STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF DUNN	711 SUSAN TART ROAD DUNN, NC 28335

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/31/23 through 6/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NC5111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/31/23 through 6/2/23. Event ID# RJF11. The following intakes were investigated NC00196076, NC00199454 and NC00202589. 2 of the 6 complaint allegations resulted in deficiency.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		6/30/23

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

Electronically Signed | 06/29/2023

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F 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interviews, the facility failed to honor residents' choice related to showers for 4 of 5 dependent residents reviewed for choices (Resident #45, Resident #42, Resident #14, and Resident #33). Findings included: 1. Resident #45 was admitted to the facility on 3/9/2022, and diagnoses included hemiparesis (partial paralysis on one side of the body). Resident #45's care plan initiated on 3/11/2022 revealed she needed one person assistance to remove and replace her clothing on one side of her body and stand by assistance with transfers from bed to wheelchair. There was no focus for activities of daily living addressing baths and showers on Resident #45's care plan. The quarterly Minimum Data Set (MDS) assessment dated 2/14/2023 indicated Resident #45 was cognitively intact and displayed no behaviors for refusal of care. The MDS further indicated Resident #45 required limited assistance of one person with transfers and total assistance of one person for baths.	F 561	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-561 ¿483.10 (f)(1)-(3)(8) □ Self Determination Issue Cited: Choices- Showers	

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F 561	Continued From page 2 A review of the facility's shower schedule indicated Resident #45 was scheduled showers on Wednesdays and Saturdays on the 7a.m. to 3 p.m. shift. Nursing documentation for baths revealed Resident #45 had not received showers as scheduled in the following months: March 2023: There were no showers documented as given on Wednesday and Saturday. There were only two showers documented on Thursdays March 9, 2023 and March 16, 2023. April 2023: There were no showers documented as given on Wednesday and Saturday. There was only one shower documented on Thursday, April 20, 2023. May 2023: There were no showers documented as given on Wednesday and Saturday. There was only one shower documented on Friday, May 19, 2023. On 5/30/2023 at 10:27 a.m., Resident # 45 was observed sitting in a motorized wheelchair well dressed in colorful personal clothing in her room. She was wearing a hair covering to match her clothing, and there were no foul odors noted. In an interview with Resident #45 on 5/30/2023 at 10:27 a.m., she stated she was scheduled showers on the 7 a.m. to 3 p.m. shift twice a week and had been getting one to two showers a month because there was not enough help in the facility. Resident #45 stated she wanted a shower twice a week. On 5/31/2023 at 4:15 p.m., Resident #45 stated this was her scheduled shower day, and Nurse Aide (NA) # 2 provided her a bed bath and did not offer to give her a	F 561	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility social worker surveyed all residents, including Resident #45, Resident #42, Resident #14 and Resident # 33, to determine bathing preferences following the May 30 □ June 2, 2023, DHHS Survey. Newly admitted residents will be asked about their preferences for activities of daily living, including baths and showers during the admission process. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents in the facility residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, clinical staff and contractors), on June 7, 2023, to address the Resident□s Right of Self-Determination, including the right to determine when they receive a shower, and other issues identified from the May 30- June 2, 2023, DHHS Survey. The facility administrator and facility nurse consultant met with the resident council on June 8, 2023, to discuss the facility□s	

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shower. When asked if she ask NA #2 for a shower, she stated she didn't ask for a shower. In a follow up interview with Resident #45 on 6/2/2023 at 1:01 p.m., she stated receiving showers meant a lot to her. Showers made her feel clean and healthy. She stated she want to smell clean and had smelled herself in the past because she had not had a shower.

In an interview with NA #2 on 5/31/2023 at 4:20 p.m., she stated she was assigned the 500-hall and Resident #45 on the 300-hall. She said she did not check the shower book before providing Resident #45 a bed bath, and Resident #45 did not ask for a shower. When asked if she had given any assigned showers on 5/31/2023, she explained due to being the only nurse aide assigned to the 500-hall and Resident #45 and had not been able to provide showers to the residents.

In an interview with Nurse #2 on 5/31/2023 at 5:40 p.m., she stated Resident #45 was scheduled a shower on Wednesdays and Saturdays. She said NA #2 had not informed her Resident #45 was not given a shower, and Resident #45 had not mention to her she did not receive a shower on 5/31/2023. Nurse #2 said NA #2 was the only nurse aide assigned to work the 500-hall and Resident #45 on the 300-hall on 5/31/2023. She explained when there was only one nurse aide on the assignment, there was not enough time to give Resident #45 a shower, and a bed bath was given instead.

In an interview with the Director of Nursing on 6/2/2023 at 2:30 p.m., she stated she was aware Resident #45 had not been receiving showers as scheduled due to staffing issues. She explained

plan for ensuring that resident preferences regarding activities of daily living, including baths and showers.

Nursing Staff (including all nurses and certified nursing assistants) were in-serviced on the Resident□s Right of Self-Determination, including the right to determine when they receive a shower, June 12, 2023, through June 14, 2023, by the Interim Director of Nursing, Administrator and CFM Corporate staff.

The facility shower schedule was revised to include residents□ preferences regarding baths and showers, including preferences for Resident #45, Resident #42, Resident #14, and Resident # 33 on June 18-19, 2023.

Resident care plans, including care plans for Resident #45, Resident #42, Resident #14 and Resident # 33, were revised to address activities of daily living, including baths and showers June 20 □ 28, 2023.

Nursing staff, including nurses and certified nursing assistants were educated regarding the new shower schedules, documentation expectations and auditing frequencies by the Director of Nursing June 19-22, 2023.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

The Interim Director of Nursing or designee will complete daily audits for four (4) consecutive weeks beginning June 20, 2023, to determine if residents□

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F 561	Continued From page 4 showers were scheduled twice a week and Resident #45 had received a shower inconsistently when extra staff was available to assign showers. 2. Resident #42 was admitted to the facility on 12/19/2014, and diagnoses included stroke. Resident #42's care plan initiated 11/16/2016 included one person providing physical assistance and constant supervision with bathing due to impaired mobility. A grievance report dated 3/7/2023 stated Resident #42 reported during a Resident Council Meeting he had not received a shower, and nursing staff were reminded to follow the shower schedule. The annual Minimum Data Set (MDS) assessment dated 4/26/2023 indicated Resident #42 was cognitively intact with limited movement to one upper and lower side of the body and required total assistance with bathing. A review of the facility's shower schedule indicated Resident #42 was scheduled showers on Mondays and Thursdays on the 7a.m. to 3 p.m. shift. Nursing documentation for baths revealed Resident #42 had not received showers as scheduled in the following months: March 2023: There were no showers documented given to Resident #42 for the month. April 2023: There were no showers documented given to Resident #42 for the month. May 2023: There were no showers	F 561	preferences regarding showers are being honored. The facility nurse consultant or other CFM corporate staff will randomly survey residents monthly for the next three (3) months to determine if residents preferences regarding showers are being honored. Survey records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: June 30, 2023.	

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documented given To Resident #42 for the month.

On 5/30/2023 at 3:46 p.m., Resident #42 was observed sitting in a wheelchair wearing a clean yellow collared shirt and khaki pants. Resident #42's combed hair did not appear greasy, and his nails were short and clean. There were no foul odors noted.

In an interview with Resident #42 on 5/30/2023 at 3:46 p.m., he stated he had received one shower in two weeks. He said the nursing staff helped him get a bath and was told there was not enough staff to provide a shower. He stated he had voiced a concern about not getting showers at the Resident Council meetings. In a follow up interview with Resident #42 on 6/1/2023, he explained that getting his two showers a week made him feel better and if he didn't get a shower, he felt like he was still dirty after getting bed baths.

In an interview with Nurse #1 on 6/1/2023 at 3:11 p.m., she explained Resident #42 was scheduled showers twice a week, and due to limited staff, nurse aides were unable to provide Resident #42 a shower and had been providing him bed baths. She stated Resident #42 had not voiced a concern to her about not getting his shower and knew Resident #42 loved getting his showers.

In an interview with Nurse Aide #1 on 6/2/2023 at 12:52 p.m., she explained due to one nurse aide assigned to Resident #42's hall the last few months, Resident #42 had received bed baths and not his showers as scheduled. She recalled hearing in a staff meeting to provide residents' showers as scheduled and explained she was not

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able to complete the scheduled showers when she was the only nurse aide on the hall and assigned 19-20 residents during the 7 a.m. to 3 p.m. shift.

