/3/25 at 3:35 PM and information. During the first speech therapy she was into perfect but all things doing good." She also had he started to use a divided als. There was a day when the facial twitching.			staff, -Reporting of changes in condition immediately to nurses, Director of Nursing, and Administrator, -Utilization of the Stop and Watch early warning tool. The DON, ADON, Unit Manager, or	ı	

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F 580	Continued From pag	e 8	F t	580				
	resident seemed awa	are of it and then it went			Facility Nurse Consultant will educate a	all		
		s told about the facial			new certified nursing assistants during	•••		
	•	end of therapy, the resident			orientation. The Administrator or Direct	tor		
		alaise. The date of 3/18/25			of Nursing will provide in-service training			
	•	t the resident received			to staff members who have not receive	•		
	speech therapy. ST work following 3/18/2	# 1 reported she was out of			the education before returning to work.			
	Work following of forz				6/13/25 through 6/21/25, the facility			
	On 3/18/25 at 11:20	AM Nurse # 1 completed a			Director of Nursing /Facility Nurse			
	SBAR narrative (situ	•			Consultant in-serviced all licensed nurs	es		
	,	commendation) which noted			on the following topics:			
		tion. Speech therapy had						
	been in with the resident and the resident				-Importance of completing nursing			
		ig to the right side of her face			assessments,			
		han baseline per therapy.			-Documentation timeliness,			
	Her vitals were within	n normal limits. The physician			-Documentation accuracy, including the	Э		
	was notified and orde	ered baclofen 10 mg (a			importance of including clinically releva	ınt		
	muscle relaxer medi	cation) twice per day as			and factual content in daily notes,			
	needed for spasms.	This was the last			-Effective communication with nursing			
	documented notificat	tion to the physician in the			assistants and therapy staff,			
	_	es about a change in the			-Utilization of the Stop and Watch early	t .		
	resident's condition p	prior to 3/25/25.			warning tool,			
					-Reporting changes in condition to the			
		# 1 on 6/4/25 at 3:50 PM			physician immediately,			
		ng she was aware of on			-Following physician orders			
		resident had some twitching.						
		e physician and the physician			The DON, ADON, Unit Manager, or			
		was related possibly to			Facility Nurse Consultant will educate a	all		
		r stroke. Nurse # 1 reported			new nursing staff members during			
	· ·	further change in the resident			orientation. The Administrator or Direct			
	on 3/18/25.				of Nursing will provide in-service trainir to staff members who have not receive	-		
		/I Nurse # 2 entered a late			before returning to work.			
		notes for the date of						
		vhich read, "Therapist			How the corrective action(s) will be			
		k to room saying resident			monitored to ensure the practice will no	ot		
	· ·	. No [mechanical lift pad]			reoccur:			
		st X 3 to bed. Assist X 2 to						
	get situated in bed. \	/S WNL [vital signs within			The DON, or designee, will audit 100%	of		

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	normal limit] for resid	ent bed low. Call light in			the 24-hour reports daily for four (4)			
	reach."	- 3			weeks to read all progress notes and n	ew		
					orders to ensure that change identification	ion		
	PTA#1 documented	in a therapy progress note			is occurring and is being communicated	d to		
	for the session of 3/2	•			all team members and the physician.			
		t # 3 was brought to the gym			Any identified adverse findings requiring	_		
		working on transfers, PTA#			follow-up will be addressed immediatel	у.		
		each attempt (2 attempts			The Administration will be a site of the collection	-1		
	made) patient required increased assist. When asking patient about what was wrong patient noted to not be attempting to verbalize as per her The Administrator will monitor the clinical meetings daily for four weeks to ensure that team communication is occurring and							
		she felt bad patient nodded			to ensure that MD notification is	iiiu		
		he was hurting anywhere			happening immediately. Any identified			
	-	yes. When asked where			adverse findings requiring follow-up wil	l be		
	_	ent put left had [as written] to			addressed immediately.			
		ly returned patient to her			,			
	room and informed n	ursing. Patient became less			The Facility Nurse Consultant or Chief			
	responsive and was a				Clinical Officer will randomly pull two (2			
		tient placed in supine and			24-hour reports weekly for four (4) wee	ks		
	hall nurse and DON (·			to audit for change identification and			
		ter in day patient noted to not			physician notification. Any identified			
		erapist was informed she			adverse findings requiring follow-up wil	lbe		
		air] with activities for bingo. nt in her room slumped with			addressed immediately.			
		open, partially responsive.			The Facility Nurse Consultant or Chief			
	-	ed with max/dep [maximum			Clinical Officer will randomly pull (5) St	an		
	'	d notified nursing. Spoke			and Watch forms weekly for (4) weeks	•		
		ated patient was sitting with			audit for compliance with follow-up and			
		ivities and said she wanted			documentation of identifying and			
	to go back to bed so	she was pushed to her room			notification of changes in condition. Ar	У		
	and call bell activated	d."			identified adverse findings requiring			
					follow-up will be addressed immediatel	у.		
		wed on 6/3/25 at 4:22 PM				_		
	-	owing information. The first			This correction plan will be monitored a	it		
		lent # 3 resided at the			the monthly Quality Assurance			
		ing progress. She could walk			Performance Improvement (QAPI)	ial		
		me "really, really good days." er point across with gestures			meeting until consistency and substant compliance are achieved.	ıdı		
	_	ed with staff in that manner.			Compliance are achieved.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING _				C 10/2025
	ROVIDER OR SUPPLIER			71	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	1 00	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	trying to gesture and She started to need a therapy with transfers this to the nursing star Review of a facility in care Resident # 3 ha facility revealed Nurse # 3 on the day of 3/2 noted Nurse # 2 had 3/17/25, 3/19/25, 3/2 2's signed 3/26/25 st opinion [Resident # 3 hospice. [Resident # 3 moaned and pointed Nurse # 2 was intervand reported the follonot routinely work wit recalled working with resident always seen doing well when she ever been communic the resident had bee and had been walkin therapist one day say	and a big change. She stopped stopped trying to verbalize. In a lot more assistance in section in the section i	F	580	Corrective action completion date: 6/22/25.		
	what she knew about had the resident out there had been some because if she had k recent weeks been a she would have had She validated she had 3/20/25. On 3/21/25 licensed	t the resident, why therapy of bed. The nurse reported e communication breakdown nown the resident had in ble to walk with a quad cane her sent out to the hospital. Id not called the physician on PT # 1 documented the cal Therapist] completes					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 06/10/2025	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI 711 SUSAN TART ROAD DUNN, NC 28335		33, 10, 2023	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 580	supine with appearaup. PT directs patien right] to finish putting mod A [moderate asscues [contact guard side. PT directs patie (Edge of Bed) transfassistance] and cues reporting dizziness, I and overall not feelin pressure], during sect 118/60 in seated from PT notes this to be a however not enough hypotension. PT disconurse and overall chadmission. Nurse plaalong to DON and/or workup on why paties status & overall feelin respond to questions written] for yes/no quentile patients.	atient today. Patient found in nee that she is ready to get at in rolling L & R [left and pants on. Patient requires sist] to roll to L side and CGA assist cues] for rolling to R ent in 2X supine < >EOB ers with max A [maximum is with both attempts patient ightheadedness, nausea, arg well. PT takes BP [blood cond attempt noting it to be in 132/58 in supine at rest. In mild decrease in BP, to be considered orthostatic cusses this change in BP with lange in status from ans to pass the message of doctor for potential further int is declining in functional ing. Patient is only able to swith head nocks/shakes [as lestions."	F 5	80			
	Occupational Therap evaluations together to the bathroom with therapy she began w her progression of the	pist conducted their initial The resident was able to go moderate assistance. In valking with a quad cane. In perapy, the resident "went up and then went down." In the					
	beginning of therapy her head yes and no doing better with con beginning. Near the minimally communic	, the resident could shake to communicate. She was nmunication near the end of her stay she was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345325	B. WING_		C 06/10/2025		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 711 SUSAN TART ROAD DUNN, NC 28335		0/10/2025	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 580	of her stay. It had be in the room on the da pressure was taken at Nurse # 1 (who was Resident # 3 on 3/21 6/4/25 at 3:50 PM an information. She kne stroke when she was had always had right person's awareness impaired after a strok same the times she to never been community in the stroke with the she to could stand, with the she to called the she had not called the known the resident he been doing more for she could stand and for sure" called the p	ent for transfers near the end en Nurse # 1 who had been ay that the resident's blood and dropped. assigned to care for /25) was interviewed on d reported the following w Resident # 3 had a major admitted to the facility and sided neglect (where a of one side of their body is te). She seemed to be the ook care of her, and it had	F 5	<u>'</u>			
	11:22 AM and report change in condition f notified the physician The DON (Director o on 6/5/25 at 4:00 PM following. She only re change in condition h	as interviewed on 6/5/25 at ed she was not aware of a or Resident # 3 and had not i. f Nursing) was interviewed i. The DON reported the ecalled one time when a had been mentioned to her not that was regarding the					
	about Resident # 3 a twitching the residen						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		00/10/2023
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	decline. Therefore, with the physician sinclear to her. On 3/22/25 a Point of COVID showed Res COVID infection. On checked as having in the contact and informed positive for COVID in start antiviral medical Record review reveau progress notes or or the physician was no positive for COVID of the physician was not positive for COVID of the physician and decrease to provide the physician and decrease the physician a	t aware of the resident's she had not communicated noe it had not been made of Care Testing Result for ident # 3 tested positive for a the form, the resident was so symptoms. AM Nurse # 1 documented alked to Resident # 3's d that the resident's vitals ident had left sided neglect, ving, was pocketing food, and erapy services. PM the Unit Manager called first Emergency d her of resident testing eccived verbal consent to ation." Aled no notation in the notation in the notation in the notation in the notation of the resident testing in 3/22/25. Afford Chief Clinical Officer were corted the following ministrator reported they had all D on 3/18/25 and Resident # a until 3/22/25. When it ive, there was a procedure for was supposed to contact etermine if he wanted them to the timent. They could not find in	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325			` ′	PLE CONSTRUCTION G	. ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 06/40/2025		
