STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 03/13/2024

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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E 000	Initial Comments A unannounced complaint investigation and recertification survey were conducted on 3/10/24 through 3/13/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6NQQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/10/24 through 03/13/24. Event ID# 6NQQ11. The following intakes were investigated NC00204468, NC00204456, NC00206515, NC00207847, NC00209274, NC00212491, NC00213119, NC00214449. 11 of the 23 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		4/12/24

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

Electronically Signed | 04/07/2024

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff communicated to a resident in a respectful and dignified manner for 1 of 2 resident reviewed for dignity (Resident #93). The reasonable person concept was applied to this deficiency as individuals have the expectation to be addressed by staff using language and tone that portrays respect and dignity. Findings included: Resident #93 was admitted to the facility on 4/4/2023, and her diagnoses included intellectual disabilities.	F 550	Immediate action(s) taken for the resident(s) found to have been affected include: 1. Nursing Assistant # 10 was terminated upon substantiation of the allegation received on 1/22/24. 2. Resident # 93 was assessed by the facility nurses and social worker for psychosocial harm. There was no evidence of harm or incident recall from the resident. Identification of other residents having the potential to be affected was accomplished by:	

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F 550	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 1/15/2024 indicated Resident #93 was cognitively intact and exhibited no behaviors in the seven-day look back period. The MDS assessment also indicated Resident #93 was incontinent of urine and stool and required assistance with activities of daily living including toileting and mobility in bed and transfers. A psychiatric physician note dated 1/18/2024 reported Resident #93 had an intellectual disability. The psychiatric physician recorded Resident #93's depression was stable with current medication regimen, and the staff had reported no behaviors recently. A review of the daily nursing assignment sheet dated 1/22/2024 recorded Nurse Aide (NA) #10 worked 11:00 p.m. to 7:00 a.m. shift and was assigned to Resident #93. The daily nursing assignment sheet dated 1/23/2024 recorded NA #5 worked 7:00 a.m. to 3: 00 p.m. and her assignment consisted of residents at the far end of the hall from Resident #93's room. A review of an undated written statement from NA #5 reported as NA #5 was walking by Resident #93's room, she heard NA #10 saying to Resident #93, "Didn't I tell you about this damn sh**. You don't want to go back to the hospital". A written statement dated 1/24/2024 10:20 a.m. recorded an interview with Resident #93 by the Social Worker. The written statement reported when Resident #93 was asked to tell the Social Worker if anything happened yesterday (1/23/2024) with anything, the Resident could not think of anything. Resident #93 was asked again if she was sure nothing happened, and Resident	F 550	The facility has determined that all residents have the potential to be affected. All residents residing on the hall were interviewed and no other residents were found to be negatively impacted. Actions taken/systems put into place to reduce the risk of future occurrence include: 1. Mandatory staff in-services were conducted by a Senior DON from within Carrolton who is also a Medication Aide and CNA Instructor. Inservices were held on Wednesday, April 10, 2024 regarding the importance of treating patients with dignity and respect and included management of patients who exhibit aggressive behaviors. All staff in all departments were required to attend. No employee will be allowed to work until the inservice education is completed. The in-service included the following topics: a. Resident Rights/Exercise of Rights, Maintaining Dignity, and Resident Communication b. Review of Residents Rights and Facility Expectations of Staff Behavior c. Management of residents who exhibit Aggressive Behavior d. Review of Carrolton Policy #2.1 Resident Rights e. Review of Carrolton Policy # 2.4 Promoting-Maintaining Resident Dignity f. Resident Communication 2. Implemented Daily Administrative	

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F 550	Continued From page 3 #93 replied, "Everything was fine." In an interview with NA #5 on 3/12/2024 at 7:02 a.m., she stated when she arrived to work around 6:30 a.m. and while walking pass Resident #93's closed door, she overheard NA #10 fussing and cursing at Resident #93. She stated NA #10 said, "Didn't I tell you about that damn shit. You going right back to the hospital" to Resident #93. NA #5 reported she did not hear Resident #93 say anything in response and did not enter the room to determine what was occurring behind the closed door. She said she did not speak to NA #10 about the incident or inform the assigned nurse to Resident #93. She stated she informed the Director of Nursing and the Administrator after they reported to work. In a phone interview with NA #10 on 3/12/2024 at 12:10 p.m., she recalled working 1/22/2024 11:00 p.m. to 7:00 a.m. and receiving a call from the Administrator late in the evening on 1/23/2024 questioning her about cursing at Resident #93. NA #10 stated she did not curse or raise her voice at Resident #93 the morning of 1/23/2024, and she was placed on suspension while the facility investigated the incident. She stated she received a call after one to two weeks and was informed she was not allowed to return to work. During the survey, Resident #93 was hospitalized and was unable to conduct an interview with Resident #93 due to her medical condition. In an interview with the Social Worker on 3/13/2024 at 7:50 a.m., she described Resident #93's mental status like that of an elementary child. She recalled obtaining a statement from Resident #93 on 1/23/2024 and stated based on	F 550	Rounds to determine that residents' needs are being met and that concerns are being addressed timely. All department heads and administrative staff are assigned specific sections of the building to make rounds, interview residents, observe behaviors and facility cleanliness. Results will be taken to morning stand up meeting and afternoon stand down meeting. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. The Director of Nursing (DON), Social Worker, or designee, will conduct random interviews and staff observations to determine that staff members are treating residents with dignity and respect. 10% of the residents will be observed via daily / weekly rounds to ensure staff are promoting and maintaining resident dignity. Observations and interviews will continue for 8 weeks following facility compliance. 2. Observation reports will be reviewed by the Carrolton Facility Management (CFM) Compliance Team monthly until such time consistent and substantial compliance has been achieved as determined by CFM. 3. The Administrator, or designee, will review the results of observation reports and any corrective measures taken with the Resident/Family Group Council during their monthly meetings for comments and	

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F 550	Continued From page 4	F 550		

her opinion, she could not say it was true or not because Resident #93 was the type of person who would not want to get anyone in trouble. She reported not observing any change in Resident #93's behaviors after the incident.

In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:52 a.m., she stated on 1/23/2024 she overheard NA #5 discussing with other nurse aides how NA #10 was rude, cursing and raising her voice with Resident #93. She explained she went to inform the Administrator, who was out of the facility at the time, because she was new to the role as DON (1/8/2024) and did not know the process for reporting verbal abuse to the state agency. She stated on 1/23/2024 when she saw Resident #93 as she was leaving the facility she questioned Resident #93 if any yelling or cussing occurred the morning of 1/23/2024, and Resident #93 said, "Oh Yah". She explained she did not mention any staff members names to Resident #93 because she did not know how to proceed with the investigation. She stated Resident #93 was informed to let the DON know if staff cursed and raised their voices at her and reassured Resident #93 the staff were there to help her with her needs.

In an interview with the Administrator on 3/13/2024 at 5:07 p.m., she explained upon learning NA #5 overheard NA #10 cursing at Resident #93 on 1/23/2024, NA #10 was placed on suspension and stated she was not aware of any prior disciplinary issues for NA #10. She stated Resident #93 was easy to redirect and was known to smear feces (stool) everywhere at times, and when NA #10 was questioned, she stated she was in Resident #93's room providing

suggestions.