In an interview with the Director of Nursing on 6/2/2023 at 2:30 p.m., she stated she was aware Resident #42 had not been getting his scheduled showers twice a week due to not enough staff assigned to the hall. She explained showers were provided inconsistently when there was extra staff scheduled in the facility and had reminded the nursing staff during a staff meeting to provide residents their scheduled showers.

3. Resident #14 was admitted to the facility on 10/10/2020, and diagnoses included musculoskeletal impairment.

Resident #14's care plan initiated on 12/29/2020 included a focus for activities of daily living due to limited mobility and stated Resident #14 required total assistance of one person for bathing and showering.

The quarterly Minimum Data Set (MDS) assessment dated 3/24/2023 indicated Resident #14 was cognitively intact with limited movement to the upper and lower extremities on both sides of the body and required total assistance with all activities of daily living.

A review of the facility's shower schedule indicated Resident #14 was scheduled showers on Tuesdays and Fridays on the 3 p.m. to 11 p.m. shift.

Nursing documentation for baths revealed Resident #42 had received one shower on

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5/26/2023 for the month of May 2023.

On 5/30/2023 at 11:15 a.m., Resident #14 was observed lying in the bed with his head down leaning toward the left side. Resident #14 was wearing a gown that was wet on the upper left side. His short brown hair did not appear greasy and was uncombed. His contracted clean hands were resting on his stomach area, as well as a computer device that resting up against the over bed table. There were no foul odors noted while sitting beside Resident #42 during the interview.

In an interview with Resident #14 on 5/30/2023 at 11:15 a.m., he stated he would go get a shower if offered on the days scheduled for a shower and he knew when there was only one nurse aide assigned to the hall, he would not get a shower. Resident #14 stated he was receiving bed baths. In a follow up interview with Resident #14 on 6/2/2023 at 1:13 p.m., he explained showers made him feel better, but understood why not getting showers when one nurse aide assigned to the hall. He said he had not refused any showers because the nursing staff had not offered to give him a shower.

In an interview with Nurse Aide #3 on 6/2/2023 at 2:02 p.m., she stated she had not been providing Resident #14 his scheduled showers because she was the only nurse aide assigned to the hall for the 3:00 p.m. to 11:00 p.m. shift. She explained when working with one nurse aide on the hall, she was unable to complete scheduled showers and provide bed baths to Resident #14.

In an interview with Nurse #3 on 6/2/2023 at 3:06 p.m., she stated Resident #14 had not been receiving showers twice a week as scheduled.

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She explained when one nursing aide was assigned to Resident #14's hall, the nurse aides were unable to complete scheduled showers. She stated Resident #14 had received bed baths and administration was aware Resident #14 and the residents were not receiving scheduled showers.

In an interview with the Director of Nursing on 6/2/2023 at 2:30 p.m., she stated she was aware Resident #14 was not receiving his scheduled showers consistently due to limited staff assigned to the hall Resident #14 resided. She stated pulling the nurse aides from the hall to provide showers left the hall with no one to watch the call lights and bed baths were given. She stated she had reminded the nursing staff to provide scheduled showers and when extra staff was available in the facility, providing showers to residents was a priority.

4. Resident #33 was admitted to the facility on 9/22/2022 with diagnoses that included depression and polycystic ovarian syndrome.

The quarterly Minimum Data Set (MDS) assessment dated 4/1/2023 indicated Resident #33 was cognitively intact and displayed no behaviors for refusal of care. The MDS further indicated Resident #33 required total assistance of one person for baths.

A review of the facility's shower schedule indicated Resident #33 had scheduled showers on Mondays and Thursdays on the 7a.m. to 3 p.m. shift.

Nursing documentation for baths revealed Resident #33 had not received showers as

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scheduled in the following months:

March 2023: There were no showers documented as given on Mondays and Thursdays. There was only one shower documented on Friday, March 3, 2023.

April 2023: There were no showers documented as given on Mondays and Thursdays. There was only one shower documented on Saturday, April 29, 2023.

May 2023: There were no showers documented as given on Mondays and Thursdays. There were only two showers documented on Friday, May 5, 2023, and Friday, May 12, 2023.

In an interview with Resident #33 on 5/30/2023 at 11:46 a.m., she stated she had not been receiving her showers twice a week since being transferred to the 500 hall approximately two weeks ago. Resident #33 stated she wanted a shower twice a week, and that staff knew about her desire for showers instead of bed baths. She added that she thought she was unable to receive her showers due to there not being enough staff on the halls. Resident #33 was observed to be clean with some facial hair on her chin. A later interview with Resident #33 on 6/1/2023 at 1:14 PM revealed she had access to her own razor, and she was able to shave at any time.

In an interview with Nurse #4 on 6/1/2023 at 1:57 p.m., she stated Resident #33 had not been receiving showers twice a week as scheduled. She explained that there were not enough nurse aides to complete scheduled showers. She stated Resident #33 had received bed baths but added that she was aware resident #33 preferred showers. Nurse #4 confirmed Resident #33 had been assessed for self-performance with a razor

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F 561	Continued From page 10 and explained it would be a dignity concern if Resident #33 was not able to shave at her leisure. In an interview with the Director of Nursing on 6/2/2023 at 2:30 p.m., she stated she was aware Resident #33 had not been getting his scheduled showers twice a week due to not enough staff assigned to the hall. She explained showers were provided inconsistently when there were extra staff scheduled in the facility and had reminded the nursing staff during a staff meeting to provide residents with their scheduled showers.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F 577		6/30/23

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F 577	Continued From page 11 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to inform residents (Resident #47, #42, #45, #59 and #41) the location of the state inspection results and failed to display state inspection results accessible to a wheelchair bound resident (Resident #45) for 6 of 6 residents in attendance of the Resident Council meeting. The findings included: On 6/1/23 at 10:20 am during a Resident Council meeting, Resident #47, Resident #42, Resident #45, Resident #59 and Resident #41 stated state inspection results were not made available for residents to read and they did not know the location of the state inspection results. On 6/1/23 at 10:48 am the state inspection results black binder for the facility was observed on the wall in a clear file holder, with the base of the clear file holder located approximately fifty-six inches from the floor, in the hallway across from the administration office. There was no label identifying the state inspection results binder observed in the clear file holder. The binder was placed with the label reading survey results towards the wall. On 6/1/23 at 10:50 am Resident #45 was observed unable to reach the State Inspection Results binder while sitting in her wheelchair and stated she would be unable to read a label of a binder placed at that height.	F 577	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F- 577 ¿ 483.10 (6-9) Right to Survey Results Issue Cited: State inspection results were not within reach for all residents. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility survey book was lowered to ensure readily accessibility to all residents, family members and legal	

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	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 577	Continued From page 12 An interview was conducted with the Administrator on 6/1/23 at 11:00 AM who stated the survey inspection results binder should be accessible to residents without assistance. He reported he would have the clear file holder moved to a lower position so it would be within reach of wheelchair bound residents.	F 577	representatives of residents. The facility Administrator and facility nurse consultant met with the Resident Council on June 6, 2023, and educated the group on the of the location of the survey result notebook. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Letters were mailed to every responsible party on June 20, 2023, with an update regarding where survey results can be located. Letters were distributed directly to all patients on June 20, 2023, providing them an update on where survey results are located. This information is also provided during the admissions process. All residents, family members, legal representatives of residents and guests, and family members will consistently have access to the survey results. General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including	

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administrative staff, clinical staff and contractors), on June 7, 2023, about the location and availability of survey results and other issues identified from the May 30- June 2, 2023, DHHS Survey.

Nursing Staff (including all nurses and certified nursing assistants) were in-serviced about the location and availability of survey results, June 12, 2023, through June 14, 2023, by the Interim Director of Nursing, Administrator and CFM Corporate staff.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
Walking rounds by the Administrator or designee will incorporate a conversation with the residents about the location of survey results. These will occur a minimum of twice weekly for four (4) weeks beginning June 19, 2023. Immediate corrective action, including re-education, will follow as needed. Audits and Survey records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Audit results will be shared with the Resident Council for comments and suggestions.

Corrective action completion date: June 30, 2023.