	ROVIDER OR SUPPLIER	1 0.0020		STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335		6/10/2025	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 580	11:22 AM and report There was a lot that outbreak, and she con what he said about FON 3/23/25 OTA# 1 Assistant) document to follow commands, self-feeding in any massistance. OTA # 1 dehydrated. Pt (paties sucking for brief peribringing drink or food nursing regarding Pot therapeutic potential to engage in meal ta OTA # 1 was intervied and reported the follospecific details of whom the working or working with She would not have "appeared dehydrate mouth was dry or the "skin pinch test." (A skin elasticity by see returns to its normal released) On 3/23/25 at 3:24 For the following in a nur	as interviewed on 6/5/25 at ed the following information. happened during the ould not recall for sure ntacted the physician and Resident # 3 having COVID. (Occupational Therapist ed Resident # 3 was unable utilize utensils, or engage in nanner without total further noted, "Pt appeared ent) able to utilize straw for od and did not react to d to mouth. Collaborated with D [oral] intake to improve, however Pt (patient) unable sk at this time." Evwed on 6/5/25 at 9:30 AM owing. She could not recall to she had talked to in with Resident # 3 on 3/23/25.	F 5	80			
	side, but without pur resident would look	e resident was moving her left poseful movements. The when spoken to and her eyes ne left side. Her vitals were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345325	B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		00/10/2023
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	3/23/25 at 8:23 PM R sided neglect." On 3/24/25 COTA # Therapist Assistant Required max cues participate. Pt was a Licensed Occupation interviewed on 6/3/2 the following. The ruth the start of her through the start of her through the start of her through the start of the start on ticed a distinct chrows discharged from functioning per her This had been com the licensed OT coubeen told. Review of a facility care Resident # 3 h facility revealed Nu Resident # 3 on the 3/15/25, 3/16/25, 3/3/25/25. Review of	ge 15 not in apparent distress. On Nurse # 1 noted, "correction £ 2 (Certified Occupational) wrote, "Pt very lethargic. to maintain alertness and dependent for all tasks." anal Therapist # 1 was 25 at 3:53 PM and reported esident could stand and pivot erapy treatment. She would and try to tell the staff things ed therapy. The therapy staff hange a few days before she in the facility. She was not normal and was not as alert. municated to the nurses, but ald not recall which nurses had investigative file regarding the ad received while at the ree Aide (NA) #1 had cared for dates of 3/10/25, 3/11/25, 18/25, 3/19/25, 3/24/25, and NA # 1's signed 3/26/25 restigative file revealed in part	F 58	,		
	first arrived at the faunable to verbalize hands and head to needed assistance went by she was gowas able to feed he condition on approx 3] was acting different at the factor of the fa	ation. "When [Resident # 3] acility [Resident # 3] was her needs; she used her communicate. [Resident # 3] with feeding. As a few days etting up in her wheelchair and arself. I noticed a change in timately 3/18/25, [Resident # ently having facial twitching. I 3] eating less and [Resident #				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING _		C 06/10/2025	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	Continued From page		F 5	80		
	had been doing prethe change of condivided his condition which nurse was wowent into the room at NA # 1's statement information about the "On 3/24/25 I notice her hands in her briat lunch, [Resident; off of the over the be [Resident # 3] was a moaning, but unable wrong when she was changes to the hall went into the room at NA # 1 was intervier reported the following Resident # 1 was as with therapy and convict wheelchair. She county good hand." She county good hand. "She county good hand." She county good hand had been to wer near her heready to hit the floor obtained the assistating the resident back to and seemed out of episode, she (NA # started to twitch. It was the twitching. The two better some days the started some days the started to some days the started to some days the better some days the started to some days the started to some days the better some days the started to some days the started	up in a wheelchair like she viously. I notified the hall in tion (as written), not sure orking that day. The nurse and assessed [Resident # 3]." specifically included le date of 3/24/25 which read, and [Resident # 3] was placing left, pulling off her clothes and left also staring off into space and left to verbalize if anything was less asked. I reported the nurse [Nurse # 2]. [Nurse #2] and assessed [Resident # 3]." wed on 6/3/25 at 2:40 PM and left information. When dimitted the resident worked luld sit up all day in her full left and have she could communicate by leds. Prior to Resident # 3 sources, and she was "almost continued by lifted left. The resident was limp lift. At some point after that the recalled Resident # 3 was not just in her face but at would move up and down with witching continued but was lan other days. The resident lace and not eat. She seemed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325			IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		345325	345325 B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	' _	00/10/2023
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	to have less urine in changed her about to resident would put he the change that she is seemed to be cold in Resident # 3 would so NA # 2 was interview reported the following Lead NA and helped there was a day whe Resident # 3 back to was slouching and it sit up. That was new not seem herself. Review of a facility in care Resident # 3 ha facility revealed NA # 3 on the dates of 3/13/3/20/25, 3/22/25, and 3/26/25 signed stater revealed in part the fill [Resident # 3] first ar # 3] would attempt to paper, [Resident # 3] verbally. After [Resid COVID her condition started placing hand space, taking off her turning in the bed." No statement that she had 3/22/25 and 3/23/25 not noted a difference or bowels, but the resmuch either day whice	her brief. She (NA #1) we times per shift. The er hand in her brief. Prior to (NA #1) noticed, the resident nature. After the change, natch off her clothes. ed on 6/3/25 at 2:52 PM and g information. She was the everywhere. She did recall in she had helped NA # 1 get bed because the resident seemed like she could not for Resident # 3 and she did vestigative file regarding the d received while at the 3 had cared for Resident # 3/25, 3/14/25, 3/17/25, 13/23/25. Review of NA # 3's ment in the investigative file bollowing information. "When rived at the facility [Resident communicate utilizing was unable to communicate ent # 3] was diagnosed with changed. [Resident # 3] in her brief, staring off in to clothes and twisting and A # 3 further added in her ad worked the weekend of with Resident # 3. She had e in the resident's urination sident did not eat or drink th NA # 3 noted was a red to before the time the	F	580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345325	345325 B. WING			C 06/10/2025	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335		37.137.2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	reported the following Resident # 3 was ad worked with therapy watched the therapis Resident # 3 to the blearned to do this from Resident # 3 could so wheelchair and then The resident made a paper with her family for meals and progres could feed herself. A she did a complete "would look off into sphelped turn the reside would swing her arm her brief off her body had to be fed and did mouth looked dry as (NA # 3) would tell that "this person is n # 1 saying that Resident # 3 has facility revealed NA # 3 on the dates of 3/2 during the 3:00 PM to NA # 4's signed 3/25 investigative file reversinformation. "I'm not 3] due to the fact I or on a few occasions. # 3] and get [Resident # 3] would when a therapist states.	g information. When mitted the resident had and she (NA # #3) had at use the gait belt and take bathroom. She (NA # 3) m the therapist, and tand and pivot to the stand and pivot to the stand and pivot to the stand and pivot to the other terms to communicate with the transition of the stand and pivot to the other terms to communicate with the transition of the point where she would rip of the point where the p	F 58	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325		(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345325	345325 B. WING		C 06/10/2025
	ROVIDER OR SUPPLIER		71	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	7 33/10/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 580	incontinent care [Resmall amount. I do not small bowel movem black in color. I do not remember her placing picking at the brief. Would throw her pilled [Resident # 3] would ceiling. Family mem asking about how meating. I informed fareat dinner for you [a [Nurse # 2] asked [N] [Resident # 3] had eat dinner for you fareat dinner for following dat the facility resident would stare fixated on the ceiling her to focus. It was would pick at her brown the therapist was in would not swallow. It was no docur physician being notice eating, staring off dinaving dark bowel nexhibiting these synthetics.	do either. When I provided esident # 3] had urinated a ecall that [Resident # 3] had a ent that was noted to be not recall foul odors; I do ng her hands in her brief and I do recall [Resident # 3] ows on the floor consistently. I do constantly stare at the ober came in on 3/24/25 ouch [Resident # 3] was amily member that she didn't as written]. Family went to old written and confused." Wed on 6/3/25 at 3:06 PM and ng information. She did not # 3 had been when she first when she cared for her, the exact of the off distantly and seemed g. She (NA # 4) could not get "very noticeable" that she itef. There was one day when the room and the resident when the resident was I she did not notice blood or a nool. The mentation in the record of the fied the resident was not stantly, would not focus, was novements while also	F 580		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 711 SUSAN TART ROAD DUNN, NC 28335		0/10/2020	
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F 580	3 on the 11:00 PM st 3/15/25, 3/16/25, 3/16/25, 3/16/25, 3/13/21/25, 3/24/25. Re statement in the inversion following information observed [Resident # food/snacks were in never communicated light while I was work incontinent and did nowel movements. [Falot in bed, moved her pillow on the floor. O [Resident # 3's] mour incontinent care [Resident # 3's] mour incontinent care [Resident # 3's] wou incontinent care [Resident # 3's] go into [Fapproximately 2-3 mit the room again befor NA # 5 was interview and reported the follocated for Resident # awake at night. She was and forth and she alwhen she had cared had cared for Resident # attitle in the resident's bedside. The resident would not respond. Stresident's room after	# 5 had cared for Resident # hift to 7:00 AM shift on 7/25, 3/19/25, 3/20/25, view of NA # 5's signed stigative file revealed the . "I worked 3rd shift I never # 3] eating or drinking but her room. [Resident # 3] with me or used her call king. [Resident # 3] was ot urinate or have a lot of Resident # 3] moved around er legs, removed her bed brief and would throw her n 3/24/25, I noticed around th that it was dry. During sident # 3] had a dark, almost ent on the morning of	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345325	B. WING _	B. WING			C 06/10/2025	
	ROVIDER OR SUPPLIER			711 S	EET ADDRESS, CITY, STATE, ZIP CODE BUSAN TART ROAD IN, NC 28335	1 00/	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<		(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		
F 580	and reported she had Resident # 3, was not resident, and did not Nurse # 6 had cared which began at 7:00 7:00 AM on 3/25/25. following. She had not record any other change to the physician prior on duty on 3/25/25. Nurse Aide (NA # 1) not right" and she had ayshift for two days right." On 3/25/25 at 8:20 A "Writer made aware acting like herself. Wresident to be swing Resident did not resoname. Attempted to and pulse and accurresident agitation. Wo other nurses entered [Name of physician] ordered writer to ser in 911. Approximate	on the resident. riewed on 6/3/25 at 11:12 PM d not been assigned to ot aware of a change in the	F	580				