4. Routine monitoring regarding promoting and maintaining resident dignity has been added to the weekly QAPI meeting and will be reviewed weekly until such time as compliance is achieved.

Corrective action completion date: 4/12/24

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F 550	Continued From page 5 incontinent care. The Administrator said NA #10 reported she did not curse at Resident #93 and refused to write a statement of what happened in Resident #93's room on the morning of 1/23/2024. She explained since there was a witness that heard NA #10 curse and raise her voice at Resident #93, the incident was substantiated, and NA #10 was terminated.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		4/12/24

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F 584	Continued From page 6 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure bathrooms (Room #57, #60, #61, #65, #67/69, #70) on the locked unit were free of fecal matter or black/brown matter on various surfaces for 6 of 10 bathrooms reviewed for clean and homelike living environment. The findings included: On 3/10/24, a Sunday, at 1:02 PM, an observation of the bathroom between rooms 67 and 69, rooms on the locked unit, revealed the inner and outer parts of the toilet had multiple areas of dried black matter. Room 67 was occupied by 2 residents, and room 69 was occupied by 1 resident. The residents of these rooms were able to use the bathroom on their own or with supervision assistance by staff. On 3/10/24 at 1:03 PM, an observation of the bathroom in room 70, a room on the locked unit, revealed brown matter on multiple areas of the toilet. Room 70 was occupied by 1 resident. The resident of this room was able to use the	F 584	Immediate action(s) taken for the resident(s) found to have been affected include: Residents with room numbers 57, 60, 61, 65, 67, 69, 70 had bathrooms cleaned immediately on 3/10/24 and again on 3/11/24. Those resident rooms were deep cleaned on 3/11/24. 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. Actions taken/systems put into place to reduce the risk of future occurrence include: All housekeeping staff was inserviced on 4/2/24 and 4/3/24 regarding proper cleaning techniques every time a toilet is cleaned. All nursing staff will be inserviced on 4/10/24 regarding nursing responsibility to	

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F 584	Continued From page 7 bathroom on her own. On 3/10/24 at 1:04 PM, an observation of the bathroom in room 65 revealed multiple areas of a dried brown matter along the inner rim of the toilet. Room 65 was occupied by 2 residents. The residents were able to use the bathroom on their own or with supervision assistance by staff. During a continuous observation and interview with the Environmental Services Manager (ESM) on 3/10/24 from 1:05 PM until 1:16 PM, she revealed that every resident room and bathroom were cleaned daily and deep cleaned monthly. Deep cleaning consisted of moving furniture to clean behind and below surfaces, clean the floors and the walls of the bathrooms, and in addition to mopping and sweeping, the floor was also polished. She stated there should have been 4 housekeepers scheduled each day for the whole facility, but on 3/9/24 and 3/10/24 only 2 housekeepers were in the building. An observation of room 61, on the locked unit, revealed multiple areas of brown matter on the inside of the toilet bowl and on the outer rim. ESM confirmed the observation and identified the brown matter as feces. Observation of room 57on the locked unit, revealed a dried, light brown matter on the toilet cover that the ESM was able to wipe off. The ESM stated she would have a housekeeper clean the locked unit after lunch meal, and it should take them about 2 hours to clean. On 3/11/24 at 8:07 AM, an observation was made in the bathroom between rooms 67 and 69 and brown matter was smeared all over the toilet paper roll sitting on the handlebar next to toilet.	F 584	ensure that patient rooms and bathrooms are clean and safe at all times. All staff will be trained on maintaining clean and safe bathrooms as a part of new employee orientation. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Housekeeping manager will audit all restrooms throughout the facility 2x daily to ensure proper cleaning and follow up has been done utilizing a housekeeping checklist / audit form. 2. Weekend staffing will be verified every weekend, and manager will address any short staffing to ensure that sufficient staff members are present to maintain a safe, clean, homelike environment. 3. Results of all audits will be presented and managed through the QAPI committee for a period of 4 weeks to ensure system change has occurred. Corrective action completion date: 4/12/24	

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F 584	Continued From page 8 On 3/11/24 at 8:10 AM, an observation was made in the bathroom of room 60. Brown matter was all over the commode cover, on the toilet seat, and on the floor. On 3/11/24 at 10:09 AM, an observation was made of the bathroom in room 60. The brown matter on the toilet and commode was cleaned slightly, but a brown residue remained on the toilet seat and inside the toilet bowl. An interview was conducted with the Administrator on 3/13/24 at 8:11 AM. She revealed the locked unit should be cleaned daily and as needed. The Administrator indicated she had not heard of any complaints about resident bathrooms. She further stated Housekeeping was short staffed often and cleaned the locked unit at some point on the same day. She stated that fecal matter on the toilets would need to be cleaned as soon as possible.	F 584		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the 14-day required timeframe for 3 of 41 residents reviewed for quarterly Minimum Data Set (MDS) assessments (Resident #29, Resident #16, and Resident #75).	F 638	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility will ensure Residents #2, #16 #75 Quarterly MDS assessments will be completed timely as scheduled.	4/12/24

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F 638	Continued From page 9 Findings included: 1. Resident #29 was admitted to the facility on 1/13/2014. Review of the quarterly Minimum Data Set (MDS) dated 8/23/23 showed the assessment was signed as completed on 9/11/23. An interview was conducted with the MDS Nurse on 3/13/24 at 8:25 A.M. The MDS nurse indicated she was aware of the timeline requirements for completion of the MDS assessments and unsure why Resident #29's quarterly assessment was completed late. An interview was conducted with the Administrator on 3/13/24 at 1:01 P.M. The Administrator stated she had identified late MDS assessments during a spot check and worked to get them caught up. She stated she was aware of the required completion date had been missed and stated the deadline shouldn't have been missed. 2. Resident #16 was admitted to the facility on 7/27/2018. Review of the quarterly Minimum Data Set (MDS) dated 12/20/23 showed the assessment was signed as completed on 1/8/24. An interview was conducted with the MDS Nurse on 3/13/24 at 8:25 A.M. The MDS nurse indicated she was aware of the timeline requirements for completion of the MDS assessments and unsure why Resident #16's quarterly assessment was	F 638	A second MDS nurse has been hired and will begin work May 3, 2024. 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: Corporate compliance nurse educated the NHA, DON, and MDS Nurse on April 5 about the MDS schedules and requirement for timely completion and submission. Corporate compliance team completed a 100% facility audit to determine resident quarterly MDS assessments due dates on 4/1/24. Audit findings and education on assessment frequency and timeliness was provided to the MDS Nurses on 4/3/24 per Assessment Frequency and Timeliness Policy 5.3. Daily monitoring has occurred since April 1, 2024. All assessments are compliant. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Administrator / DON will monitor assessments in progress on a daily basis at morning meeting to ensure all assessments are submitted timely. Monitoring will occur at the facility daily for	