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F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		6/30/23

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completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 16 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to resolve and provide a written grievance response for 2 of 2 residents reviewed for grievances (Resident #45, Resident #42). Findings included: a. Resident #45 was admitted to the facility on 3/9/2022. The quarterly Minimum Assessment Data (MDS) assessment dated 2/14/2023 indicted Resident #45 was cognitively intact. A review of the grievance reports revealed the following grievances for Resident #45: *On 3/6/2023, Resident #45 voiced concern for having to wait an extended about of time to received incontinent care on 3/5/2023. The grievance report indicated the form was completed by the Director of Nursing (DON) and the concern was investigated by the Don and	F 585	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 585	Continued From page 17 Administrator. There was no date of resolution on the grievance report, and the grievance report stated the investigation continued. The grievance report also indicated notification of the representative was pending state investigation. *On 3/7/2023, Resident #45 voiced concern for not receiving a bath since February 2023. The DON and Administrator completed and investigation and reported on the grievance report Resident #86 could not receive a shower due having an unna boot dressing to lower leg. Grievance report indicated resolution of the grievance and notification of Resident #86 on 3/7/2023. *On 4/4/2023, a grievance report for Resident #45 voiced a concern for waiting until lunch time to get incontinent care and assisted up into her wheelchair. The concerns were investigated by the DON and Administrator. The grievance report indicated nursing staff would be ins-services on conducting frequent rounds and the complainant, Resident #45's sister was notified of the resolution on 4/5/2023. There was no evidence of copies of written grievance response the grievances for Resident #45. Physician orders dated 3/20/2023 included discontinuation of the unna boot dressing to lower leg. In an interview with Resident #45 on 5/30/2023 at 10:27 a.m., she stated she was not receiving her scheduled showers, and since 3/5/2023 the staff had been meeting her incontinent needs in a more timely manner. b. Resident #42 was admitted to the facility on	F 585	Tag Cited: F-585 ¿483.10(j) (1)- (4) - Grievances Issue Cited: Failure to Follow Up on Grievances 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility Administrator began providing written responses and follow up to all outstanding grievances during the May 30 □ June 2, 2023, DHHS Survey. Carrolton Facility Management (CFM) Corporate staff met with the facility Administrator on June 5, 2023, to discuss expectations regarding prompt response to all grievances and recommendations concerning issues of resident care and life in the facility. The facility nurse consultant and the facility administrator met with the Resident Council on June 6, 2023, to address grievance follow up and to address any outstanding concerns. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. CFM Corporate staff reviewed all grievances for the past six (6) months following the May 30-June 2, 2023, DHHS Survey and determined that the facility has addressed outstanding grievances.	

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F 585	Continued From page 18 12/19/2014. The annual Minimum Data Set (MDS) assessment dated 4/26/2023 indicated Resident #42 was cognitively intact. A review of the grievance reports revealed the following grievances for Resident #42: *On 3/7/2023 during resident council meeting Resident #42 voiced a concern for not receiving a shower. The grievance report indicated the Director of Nursing (DON) investigated and remind ed nursing staff for follow the shower schedule. Resolution was dated 3/7/2023. *On 4/3/2023 during resident council meeting Resident #42 voiced a concern for not receiving a shower in the past 2-3 weeks. *On 5/12/2023, Resident #42 voiced a concern on the staff attitude when asked to change wet linen. The grievance report indicated the DON completed and investigated the concern, and resolution was dated 5/12/2023. There was no evidence of copies of written grievance response the grievances for Resident #42. In an interview with Resident #42 on 5/30/2023 at 3:36 p.m., Resident #42 stated he had voiced concerns about not receiving showers in the resident council meeting and was unsure if the concerns had been taken to the Director of Nursing because he had not heard anything and still was not getting his scheduled showers. In a follow up interview, Resident #42 stated he spoke with the Administrator on 5/31/2023 about not getting my showers, but the Administrator didn't say what he was going to do about it.	F 585	3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Carrolton Grievance Form was updated on June 1, 2023, to better facilitate documentation of grievance follow up and resolution. The facility social worker was appointed the Grievance Official, responsible for overseeing the grievance process following the May 30-June 2, 2023, DHHS Survey. General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, clinical staff and contractors), on June 7, 2023, to address Resident Rights concerning Grievances, including Response to Grievances, and other issues identified from the May 30-June 2, 2023, DHHS Survey. The Director of Nursing, the Social Worker and the Activity Director were in-serviced on June 8, 2023, by CFM Chief Clinical Officer on Response to Grievances. Nursing Staff (including all nurses and certified nursing assistants) were in-serviced on Resident Rights concerning Grievances, including Response to Grievances, June 12, 2023, through June 14, 2023, by the Interim Director of Nursing, Administrator and CFM	

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F 585	Continued From page 19 In an interview with the Social Worker on 5/31/2023 at 4:11 p.m., she stated she was responsible for logging the grievance reports, and the greivance reports were given to Housekeeping Director, DON and Administration to address. She stated she did not send written grievance response letters after the resolution of the grievance. In an interview with the Administrator on 5/31/2023 at 2:30 p.m., he stated since January 2023 the DON was responsible for sending the written grievance response after resolution of the grievance due to training a new Social Worker. He stated the DON sent written grievance responses to the residents and did not make a copy for the medical records. In a follow up interview with the Administrator on 5/31/2023 at 4:28 p.m., he said nursing in-services were held on 3/31/2023 for neglect and provision of incontinent care due to Resident #45 not receiving incontinent care timely, and there were no in-services to the staff related to providing showers and incontinent care after 3/31/2023. He stated Resident #45 was not given a letter of resolution for the grievances dated 3/6/2023, 3/7/2023 and 4/4/2023, and Resident #42 was not given a letter of resolution for the grievances dated 3/7/2023, 4/3/2023 and 5/12/2023. Therefore, Resident #45 and Resident #42 were re-interviewed on 5/31/2023. He said Resident #45 stated the staff meeting her incontinent needs in a timely manner had improved and she was getting up into the chair regularly. He stated although she had received bed baths regularly, she stated she was not receiving scheduled showers and still was an issue. He stated Resident #42 said not receiving showers on his scheduled days continued to be a concern for	F 585	Corporate staff. Topics covered in these in-services included the following: A. Resident Rights Regarding Grievances a. Review of Carrolton Policy # 2.3 Resident and Family Grievances i. Use of the Grievance Officer ii. Revised Grievance Form iii. Grievance Resolution The facility social worker received additional training from a seasoned Carrolton social worker on June 13, 2023, regarding Grievance Resolution. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility Administrator will monitor all grievances and follow up to assure timely resolution. This will include a weekly audit for four (4) weeks, beginning June 19, 2013, of Grievance Resolution using the Grievance Resolution QI Tool to assure that compliance is maintained. Grievances and follow up to all grievances will be audited by the Carrolton Facility Management (CFM) Compliance Team monthly using the Grievance Resolution QI Tool to assure that compliance is maintained. The monitoring will continue for three (3) months. Survey records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until	

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F 585	Continued From page 20 Resident #42 and voiced no further concerns with staff attitudes in providing care. He stated the facility would look at changing the shower schedule to adjust workload for staff and a written grievance response was given to Resident #45 and #42 on 5/31/2023. In an interview with the Director of Nursing on 6/2/2023 at 2:30 p.m., she stated Resident #45's grievances dated 3/6/2023, 3/7/2023 and 4/4/2023 and Resident #45's grievances dated 3/7/2023, 4/3/2023 and 5/12/2023 were investigated. She explained nursing staff were in-serviced on neglect and providing incontinent care, and staff were reminded to provide resident showers as scheduled. She stated she did not send out letters of written grievance responses and nothing had changed to consistently provide Resident #45 and #42 scheduled showers due to limited staffing assigned to the halls.	F 585	such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council for comments and suggestions. Corrective action completion date: June 30, 2023.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		6/30/23

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F 623	Continued From page 21 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF DUNN	711 SUSAN TART ROAD DUNN, NC 28335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of the reason for transfer to the resident and/or responsible party (RP) for 1 of 1 resident (Resident #86) reviewed for hospitalization. Findings included: Resident #86 was admitted to the facility on 9/9/2022. The quarterly Minimum Data Set (MDS) assessment dated 2/8/2023 indicated Resident #86 was cognitively intact. A review of the transfer form dated 3/17/2023 at 3:21 p.m. indicated Resident #86 started treatment for a urinary tract infection (UTI) on 3/17/2023. When Resident #86 experienced a changed in mental status, the physician and the resident representative was notified, and Resident #86 was sent to the hospital for an evaluation. A review of Resident #86's medical record revealed no evidence that a copy of a written notice of reason for transfer from the facility on 3/17/2023 was provided to Resident #86 or Resident #86's Representative. On 6/2/2023 at 5:18 p.m. in a phone interview with Nurse #5, she stated she did not provide Resident #86 or Resident #86's Representative with a written letter of reason for discharge on 3/17/2023 when discharge to the hospital. She stated the Director of Nursing was responsible for mailing the information to Resident #86 or	F 623	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-623 ¿483.15(d) □ Notice of Transfer Issue Cited: Failure to Provide Notification of Transfer 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #86 record was reviewed for notification of transfer. The resident and/or legal representative was notified of the facility□s transfer policy. 2. Identification of other residents having	