	[Name of Hospital]." On 3/25/25 at 8:52 A	t condition and transfer out to MM Nurse # 4 documented, g with altered mental status,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		00/10/2023
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	appropriately, [Resident is morning per CN gown off repeatedly. [temperature] 97.1, In 18, BP 86/56 SPO2 Nurse # 4 further now the resident was beig altered mental status. Nurse # 4 was intervand reported the following and shake her heart the first day that she and she did not recarreport about something resident or a change resident sent out to something the first day that she and she did not recarreport about something resident or a change resident sent out to something the first day that she and reported the following resident sent out to something the first day that was intervand reported the followerheard a NA saying acting right and wen moving but did not rethrowing her hands at that was not the way Review of Emergency records for the date following information 3/25/25 at 8:30 AM. 3/25/25 at 8:30 AM. patient was wildly my groaning. The patient	ands or answer questions lent] would not eat breakfast A staff, [resident] is taking her VS [vital signs] T P [Pulse] 97, R [respirations] , [oxygen level] 100 %." ted the RP was notified and ng sent to the hospital for s. riewed on 6/4/25 at 3:34 PM owing information. The Nurse er know that she could not vat and the resident would not When she (Nurse # 4) went sident had her eyes closed, ad, and was fidgety. That was had cared for Resident # 3 Ill any communication in ing being wrong with the er prior to that. She had the the hospital. riewed on 6/4/25 at 3:24 PM owing information. She had ng the resident was not t to help. The resident was espond to the nurse. She was and the Nurse Aide reported	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 06/10/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		06/10/2023
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	of 3/25/25 and the for the date of 4/8/2 information. - Upon arrival to the the physician noted painful stimuli, start but does not move not withdraw from pthe right side." The weight was 140 polindicated a weight li 3/18/25 of 150.3 poline.	admission records for the date nospital discharge summary 5 revealed the following EED (Emergency Department) "Patient barely responds to s moving left upper extremity the lower extremities and does rainful stimuli. Does not move resident's hospital admission and 10.5 ounces (which loss from her facility weight on	F 580			
	12-16); a white block 4.5-12.5); sodium I Blood urea nitroger 3.35 (normal .60 to troponin level (card elevated with heart - The hospital physicabnormalities seen dehydration and ach hypernatremia [high acidosis with anion body], AKI [acute ki troponin, leukocytos count]. Significant a [hemoglobin] of 4.0 positive [the resider tested], and nurse siblood] on exam. Block and significant and positive [the resider tested], and nurse siblood] on exam. Block and significant and positive [the resider tested], and nurse siblood] on exam. Block and significant and positive [the resider tested], and nurse siblood] on exam. Block and significant and signifi	d a hemoglobin of 4.0 (normal od count of 31.9 (normal evel of 153 (normal 136-145). In 115 (normal 7-25); creatinine 1.30) and an elevated face enzyme which can be damage). It cian noted, "Significant on labs consistent with tive COVID infection, in sodium levels], metabolic gap [acids build up in the dney injury], elevated sis [elevated white blood in emia noted with a hgb in Stool occult blood was noted staff reported frank blood [red bood transfusion, sepsis bolus and antibiotics ordered by ED."				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		DATE SURVEY COMPLETED
		345325	B. WING			C
	ROVIDER OR SUPPLIER	1 01020		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	I	06/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	COVID infection and	aced on oxygen for her d intravenous Decadron	F 58	0		
	The physician also	rol (respiratory medication). documented upon admission red dry" and her labs were /dration.				
	- The resident was admitted to the Intensive Care Unit. She remained hospitalized until 4/8/25. Review of her discharge summary revealed her primary diagnosis was sepsis secondary to COVID infection. The resident was also noted to have myocardial injury (heart injury) due to sepsis, pneumonia, and COVID. The resident					
	had received a total hemoglobin, and for	of 3 units of blood for her low und to have a superficial cer in the lower part of the				
	part of the small into	enitis (inflammation of the first estines). An incidental finding sident had likely uterine				
	followed after hospi					
	on 6/4/25 at 5:50 Pt in part reviewed with	y physician was interviewed If and the therapy notes were If the physician at this time. If the following information.				
	He did not recall if h	e had been notified of the ositive COVID test. He did				
	know he had not been notified of a change in her medical condition and a decline. He should have been notified days prior to the resident being transferred to the hospital. He was in the facility					
	resident, probably d work, and probably	would have seen the one stat (right away) blood sent her back to the hospital.				
	to the physician tha	therapy notes, it was evident t the facility had noted a on 3/21/25 when there was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345325	B. WING _			C 06/10/2025		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	'	30.10.2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 580	functional status and physician reported to experienced a chant that the resident rect to three days to find condition, and this help and the resident rect to three days to find condition, and this help are the feet the possible and the resident could have been away treatment earlier. As felt the days she has treatment had made the reported the resident that she had CON bleed and both had severity of illness. The facility provided was not acceptable plan included education of the facility provided was not acceptable plan included education of the facility provided was not acceptable plan included education of the facility provided was not acceptable plan included education of the facility failed to facility the resident likely to suffer, a ser result of the nonconsultation of the facility failed to notification of the facili	she was declining in doverall feeling. The hat when a resident ge in condition it was critical eive treatment in the first two the problem and treat the ad not occurred for Resident was interviewed regarding the heart injury from the sepsis bided if the resident had had cording to the physician head not had evaluation and a change in her outcome, dent had a "double whammy" //ID and a gastrointestinal contributed to her decline and to the State Agency. The tion for nursing staff but did in to therapy staff. PM the Administrator was ate Jeopardy. The need the following Immediate lan. Is who have suffered, or are rious adverse outcome as a	F 5	80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			·	10/2025	
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD DUNN, NC 28335	1 00/	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	notes stated that nurs notified, however, the reveal evidence of coamong nursing staff r Resident #3 also test there was no docume was made aware. On 6/4/25 and 6/5/25 (from the electronic in (for daily meetings 3/reviewed by the facilit Consultant, Administr Officer to ensure that appropriately of resid condition and that ordimplemented appropries report summarizes rein the last 24 hours in vital signs, incident renotes, physician ordenotes, admissions, dior returning from leave problems identified. The facility has determine potential to be aff fail to communicate a condition to other tear physician. On 6/5/25 meetings work of the potential of the potential to the reaction of the potential	functional decline. Therapy sing staff members were medical record did not mmunicating the decline nembers or to the physician. ed positive for COVID and entation that the physician where the decline in a resident in the decline in the d	F	580				

in the second se		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED
		345325	B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	experienced a declin through 6/5/25. Nan Chief Clinical Officer Officer. Three changeday (6/5/25), were by medical record revie events had been shain the day and approximmediately (including to the hospital). Specify the action the process or system for adverse outcome frowhen the action will. All staff members we the Chief Operating Officer and all therapserviced by the Lead Officer regarding decephysician notification. The education agency following: Survey findings relaphysician of residents. Effective communication interdisciplinary team team members and changes identified at Physicians, Nurses, Nursing; Processes that enserged the processes that enserged all episodes ocommunicate with plants.	abers were given the y residents that have e in condition from 3/25/25 mes were documented by the and the Chief Operations ges, from earlier in the same rought forward. Immediate w revealed that the three ared with the physician earlier priate actions were taken ag one resident that was sent e entity will take to alter the allure to prevent a serious m occurring or recurring, and be complete: The in serviced on 6/5/25 by Officer and Chief Clinical by team members were in a Therapist and Chief Clinical cline identification and of all decline. The aspecifically included the ated to failure to notifying the changes;	F 5	30		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MPLETED
		345325	B. WING			C 06/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	1 (00/10/2023
(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 SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	secure email, phone - Change identification to both nursing team Education will continue staff members and of educated. No staff report be allowed to work used the education session. Administrator, or desteam members are estimated to the facility. They will shift to assist with education session and the facility. They will shift to assist with education session and the facility. They will shift to assist with education staff sign in to verify completed. Alleged date of immed 6/6/25 On 6/10/25 the follow facility's removal plan. The facility presente had completed inservence and plan. Beginning on 6/10/2 interviews were condifferent shifts. Staff through training perwere able to verbalize Multiple staff member regarding whether than yourrent residents change in condition made aware. Staff reform of any residents who condition for which the	ian for information share via , and secure text. on with immediate reporting and physician. ue every shift until 100% of contractors have been members or contractors will until they have participated in ons. The DON and signee, will ensure that all educated prior to working in I utilize one nurse on each ducation documentation and the education was ediate jeopardy removal: wing was done to validate the n: d documentation that they vice training per their of at 9:55 AM multiple ducted with staff from verified they had gone the removal plan and staff the points that were covered.	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345325	B. WING				C 10/2025
NAME OF PE	ROVIDER OR SUPPLIER	0.0020			TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	10/2025
	10112211 011 001 1 21211				11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN				DUNN, NC 28335		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 29	F	580			
	report regarding the s	status of their residents at					
		munication had been clear					
	so they would know if	they needed to call the					
	physician.						
		evidence that they had					
	reviewed 24 hour rep ensure the physician	orts and therapy notes to					
	changes in condition.	nad been notified for					
	changes in condition.						
	The facility's immediate jeopardy removal date of						
	6/6/25 was validated	on 6/10/25.					