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F 638	Continued From page 10 completed late. An interview was conducted with the Administrator on 3/13/24 at 1:01 P.M. The Administrator stated she had identified late MDS assessments during a spot check and worked to get them caught up. She stated she was aware of the required completion date had been missed and stated the deadline shouldn't have been missed. 3. Resident #75 was admitted into the facility on 1/6/23 with diagnoses of dementia, diabetes, and hypertension. A review of Resident #75's medical record revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of 8/14/23 was completed on 8/29/23. The MDS Nurse was interviewed on 3/13/24 at 8:25 AM. She stated that she had 14 days from the ARD to complete quarterly assessments. The MDS Nurse explained she should have completed the quarterly assessment for Resident #75 sooner and could not provide a reason for why it was late. An interview was conducted with the Administrator on 3/13/24 at 9:38 AM. She revealed that MDS assessments should be completed within 14 days of the ARD date.	F 638	four weeks. Once compliance is achieved for four weeks, the Administrator/DON will audit for timely completion of quarterly MDS assessments weekly for 4 weeks and then monthly for 2 months or until QAPI teams deems compliance. Corporate compliance team will audit the report 3 times per week to ensure system correction is on track and deemed to be working for 4 weeks; 2 times per week for 2 weeks, and 1 time per week for four more weeks. Corrective action completion date: 4/12/24	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		4/12/24

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

(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 686	Continued From page 11 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and interviews with Wound Care Physician Assistant (PA), the facility failed to (1) perform wound care to a pressure ulcer per physician's order (Resident #19), (2) set the alternating pressure air mattress at the correct setting based on the resident's weight (Resident #104), and (3) change the treatment for a pressure ulcer when ordered by the Wound Care PA (Resident #77) for 3 of 4 residents reviewed for pressure ulcers. The findings included: 1. Resident #19 was admitted to the facility on 10/27/2023, and diagnoses included dementia and right hip fracture. Resident #19's care plan dated 1/14/2024 included a focus for a right heel suspected deep tissue injury (SDTI). Interventions included administration of treatments as ordered by the physician and monitor effectiveness of treatments. The quarterly Minimum Data Set (MDS) assessment dated 2/12/2024 indicated Resident	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 3/12/24, an order was obtained to change the dressing to the resident # 19 right heel. Resident #19 dressing to the right heel was changed on 3/12/24. On 3/13/24, the air mattress setting was adjusted to the 150lb setting which is the appropriate setting for resident #104. On 3/6/24, an order for a change in wound care for Dakin's 0.5% wet to dry dressing was missed on resident #77. The error was realized on 3/13/24. The Wound Care PA changed the order back to the previous order of calcium alginate with silver on 3/13/24 for resident #77. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with wounds and air mattresses have the potential to be affected. A skin audit on all residents was completed on 4/6/24-4/824.	

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F 686	Continued From page 12 #19 was moderately cognitively impaired and was receiving treatments for a pressure ulcer. Wound Care PA notes reported an odorless slough adherence to the right heel pressure ulcer, tenderness and mild redness to the skin around the wound on 2/21/2024. Visible necrotic tissue was debrided, and Resident #19 was stated on Doxycycline, an antibiotic, for seven days. On 3/6/2024, the Wound Care PA documented improvement of Resident #19's right heel pressure ulcer measuring 1.05 x 1.5 x 0.7 x 0.3 centimeters with 90% pink granulated tissue and 10% yellow tissue and moderate amounts of serosanguineous drainage. Physician orders dated 2/29/2024 included an order to cleanse the right heel with wound cleaner, to apply collagen particles before applying calcium silver alginate and a foam heel dressing and to secure the dressing with kerlix (a wrap to hold primary and secondary dressings in place) every other day for wound healing. A review of the March 2024 Treatment Administration Record (TAR) for Resident #19 indicated Nurse #3 recorded providing treatment of the right heel pressure ulcer on 3/11/2024. During observation of wound care to Resident #19's right heel pressure ulcer on 3/12/2024 at 10:05 a.m., the old foam dressing to the right heel was observed dated 3/9/2024 with NA #6 initials. On 3/12/2024 at 10:12 a.m. in an interview with the Director of Nursing (the nurse who provided Resident #19's wound care on 3/12/202), she stated Nurse #3 had documented on 3/11/2024 changing the pressure ulcer dressing to the right	F 686	A wound care audit on all residents with wounds to ensure all orders are implemented was completed on 4/9/24 and 4/10/24. An air mattress audit to check for proper settings was completed on 4/9/24 and 4/10/24 for 100% of the residents with air mattresses in use. One resident was noted to have redness to bilateral heels. An order was obtained and implemented to offload heals and apply skin prep daily. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All air mattress settings were verified based on the residents' weights. Current weights for all residents with an air mattress were obtained and setting adjusted accordingly. Orders to check the air mattress settings daily were entered on the MAR of each resident with an air mattress. The DON educated all licensed nurses to include the treatment nurse on documentation requirements, air mattress management, and wound care orders implementation on 4/9/24-4/10/24. The education included the following: documentation requirements; air mattress management; wound care orders management. CNAs were educated on preventative skin care on 4/11/24. All new nursing staff including licensed nurses and nursing assistants will be trained on treatment to prevent pressure	

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F 686	Continued From page 13 heel on Resident #19's TAR and stated obviously based on the date and NA #6 initials (who was a NA II that had been trained to help with stage I and Stage II pressure ulcer dressings) on the right heel dressing it was not changed. The Director of Nursing explained due to the absence of the Wound Nurse, she had informed Nurse #3 on 3/11/2024 she was responsible for Resident #19's wound care, and Nurse #3 assured her she had performed Resident #19's wound care. Attempts to interview Nurse #3 were unsuccessful. On 3/13/2024 at 8:30 a.m. in an interview with the Wound Care Nurse and the Wound Care PA, they stated Resident #19's right heel pressure ulcer was treated with antibiotics in February due to increased pain and inflammation to the area. They stated Resident #19's right heel pressure ulcer had improved and was slowing decreasing in size. They stated in the absence of the wound nurse, the nursing staff were responsible for changing Resident #19's right heel pressure ulcer dressing every other day as ordered. 2. Resident #104 was admitted to the facility on 1/15/24 with diagnoses that included a stage 3 pressure ulcer of other site, diabetes, and hypertension. Review of the admission Minimum Data Set (MDS) dated 1/22/24 assessed Resident #104 as moderately cognitively impaired and required supervision or touching assistance with rolling left to right in bed. The MDS indicated a stage 3 pressure ulcer was present on admission and a pressure reducing device was used for the bed.	F 686	ulcers as a part of new employee orientation. Wound Care Order Management and air mattress management will be included in new employee orientation for all licensed nurses. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON or designee will audit 5 TARs for accurate documentation weekly for 4 weeks, then monthly for 2 months to ensure the documentation is accurate. The DON or designee will audit all air mattresses in use for appropriate settings weekly for 4 weeks and then monthly for 2 months to ensure proper air mattress management. The DON or designee will monitor all wound care recommendations and wound care orders to ensure accurate implementation weekly for 4 weeks and then monthly for 2 months. The DON will present the audit findings to the QAPI team weekly for 4 weeks or until deemed compliant. Corrective action completion date: 4/12/24	

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The care plan revised on 1/24/24 identified Resident #104 had a stage 3 pressure ulcer to her sacrum on admission. Interventions included: administer treatments as ordered and monitor for effectiveness, educate the resident/family/caregivers as to causes of skin breakdown, and follow facility policies/protocols for the prevention/treatment of skin breakdown.