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F 623	Continued From page 24 Resident #86's Representative at that time. On 6/2/2023 at 1:54 p.m. in an interview with the Director of Nursing, she stated Resident #86 did not receive a written letter of reason for discharge on 3/17/2023 because she did not learn until 4/4/2023 from the Corporate Office that residents were to receive a written notification letter. She explained since 4/4/2023 she had developed and provided nursing education on the notification for reason of transfer letter for the facility. She stated auditing of the discharge process to determine compliance of residents receiving the notification for reason of transfer letter had not been started.	F 623	the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Staff (including all nurses and certified nursing assistants) were in-serviced on the facility□s procedures regarding notification of transfer, June 12, 2023, through June 14, 2023, by the Director of Nursing, Administrator and CFM Corporate staff. The CFM Nurse Consultant in-serviced the social worker on June 14, 2023, addressing the facility□s procedures regarding notification of transfer. These in-services covered the following items: " Carrolton Policy 4.5 Transfer and Discharge " Transfer/Discharge to Hospital Checklist to include the issuing of the Notice of Transfer " The staff member□s responsibilities in the Transfer and Discharge process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee, will conduct weekly audits for four (4) consecutive weeks of residents that have been transferred/discharged using the Transfer/Discharge to Hospital QI Tool to	

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F 623	Continued From page 25	F 623	ensure proper notification of transfer was provided to the resident /legal representative. Audits will begin the week of June 19, 2023. The facility nurse consultant or other CFM corporate staff will randomly audit five (5) resident records monthly for the next three (3) months to ensure the proper notification of transfer was provided to the resident and/or legal representative. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		6/30/23

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F 625	Continued From page 26 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the bed hold policy in writing at the time of transfer to 1 of 1 resident discharged to the hospital (Resident #86). This practice had the potential to impact other residents. The findings included: Resident #86 was admitted to the facility on 09/09/2022 and was discharged to the hospital on 3/17/2023. The quarterly Minimum Data Set (MDS) assessment dated 2/8/2023 indicated Resident #86 was cognitively intact. A review of the transfer form dated 3/17/2023 at 3:21 p.m. indicated Resident #86 experienced a changed in mental status, the physician and the resident representative were notified, and Resident #86 was sent to the hospital for an evaluation. Nursing documentation revealed Resident #86 was admitted to the hospital on 3/17/2023.	F 625	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-625 ¿483.15(d) □ Notice of Bed Hold Policy	

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F 625	Continued From page 27 There was no documentation a bed hold policy was provided to Resident #86 in the medical record. On 6/2/2023 at 5:18 p.m. in a phone interview with Nurse #5, she stated on 3/17/2023 she did not give Resident #86 a copy of the bed hold policy or Resident #86's representative when she was discharged to the hospital because the Director of Nursing was responsible for mailing the bed hold information to Resident #86's representative. Nurse #5 said Resident #86 was place on Hospice care at home upon discharge to the hospital. On 6/2/2023 at 1:54 p.m. in an interview with Director of Nursing, she stated prior to April 2023 she was responsible for sending the bed hold policy to Resident #86. She said the census was low in the facility and Resident #86 was not sent a bed hold policy on 3/17/2023. She explained since Resident #86's discharge, she had learned in April 2023 of changes for the discharge information given to residents discharged from the facility to the hospital, and nursing staff had been educated on the new discharge letter and bed hold policy to give to residents and/or resident representatives in April 2023. She stated the facility had not started auditing the discharge process for compliance of the changes.	F 625	and Return Issue Cited: Failure to Provide Notification of Bed Hold 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #86□s record was reviewed for notification of Bed Hold. The resident and/or legal representative was notified of the facility□s bed hold policy. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Staff (including all nurses and certified nursing assistants) were in-serviced on the facility□s procedures regarding Bed Hold Notice Upon Transfer, June 12, 2023, through June 14, 2023, by the Interim Director of Nursing, Administrator and CFM Corporate staff. The CFM Nurse Consultant in-serviced the social worker on June 14, 2023, addressing Bed Hold Notice Upon Transfer. These in-services covered the following items: " Carrolton Policy 4.6 Bed Hold Notice Upon Transfer " Transfer/Discharge to Hospital	

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F 625	Continued From page 28	F 625	Checklist to include the issuing of the Bed Hold Notice " The staff member□s responsibilities in the Transfer and Discharge process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee, will conduct weekly audits for four (4) consecutive weeks of residents that have been transferred/discharged using the Transfer/Discharge to Hospital QI Tool to ensure proper notification of bed hold was provided to the resident /legal representative. Audits will begin the week of June 19, 2023. The facility nurse consultant or other CFM corporate staff will randomly audit five (5) resident records monthly for the next three (3) months to ensure the proper notification of bed hold was provided to the resident and/or legal representative. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a	F 640		6/30/23

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F 640	Continued From page 29	F 640		

facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 30 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit and/or complete discharge Minimum Data Set (MDS) assessments within the required timeframe for 2 of 2 residents reviewed for discharge. (Resident #38 and Resident #78). The findings included: 1. Resident #38 was admitted to the facility on 12/19/22. She was discharged to the community on 1/14/23 based upon record review. Review of Resident #38's medical record revealed her last assessment completed was dated 12/26/22, an admission assessment. On 5/31/23 Resident #38's medical record was reviewed and there was no discharge assessment in the record. During an interview with MDS Nurse #2 on 6/1/23 at 1:22 PM she stated Resident #38's discharge assessment should have been completed and transmitted. She reported the assessment had been overlooked. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated Resident 38's MDS assessment dated should have been completed with the federal timeframes. He stated there had been staff	F 640	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-640 ¿483.20 (f)(1)-(4) □ Encoding/Transmitting Resident Assessments Issue Cited: Resident Assessment 1. Immediate action(s) taken for the resident(s) found to have been affected	

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F 640	Continued From page 31 turnover in the MDS department which may have led to the oversight. 2. Resident #78 was admitted to the facility on 12/3/22. She was discharged to a local hospital on 12/4/23 based upon review of her medical record. Review of #78's medical record revealed her discharge MDS assessment dated 12/4/22 had a completion date of 1/9/23. During an interview with MDS Nurse #2 on 6/1/23 at 1:22 PM she stated Resident #78's discharge assessment dated 12/4/22 should have been completed by 12/18/22. She stated she was not employed by the facility at that time so was not sure the reason it was not completed prior to 12/18/22. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated Resident 78's MDS assessment dated should have been completed with the federal timeframes. He stated there had been staff turnover in the MDS department which may have led to the oversight.	F 640	include: Resident #38 had a discharge assessment completed by the MDS nurse on June 2, 2023, and transmitted to the state on June 8, 2023. . Resident # 78□s record was reviewed and the delay in assessment completion and transmitted was confirmed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The MDS nurse was replaced with a seasoned Carrolton MDS nurse following the DHHS survey. General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, MDS, clinical staff, and contractors), on June 7, 2023, to address Transmitting Resident Assessments, and other issues identified from the May 30- June 2, 2023, DHHS Survey. The facility nurse consultant educated the MDS nurse regarding timelines for completion of MDS and transmission of the assessments on June 8, 2023. The MDS nurse and the Carrolton Facility	

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F 640	Continued From page 32	F 640	Nurse Consultant completed a full transmission of all assessments that were ready for export on June 8, 2023. The MDS nurse and the Carrolton Facility Nurse Consultant reviewed all discharges from the facility for the last 30 days on 6-8-23 to ensure that all discharge assessments were completed and transmitted as per regulation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The MDS nurse will transmit to the state weekly and provide the administrator a copy of the transmission report for review. The facility nurse consultant will audit all discharges from the facility to ensure that the Discharge MDS are completed and transmitted timely. The audits will occur weekly for four (4) weeks beginning the week of June 19, 2023. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		6/30/23