F 684	, -· ,		F	684			6/22/25
SS=J	CFR(s): 483.25						
	§ 483.25 Quality of ca	aro					
	_	ndamental principle that					
	_	nt and care provided to					
		ed on the comprehensive					
	assessment of a resid	dent, the facility must ensure					
		treatment and care in					
	accordance with profe						
		nensive person-centered					
	care plan, and the res	idents choices. is not met as evidenced					
	by:	is not met as evidenced					
		ew and interviews with staff,			Immediate action taken for the residen	ıt	
), therapy staff, and the			found to have been affected include:		
		failed to obtain labs as					
	directed by the physic				The facility failed to implement physicia	ın	
		ated amongst themselves in			orders and communicate effectively		
		n condition be recognized by staff and a resident receive			amongst the staff to ensure the seriousness of a change in condition w	26	
		sary medical treatment.			recognized and necessary medical care		
		the facility for rehabilitation.			was provided to Resident #3. Residen		
		Aides revealed Resident #			was discharged from the facility on		
	3 was initially making progress in therapy to the				3/25/25.		
degree that she could feed herself, ambulate							
	short distances with t	herapy in parallel bars or			Identification of other residents having	the	

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(С
		345325	B. WING _				10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				71	11 SUSAN TART ROAD		
THE CAR	ROLTON OF DUNN			D	UNN, NC 28335		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 30	F 6	584			
		let to the commode, and			potential to be affected was accomplish	ned	
		eds by gestures. Days prior			by:		
		je, Resident # 3 had a					
	decline in functional s				On 6/5/25, the facility held meetings wi	th	
	symptoms of dizzines	ss, lightheadedness, nausea,			the Chief Operating Officer, Chief Clini	cal	
	and periods of altered	d responsiveness. Following			Officer, Facility Nurse Consultant, Dire		
	I .	t # 3 tested positive for			of Nursing (DON), Facility Administrate		
	'	Disease) on 3/22/25 with no			and staff members, including all license	ed	
		on or treatment for her			nurses, therapists, certified nursing		
		nfection. Following 3/22/25,			assistants, social workers, and facility		
		or appetite, her mouth			contractors working at the time of the		
		ould stare off in space, and			meeting.		
		e resident did not receive cal treatment to treat her			All staff were asked to identify regident	•	
		intil she was transferred to			All staff were asked to identify resident with a noted decline in condition. The	5	
	_	25 where she was found to			Chief Clinical Officer and Chief		
	1	idividual's body has an			Operations Officer documented identifi	ed	
		in infection, and which can			changes. Three changes from earlier		
		due to her COVID infection.			the same day (6/5/25) were brought		
		ditionally found to have			forward. Immediate medical record		
	gastrointestinal bleed	ling, which resulted in a			review revealed that the three events h	ad	
	critical hemoglobin of	f 4.0 (normal 12-16) and			been shared with the physician earlier	in	
	required three units o	of blood. The resident was			the day, and appropriate actions were		
	1	tensive Care Unit. The			taken immediately (including one resid	ent	
		pital discharge summary			who was sent to the hospital).		
		d sustained heart injury due					
	to the sepsis. This wa	·			The facility has determined that all		
	I .	or professional standards of			residents have the potential to be affect		
		change in medical condition			when staff members fail to recognize the	ie	
	(Resident # 3).				seriousness of a change in condition, communicate effectively, provide the		
	Immediate jeonardy k	pegan on 3/21/25 when a			necessary medical care, or deviate froi	m	
	' '	Resident #3's condition was			the care ordered by the physician.		
		orehensive evaluation was			the care ordered by the physician.		
	not conducted and tre				Actions taken/systems put into place to)	
	implemented. Immediate Jeopardy was removed			reduce the risk of future occurrence			
		acility implemented an			include:		
	I .	allegation of immediate					
		e facility will remain out of			All staff members including all licensed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			1	C	
NAME OF D	ROVIDER OR SUPPLIER	0-10020			TREET ADDRESS, CITY, STATE, ZIP CODE	1 06	/10/2025	
NAME OF PI	ROVIDER OR SUPPLIER							
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD			
				D	OUNN, NC 28335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 684	Continued From pag	e 31	F	684				
	compliance at a lowe	er scope and severity D to			nurses, therapists, certified nursing			
		completed and monitoring			assistants, social workers, and facility			
	systems put in place				contractors were in-serviced on 6/5/25	bv		
	-,				the Chief Operating Officer and Chief)		
	The findings included	d:			Clinical Officer, and the training include	ed		
	3				the following:			
	Review of Resident #	# 3's 3/3/25 hospital history						
		resident's 3/8/25 hospital			A review of the survey findings including	q		
		revealed the following			non-compliance with professional	J		
		hospitalization the resident			standards (F-684) as evidenced by the			
		ly at home and presented to			facility failing to:			
		5 with slurred speech. While						
		dent underwent an MRI			-recognize the seriousness of a change	e in		
		e Imaging) which revealed			condition,			
	multiple acute small i	infarcts (areas of brain			-communicate effectively,			
	damage from a lack	of oxygen). The resident was			-provide the necessary medical care a	nd,		
	diagnosed with a stro	oke with right-sided			-provide care as ordered by the physic	an.		
	weakness and slurre	d speech. At the time of the						
	3/8/25 hospital disch	arge the resident's physical			Review of key elements of			
	exam showed left sid	led facial deviation			non-compliance including:			
		er extremity strength of 2 out						
	_	emity strength of 5 out of 5			-Orders for baseline lab results were			
		ft lower extremity strength of			missed			
	•	ting normal strength against			-Antiviral treatment for COVID was not			
	, ,	e whereas 2 representing a			provided			
		t in muscle strength).			-Lack of communication and coordinati	on		
	•	ns included Plavix 75			amongst the interdisciplinary team			
		y day for 41 doses (an			-Lack of physician notification of a char	nge		
		nox 40 mg injection for 13			in condition.			
		nt), and Aspirin 81 mg every						
		sident # 3 was also identified			Effective communication among the	- c		
		ypochromic anemia (a			interdisciplinary team (including 100%			
	_	mia when the red blood cells			facility team members and contractors			
		dence of acute blood loss.			This communication includes but is not			
		nd Hct (hemoglobin and			limited to:			
		cumented to be stable at time			Niverina posistante en delle consist			
	of her 3/8/25 dischar				-Nursing assistants and therapists			
		ed Resident # 3 needed to be eatient for chronic blood loss			reporting changes to nurses promptly, -Nurses reporting changes in condition	to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343323	5:	27	FREET ADDRESS, CITY, STATE, ZIP CODE	06/	10/2025
NAME OF PI	ROVIDER OR SUPPLIER						
THE CAR	ROLTON OF DUNN				11 SUSAN TART ROAD		
				D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 684	4 Continued From page 32		F 6	84			
	deferred to the primar	estinal workup would be ry care physician. The harge summary also noted gn hypertension.			physicians timely, -All staff keep the Director of Nursing a Administrator or significant changes wi residents.		
	Resident # 3 was admitted to the facility on 3/8/25 with diagnoses of stroke, anemia, and hypertension. An admission nursing note on 3/8/25 at 3:08 PM noted the resident had a right sided deficit, was awake, alert, oriented to self, and denied any discomfort.				Change identification- all residents with reported change in condition must be assessed by a nurse immediately. Assessment findings indicating decline		
					the need for emergent physician intervention will be immediately called the Physician and documented in the medical record. Other changes identifi must be communicated to the physicial	to ed	
	code. Occupational T	ealed Resident # 3 was a full herapy, Physical Therapy, were ordered on 3/10/25.			before the shift ends. Calls to physicia and family members must be documen as notifications are completed.		
	Resident # 3's care plan initiated on 3/10/25 indicated the resident had a self-care deficit related to weakness, deconditioning, and mobility limitations related to her stroke. The care plan noted Resident # 3 would receive therapy. There were also directions on the care plan to monitor/document as needed any changes and any potential for improvement, reasons for self-care deficit, expected course and declines in				Education continued every shift (6/5/25-6/13/25) until 100% of staff members and contractors were educated. The Director of Nursing (DON) and Administrator ensured that all team members were educated before working in the facility. New staff members will be educated by	ng /	
	3/10/25 Resident # 3 physical therapy. PT following information session on 3/10/25. Statement # 3 to go fro to a sitting position. T good balance and with and bilateral lower ex	regarding the treatment			the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, or Facility Nurse Consultant during the orientation process. On 6/9/25, Carrolton Facility Managem corporate employees, including the Ch Operating Officer, Chief Clinical Officer and Facility Nurse Consultant, met with therapy leaders, including the Therapy Lead, Clinical Specialists, and the Area Director. The following issues and plant	ent ief -,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						l	С
		345325	B. WING _			06	/10/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CARE	ROLTON OF DUNN			7′	11 SUSAN TART ROAD		
THE CAN	COLION OF BONN			D	UNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	PT # 1 helped Residu with a quad cane and trial with the quad cane device for individuals of their hands) during during the next thera. According to the recodocumented visit from the resident resided a Within the 3/11/25 physician included furthrombocytosis (elevocardiomyopathy (disedyslipidemia (elevate aphasia (loss of abilition understand). The tocomplete labs whice count, a thyroid stimus 12 level, Vitamin Diemetabolic panel, and physician's plan also resident's prognosis and their trial with the side of the sid	pational Therapist present. ent # 3 with trials of transfers of the future plan was to do a ne or hemi-walker (a mobility is who have limited use of one of transfers and ambulation progress and the facility on 3/11/25. In a second the facility on 3/11/25 and and progress of a second platelets), and and the plan was concluded a complete blood control of the plan was control of the plan wa	F	384	for resolution were discussed during th meeting: The need to see therapy documentatio real-time: -Carrolton Facility management reques an upgrade to allow therapy notes to be visible in the electronic medical records. Therapy notes will be brought to the morning clinical meeting the day after to care provision and reviewed by the DO and Therapy Lead. Documentation Issues (timeliness and accuracy of notes): -Education plan for clinical staff (licensinurses and therapists as well as certificant assistants). -Therapy notes will be brought to the morning clinical meeting the day after to care provision and reviewed by the DO and Therapy Lead.	n in ted e s. he N	
	Review of the facility record revealed no orders for the lab work the physician had documented in the plan in the 3/11/25 progress note were entered into the computer and they were never completed while the resident resided at the facility. Interview with Resident # 3's Physician on 6/4/25 at 5:50 PM revealed he made rounds with the nurses, instructed nurses to read his notes, and				Ways to improve communication: -Nametags to clearly identify medicatio aides -Utilization of the Stop and Watch early warning tool -Increased interdisciplinary clinical meetings (morning and afternoon) -Nursing will attend rehabilitation team meetings weekly for the next four (4)		
	follow the directions i	in his notes. According to the oted in the 3/11/25 physician			weeks. Following the meeting with therapy, Carrolton Facility Management corpora	te	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 684	4 Continued From page 34		F 68	4			
	documented a care p resident, family, social	al worker, and that the Resident # 3 go home with		employees, including the Chief Ope Officer, Chief Clinical Officer, and F Nurse Consultant, met with the faci administrator and the DON to discu issues and corrective action plans.	acility lity		
	progress note, "Pt [Pa lunch meal. Pt alert a wheelchair. Pt able to hand for the most par Resident # 1 consum before indicating she that she was able to be intermittent minimal a noted Resident # 3 w On 3/12/25 PTA # 1 of treatment modalities in progress note. One in begun in the parallel I able to complete the I	wing in a speech therapy atient] assessed with her and sitting up in her of feed herself with her left tt." ST # 1 further noted ed 40 percent of her meal did not want any more and brush her teeth with assistance. The ST also as receptive to education. Independent of the state		On 6/9/25, the therapy Clinical Spein-serviced all therapy teams (company-wide), including the Duntherapy team (licensed therapists, assistants, and rehabilitation aides) the following topics: -The Provision of Quality Care-Documentation timeliness, -Documentation accuracy, including importance of including clinically reand factual content in daily notes, -Effective communication with nursistaff, -Reporting a change in condition, including utilization of the Stop and early warning tool.	n), on g the levant ing		
	on 3/14/25 PTA # 1 d progress note for the following information. Resident # 3 in the us quad cane and the re moderate assist due to support her right upper deficits. The resident 12 feet with both the locane on 3/13/25. The as needing minimal at the session date of 3/	locumented in a therapy session of 3/13/25 the She (PTA # 1) instructed se of the hemi-walker and sident required minimal to to impulsivity, the need to er extremity, and balance was documented as walking nemi-walker and the quad resident was documented ssistance for transfers on 13/25. The resident had nobility because she (the		The Therapy Lead or Clinical Spec provided in-service training to any smembers who had not received it be they returned to work. The Therapy will educate all new rehabilitation smembers during orientation. The therapy staff began use of the and Watch early warning tool on 6/On 6/11/25, the facility Stop and Watch was revised by the Chief Clini Officer and sent to the print shop for triplicate carbon copies. The facility copies of the form until the triplicate carbon copy form was available.	staff vefore v Lead taff Stop 11/25. atch cal vr		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page		F 6	684			
	resident) wanted to to	ocus on transfers and gait.			0/40/05 # 1 0/04/05 # 6 ## 50		
	Resident # 3's admission MDS (Minimum Data				6/13/25 through 6/21/25, the facility DC /Facility Nurse Consultant in-serviced a		
	Set) assessment, dat				certified nursing assistants on the		
	_	clear speech and was			following topics:		
	moderately cognitivel						
	assessed to need sub				-The Provision of Quality Care		
	assistance with bathii	ng, dressing, and hygiene.			-Effective communication with nursing staff,		
	PTA#1 documented	in a therapy progress note			-Reporting a change in condition,		
	for the session of 3/14	4/25 the following			including utilization of the Stop and Wa	tch	
	information. She (PTA #1) had instructed the				early warning tool.		