Review of the documented weights for Resident #104 revealed on 3/4/24 the resident weighed 140.6 pounds (lbs.).

Observations on 3/10/24 at 11:56 AM and 3/12/24 at 8:18 AM revealed Resident #104 was in bed with an alternating pressure air mattress in place that was functioning. The air mattress settings were locked, and the weight set at 350 lbs. During both observations, Resident #104 complained that the air mattress was lumpy and caused pain to the sacral pressure ulcer site.

The Wound Care Nurse was interviewed on 3/13/24 at 8:38 AM. She revealed that Resident #104's air mattress setting was supposed to be at 120 lbs. During her rounds, the Wound Care Nurse indicated that she would double check the air mattress settings for all residents with wounds. She stated Resident #104 never complained that the air mattress caused her pain in the sacral area.

During an interview with the Wound Care Physician Assistant on 3/13/24 at 8:45 AM, she revealed that Resident #104's air mattress should have been set at the appropriate setting. During rounds, she and the Wound Care Nurse would correct the settings if not accurate.

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An observation and interview were conducted on 3/13/24 at 9:00 AM with Nurse #1.
Nurse #1 observed Resident #104 in bed with the alternating pressure air mattress functioning and the settings locked and the weight at 350 lbs. Nurse #1 stated Resident #104 did not weigh 350 lbs. and that maintenance usually set up the air mattresses in resident rooms. Nurse #1 then adjusted the weight setting to 150 lbs., which was closest to Resident #104's weight value.

An interview was conducted with the Maintenance Director on 3/13/24 at 9:10 AM. He stated the air mattresses were calibrated by the resident's weight. He indicated that he did not adjust the settings on the air mattresses, he only installed them when needed. The Maintenance Director revealed the Wound Care Nurse adjusted the correct settings.

The Director of Nursing (DON) was interviewed on 3/13/24 at 9:41 AM. She revealed according to the manufacturer, the resident's weight determines the setting. The Wound Care Nurse was responsible for setting the weight on Resident #104's air mattress. The DON indicated that the Wound Care Nurse just came back to the facility after being away for 3-4 days. She stated that she was not aware of Resident #104's complaint related to the firmness of the air mattress. The DON revealed that she did not know why Resident #104's air mattress was set to 350 lbs. She stated she had discussed with the Maintenance Director last week about the air mattress control settings and witnessed him turn the weight all the up in a resident's room. She notified him that was incorrect. The Maintenance Director told her that was what he was told to do.

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The air mattress was supposed to pressure reducing. The DON stated that if it was on the wrong setting, the pressure ulcer could worsen or a new pressure ulcer could develop on the bony prominence.

During an interview with the Administrator on 3/13/24 at 9:58 AM, she revealed that maintenance puts the air mattresses in the rooms. The Wound Care Nurse researched the resident's weight and adjusted the settings for the air mattress. The Administrator stated she was not sure why Resident #104's air mattress was set to 350 lbs. The Wound Care Nurse checked the air mattress settings when providing wound care. She indicated that she was not aware Resident #104 complained the air mattress was too lumpy and caused her pain.

3. Resident #77 was admitted to the facility on 8/19/22 with diagnoses including history of prostate cancer, Chronic Obstructive Pulmonary Disorder (COPD), and a sacral pressure sore.

Resident #77 Minimum Data Set dated 2/9/24 revealed Resident #77 had short- and long-term memory and severely impaired decision making. Resident #77 was totally dependent on staff for all Activities of Daily Living. Resident #77 was at risk of pressure ulcers and had 1 unstageable pressure ulcer which was present on admission.

Resident #77's care plan updated 3/3/24 revealed he had a Stage 4 pressure ulcer on his sacrum with osteomyelitis. The treatment listed on the care plan was Silver Alginate and a foam dressing. Interventions included to administer treatments as ordered and monitor for effectiveness.

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Record review of Resident #77's physician's orders revealed a wound treatment order dated 1/21/24 to clean the unstageable pressure ulcer with normal saline/wound cleanser. Apply calcium silver alginate and cover with a foam dressing every day shift for wound healing.

Record review of Resident #77's wound consultant Progress Notes Report dated 3/6/24 revealed the treatment order was "Change to Dakin's 0.5% wet to moist gauze covered with super absorbent dressing - change daily."

An interview was conducted on 3/13/24 at 8:33 AM with the Wound Care Nurse and the Wound Care Physician Assistant. The Wound Care Nurse stated when the Wound Care Physician Assistant changed the treatment orders, the Wound Care Nurse usually wrote the wound care order change. If the Wound Care Nurse was not available, the nurse on the hall had the responsibility to change any wound care order from a provider in her absence.

Observation on 3/13/24 at 9:20 AM of Resident #77's wound dressing change by the Wound Care Nurse. Resident #77's wound bed was beefy red with a small amount of slough in the center. Resident #77's wound had copious amounts of drainage. There was no odor. The Wound Care Physician Assistant measured the wound in centimeters 6.6 x3.8 tunneling was 15cm at 3 o'clock, 7cm at 12 o'clock and 0.9 cm at 9 o'clock. During the interview the wound was scraped by the Wound Care Physician Assistant, who described removing the slough to encourage tissue growth. The wound was dressed in Calcium Alginate and a foam silicone dressing.

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In an interview with the Wound Care Physician Assistant on 3/13/24 at 9:30 AM, she changed the treatment order on 3/6/24 to Dakin's 0.5% wet to moist gauze covered with a super absorbent dressing the be changed daily. However, because the wound was draining and had not progressed, she would change the order back to calcium silver alginate and with a foam dressing. The Wound Care Nurse indicated that the staff had not changed the order from the wound visit on 3/6/24 while the Wound Care Nurse was on leave.

Review of the Treatment Administration Record for March 2024 revealed Resident #77 received the calcium silver alginate and foam dressing treatment every day shift from 3/6/24 through 3/11/24.

Record review revealed that on 3/6/24 that Nurse #5 was the assigned nurse and responsible for the dressing change.
In an interview 3/13/24 at 11:08 AM with Nurse #5 indicated that she changed the dressing order on 3/6/24 but did not recall who worked with the Wound Care Physician Assistant that day. She did not know how the wound care orders were communicated to the facility from the Wound Care Physician Assistant. She stated that if she made rounds with the Wound Care Physician Assistant, she would have known there was a change. She stated that she did not know who was responsible for putting the wound care orders into the medical record system, that the Wound Care Nurse always changed those.