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F 641	Continued From page 33 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to accurately assess the use of a urinary indwelling catheter (Resident #61), antipsychotic medication use (Resident #55, Resident #54), and a diagnosis for anxiety (Resident #33) for 4 of 21 residents whose Minimum Data Set (MDS) assessments were reviewed. Finding included: 1. Resident #61 was admitted to the facility on 5/2/2020, and diagnoses included obstructive reflux uropathy and retention of urine. The annual Minimum Data Set (MDS) assessment dated 3/13/2023 indicated Resident #61 was severely cognitively impaired. The MDS did not indicate Resident #61 had an indwelling catheter, and urinary elimination was marked not rated. Resident #61's care plan last revised on 5/21/2023 revealed the resident had an indwelling catheter due to a neurogenic bladder. On 5/30/2023 at 2:51 p.m., Resident #61 was observed with an indwelling urinary catheter. On 6/1/2023 at 10:48 a.m. in an interview with the part-time MDS Nurse #1, she stated Resident #61 had always had an indwelling urinary catheter. In reviewing Resident #61's annual MDS dated 3/13/2023, she stated the MDS was not marked for an indwelling catheter for	F 641	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-641 ¿483.20 (g) □ Accuracy of Assessments Issue Cited: Accuracy of Assessments 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #61 MDS was modified by the MDS nurse on June 8, 2023, reflect the indwelling urinary catheter. Resident #55 MDS was modified by the	

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F 641	Continued From page 34 elimination. She stated nursing documentation revealed Resident #61 had an indwelling catheter the entire month of March 2023 and not marking an indwelling catheter for elimination on the MDS was an oversight. On 6/1/2023 at 10:55 a.m. in an interview with the Administrator, he stated the facility's full time MDS nurse had been out of work and the part-time MDS Nurse #1 and the Assistant Director of Nursing (ADON) had been helping to conduct MDS assessments as needed. He explained the facility had identified MDS inaccuracies in the fall of 2022 and audits for improvement of MDS assessments were conducted. He stated he was unsure how the indwelling catheter for Resident #61 was missed and would need to conduct another audit for the accuracy of MDS assessments. 2. Resident #55 was admitted to the facility on 10/4/21 with diagnoses that included post-traumatic stress disorder. A progress note dated 2/22/23 revealed a gradual dosage reduction of an antipsychotic medication was contraindicated. Resident #55's quarterly Minimum Data Set (MDS) assessment dated 4/19/23 indicated a gradual dosage reduction of an antipsychotic medication was not contraindicated. During an interview with MDS Nurse #2 on 6/1/23 at 1:22 PM she stated Resident #55's assessment should have been coded to reflect a contraindication of gradual dose reduction for an antipsychotic medication. She reported there was some confusion about this and thought the contraindication had to be done during the 7-day	F 641	MDS nurse on June8, 2023, to reflect a contraindication for dose reduction of the antipsychotic medication. Resident #54 MDS was modified by the MDS nurse on June8, 2023, to reflect the resident□s routine use of antipsychotic medication. Resident #33 MDS was modified by the MDS nurse on June 8, 2023, to reflect her diagnosis of anxiety. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The MDS nurse was replaced with a seasoned Carrolton MDS nurse following the DHHS survey. General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, including MDS, clinical staff, and contractors), on June 7, 2023, to address Accuracy of Assessments, and other issues identified from the May 30- June 2, 2023, DHHS Survey. The facility nurse consultant educated the MDS nurse regarding the accurate completion of MDS assessments on June 8, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 641	Continued From page 35 lookback period. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated Resident #55's MDS assessment dated should have been coded accurately to reflect the contraindication of a gradual dosage reduction of antipsychotic medication. He stated there had been staff turnover in the MDS department which may have led to the error. 3. Resident #54 was admitted to the facility on 12/26/17 with diagnoses that included dementia. Review of Resident #54's medication orders revealed an order dated 4/13/21 which prescribed Risperidone .5 milligrams (an antipsychotic medication) twice a day. Review of Resident #54's Medication Administration Records for April and May 2023 revealed she received antipsychotic medication daily. Resident #54's quarterly Minimum Data Set (MDS) assessment dated 5/4/23 revealed she received an antipsychotic 7 days of the 7-day lookback period. The assessment further revealed she did not take antipsychotic medication. During an interview with MDS Nurse #2 on 6/1/23 at 1:22 PM she stated Resident #54's assessment should have been coded to reflect her routine use of an antipsychotic medication. She reported it was an oversight. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated	F 641	The Nursing consultant, DON and nurse managers completed a 100% review of the MDS coding June 16 □ June 27, 2023, to ensure that all appropriate items for resident care and services were captured on the MDS. Any coding errors noted in the assessment have been modified by the MDS nurse. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility nurse consultant will audit three (3) newly completed MDS assessments per week for four (4) weeks to check for assessment accuracy. The audits will beginning the week of June 19, 2023. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	

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F 641	Continued From page 36 Resident #54's MDS assessment dated should have been coded accurately to reflect her use of an antipsychotic medication. He stated there had been staff turnover in the MDS department which may have led to the error. 4. Resident #33 was admitted to the facility on 9/22/23 Review of Resident #33's medication orders revealed an order dated 9/26/22 which prescribed Ativan .5 milligrams at bedtime for anxiety. Resident #33's quarterly Minimum Data Set (MDS) assessment dated 3/14/23 revealed she received an antianxiety 7 days of the 7-day lookback period. The assessment further revealed Resident #33 was not coded as having anxiety disorder. During an interview with MDS Nurse #1 on 6/1/23 at 3:04 PM she stated Resident #33's assessment should have been coded to reflect her diagnosis of anxiety. She stated it was an oversight. An interview was conducted with the Administrator on 6/2/23 at 2:24 PM. He stated Resident #33's MDS assessment should have been coded accurately to reflect her diagnosis of anxiety disorder. He stated there had been staff turnover in the MDS department which may have led to the error.	F 641		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		6/30/23

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F 656	Continued From page 37	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

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F 656	Continued From page 38 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an individualized care person centered care plan in the areas of Activity of Daily Living (ADL) and discharge for 2 of 21 residents reviewed for comprehensive care plans (Resident #45, Resident #88). Findings included: 1. Resident #45 was admitted to the facility on 3/9/2022, and diagnoses included hemiparesis (partial paralysis on one side of the body). The resident care guide in Resident #45's care plan initiated 3/11/2022 did not included a focus for bathing. Resident #45's care plan did not include a focus for ADL addressing Resident #45's need for assistance with baths. The annual Minimum Data Set (MDS) assessment dated 11/9/2022 indicated Resident #45 was cognitively intact, had limited movement to the upper and lower extremity on one side of her body and required total assistance of one person with bathing. The MDS assessment also triggered ADL function as a concern for care planning, and ADLs was marked to address in Resident #45's care plan on the MDS. The quarterly MDS assessment dated 2/14/2023 indicated Resident #45 remained cognitively intact with limited movement to the upper and lower extremity on one side of the body and required total assistance of one person with	F 656	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-656 ¿483.21(b)(1)□ Comprehensive Resident Centered Care Plans Issue Cited: Develop/Implement Comprehensive Care Plan 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #45□s care plan was updated	

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F 656	Continued From page 39 bathing. In an interview with Assistant Director of Nursing (ADON) on 6/2/2023 at 11:13 a.m., she stated she and the MDS Nurse completed care plans for the residents, and care plans were updated quarterly or when there was a significant change. After reviewing Resident #45 's care plan she stated there was no focus area that included baths and showers on the care plan for Resident #45. She said based on the quarterly MDS assessment dated 2/1/2023, Resident #45's care plan needed to included total assistance of one person in bathing and could not explain why it was not included on the care plan. In an interview with Director of Nursing on 6/2/2023 at 2:19 p.m., she stated Resident #45 required assistance with bathing and showering and it should have been included in her care plan. She stated the full time MDS Nurse #2 had been out on family medical leave, and the ADON had been assisting with completing and updating care plans. 2. Resident #88 was admitted to the facility on 2/15/2023 for rehabilitation services following surgery. Resident #88 was discharged on 3/9/2023 from the facility back to the community. Resident #88's care plan initiated 2/16/2023 did not include a discharge plan. The admission Minimum Data Set (MDS) dated 2/22/2023 indicated Resident #88 was cognitively intact, and he expected to be discharged to the community. A social service note dated 2/22/2023 initiated an	F 656	on June 23, 2023, by the MDS nurse to reflect ADLs including bathing or shower preferences. Resident #88 was discharged from the facility on March 9, 2023. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility MDS nurse is currently on FMLA and has been replaced with a seasoned Carrolton MDS nurse. A 100% audit was completed by Carrollton Facility Management nurse consultants and facility administrative nurses on June 16, 2023, to ensure that all areas of care and treatment have been updated on the comprehensive care plan. Areas found to be deficient were corrected June 16- June 27, 2023. Carrolton General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, MDS nurses, clinical staff, and contractors), on June 7, 2023, to address Comprehensive Care Plans, and other issues identified from the May 30- June 2, 2023, DHHS	