		r use of the quad cane					
	because she was not	using it properly. The			The DON, ADON, Unit Manager, or		
	resident had also par	ticipated in bean bag			Facility Nurse Consultant will educate a	all	
	tossing, transfers fron	n sitting to standing, and ball			new certified nursing assistants during		
	kicking.				orientation. The Administrator or Direc		
					of Nursing will provide in-service trainir	ng	
	PTA#1 documented	in a therapy progress note			to staff members who have not receive	d	
	for the session of 3/17	7/25 that Resident # 3			the education before returning to work.		
		stance to transfer to the left					
	and that training was	done with a Nurse Aide (NA)			6/13/25 through 6/21/25, the facility DC	DΝ,	
	to allow for the reside	nt to be toileted by the			Administrator, and Facility Nurse		
	Nurse Aide.				Consultant in-serviced all licensed nurs	ses	
					on the following topics:		
		a speech therapy progress					
		of 3/17/25 the following			-The Provision of Quality Care		
		ipated with expressive			-Importance of completing nursing		
		mple phrase completion and			assessments,		
	simple responsive na	•			-Documentation timeliness,		
		Pt completed tasks with 80%			-Documentation accuracy, including the		
		mod [minimal to moderate]			importance of including clinically releva	ınt	
		d simple functional phrases			and factual content in daily notes,		
	· ·	d fluency. Pt approximately			-Effective communication with nursing		
		reading simple phrases			assistants and therapy staff,		
		g (pt wearing glasses for			-Utilization of the Stop and Watch early	′	
	,	and up in her wheelchair			warning tool,		
		「# 1 further noted she			-Reporting changes in condition,		
	educated the resident	t on swallowing			-Following physician orders		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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				,			
F 684	Continued From pa	age 36	F 6	84			
		and the resident participated od with minimal improvement		The DON, ADON, Unit Mana Facility Nurse Consultant will new nursing staff members do	educate all		
Resident # 3's wei pounds, which ind		ecords revealed on 3/18/25 ght was documented as 150.3 cated she had gained weight ed 3/8/25 admission weight of		orientation. The Administrator of Nursing will provide in-serv to staff members who have no before returning to work.	or Director vice training		
	147.1.	-		How the corrective action(s) v			
	note for the session	d in a speech therapy progress n of 3/18/25 the following ent # 3 was dysarthric (difficulty		monitored to ensure the pract reoccur:	tice will not		
	information. Resident # 3 was dysarthric (difficulty speaking) but she participated with naming common pictured items with 75% accuracy when given minimal to moderate cueing. Her speech was approximately 75% intelligible. During the			The DON, or designee, will at the 24-hour reports daily for for weeks to monitor for the prov quality care, including the follo	our (4) ision of		
	suddenly started to grabbed her face. I nursing. The reside with minimal assist	nt's right side of her face twitch and Resident # 3 The physician was notified via ent was able to brush her teeth ance. The resident was able to aw without signs of aspiration.		-Identifying changes in condit -Notifying the physician of cha- condition, -Provision of medical care, -Implementing new physician	anges in		
	reported the followi	wed on 6/3/25 at 3:35 PM and ng information. During the first 3's speech therapy she was		Any identified adverse finding follow-up will be addressed in			
	considered she wa the will to do good. plate to help with m	vas "not perfect but all things s doing good." She also had She started to use a divided neals. There was a day when ome facial twitching. The		The Facility Nurse Consultant Clinical Officer will randomly page 24-hour reports weekly for four to audit for the provision of quality including the following:	oull two (2) ur (4) weeks		
	resident seemed an away. The nurse w twitching. During th had some general being unwell). The date that the reside	ware of it and then it went as told about the facial ae end of therapy, the resident malaise (general feeling of date of 3/18/25 was the last ent received speech therapy. e was out of work following		-Identifying changes in condit -Notifying the physician of cha condition, -Provision of medical care, -Implementing new physician	anges in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345325	B. WING			C 06/10/2025	
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F 684	SBAR narrative (situassessment, and rethe following information been in with the resiexperiencing twitching with slower speech. Her vitals were within was notified and ord muscle relaxer medineeded for spasms. Interview with Nurse revealed the only this 3/18/25 was that the She had talked to the thought the twitching residual effects of his he did not see any on 3/18/25. PTA # 1 documented for the session of 3/2 information. Resider for the rapy and while 1 documented, "With made) patient require asking patient about noted to not be atterusual. When asked yes. When asked if patient again noddes she was hurting patient required in the read. Immediate room and informed in responsive and was	AM Nurse # 1 completed a pation, background, commendation) which noted ation. Speech therapy had ident and the resident and the right side of her face than baseline per therapy. In normal limits. The physician dered baclofen 10 mg (a pation) twice per day as a set # 1 on 6/4/25 at 3:50 PM are she was aware of on the resident had some twitching. The physician and the physician gray was related possibly to the er stroke. Nurse # 1 reported further change in the resident and in a therapy progress note	F	Any identified adverse follow-up will be addre The Facility Nurse Cor Clinical Officer will ran and Watch forms week audit for compliance we documentation of iden notification of changes identified adverse findifollow-up will be addre This correction plan with the monthly Quality As Performance Improver meeting until consister compliance are achieved Corrective action comple/22/25.	essed immediately nsultant or Chief adomly pull (5) Sto kly for (4) weeks to with follow-up and attifying and as in condition. An ings requiring essed immediately will be monitored at assurance ment (QAPI) ncy and substantifyed.	pp to y /. t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		06/10/2025	
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F 684	assessed patient. Labe in bed and this the was in WC [wheelch Still later found patie head back and eyes Returned patient to dependent] assist at with activities who shead back during act to go back to bed so and call bell activate. PTA # 1 was intervite and reported the foll few days when Resifacility, she was mal with help and had so She also could get hand she communicated therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong to gesture and She started to need therapy with transfer this to the nursing stong the started to need therapy with transfer the started to need the started to need therapy with transfer this to the nursing stong the started to need the started to need therapy with transfer this to the nursing started to need therapy with transfer this to the nursing started to need therapy with transfer the started to need therapy with transfer this to the nursing started to need the started	[Director of Nursing] ater in day patient noted to not herapist was informed she hair] with activities for bingo. And in her room slumped with he open, partially responsive. And hed with max/dep [maximum had notified nursing. Spoke hatted patient was sitting with hetivities and said she wanted he she was pushed to her room had." And he was pushed to her room had." And he was pushed at the hair progress. She could walk have "really, really good days." her point across with gestures hatted with staff in that manner. had a big change. She stopped had stopped trying to verbalize. ha lot more assistance in had. M Nurse # 2 entered a late had gnotes for the date of hatter which read, "Therapist had to room saying resident had. No [mechanical lift pad] hat X 3 [assistance of 3 hist X 2 to get situated in bed. had. within normal limits] for	F 6	84			
		ad received while at the se # 2 had cared for Resident					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING		C 06/10/2025	
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F 684	noted Nurse # 2 ha 3/17/25, 3/19/25, 3/26/25 signed opinion [Resident # hospice. [Resident moaned and pointed opinion	220/25. Additionally the file d cared for Resident # 3 on /20/25 and 3/24/25. Nurse # statement included, "In my fall was a candidate for # 3] was unable to speak, she	F 684	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325		, ,	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 711 SUSAN TART ROAD DUNN, NC 28335		0/10/2020	
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F 684	<>EOB (Edge of Be [maximum assistand attempts patient replightheadedness, nawell. PT takes BP [be second attempt notifrom 132/58 in supina mild decrease in Ebe considered orthodiscusses this chan overall change in steplans to pass the modetor for potential is declining in functiful Patient is only able head nocks/shakes questions." PT # 1 was interview reported the following Resident # 3 was in Occupational Theratevaluations togethe to the bathroom with therapy she begand her progression of the and did really well as beginning of therapy her head yes and noting better with cobeginning. Near the minimally communications totally dependent of her stay. It had be in the patient of the stay. It had be in the patient of the stay. It had be in the patient of the stay. It had be in the patient of the stay. It had be in the patient of the stay. It had be in the patient of the stay. It had be in the patient of the patient of the stay. It had be in the patient of the	directs patient in 2 X supine ed) transfers with max A ce and cues with both orting dizziness, ausea, and overall not feeling plood pressure], during it to be 118/60 in seated the at rest. PT notes this to be care in BP with nurse and catus from admission. Nurse ressage along to DON and/or further workup on why patient conal status & overall feeling. The resident was able to go in moderate assistance. In walking with a quad cane. In the resident could shake to to communicate. She was mmunication near the end of her stay she was cating. She went from lay that the resident's blood end way that the resident's blood	F	684			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 684	Resident # 3 on 3/2 6/4/25 at 3:50 PM a information. She kr stroke when she was had always had rigit person's awareness impaired after a strasame the times she never been communicated to communicate the therapy talking to have the pool and	assigned to care for 21/25) was interviewed on and reported the following new Resident # 3 had a major as admitted to the facility and the sided neglect (where a so of one side of their body is oke). She seemed to be the etook care of her, and it had inicated to her that the d, pivot, and was progressing after admission. She did not erself. She did not recall er about changes. At times, e Unit Manager. Viewed on 6/5/25 at 4:00 PM. the following. She only when a change in condition had her about Resident # 3 and the twitching the resident had the DON) knew physician orders that and she was not aware of the condition that the twitching the resident was not symptoms. Of Care Testing Result for sident # 3 tested positive for a sident # 3 tested positi	F 684	1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 684	positive for COVID start antiviral medical Review of the record treatment orders were started to the Unit Manager will 11:22 AM and report of the Unit Manager will 11:22 AM and report of the Unit Manager will 11:22 AM and report of the Unit Manager will 11:22 AM and report of the Unit Manager will 11:22 AM and report of the Unit Manager will 11:22 AM and resident of the Will 11:22 AM and resident chose and the family and placing the resident chose to do so when the Will 11:22 AM and she will 11:22 AM and she had not realized Redecline. If it had become under the Unit Manager will 11:22 AM and she had have gone into action treatment.	ed her of resident testing received verbal consent to	F 684	· · · · · · · · · · · · · · · · · · ·		