In an interview on 3/13/24 at 11:15 AM, the Wound Care Physician Assistant indicated on 3/6/24, NA #6 made rounds with her. She said

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F 686	Continued From page 19 that the wound care notes were sent to the facility. In an interview with Nurse #6 on 3/13/24 at 11:47 am, she stated she was also the unit manager. She said she was responsible for confirming the physician orders and the Wound Care Nurse updated the wound care orders. The Wound Care Physician Assistant sent the order change by email to the Director of Nurses (DON). The DON would update the orders or would delegate the order updates to Nurse #6 or the floor nurse. Nurse #6 indicated that on 3/6/24, the Wound Care Nurse was not on duty, and she was not aware of any change to any wound treatments. Interview on 3/13/14 at 1:48PM with the DON revealed that the wound care nurse was responsible for changing wound orders made by the Wound Care Physician Assistant. She indicated she did not know how the wound care nurse obtained the order changes. She stated she was provided the wound care consultant treatment notes via email for all residents treated. Review of the reports with the DON revealed that the documents included the order changes in bold print. When asked if the bold printed text was considered an order, the DON said "Yes." She stated she should have had someone change the orders.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/12/24

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F 689	Continued From page 20 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to implement effective interventions to prevent a severely cognitively impaired resident (Resident #46) from hitting another resident (Resident #31) in the face two days after he initially exhibited physically aggressive behaviors directed toward another resident (Resident #55). Resident #31 sustained a scratch to the face as a result of the incident. This was for 1 of 4 residents reviewed for accidents (Resident #46). Findings included: 1. Resident #46 was admitted to the facility on 7/13/20 with diagnoses which included dementia and schizoaffective disorder. The Minimum Data Set (MDS) Quarterly Assessment dated 7/24/23 revealed Resident #46 was severely cognitively impaired and required supervision of 1 person for locomotion on the unit. Resident #46 was coded with no physical behaviors directed towards others. As of 7/24/23 Resident #46's comprehensive care plan revealed no evidence the resident had any physical behaviors directed toward other residents. a. Resident #55's Minimum Data Set (MDS) Quarterly Assessment dated 7/6/23 revealed Resident #55 was severely cognitively impaired.	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents #46 has a diagnosis of Schizoaffective Disorder and Dementia. Resident #31 has a diagnosis of Alzheimer's Disease. Both residents reside on the locked unit. Residents #31 and #46 were immediately separated after resident #46 hit resident #31 in the face on July 27, 2024. A skin assessment was completed for resident #31 on July 27, 2024 noting a scratch to left cheek. Ice was applied to resident #31 left cheek. The wound was cleaned and a X-Ray was obtained on July 27, 2024. No abnormalities of the mandible were identified. Monitoring of resident #46 was increased on July 27, 2024, through July 31, 2024. Monitoring included one-on-one staff observation followed by every fifteen-minute checks by the unit staff (nurses and CNAs). Psychiatry services were notified of the indent and an eval for resident #46 was requested. Psychiatry PA made changes to resident #46 medication regimen increasing Ativan to 0.75mg twice daily and a prn order for Ativan 0.5mg every 12 hrs. for agitation on July 27, 2024.	

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F 689	Continued From page 21 Nursing Progress note dated 7/25/23 and written by Nurse #2 revealed at approximately 7:30 PM, Nurse #2 was called onto the locked unit because Resident #46 had hit Resident #55 in the face. Resident #46 was sitting on his buttocks on the floor. Resident #55 was hit in face, in return hit Resident #46 back knocking him to the floor. Both residents were separated. The Administrator was notified, who then notified the Director of Nursing (DON). The Medical Director (MD) was also called and notified. A new order was received for Resident #46 of Ativan 1 milligram (mg) now. Ativan was given. Both residents continued to be separated and Resident #46 was currently in bed with his eyes closed. Review of Resident #46's physician orders revealed on 7/25/23 Ativan 1 milligram (mg) was given one time only. Review of the Initial Allegation Report dated 7/25/23 and completed by the Administrator revealed the incident occurred on 7/25/23. The facility was notified the same day at 7:30 PM. Resident #46 hit Resident #55. Law Enforcement was notified. Review of the Investigation Report dated 7/31/23 and completed by the Administrator revealed the incident on 7/25/23 occurred in the day room of the locked unit. The witness to the event was Nursing Assistant (NA) #3. Resident #46 hit Resident #55 unprovoked. Resident #55 got up from her chair and hit Resident #46 back. Both residents were separated, and safety was assured for both with redirection as indicated. The facility had to substantiate the abuse because the residents did make contact with each other. There were not any injuries, and the	F 689	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: Carrolton Senior DON provided education on managing aggressive behaviors week of April 8-11, 2024, to all licensed nurses and CNAs including the locked unit staff. Licensed nurses and CNAs were not allowed to work until this education was completed. All new licensed nurses and CNAs will be trained on aggressive behavior management as a part of new employee orientation by the Facility Nurse Consultant or designee. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The administrator and the facility leadership team will review all new accidents/hazards daily in morning stand up. The Corporate Clinical Team will review monthly all accidents/hazards to ensure appropriate interventions were implemented for the next 3 months. The results will be reviewed in the QAPI meeting over the next 3 months.	

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facility quickly responded to ensure safety for both parties involved in the altercation. The facility could not have anticipated the interaction of the residents. Staff increased monitoring of both residents. A Psychiatry service referral was made for Resident #46 due to the unprovoked response. The Department of Social Services (DSS) was notified but did not conduct an investigation.

An interview was conducted with NA #3 on 3/12/24 at 10:32 AM. She revealed she was assigned to the locked unit in the evening of 7/25/23. NA #3 indicated that she was sitting next to Resident #46 and Resident #55 was sitting with other residents nearby. Resident #46 was standing and began to say "[Resident #55] has my money." NA #3 told him that Resident #55 did not have any money, and "the bank was closed." He (Resident #46) then hit her (Resident #55) in the mouth, and NA #3 jumped up to separate them. She called for help and another staff member (name unknown) brought Resident #55 to her room, and Resident #46 remained in the dining room of the locked unit. She notified Nurse #2.

Nurse #2 was interviewed by phone on 3/13/24 at 9:17 AM, and she revealed that she no longer worked at the facility. Nurse #2 stated she did not witness the incident on 7/25/23. NA #3 notified her and took her to the locked unit. After she was notified, the residents were already separated by 2 staff members (names unknown).

During an interview with the Administrator on 3/13/24 at 8:27 AM, she revealed that the incident between Residents #46 and #55 was an isolated incident. He hit her, and she hit him back. They

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were separated immediately, and both were redirected. No injuries were noted, and staff made more frequent rounds of both residents. Psychiatric services were referred for Resident #46 due to an unprovoked response. The Administrator stated that the allegation was substantiated because it did occur.

b. Resident #31's Minimum Data Set (MDS) Quarterly Assessment dated 7/6/23 revealed Resident #31 was moderately cognitively impaired.

Review of a Health Status note dated 7/27/23 and written by Nurse #2 revealed that at approximately 9:00 AM, it was reported to her that Resident #46 was cussing and walked by Resident #31 in the hallway. Resident #31 told him to be quiet. Staff attempted to re-direct her (Resident #31), but Resident #46 hit her. Both parties were separated. An open area noted to Resident #31's left cheek, and she complained of left sided jaw pain. An x-ray was ordered to her left jaw. The Administrator and MD were notified.

Review of a Health Status note dated 7/27/23 and written by Nurse #2 revealed an x-ray was performed on Resident #31's left jaw. Results were pending.

Review of x-ray results to the left mandible (jawbone) of Resident #31 dated 7/27/23 revealed no abnormalities of the mandible were identified in the available views, and there was not any evidence of acute bony injury.