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F 656	Continued From page 40 expected discharge for Resident #88 to the community in a month or less. In an interview with the Assistant Director of Nursing (ADON) on 6/2/2023 at 11:19 a.m., she stated Resident #88's goal for discharge to the community was discussed in morning meetings, and his care plan should had included a discharge goal to communicate the plan for discharge. She said she helped with MDS assessments and care plans with the MDS Nurse #2 on family medical leave and did not know why a discharge goal was not included in Resident #88's care plan. She further stated she was not sure if the social worker or the MDS nurse was responsible for entering the discharge goal on the care plan. In an interview with the Social Worker on 06/02/23 at 11:33 a.m., she stated she placed Resident #88 discharge plan in a note on the electric medical record and stated MDS nurse conducted the care plan for Resident #88. In an interview with the Director of Nursing on 6/2/2023 at 2:19 p.m., she explained the Social Worker, who was a new graduate in social services to the facility, conducted the initial discharge review and should had entered a discharge plan on the care plan for Resident #88.	F 656	Survey. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility nurse consultant or other CFM corporate staff will audit three (3) care plans a week for the next four (4) weeks, beginning June 19, 2023, based on the MDS assessment schedule. Audit records will be reviewed by the Quality Assurance/ Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		6/30/23

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F 657	Continued From page 41 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to: 1) conduct quarterly care plan meetings with cognitive residents and/or the resident representatives (Resident #45, Resident #42, and Resident #77) and 2) revise a resident's care plan post a fall with new fall prevention interventions (Resident #77) for 3 of 13 residents reviewed for care planning. Finding included: 1. a. Resident #45 was admitted to the facility on 3/9/2022, and diagnoses included Diabetes Mellitus and hemiparesis (partial paralysis	F 657	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an	

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F 657	Continued From page 42 restricted to one side of the body). The quarterly Minimum Data Set (MDS) assessment dated 2/14/2023 indicated Resident #45 was cognitively intact. A review of Resident #45's electronic medical record revealed documentation of the last care plan meeting was on 10/4/2022 that occurred by phone with Resident #45 and a family member. A review of Resident #45's care plan indicated on 5/16/2023 the resident care guide related to Resident #45's diet was revised, and a new focus area was created for allergies. Resident #45's care plan was further updated on 5/26/2023 to include restorative care for splint application assistance of the left hand and wrist. In an interview with Resident #45 on 5/30/2023 at 10:39 a.m., she stated the facility had not scheduled and conduct quarterly care plan meetings with her. b. Resident #42 was admitted to the facility on 12/19/2014, and diagnoses included stroke with hemiparesis (paralysis to one side of the body). The annual Minimum Data Set (MDS) assessment dated 4/26/2023 indicated Resident #42 was cognitively intact. A review of Resident #42's electronic medical record revealed documentation of the last care plan meeting was on 3/29/2022. A review of Resident #42's care plan indicated revision of all current goals occurred on 5/7/2023,	F 657	admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-657 ¿483.21(b)(2)(i)-(iii) □ Comprehensive Resident Centered Care Plans Issue Cited: Care Plan Timing and Revision 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility interdisciplinary team scheduled care plan meetings with residents #45 (June 20, 2023), #42 (June 21, 2023) and #77 (June 21, 2023) between June 2- 23, 2023. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility MDS nurse is currently on FMLA and has been replaced with a seasoned Carrolton MDS nurse. A 100% audit was completed June 16, 2023, by the MDS nurse to determine	

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F 657	Continued From page 43 and new focuses for advance directives, Diabetes Mellitus, coronary heart disease, hypothyroidism and gastroesophageal reflex disease were initiated on 5/15/2023. In an interview with Resident #42 on 5/30/2023 at 3:46 p.m., he stated the facility was not conducting quarterly care plan meetings with him. c. Resident #77 was admitted to the facility on 9/19/2022, and diagnoses included ischemic stroke. The quarterly Minimum Data Set (MDS) assessment dated 4/7/2023 indicated Resident #77 was severely cognitively impaired and was fully dependent on staff for all activities of daily living. A review of Resident #77's electronic medical record revealed documentation of the last care plan meeting was on 9/21/2022. A review of Resident #77's care plan indicated new focuses for diabetes mellitus, bed mobility, cognitive function, communication, tube feeding, falls, and swallowing difficulties, were implemented on multiple dates in November 2023, as well as new focuses of bed rails, hypertension, gastroesophageal reflux disease, stroke, resident needs, and pressure ulcers on multiple dates in April 2023. In an interview with the Social Worker on 5/31/2023 at 4:11 p.m. she stated she started employment with the facility in January 2023. She explained she scheduled and conducted resident	F 657	care plan needs for the next three (3) months. A calendar was created for the facility social worker to use for invitations. General in-services led by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing for all staff (including administrative staff, clinical staff, and contractors), on June 7, 2023, to address Care Plan Timing and Revision, and other issues identified from the May 30- June 2, 2023, DHHS Survey. The facility social worker was educated by a seasoned Carrolton social worker on June 13, 2023, regarding invitations to care plan meetings, who should attend the care plan meetings and the timeframes of care plans based on the MDS calendar. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility administrator will monitor the care plan schedule daily in the morning meetings to ensure they are scheduled and completed as per the calendar. This daily monitoring will begin on June 19, 2023, and continue for four (4) weeks. The facility nurse consultant or other CFM corporate staff will audit the care plan schedule weekly for the four (4) weeks and monthly for three (3) months to monitor compliance. Audit records will be reviewed by the Quality Assurance/ Performance	

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F 657	Continued From page 44 care plan meetings within 72 hours of admission to the facility and for residents with significant changes as needed. She said she had not been informed to schedule and conduct care plan meetings quarterly with the MDS assessments and had not scheduled quarterly care plan meetings for the residents. In an interview with MDS Nurse #1 on 5/31/2023 at 4:25 p.m., she stated resident care plan meetings coincided with the MDS assessments quarterly, and the Social Worker would know when quarterly MDS assessments were occurring when completing the Social Worker components of the MDS assessment. In an interview with the Administrator on 5/31/2023 at 4:28 p.m., he stated MDS Nurse #2 shared upcoming and significant change MDS assessments in the morning meetings, and the Social Worker was responsible for scheduling and conducting resident care plan meetings with other interdisciplinary team members. He explained since August 2022 there had been three different Social Workers employed at the facility and may have contributed to quarterly care plan meetings not conducted with cognitive residents and/or resident representatives. 2. Resident #77 was admitted to the facility on 9/19/2022. The quarterly Minimum Data Set (MDS) assessment dated 4/7/2023 indicated Resident #77 was severely cognitively impaired and was fully dependent on staff for all activities of daily	F 657	Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45 living. A review of incident reports revealed Resident #77 had a fall on 5/7/23 and 5/9/23. The incident report for the fall on 5/7/23 revealed that a fall mat was placed in the resident's room following the incident. The incident report for the fall on 5/9/23 revealed that the fall mat was in place at the time of Resident #77's fall. Resident #77 was observed resting in her room on 6/1/2023. A fall mat was in place on the right side of the resident's bed. A review of Resident #77's care plan revealed that her care plan had not been updated to include the use of a fall mat. An interview was conducted on 6/1/23 at 2:45 PM with Nurse #5, who stated she worked with Resident #77 often. She explained that new interventions following a fall were listed on the incident report. She added that the MDS staff completed a 24 hour report each day and that was how they knew to update a resident's care plan. On 6/1/23 at 3:04 PM an interview was conducted with MDS Nurse 1#, who stated that Resident #77's care plan should have been updated to include the use of a fall mat following its implementation on 5/7/23. She stated she was not sure why the care plan was not updated and explained it must have been an oversight.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		6/30/23

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	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 690	Continued From page 46 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to attach an indwelling urinary catheter tubing to a secure device to prevent tension and possible injury for 1	F 690	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to	