	were interviewed wi Chief Clinical Office information was pre reported they had a 3/18/25 and Reside 3/22/25. The DON a Unit Manager tested	th the Nurse Consultant and r also present. The following sent. The Administrator n outbreak of COVID on nt # 3 did not test positive until and Administrator reported the d the residents tested positive,				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	 	1 00/10/2025	
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F 684	there was a procedus upposed to contact if he wanted them to The family would also of the antivirals coulcuse of any ordered a reviewed by the pharesident's kidney fun medication. They (the looked at Resident # previous evening (6/ Manager's actions to antiviral, they could had been done for FO On 3/23/25 OTA # 1 Assistant) document to follow commands self-feeding in any massistance. OTA # 1 dehydrated. Pt able brief period and did food to mouth. Collar egarding PO intake potential, however Ptask at this time." OTA # 1 was interviand reported the foll specific details of whous mursing or working who she would not have "appeared dehydrate mouth was dry or the "skin pinch test" (assipotentially indicate of On 3/23/25 at 3:24 FO ON The suppose of the contact of the suppose of the	the physician and determine receive antiviral treatment. To be notified. Because some diaffect kidney function, the antiviral would also be rmacy in conjunction with a action before starting the these administrative staff) had a size administrative staff) had a si	F 6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 684	side was flaccid. The side, but without pur	sided neglect and her right e resident was moving her left poseful movements. The	F 6	684			
	would drift towards the stable and she was r	when spoken to and her eyes ne left side. Her vitals were not in apparent distress. On Nurse # 1 noted, "correction					
	which began at 7 PM 3/24/25. Nurse # 7 w 4:56 PM and reporte She did not recall a k Resident # 3 had alw knowledge had been in as a nurse at the f been told in report the walking or trying to e	for Resident # 3 on the shift I on 3/23/25 and ended on ras interviewed on 6/3/25 at d the following information. big change in Resident # 3. rays been sluggish and to her admitted that way. She filled acility and she had never at the resident had been up at on her own. If so, she are concerned about any					
	Review of narrative r revealed no notation On 3/24/25 COTA # Therapist Assistant) Required max cues to						
	6/3/25 at 3:53 PM ar resident could stand therapy treatment. S and try to tell the star started therapy. The distinct change a few discharged from the	oist # 1 was interviewed on and reported the following. The and pivot at the start of her he would make eye contact ff things when she first therapy staff noticed a v days before she was facility. She was not ormal and was not as alert.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 711 SUSAN TART ROAD DUNN, NC 28335	DE	00/10/2020	
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F 684	OT # 1 could not rectold. Review of a facility is care Resident # 3 h facility revealed Nur Resident # 3 on the 3/15/25, 3/16/25, 3/3/25/25. Review of statement in the invited following information arrived at the facility verbalize her needs head to communica assistance with feeds head to communica assistance with feeds he was getting up able to feed herself. condition on approx 3] was acting differenticed [Resident # 3] was unable to sit had been doing prethe change of condition which nurse was wowent into the room a NA # 1's statement information about the "On 3/24/25 I notice her hands in her briat lunch, [Resident a off of the over the based on the state of the state	nunicated to the nurses, but call which nurses had been needed while at the see Aide (NA) #1 had cared for dates of 3/10/25, 3/11/25, 18/25, 3/19/25, 3/24/25, and NA # 1's 3/26/25 signed estigative file revealed the n. "When [Resident # 3] first of [Resident # 3] was unable to she used her hands and the [Resident # 3] needed ding. As a few days went by in her wheelchair and was I noticed a change in imately 3/18/25, [Resident # 2] entity having facial twitching. If 3] eating less and [Resident # 2] up in a wheelchair like she viously. I notified the hall in tion [as written], not sure orking that day. The nurse and assessed [Resident # 3]." specifically included the date of 3/24/25 which read, and [Resident # 3] was placing ef, pulling off her clothes and # 3] had pulled her lunch tray the datable into the bed.	Fé	584			
	moaning, but unable wrong when she wa changes to the hall went into the room a	also staring off into space and the to verbalize if anything was also asked. I reported the anurse [Nurse # 2]. [Nurse #2] and assessed [Resident # 3]." was interviewed on 6/3/25 at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345325	B. WING			06/	10/2025
NAME OF P	ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE	-	
THE CARE	THE CARROLTON OF DUNN			711	SUSAN TART ROAD		
IIIL CAN	COLION OF BONN			DU	NN, NC 28335		
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F 684	When Resident # 3 worked with therapy wheelchair. She cougood hand." She cougood hand. She cougo hand. Sh	ed the following information. was admitted the resident and could sit up all day in her ald eat and drink "with her uld pivot to the toilet and have She could communicate by eds. Prior to Resident # 3 COVID there was a day when served Resident # 3 slumped air. The resident's head was nees and she was "almost ." She (NA # 1) recalled she nce of NA # 2 and they lifted bed. The resident was limp t. At some point after that) recalled Resident # 3 vas not just in her face but at vould move up and down with vitching continued but was an other days. The resident ace and not eat. She seemed her brief. She (NA #1) wo times per shift. The er hand in her brief. Prior to (NA #1) noticed, the resident in nature. After the change, snatch off her clothes. ved on 6/3/25 at 2:52 PM and ag information. She was the deverywhere. She did recall the she had helped NA # 1 get to bed because the resident a seemed like she could not a for Resident # 3 and she did envestigative file regarding the	F	684			
	care Resident # 3 ha	ad received while at the					

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345325	B. WING		C 06/10/2025		
	NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN			TREET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD UNN, NC 28335	06/10/2025		
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F 684	3 on the dates of 3/3/20/25, 3/22/25, ar signed 3/26/25 state revealed in part the [Resident # 3] first a # 3] would attempt a paper, [Resident # 3] would attempt a verbally. After [ResicovID her conditions started placing hand space, taking off her turning in the bed." statement that she a 3/22/25 and 3/23/25 and 3/23/25 and signer or bowels but the remuch either day who change when compresident had COVID NA # 3 was intervied reported the following Resident # 3 was a worked with therapy watched the theraping Resident # 3 to the learned to do this from Resident # 3 could wheelchair and the sident # 3 could a complete would look off into shelped turn the resident would swing her arr	# 3 had cared for Resident # 13/25, 3/14/25, 3/17/25, and 3/23/25. Review of NA # 3's rement in the investigative file following information. "When carrived at the facility [Resident to communicate utilizing and was unable to communicate dent # 3] was diagnosed with an changed. [Resident # 3] din her brief, staring off in tour clothes and twisting and NA # 3 further added in her had worked the weekend of 5 with Resident # 3. She had ce in the resident's urination resident did not eat or drink ich NA # 3 noted was a ared to before the time the	F 684				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER	345325	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO] DE	06/10/2025
THE CARI	ROLTON OF DUNN			711 SUSAN TART ROAD DUNN, NC 28335		
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F 684	mouth looked dry as (NA # 3) would tell that "this person is no # 1 saying that Reside Review of a facility in care Resident # 3 has facility revealed NA # 3 on the dates of 3/20 during the 3:00 PM to NA # 4's signed 3/25/investigative file reve information. "I'm not r 3] due to the fact I on on a few occasions. I # 3] and get [Resident days I was assigned [Resident # 3] would when a therapist state [Resident # 3] to eat get [Resident # 3] would when a therapist state [Resident # 3] to eat get [Resident # 3] to eat get [Resident # 3] would ceiling at the brief. I would throw her pillow [Resident # 3] would ceiling. Family membasking about how mue eating. I informed fan eat dinner for you [as [Nurse # 2] asked [Nurse # 2] asked [Nurse # 2] asked [Nurse # 3] had eat	not eat or drink much. Her if she had a film over it. She enurses she worked with of right." She recalled Nurse ent # 3 was declining. vestigative file regarding the dreceived while at the 4 had cared for Resident # 0/25, 3/21/25, and 3/24/25 of 11:00 PM shift. Review of 25 statement in the aled the following real familiar with [Resident # 1/2 worked with [Resident # 3] attempted to feed [Resident to the state of the something the state of the something the state of the shadow of the sh	F 6	584		
	NA#4 was interview	ed on 6/3/25 at 3:06 PM and				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	N (X3) DATE SURVEY COMPLETED
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	ROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 684 Continued From page 49 reported the following information. She did not know how Resident # 3 had been when she first arrived at the facility. When she cared for her, the resident would stare off distantly and seemed fixated on the ceiling. She (NA # 4) could not get her to focus. It was "very noticeable" that she would pick at her brief. There was one day when the therapist was in the room and the resident would not swallow. When the resident had a dark stool, she (NA #4) thought that the resident was possibly on iron and she did not notice blood or a foul odor with the stool. A review of Nurse # 2's 3/26/25 statement in the facility's investigative file which included specific information about the date of 3/24/25 read, "On 3/24/25 I was informed by [NA # 4] that [Resident # 3] did not eat her dinner. I never recall seeing the call light on for [Resident # 3's] room. No [NAs] reported any change of conditions other than her lack of eating on 3/24/25." Resident # 3's RP was interviewed on 6/2/25 at 12:07 PM and reported the following information. When Resident # 3 was initially admitted to the facility she seemed to be doing well and was eating and going to the bathroom. She then seemed to "go downhill." She (the RP) came on the evening of 3/24/25 around 7:00 PM and the resident "looked bad." She talked to the nurse (did not recall which nurse) and asked if Resident # 3 was eating. She was told she had eaten 25% that day (3/24/25), nothing the day prior and 25% the day prior to that. She could not understand why the resident had changed so much. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 5 had cared for Resident #	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335		0.10.2020