Review of a Skin Referral dated 7/27/23 revealed Resident #31 had a scratch to the left cheek.

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Review of a Psychiatry Progress Note dated 7/27/23 and written by the Psychiatry Physician Assistant (PA) revealed Resident #46 was in physical altercations twice this week. Resident #46 walked up to another resident on 7/25/23 and punched Resident #55 in the face, which was witnessed by staff. Today, Resident #31 stated Resident #46 hit her in the face, leaving a red mark. This incident was unwitnessed. As a result, changes to Resident #46's medication regimen included: Increase scheduled Ativan to 0.75 mg twice daily. Start Ativan 0.5 mg tab by mouth every 12 hours as needed for agitation. Hold for sedation.

Review of Resident #46's physician orders revealed Ativan was increased to 0.75 mg twice daily for anxiety on 7/27/23. Also on 7/27, Ativan 0.5 mg was added every 12 hours as needed for agitation.

Review of the Initial Allegation Report dated 7/27/23 and completed by the Administrator revealed the facility became aware on 7/27/23 at 9:00 AM. Resident #46 hit Resident #31 on the left side of her face while in the locked unit. A skin assessment was completed on Resident #31, and a scratch to the left side of her face resulted. Law enforcement was notified.

Review of the Investigation Report dated 8/2/23 and completed by the Administrator revealed Resident #31 was antagonizing Resident #46, per staff, prior to him hitting her. A scratch to the side of Resident #31's face was noted. Staff applied ice to the area to decrease the chance of swelling. No mental anguish was identified. DSS was notified and did not complete an investigation.

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Resident #31 was interviewed on 3/13/24 at 5:33 PM, and she revealed that on the date of the incident, Resident #46 was in the hallway cussing. She went out to tell him not to cuss around women. He then struck her in the face. Staff responded and cleaned her wound.

Review of the Activities Director's witness statement dated 7/27/23 read: "At 9:05 AM, the [former] Activity Aide came to her office to report that [Resident #31] had a 'scar' that [Resident #46] had hit her ..."

The former Activity Aide was interviewed by phone on 3/12/24 at 9:29 AM. She revealed that she witnessed the incident on 7/27/23 between Residents #46 and #31. Resident #46 was cursing in the hallway and appeared mad. He approached Resident #31, but he did not hit her. She stated she needed to call this surveyor back but never did.

Review of the witness statement by Medication Aide [MA] #1 (date not specified) revealed that it read: "I, [MA #1], witnessed [Residents #46 and #31] exchanging harsh words. (Resident #46) began swinging in the air in the direction of [Resident #31], and [she] was swinging her walker in the direction of him. I intervened and separated them. It was then that I noticed a scratch on the left side of Resident #31's face."

MA #1 was interviewed on 3/12/24 at 10:51 AM, and she revealed that she was performing medication pass on 7/27/23, and Resident #46 was already having behavioral issues or "in a mood" (agitated). At first, he was just walking and "fussing" at the residents. Resident #46 said

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something to Resident #31 and she said something back. MA #1 could not recall what was said or if he (Resident #46) hit her (Resident #31). Resident #31 had a scratch on her face. MA #1 stated she could not recall all the exact details. She approached both residents after she locked her medication cart, and the NA (unknown name) helped separate the residents. Nurse #2 was working that day, and she (MA #1) notified her of the incident. Nurse #2 notified the Administrator, who visited the locked unit and assigned another NA (name unknown) to provide 1:1 supervision for Resident #46.

An interview was conducted with Nurse #2 on 3/13/24 at 9:17 AM. She indicated on 7/27/23 the residents were already separated when she came to the locked unit and were monitored by separate staff members. Skin assessments were performed on both residents.

During an interview with the Psychiatry Nurse Practitioner (NP) on 3/12/24 at 2:45 PM, she revealed that the Psychiatry PA who worked at the facility in July 2023 was no longer employed at the facility. She began in October 2023. The Psychiatry NP stated when a resident had behaviors, facility staff would contact her. She made recommendations, and the MD wrote the orders. She often recommended that residents be separated and put on 1:1 supervision for a specified period. They may need medication adjustment, if agitated.

NA #2, who worked during the day shift on the locked unit on 7/27/23, was interviewed. She indicated she did not witness the incident between Resident #46 and Resident #31 on 7/27/23. NA #2 stated she could not recall if she

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was aware that Resident #46 was aggressive with another resident 2 days prior. She indicated if she knew about Resident #46's incident on 7/25/23, she would have closely monitored him and checked on him frequently.

NA #1, who worked on the locked unit during the day on 7/27/23, was interviewed. She revealed that she did not recall the incident that took place on 7/27/23 between Residents #46 and #31. NA #1 stated she was not aware that Resident #46 was aggressive 2 days prior to 7/27/23. She stated redirection and close monitoring would have helped prevent Resident #46 hit Resident #31.

During an interview with the Administrator on 3/13/24 at 8:27 AM, she revealed that when the sun went down, Resident #31 turned into someone else. On 7/27/23, Resident #31 tried to get Resident #46 to quiet down, and she was the instigator. The Administrator stated Resident #31 told her that he (Resident #46) hit her. They were separated immediately, and Psychiatry services were referred. A skin check was completed for Resident #31, and she changed rooms. She indicated that the allegation of abuse was substantiated because it happened. The Administrator stated that monitoring was increased on 7/25 for Resident #46 but maybe not enough. Ideally, he would not have hit Resident #31 on 7/27/23. Resident #46 should have been on 1:1 supervision beginning 7/25/23 to prevent the 7/27 incident from occurring. During that time, there were enough staff to assign 1:1 supervision. If 2 residents were arguing, then they should have been separated immediately to prevent further escalation.

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F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility failed to obtain post dialysis vital signs, record post dialysis weights, and maintain ongoing communication with the dialysis facility for 1 of 1 resident reviewed for dialysis (Resident #58). Findings included: Resident #58 was admitted to the facility on 10/8/2019 with diagnoses which included renal insufficiency and dependence on renal dialysis. The quarterly Minimum Data Set dated 1/16/24 revealed that Resident #58 was cognitive intact. He was also coded for dialysis. Review of Resident #58's care plan last reviewed 2/6/24 indicated a focus for dialysis related to renal failure with an intervention check and change dressing daily at access site and monitor for signs/symptoms of bleeding, hemorrhage, and septic shock. Review of Resident #58's Physician's orders revealed an order dated 2/29/24 record post dialysis weight and vitals upon return every Tuesday, Thursday, and Saturday.	F 698	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility verified resident #58 has a dialysis communication folder in use and available to accompany resident to the dialysis center. To update our files and increase communication, dialysis visit communication for the previous two months was requested of the dialysis center for resident #58. Requested information was received as requested. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all dialysis residents have the potential to be affected however we are not aware of any patients that have been negatively impacted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	4/12/24