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F 690	Continued From page 47 of 1 resident reviewed for urinary catheter (Resident #61). Finding included: Resident #61 was admitted to the facility on 5/2/2020, and diagnoses included obstructive uropathy. Resident #61's care plan dated 9/21/2020 included a focus for an alteration in urinary elimination due to an indwelling catheter, and interventions included ensuring that the drainage tubing was secured with an anchoring device (leg strap) to prevent tension or accidental removal. Physician orders dated 3/16/2022 included an indwelling urinary catheter due to urinary retention related to obstructive and reflux uropathy and checking daily to ensure the anchoring device (leg strap) was in place. The annual Minimum Data Set (MDS) assessment dated 3/13/2023 indicated Resident #61 was severely cognitively impaired and had limited mobility to one upper and lower side of the body. The MDS assessment did not indicate the use of an indwelling catheter for urinary elimination. A review of May 2023 Treatment Administration Record (TAR) indicated Resident #61 had an indwelling urinary catheter, and nursing staff checked daily to ensure Resident #61's anchoring device (leg strap) was in place. On 6/1/2023 at 7:36 a.m., there was no anchoring device observed on Resident #61's right or left thigh to secure the indwelling urinary catheter	F 690	the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-690 ¿483.25 Quality of Care Issue Cited: Bowel/Bladder Incontinence, Catheter, UTI- No Leg Strap 1. Immediate action(s) taken for the resident(s) found to have been affected include: A stabilization device (leg strap) was applied to Resident□s #61□s indwelling urinary catheter to prevent kinking of the catheter and excessive tension on the catheter which can lead to urethral trauma and tears on June 1, 2023, during the DHHS recertification survey. 2. Identification of other residents having the potential to be affected was	

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F 690	Continued From page 48 tubing. The urinary catheter tubing was observed exiting from underneath the adult brief and laying across the upper right thigh area unsecured. On 6/1/2023 at 7:36 a.m. in an interview with Nurse Aide (NA) #1, she stated anchoring devices (leg straps) were used to prevent movement and pulling of the catheter. She explained Resident #61's anchoring device (leg strap) was not attached because Resident #61 would unstrap the anchoring device. Therefore, the anchoring device (leg strap) was not applied as ordered. She further stated at times Resident #61 would pull on the urinary catheter tubing. On 6/1/2023 at 7:55 a.m. in an interview with Nurse #1, she stated Resident #61 was to have an anchoring device (leg strap) to attach the urinary catheter tubing and was unsure why Resident #61's anchoring device was not attached for the urinary catheter tubing. At 7:57 am on 6/1/2023 when NA #1 informed Nurse #1 Resident #61 needed an anchoring device (leg strap), Nurse #1 stated she would get an anchoring device for Resident #61. On 6/1/2023 at 11:02 a.m., in an interview with Chief Clinical Officer, she stated an anchoring device (leg strap) should have been applied to Resident #61 with the urinary catheter tubing attached to secure the urinary catheter in place.	F 690	accomplished by: The administrative nursing team observed all residents with urinary catheters on June 1, 2023, and found no other residents without stabilization straps. The facility has determined that 100% of residents with indwelling urinary catheters have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The procedure for Indwelling Catheter Care was revised June 8, 2023, to include the use of stabilization devices for indwelling catheters. All direct care nursing staff, including nurses and certified nursing assistants (CNAs) were in-serviced regarding the facility procedure for Indwelling Catheter Care and the facility procedure for Catheter Insertion and Removal on June 12, 2023, through June 14, 2023, by the Director of Nursing (DON) and Carrolton Facility Management (CFM) corporate clinical staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON, RN Supervisor or designee will complete weekly audits on all residents with indwelling urinary catheters for four (4) consecutive weeks beginning June 19, 2023, monitoring compliance with the use of stabilization devices on residents with indwelling catheters.	

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F 690	Continued From page 49	F 690	Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow orders for the use of oxygen for 1 of 3 residents reviewed for oxygen use (Resident #74). The findings included: Resident #74 was admitted to the facility on 10/20/22 with diagnoses that included acute respiratory failure, pleural effusion, and chronic obstructive pulmonary disease. A review of the March 2023 active physician orders revealed an order for oxygen continuously at 2 liters via nasal cannula dated 3/12/23.	F 695	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an	6/30/23

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F 695	Continued From page 50 A quarterly Minimum Data Set (MDS) assessment dated 4/25/23 indicated Resident #74 was coded as receiving oxygen therapy. The MDS further revealed that Resident #74's cognition was moderately impaired. Resident #74's care plan dated 3/10/23 included a focus area for potential for altered respiratory status/difficulty breathing related to acute respiratory failure. The interventions included administering oxygen as ordered. On 5/30/23 at 11:52 AM, Resident #74 was observed sitting in bed and indicated she was dependent on oxygen via nasal cannula. The oxygen regulator on the concentrator was set at 3.0 liters per minute when viewed horizontally at eye level. During subsequent observations made on 5/31/23 at 2:47 PM and 6/1/23 at 11:36 AM Resident #74 was receiving oxygen via nasal cannula at 3.0 liters per minute when viewed horizontally at eye level. An observation was made with Nurse #1 of Resident #74's oxygen concentrator on 6/1/23 at 4:47 PM, followed by an interview. Nurse #1 confirmed the oxygen regulator on the concentrator was set at 3 liters when viewed horizontally at eye level. Nurse #1 checked Resident #74's order for oxygen and stated it should have been set to 2.0 liters per minute. Nurse #1 adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #1 stated that oxygen rates were checked throughout the day and should only be adjusted by nurses.	F 695	admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-695 ¿483.25(i)□ Respiratory/Tracheostomy Care and Suctioning Issue Cited: O2 at Wrong Liter Flow 1. Immediate action(s) taken for the resident(s) found to have been affected include: The oxygen liter flow for Resident # 74 was corrected to 2 liters as ordered on June 1, 2023, during the DHHS recertification survey. 2. Identification of other residents having the potential to be affected was accomplished by: The administrative nursing team observed all residents with oxygen on June 8, 2023, and June 12, 2023, and all residents now have the correct liter flow. The facility has determined that all (100%) residents identified with the use of oxygen have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All direct care nursing staff, including nurses were in-serviced regarding the	

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F 695	Continued From page 51 During an interview with the Chief Clinical Officer on 6/1/23 at 4:53 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.	F 695	facility procedure for Oxygen Administration Care on June 12, 2023, through June 14, 2023, by the Director of Nursing (DON) and Carrolton Facility Management (CFM) corporate clinical staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON, RN Supervisor or designee will complete weekly audits on all residents with oxygen for four (4) consecutive weeks beginning June 19, 2023, monitoring compliance with the ordered oxygen liter flow for all residents receiving oxygen. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		6/30/23

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F 725	Continued From page 52 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interviews and staff interviews, the facility failed to provide sufficient nurse staff to ensure 4 of 4 dependent residents received scheduled showers (Resident #45, Resident #42, Resident #14, and Resident #33). The findings included: This tag is cross-referenced to: F561 Based on observations, record review, resident interviews and staff interviews, the facility failed to honor residents' choice related to showers for 4 of 5 dependent residents reviewed for choices (Resident #45, Resident #42, Resident #14, and Resident #33).	F 725	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to	

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F 725	Continued From page 53 In an interview with Nurse Aide #1 on 6/2/2023 at 12:52 p.m., she stated she had been the only nurse aide assigned to a hall for months. She had informed the nursing staff and administration was aware scheduled showers were not being administered to the residents. She stated administrative staff helped pass meal trays at times on the halls but did not help with resident showers. In an interview with Director of Nursing on 6/2/2023 at 2:30 p.m., she stated the facility had asked the Corporate Office for agency contracted staff to help with the staffing concerns and were told "no". She said she had asked for bonus pay and extra staffing position on the evening shift, and the Corporate Office would not deviate from the strict payroll. She explained when bonus pay was approved for the weekend, it was so late on Friday evening they were unable to find staff to work. She stated new staff were not staying periods of time after employment. She said Administration staff were working on the halls as nursing aides to help with staffing needs, and shower schedules and staffing schedules were changed to help cover staffing needs and provide more help to conduct showers. She explained residents were not consistently receiving showers as scheduled, but showers were given when extra staff was available and nursing staff had been too busy to document the care provided.	F 725	refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-725 ¿483.35 (a)(1)(2) □ Sufficient Nursing Staff Issue Cited: Sufficient nursing staff to provide showers 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility implemented the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. " Changes were made to scheduling practices to maximize staff availability and efficiency. " The staffing coordinator was changed. " Additional facility staff were scheduled to ensure adequate staffing levels and to provide the necessary resident care. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All facility staffing practices and patterns were reviewed. An all-staff meeting (including	

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F 725	Continued From page 54	F 725		

administrative staff, clinical staff and contractors), was held on June 7, 2023, facilitated by Carrolton Facility Management (CFM) corporate staff, the facility Administrator and Director of Nursing to address facility staffing policies and procedures as well as survey findings from the May 30- June 2, 2023, DHHS Survey. All-staff meetings will be held monthly to provide updates to staff, as well as to receive staff feedback and input.