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F 684	3/15/25, 3/16/25, 3/1 3/21/25, 3/24/25. Re statement, which wa investigative file reve information. "I worke [Resident # 3] eating were in her room. [R communicated with r I was working. [Resident # 3] moved her legs, removed he brief and would throw 3/24/25, I noticed are that it was dry. Durin # 3] had a dark, almost the morning of 3/25/2 while providing incorsound in her throat, 1 notified [Nurse # 5] as [Nurse # 5] go into [F approximately 2-3 m the room again before NA # 5 was interview and reported the folio cared for Resident #	nift to 7:00 AM shift on 7/25, 3/19/25, 3/20/25, view of NA # 5's signed s undated, in the saled in part the following d 3rd shift I never observed or drinking but food/snacks	F	584		
	and forth and she all when she had cared had cared for Reside been in the room at strattle in the resident's bedside. The resident would not respond. Stresident's room after	vays appeared that way for her. On the last night she ent # 3, she (NA # 5) had 5:15 AM and could hear a s throat while standing at her at had her eyes open but she She saw Nurse # 5 go into the she reported the rattle. She ack in the room after the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 711 SUSAN TART ROAD DUNN, NC 28335	I	00/10/2023
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F 684	care Resident # 3 has facility revealed Nurse which was not dated into Resident # 3's recare while the reside. Nurse # 5 was intervand reported the follonot assigned to Resi which began at 7PM 7:00 AM on 3/25/25. Nurse Aide coming to while they were toge something, but did not (Nurse # 5) never we was not her resident to Nurse # 6. Review of a facility in care Resident # 3 has facility revealed Nurse # 3 on 3/14/25, 3/20/PM to 7:00 AM shifts statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement read, "[Remedication during more resident materials of the statement	nvestigative file regarding the ad received while at the se # 5 had given a statement, noting she had not gone from or provided any type of an tresided at the facility. Siewed on 6/3/25 at 11:12 PM owing information. She was dent # 3 on the night shift on 3/24/25 and ended at She (Nurse # 5) did recall a up to both her and Nurse # 6	F	584		
	no signs of distress, 3/25/25, I was appro informed me that [Reright. I went into [Res [Nurse # 4] and [Nur 3]. As far as my expeconcerned, she was of 3/25/25.	s closed during my shift, with discomfort or pain. On ached by [NA # 1] who esident # 3] was not acting sident # 3's] room along with se # 3] to assess [Resident # erience with [Resident # 3] is at her base line the morning liewed on 6/3/25 at 12:45 PM				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
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F 684	been nothing commutimes she had taken resident was not eati resident only got one able to swallow it during the seident during the number of the resident appearer recall problems reported in the first she recalled change in condition of the first she recalled change in condition of the resident appearer and the was not rignurse and and nurse thought the resident and Nurse thought the resident the way she was. On 3/25/25 at 8:20 A "Writer made aware acting like herself. We resident to be swinging Resident did not response and pulse and accurresident agitation. We other nurses entered [Name of physician] Physician] ordered we writer called in 911. EMS [Emergency Metals and taken and taken appeared to get a supplied to the physician] Physician] ordered we writer called in 911.	owing information. There had inicated in report during the care of Resident # 3 that the ing or having a change. The medication and was always fing her 12 hour 7:00 PM to efore, after she gave the she would peek in on the lights she cared for her and do to be sleeping. She did not reted by the Nurse Aides and reporting Resident # 3 was ing had been reported to have been a "huge concern." If anyone communicating a was when the day shift NA the change of shift if 3/25/25. NA # 1 reported to right and she had been dayshift for two days that the int." She (Nurse # 6) got # 3 to go with her. Nurse # 4 was a little off but that was the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was a little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was more interrupted of the little off but that was not was not was more interrupted of the little off but that was not wa	F6	84			

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(9:35 AM) of resident [Name of Hospital]. On 3/25/25 at 8:52 A "[Resident] presentin will not follow comma appropriately, [reside this morning per [NA] gown off repeatedly. [Pulse] 97, R [respiral [oxygen level] 100 % RP was notified and to the hospital for alternative and reported the following and reported the following and shake her hear the first day that she and she did not recal report about somethic resident or a change resident sent out to the Nurse # 3 was interviand reported the following and reported the following resident sent out to the Nurse # 3 was interviand reported the following right on 3/25/2 resident was moving nurse. She was throw Nurse Aide reported in normally was. Review of EMS records.	M Nurse # 4 documented, g with altered mental status, ands or answer questions nt] would not eat breakfast staff, [resident] is taking her VS T [temperature] 97.1, P tions] 18, BP 86/56, SPO2. "Nurse # 4 further noted the the resident was being sent ered mental status. ewed on 6/4/25 at 3:34 PM owing information. The Nurse in know that she could not at and the resident would not had her eyes closed, d, and was fidgety. That was had cared for Resident # 3 I any communication in any being wrong with the prior to that. She had the he hospital. ewed on 6/4/25 at 3:24 PM owing information. She had the her hospital. ewed on 6/4/25 at 3:24 PM owing information. She had the her hospital. ewed on 6/4/25 at 3:24 PM owing information. She had the her hospital had not respond to the wing her hands and the that was not the way she	F	584			
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page (9:35 AM) of resident [Name of Hospital]. On 3/25/25 at 8:52 A "[Resident] presenting will not follow comman appropriately, [reside this morning per [NA] gown off repeatedly. [Pulse] 97, R [respirated lower of the hospital for altered lower of the lower of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 (9:35 AM) of resident condition and transfer out to [Name of Hospital]. On 3/25/25 at 8:52 AM Nurse # 4 documented, "[Resident] presenting with altered mental status, will not follow commands or answer questions appropriately, [resident] would not eat breakfast this morning per [NA] staff, [resident] is taking her gown off repeatedly. VS T [temperature] 97.1, P [Pulse] 97, R [respirations] 18, BP 86/56, SPO2 [oxygen level] 100 %." Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status. Nurse # 4 was interviewed on 6/4/25 at 3:34 PM and reported the following information. The Nurse Aide came and let her know that she could not get Resident # 3 to eat and the resident would not respond to the NA. When she (Nurse # 4) went into the room the resident had her eyes closed, would shake her head, and was fidgety. That was the first day that she had cared for Resident # 3 and she did not recall any communication in report about something being wrong with the resident or a change prior to that. She had the resident sent out to the hospital. Nurse # 3 was interviewed on 6/4/25 at 3:24 PM and reported the following information. She had overheard a NA saying the resident was not acting right on 3/25/25 and went to help. The resident was moving but did not respond to the nurse. She was throwing her hands and the Nurse Aide reported that was not the surse Aide reported that was not the nurse. She was throwing her hands and the Nurse Aide reported that was not the way she	ROVIDER OR SUPPLIER ROLTON OF DUNN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 (9:35 AM) of resident condition and transfer out to [Name of Hospital]. On 3/25/25 at 8:52 AM Nurse # 4 documented, "[Resident] presenting with altered mental status, will not follow commands or answer questions appropriately, [resident] would not eat breakfast this morning per [NA] staff. [resident] is taking her gown off repeatedly. VS T [temperature] 97.1, P [Pulse] 97, R [respirations] 18, BP 86/56, SPO2 [oxygen level] 100 %." Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status. 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EMS received	ROUTON OF DUNN SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLACED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684	TOTAL STATE AND A STREET ADDRESS. CITY, STATE, ZIP CODE 345325 ROWIDER OR SUPPLIER ROLTON OF DUNN SUMMARY STATEMENT OF DESIGNICIES (EACH OFFICIENCY WIST SEP PERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 (9:35 AM) of resident condition and transfer out to [Name of Hospital]. On 3/25/25 at 8:52 AM Nurse # 4 documented, "[Resident] presenting with altered mental status, will not follow commands or answer questions appropriately, [resident] would not eat breakfast this morning per [NA] staff, [resident] is taking her gown off repeatedly, VST [temperature] 97.1, P. [Pulse] 97, R. [respirations] 18, BP 86/56, SPO2 [coxyen] evel 100 %. "Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status. Nurse # 4 was interviewed on 6/4/25 at 3:34 PM and reported the following information. The Nurse Aide came and let her know that she could not gest Resident # 3 to eat and the resident would not respond to the NA. When she (Nurse # 4) went into the room the resident had her eyes closed, would shake her head, and was fidgely. That was the first day that she had cared for Resident # 3 and she did not recall any communication in report about something being wrong with the resident or a change prior to that. She had the resident was not acting right on 3/25/25 and went to help. The resident was moving but did not respond to the nurse. She was throwing her hands and the Nurse Aide reported that was not the way she normally was. Review of EMS records for the date of 3/25/25 revealed the following information. EMS received	A BUILDING 345325 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28338 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 (9:35 AM) of resident condition and transfer out to [Name of Hospital]. On 3/25/25 at 8:52 AM Nurse # 4 documented, "[Resident] presenting with altered mental status, will not follow commands or answer questions appropriately, [resident] would not eat breakfast this morning per [Na] staff, [resident] to staking her gown off repeatedly. VS T [temperature] 97.1, P [Pulse] 97. R [respirations] 18, BP 86/56, SPO2 [coxygen level] 100 % "Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status. Nurse # 4 was interviewed on 6/4/25 at 3:34 PM and reported the following information. The Nurse Alde came and let her know that she could not get Resident # 3 to eat and the resident would not respond to the NA. When she (Nurse # 4) went into the room the resident and her eyes closed, would shake her head, and was frigety. That was the first day that she had careful for Resident # 3 and she did not recall any communication in report about something being wrong with the resident sent out to the hospital. Nurse # 3 was interviewed on 6/4/25 at 3:24 PM and reported the following information. She had overheard a NA saying the resident was not acting right on 3/25/52 and went to help. The resident was moving but did not respond to the nurse. She was throwing her hands and the Nurse was throwing her hands and the Nurse was throwing her hands and the nurse. She was throwing her hands and the nurse. She was throwing her hands and the nurse was throwing her hands and the nurse she was throwing her hands and the nurse she was throwing her hands and the nurse was throwing her hands and the nurse she was throwing her hands and the nurse she was throwing her hands and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED	