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F 698	Continued From page 29 Review of Resident #58's February Medication Administration Record (MAR) revealed that he was ordered to have post dialysis vital signs at 2:00 P.M. every Tuesday, Thursday, and Saturday. Of the 10 days he went to dialysis, there were 7 days documented. The MAR showed vital signs were not documented on the following days: - 2/2/24: documented as daily checks by Medication Aide #2 - 2/10/24: documented as resident absent from facility by Nurse #1 - 2/13/24: documented as resident absent from facility by Nurse #1 Review of Resident #58's medical record for February 2024 showed he had a weight entered on 2/2/24 of 119.9 pounds and on 2/29/24 of 130.9 pounds. There was no weight entered on 2/1/24, 2/3/24, 2/10/24, 2/13/24, 2/17/24, 2/20/24, or 2/22/24. Resident #58 was in the hospital on 2/24/24 and 2/27/24. Revie of Resident #58's March MAR revealed he was ordered to have post dialysis vital signs at 2:00 P.M. every Tuesday, Thursday, and Saturday. Of the 4 days he went to dialysis, there was 1 day of vital signs documented. The MAR showed vital signs were not documented on the following days: - 3/5/24: documented as resident absent from facility by Nurse #1 - 3/7/24: documented as resident absent from facility by Nurse #1 - 3/10/24: documented as resident refused by Medication Aide #3 - 3/12/24: documented as resident absent from facility by Nurse #1	F 698	The facility process was amended to include documentation of a "Dialysis Progress Note" located within PCC. Training on the PCC "Dialysis Progress Note" was provided to the DON and the Administrator on April 7, 2024. Training on the PCC "Dialysis Progress Note" was provided to all nurses in several in-services during the week of April 9 - 12, 2024. The facility requested that the dialysis center provide the visit communication detail following all dialysis appointments. Two months of data was requested and received. The facility DON or designee will request communication following each dialysis visit if documentation is not received upon the resident's return to the facility. Corporate clinical team educated the DON and Administrator on the dialysis progress note available in PCC. This note was implemented and all licensed nurses were educated on the requirements for obtaining post dialysis vital signs, recording of post dialysis weights, and maintaining ongoing communication with the dialysis facility. In-services were conducted during several nursing meetings and training session during the week of April 9 - April 12. The new nursing protocol for dialysis	

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F 698	Continued From page 30 Review of Resident #58's medical record for March 2024 showed he had a weight entered on 3/2/24 he of 127.3 pounds and on 3/5/24 of 127.3 pounds. There was no weight entered on 3/7/24 or 3/12/24. Review of Resident #58's dialysis communication forms located at the nursing station showed there were no communication sheets dated 2/2/24, 2/10/24, and 2/13/24. There was an uncompleted dialysis communication form for 3/5/24, 3/10/24, and 3/12/24. The dialysis communication form dated 3/1/24 and 3/7/24 were completed. An interview was conducted on 3/13/24 at 2:02 P.M. with Resident #58. Resident #58 indicated he usually left for dialysis treatment a little before 7:00 A.M. and returned to the facility after his dialysis treatments between 11:30 A.M. and 12:00 P.M. During the interview, he explained there was a dialysis communication form used between the facility and the dialysis facility that included his vital signs and pre and post dialysis treatment weight. Resident #58 indicated he brought the form back with him from each dialysis appointment. He explained when he arrived at the facility, his assigned nurse did not always take his vital signs or ask about his weight. During the interview Resident #58 stated on 3/12/24, he returned from dialysis about 12:00 P.M. and his assigned nurse did not take his vital signs when he returned. An interview was conducted on 3/13/24 at 11:17 P.M. with Nurse #1 who was assigned Resident #58 on 3/12/24. Nurse #1 stated he did not take Resident #58's vital signs on 3/12/24 when he returned from dialysis because he was not aware	F 698	patients is fully implemented and will be taught during new employee orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit 10% of dialysis residents weekly (for 4 weeks and monthly for 2 months) to ensure compliance with dialysis communication and the new dialysis note section in the EMR. The note includes post dialysis vital signs, recording of post dialysis weights, and evidence of communication with the dialysis facilities. Monitoring will be done weekly x 4 weeks and then monthly for 2 months or until QAPI team deems compliance. Corrective action completion date: 4/12/24	

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the resident had returned to the facility. Nurse #1 stated when Resident #58 returned from dialysis his vital signs should be assessed and documented in his medication record. During the interview, Nurse #1 stated when Resident #58 returned from dialysis without a completed dialysis communication form, he did not follow up with the dialysis clinic to get the missing information. No reason was given as to why Nurse #1 did not follow up with the dialysis clinic. When Nurse #1 reviewed Resident #58's MAR for February 2023 and March 2023, he stated he documented absent from facility because he does not always see Resident #58 prior to the end of his shift at 3:00 P.M.

An interview was attempted with Medication Aide #2 to inquire about the "daily checks" documented the MAR for 2/2/24, was unsuccessful.

An interview was conducted on 3/13/24 at 11:28 A.M. with the Unit Manager. During the interview the Unit Manager stated the assigned nurse was responsible for entering a resident's vital signs and post dialysis weight when the resident returned from dialysis. The Unit Manager explained when a resident returned from dialysis with an uncompleted dialysis communication form, the assigned nurse was responsible for calling the dialysis clinic to follow up. The Unit Manager stated on 3/12/24, Resident #58 returned to the facility from dialysis at about 12:00 P.M.

An interview was conducted on 3/13/24 at 3:20 P.M. with the Director of Nursing (DON). The DON indicated when Resident #58 returned from a dialysis appointment, staff should be getting his

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F 698	Continued From page 32 vital signs and entering his post treatment weight into his medical record as ordered. The DON explained if the information was not provided through the dialysis communication form, the assigned nurse had the responsibility to contact the dialysis facility to get the information. During the interview, the DON stated Resident #58 usually arrived back at the facility around 1:00 P.M. The DON stated she was unaware the staff had not documented vital signs or weights for Resident #58 when he returned from his dialysis appointments, and she was unsure why this hadn't been done. An interview was conducted on 3/13/24 at 1:12 P.M. with the Administrator who stated the nursing staff should be following the physician orders by documenting vital signs and post dialysis weights when Resident #58's returned from dialysis treatments.	F 698		
F 725 SS=G	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 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	F 725		4/12/24

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F 725	Continued From page 33 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 review, resident interview, staff interviews and a Physician interview, the facility failed to provide sufficient nursing staff to ensure a resident was administered morning scheduled medications in the allotted time frame for 1 of 1 resident reviewed for significant medications (Resident #211). Resident #211 not receiving her scheduled morning medications in the allotted time frame caused Resident #211 to remain in bed for fear of falling due to feeling dizzy. Findings included: This tag is cross reference to: F760: Based on record review, observation, resident interview, staff interviews and a Physician interview, the facility failed to administer significant medications of a resident's medication regimen in the scheduled time frame that caused the resident to remain in bed for fear of falling due to feeling dizzy for 1 of 1 resident reviewed for administration of significant medications (Resident #211).	F 725	Immediate action(s) taken for the resident(s) found to have been affected include: Medications for resident #211 were administered late on 3/12/24. Immediately upon learning of the tardy medication, the Unit Manager called the Attending Physician to obtain an order to administer her medications late. Medications were given appropriately after receipt of the MD order. Resident #211 no longer resides in the facility. She was discharged home with home health. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by late medication administration. No other patients were negatively impacted. Actions taken/systems put into place to reduce the risk of future occurrence	