The Carrolton Facility Management Director of Human Resources held meetings with part-time staff members to discuss incentives to convert to full-time employment. Two (2) staff members have converted from part-time to full-time status.

The facility has actively been recruiting nursing assistants. Thirteen (13) new nursing staff members have been hired since the survey. All new staff members have been added to the schedule or scheduled for orientation. Recruitment efforts continue and additional candidates have been scheduled for interview.

Corporate staff has provided daily oversight of staffing and a Corporate Facility Nurse Consultant has provided facility visits five (5) days a week for three (3) weeks. Corporate Facility Nurse Consultant visits will continue at least weekly for at least three (3) months.

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F 725	Continued From page 55	F 725	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON) or designee will complete daily audits for four (4) consecutive weeks beginning June 21, 2023, to determine if residents preferences regarding showers are being honored. The DON or designee will also conduct random call light audits weekly for four (4) weeks, then three (3) times a week for a minimum of three (3) months beginning June 19, 2023. The Administrator and corporate consultant audit staffing sheets daily. Audits will continue daily for a minimum of three (3) months. Audit records will be reviewed by the Quality Assessment/Performance Improvement Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: June 30, 2023.	
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her	F 847		6/30/23

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F 847	Continued From page 56	F 847		

representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the

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F 847	Continued From page 57 resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident, resident representative and staff interviews, the facility failed to explain the arbitration agreement to the resident or resident representative prior to having them sign the agreement and to ensure they explicitly informed the resident/representative that signing the agreement was not required as a condition of admission. This occurred for 2 of 3 residents (Resident #9 and Resident #45) reviewed for arbitration. Findings included: Review of the facility's "Arbitration Agreement" which was not dated, revealed documentation that the resident and/or the resident's representative acknowledged they had read and understood the agreement and that the agreement had been adequately explained to them in plain language. a. Resident #9 was admitted to the facility on 3/24/23. Review of Resident #9's arbitration agreement revealed the resident's representative had signed the agreement on 3/24/23. Resident #9's admission Minimum Data Set (MDS) assessment dated 3/31/23 revealed she was cognitively intact.	F 847	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F-847 ¿483.70(n)(2)(i)(ii)(3)-(5) Binding Arbitration Agreements Issue Cited: Arbitration agreements not explained	

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	345325	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 847	Continued From page 58 An interview was conducted with Resident #9 on 6/2/23 at 2:00 PM who stated her responsible party completed her admission paperwork. A telephone interview occurred with Resident #9's representative on 6/2/23 at 2:25 PM. The resident representative stated the arbitration agreement had been explained to her and she understood the concept. She added she believed signing the agreement was a condition of admission. b. Resident #45 was admitted to the facility on 3/9/22. Review of Resident #45's arbitration agreement revealed the resident had signed the agreement on 3/9/22. Resident #45's most recent Minimum Data Set (MDS) assessment dated 5/17/23, a quarterly assessment revealed she was cognitively intact. An interview was conducted with Resident #45 on 6/2/23 at 2:17 PM. She stated she did not recall signing the agreement and reported there were so many papers to sign during the admission process she did not understand them all. An interview was conducted with the Admissions Coordinator on 6/2/23 at 2:40 PM. She stated she reads each section of the arbitration agreement and asked residents or their representatives to sign during the admissions process. The Admissions Coordinator stated she asked the resident or their representative if they had any questions. When asked about explaining the agreement was not a condition of admission the Admissions Coordinator replied it was at the top of the form and she went over the	F 847	1. Immediate action(s) taken for the resident(s) found to have been affected include: Arbitration agreements for Resident #9 and Resident #45 were reviewed. The resident and/or legal representative was notified of the facility□s arbitration policy and given the opportunity to cancel the agreement. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents admitted since the hiring of the current Admission□s Coordinator (July 2021) have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility Administrator in-serviced the Admission Coordinator on June 19, 2023, regarding Binding Arbitration Agreements. This education included: " Carrolton Policy 17.13 Binding Arbitration Agreements, emphasizing 2 (d): Explicitly state that neither the resident nor his or her representative us required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. Letters were sent to every resident/legal representative, including Resident #9 and Resident # 45, on June 20, 2023, to educate arbitration agreements including that arbitration agreements are not a	

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F 847	Continued From page 59 information. She reported she did not explicitly explain the form was not a requirement of admission. The Administrator was interviewed on 6/2/23 at 3:26 PM. The Administrator stated he expected the arbitration agreement to be explained to the resident and/or the resident representative in a language they can understand. The Administrator stated prior to the Admissions Coordinator's hire he was reviewing the arbitration agreement with residents. He stated that most residents refused to sign the agreement. The Administrator continued and stated he believed the Admissions Coordinator was not explaining that signing the agreement was not a requirement for admission in a way residents and their representatives understood.	F 847	condition of admission. Resident letters were distributed directly to all residents in the facility and representative letters were mailed on June 20, 2023. On June 23, 2023, a follow up memo was sent to all residents and legal representatives/responsible party, providing instructions for rescinding binding arbitration agreements that may have been completed without the proper education. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility Administrator will review all arbitration agreements signed in June and for the next three (3) months and will make follow up calls to residents/legal representatives to ensure that they understand what they have agreed to, including that the arbitration agreement is not a condition of admission. The administrator will bring information regarding signed arbitration agreements to the Quality Assurance/Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: June 30, 2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		6/30/23

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F 867	Continued From page 60 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 61 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 62 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the complaint survey of 11/9/22. The deficiency is	F 867	Carrolton of Dunn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain	

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F 867	Continued From page 63 in the area of respiratory care (F695). The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F695: Based on observations, record reviews, and staff interviews, the facility failed to follow orders for the use of oxygen for 1 of 3 residents reviewed for oxygen use (Resident #74). During the complaint survey of 11/9/22 the facility was cited at F695 for failing to provide tracheostomy care for 1 of 2 residents reviewed for tracheostomy care. An interview with the Administrator was conducted on 6/2/23 at 3:40 PM. The Administrator stated the facility had some turnover in staff which contributed to the repeat citation.	F 867	compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Tag Cited: F 867 ¿ 483.75(c)(d)¿(g)(2)(i)(ii) QAPI/QAA Improvement Activities Issue Cited: # Recited deficiencies (F 695) 1. Immediate action(s) taken for the resident(s) found to have been affected include: Carrolton Facility Management team members held a series of meetings with the facility administrative team to discuss survey findings and develop the respective plans of correction, including the plan of correction for F 695, Respiratory Care. These meetings included but were not limited to: " June 5, 2023 " June 7, 2023 " June 12, 2023	

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F 867	Continued From page 64	F 867		

" June 19, 2023
" June 20, 2023
" June 28, 2021

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that all residents have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
Detailed plans of correction, along with monitoring tools have been developed and executed to address all survey findings including the repeat deficiency cited (F 695 Respiratory Care).

The facility administrator met with the facility administrative team to give updates regarding the plan of correction on June 19, 2023.

All areas of deficient practice have been added to the facilities QAPI plan and will be reviewed in the QAPI meeting scheduled for June 28, 2023.

Facility administrative staff will be in-serviced by the facility Nurse Consultant or designee on June 28, 2023, during the QAPI meeting. This in-service will cover implementation, monitoring and revisions of action plans and processes to achieve and sustain compliance.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The facility Administrator will ensure that

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F 867	Continued From page 65	F 867	audit schedules are followed, and findings are presented to the QAPI team monthly and as needed. Areas of concern will immediately be addressed by the Administrator and QAPI team including staff re-training and plan revisions. Carrolton Facility Management Corporate staff members will oversee facility QAPI meetings and survey corrective action monthly until consistent substantial compliance has been achieved. Corrective action completion date: June 30, 2023.	