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		345325	B. WING			06/	10/2025
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 111 SUSAN TART ROAD DUNN, NC 28335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	noted. "UOA [upon a facility staff at the pareported that they did that the patient was a but that the patient was altered was provided facility (history) of [cerebrowright-sided deficits." Resident # 3 was "latered was provided facility (history) of [cerebrowright-sided deficits." Resident # 3 was "latered was groom. The patient arm and groaning. The verbal stimuli. The patient was from painful stitus to the right throughouse or react to stimule either leg. The patient via 12-lead, NIBP [not cuff, and pulse ox. [ottemp and BGL [blood had some difficulty a quality pulse oximetr and nail polish and lonursing staff returned patient had been und decline in LOC [level mental status for apput did not know an ewritten]." The parametransferred to the stransferred	t 8:36 AM. The paramedic rrival] we were greeted by tient's room. Facility staff of not know the patient and not normally under their care, normal [NA] reported that ed from her normal. EMS paperwork. EMS noted a Hx ascular accident] with The paramedic also noted ying supine on her bed within at was wildly moving her left the patient did not respond to attent would groan and pull muli. The patient would lean at the call. The patient did not li on her right arm or use at was placed on the monitor point of the patient axillary did glucose] checked. EMS taining consistent, high y due to patient movement ong nail length. Facility did and informed EMS that the dergoing a progressive of consciousness] and prox [approximately] 1 week, exact last known well [as edic noted the resident was etcher and taken to the	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345325	B. WING			C
	ROVIDER OR SUPPLIER	04020		STREET ADDRESS, CITY, STA 711 SUSAN TART ROAD DUNN, NC 28335	TE, ZIP CODE	06/10/2025
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	
F 684	painful stimuli, starts but does not move the not withdraw from pathe right side." The reweight was 140 pour indicated a weight log 3/18/25 of 150.3 pour log and the right side." The reweight was 140 pour indicated a weight log 3/18/25 of 150.3 pour log all inclusive showed 12-16); a white blood 4.5-12.5); sodium le Blood urea nitrogen 3.35 (normal .60 to 1 troponin level (cardia elevated with heart of log and the log and	Patient barely responds to moving left upper extremity he lower extremities and does hinful stimuli. Does not move esident's hospital admission hads and 10.5 ounces (which is from her facility weight on inds). Indicate the ED and although not a hemoglobin of 4.0 (normal dount of 31.9 (normal vel of 153 (normal 136-145). 115 (normal 7-25); creatinine 1.30) and an elevated in enzyme which can be amage). It ian noted, "Significant in labs consistent with the COVID infection, sodium levels], metabolic impage [acids build up in the iney injury], elevated is [elevated white blood itemia noted with a hgb stool occult blood was its stool showed blood when aff reported frank blood [red od transfusion, sepsis bolus]	F	584		
	The resident was pla COVID infection and (steroid) and albuterd The physician also d the resident "appeard consistent with dehyd	nd antibiotics ordered by ED." ced on oxygen for her intravenous Decadron ol (respiratory medication). ocumented upon admission ed dry" and her labs were dration. dmitted to the Intensive Care				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345325	B. WING			C
	ROVIDER OR SUPPLIER	34020		STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	1 0	6/10/2025
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	Review of her dischaprimary diagnosis were COVID infection. The have myocardial injusepsis, pneumonia, received a total of 3 hemoglobin, and fou antral ulceration (ulceration) and duode part of the small interwas also that the researcoma [a type of confollowed after hospit. The resident's facility on 6/4/25 at 5:50 PM in part reviewed with The Physician report. When a resident expression of the small interval that the facility had resident in the first problem and treat the therapy notes, it that the facility had ron 3/21/25 when the she was declining in feeling. He did not know a declining in feeling. He did not know a declining in feeling. He did not know a declining whether the sepsis could have resident had had treat the Physician he felt evaluation and treating the outcome. He reproduble whammy" in	arge summary revealed her as sepsis secondary to be resident was also noted to and covid. The resident had units of blood for her low and to have a superficial be in the lower part of the anitis (inflammation of the first stines). An incidental finding sident had likely uterine ancer] and was to be alization. If physician was interviewed and the therapy notes were at the physician at this time. The therapy information are the therapy in the two to three days to find the econdition. From reviewing was evident to the Physician and the therapy in condition are was documentation that functional status and overall mow why he had not been corted he was in the facility hysician was interviewed the resident's heart injury from the been avoided if the atment earlier. According to the days she had not had ment had made a change in corted the resident had a that she had COVID and a did and both had contributed to	F 6	84		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	06/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	D BE COMPLETION
F 684	Continued From pa	ge 57	F 68	1	
	was not acceptable plan included education of include education of inclu	PM the Administrator was late Jeopardy. Presented the following ly removal plan. Its who have suffered, or are prious adverse outcome as a lampliance: 6/5/25 revealed that the facility little seriousness of a change in licate effectively, provide the care, and provide care as			
	short-term rehabilitation 23 days. No base as ordered by the process of the proce	dmitted to the facility for ation and resided in the facility seline lab work was obtained physician on 3/11/25. Sucted by the Surveyor py notes from 3/18/25 to desident #3 was experiencing d functional decline. Sonducted by the Surveyor with nurse aides and oted that a decline in the occurred from 3/18/25 to ded decreased functional revealed that the decline was d nursing staff.			
	Interviews by the S	urveyor (6/3/25 and 6/4/25)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		COMPLETED
		345325	B. WING _			C 06/10/2025
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP C 711 SUSAN TART ROAD DUNN, NC 28335	ODE	33,10,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI HE APPROPRIA	
F 684	with nurses indicated decrease in functiona 3/25/25 had not been the physician. On 3/22/25, Residen COVID, and the familitreatment. Antiviral the Resident #3 was serwhere she was diagrito COVID infection a ulceration. Resident building. On 6/4/25 and 6/5/25 from the electronic madiceration. Resident building. On 6/4/25 and 6/5/25 from the electronic madiceration in the electronic madiceration in the electronic madiceration. (The summarizes resident last 24 hours, including signs, incident report physician order note: admissions, dischargereturning from leavely were immediately and the electronic madiceration of the electronic madiceration order note: admissions, dischargereturning from leavely were immediately and the electronic madiceration of the electronic ma	It that this decline and all ability from 3/18/25 to in recognized or reported to it #3 was diagnosed with all gave consent for antiviral treatment was not initiated. It to the hospital on 3/25/25, hosed with Sepsis secondary and a gastrointestinal #3 did not return to the in twenty-four-hour reports a medical record (dated from 25) were printed and actor of Nursing to confirm a w-up had occurred for any the twenty-four report a information occurring in the ang all progress notes, vital as, physician progress notes, s, med administration notes, ges, and residents on or an All identified concerns	F6	584		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335	06/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 684	brought forward. In review revealed that shared with the phy appropriate actions (including one residual). The facility has detented the potential to be a fail to recognize the condition, commun necessary medical ordered by the physical ordered by the physical staff members of the chief Operating Officer, and the train A review of the survey.	ame day (6/5/25), were need at the three events had been visician earlier in the day and were taken immediately lent that was sent to the ermined that all residents have affected when staff members a seriousness of a change in icate effectively, provide the care or deviate from the care sician. The entity will take to alter the failure to prevent a serious non occurring or recurring, and I be complete: The vere in-serviced on 6/5/25 by gofficer and Chief Clinical ning included the following:	F 68	,	
	(F-684) as evidence - recognize the sericondition, - communicate efferences - provide the neces - provide care as one Review of key elemincluding: - Orders for baseline - Antiviral treatmences	ch professional standards ed by the facility failing to: ousness of a change in ctively, sary medical care and, rdered by the physician. ments of non-compliance e lab results were missed t for COVID was not provided cation and coordination			

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	NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF DUNN STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD DUNN, NC 28335			•	35.1672020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pagamongst the interdistribution.	_	F 6	34			
	team members and communication inclusion. Nursing assistants changes to nurses to hurses reporting complysicians timely, All staff keep the E	m (including 100% of facility contractors). This udes but is not limited to:					
	reported change in by a nurse immedial indicating decline of physician intervention physician intervention physician immediat medical record immedical record r	on- all residents with a condition must be assessed tely. Assessment findings the need for emergent on will be called to the ely and documented in the rediately. Other changes ommunicated to the physician ralls to physicians and family documented as notifications of contractors have been corrector of Nursing and resure that all team members or working in the facility. They even each shift to assist with that and staff sign in to was completed. New staff uccated during the orientation correctors.					

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F 684	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 68	4			
	per their removal p were reviewed by t interviewed about a change or medical knowledgeable abo	ed and were being addressed lan. Multiple 24 hour reports he surveyor and the DON was any documentation of status need. The DON was but any status change in the 24 was validated that residents					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD B		
F 684	who had a medical n	eed were receiving care. ate jeopardy removal date of	F	684			