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F 725	Continued From page 34 In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:15 a.m., she explained on 3/13/2024 due to the call out of a scheduled medication aide, NA (Medication Aide) #7 was assigned both the sparks unit and skills unit medication cart. She explained usually one nurse/medication aide was assigned the sparks unit and skills unit medication carts since the skills unit fluctuated in the number of residents and the level of care on the unit. She stated Nurse #6 was assigned to the cover the sparks unit and skills unit for nursing tasks, and it would have been best if she (DON) had assigned Nurse #6 to one of the medication carts so the administration of medications were administered in the scheduled time frame for Resident #211. The Director of Nursing reported attendance issues among the nursing staff and the issue of not having enough staff for the five medications carts had caused a delay in scheduled medications administered in the allotted time frame. She stated as the DON she had been assigned a medication cart to administered medications due to not having enough staff, and the facility was slowly hiring nurses and nurse aides. In an interview with the Administrator on 3/13/2024 at 4:36 p.m., she stated Resident #211 should have received her medications one hour before or after the scheduled time and explained the reason Resident #211 received her medications late was because a medication aide called out on 3/12/2024. She explained due to the residents on the sparks unit having fewer medications, one nurse/medication aide was assigned the sparks unit and skills unit medications cart when there were limited	F 725	include: 1. The DON immediately re-educated the med aide about timely medication administration on March, 12, 2024. 2. The Administrator, DON and Unit Manager were re-educated by the Chief Operating Officer on March 19, 2024 and April 8, 2024 on several topics surrounding the March 10-13, 2024 survey to include maintaining sufficient staffing. 3. Mandatory in-service training was conducted on April 8 - 11, 2024 by a facility leaders to include the DON, Administrator and Senior Director of Nursing on several on several topics surrounding the March 10-13, 2024, survey to include timely medication administration, maintaining sufficient staffing and posting nurse staffing information. All staff were required to attend, and no one was allowed to work until the education was completed. 4. Sponsored ads have been placed for additional staff members to hire to ensure sufficient staffing is available. 5. A campaign to re-recruit former nursing staff members was initiated on April 1, 2024 and is ongoing. 6. Three RNs were hired and began work in the facility April 6- 12, 2024. 7. Two additional orientation sessions have been set up and a means to conduct	

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F 725	Continued From page 35 nurses/medications aides in the facility. She stated retaining enough nurses/medications aides for the five medication carts in the facility was a challenge. She stated nursing staff worked overtime to help cover staff needs and the facility made every effort to ensure residents received their scheduled medications in a timely manner. She also stated she continued to work in recruiting new nursing staff.	F 725	orientation on site via proctored video has been made available to expedite additional staffing to meet current needs. 8. Call outs will be promptly handled by the facility leadership team (DON, Unit Manager and scheduler) to secure replacement staffing at the time the call out is received. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Staffing assignment sheets will be monitored daily by the Chief Operating Officer and the Chief Clinical Officer utilizing the missing / late med report in PCC. 2. Chief Operating Officer educated the Administrator, DON, Unit Manager and Scheduler on the importance of knowing the daily and weekly schedules always. 3. Daily administrative rounds will be conducted by the Administrator, DON, Unit Manager and the department supervisors to interview residents and staff to ensure that staffing is sufficient as evidenced by timely medication administration, treatments, and resident/staff concerns. These administrative rounds will occur for two weeks or until compliance is achieved. A minimum of 6 staff members and 6 residents will be interviewed. 4. Round results will be reviewed and presented by the Administrator, DON, Unit	

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F 725	Continued From page 36	F 725	Manager, and department supervisors in the daily afternoon stand down meeting for systemic changes if indicated. 5. Audit results will be presented by the Administrator and discussed by the QAPI team at the weekly meetings for 4 weeks. 6. A member of the corporate clinical team will participate in the weekly QAPI meeting. Corrective action completion date: 4/12/24	
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days a week, to designate a director of nursing (DON) who worked on a full-time basis, and to have the DON only serve as a charge nurse when the	F 727	Immediate action(s) taken for the resident(s) found to have been affected include: The facility will ensure that adequate staffing, not including the DON, is present and accounted for 8 hours per day / 7	4/12/24

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F 727	Continued From page 37 average daily census was 60 residents or less for 23 of 39 days reviewed for staffing. Findings included: The nursing staff schedule and staff posting was reviewed from 2/1/24 through 3/10/24. The daily staff sheet indicated a Registered Nurse (RN) was not scheduled for at least eight consecutive hours a day on 2/3/24. Review of staff timecard dated 2/3/24 showed there was not an RN on duty at the facility that day. Review of the staffs' timecards dated 2/10/24 showed one RN worked. The RN was scheduled for the day shift 7:00 A.M. to 3:00 P.M. The timecard showed the RN worked from 7:49 A.M. to 3:29 P.M. for a total of 7 hours and 40 minutes. Review of the DON time punches for the week of 2/15/24 through 2/21/24 showed the DON worked 29.36 hours in the DON role. - 2/15/24, Thursday: DON hours logged 9:30 A.M. to 3:00 P.M., RN hours logged 3:01 P.M. to 12:08 A.M./ total DON hours 5.30, total RN hours 9.07 - 2/16/24, Friday: RN hours logged 3:19 P.M. to 11:37 P.M./ total RN hours 8.18 - 2/17/24, Saturday: RN hours logged 2:15 P.M. to 9:57 P.M./ total RN hours 7.42 - 2/19/24, Monday: DON hours logged 9:01 A.M. to 3:05 P.M./ total DON hours 6.04 - 2/20/24, Tuesday: DON hours logged 7:06 A.M. to 4:50 P.M./ total DON hours 9.44 - 2/21/24, Wednesday: DON hours logged 8:32 A.M. to 5:30 P.M./ total DON hours 8.58	F 727	days per week. The DON will be excluded from the RN hour calculation. An RN will be assigned to work 7 days per week, 8 hours per day every day. Three RNs have been hired and will orient on Monday, April 8, 2024. The Chief Operating Officer educated the Administrator, DON, Scheduler, and Unit Manager on the RN coverage requirements 8 hrs per day / 7 days per week. Education was completed on Monday, April 1, 2024. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be negatively affected; however, none were negatively impacted. Actions taken/systems put into place to reduce the risk of future occurrence include: 1. Staffing and assignments will be reviewed by the NHA, DON, and scheduler daily during the morning meeting to ensure the staffing for the next day is sufficient and covered. 2. Sponsored ads have been placed for additional staff members to hire to ensure sufficient staffing is available. 3. A campaign to re-recruit former nursing staff members was initiated on April 1, 2024 and is ongoing. 4. Three RNs that previously worked in the facility have been hired to work 8-10 weeks while we find full time employees to work all the time. 5. Two additional orientation sessions	

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F 727	Continued From page 38 Review of the DON time punches showed the week of 2/22/24 through 2/28/24 the DON worked 30.47 hours in the DON role. - 2/22/24, Thursday: DON hours logged 8:29 A.M. to 3:00 P.M.; RN hours logged 3:01 P.M. to 11:25 P.M./ total DON hours 6.32, total RN hours 8.24 - 2/23/24, Friday: DON hours logged 12:11 P.M. to 3:00 P.M./ total DON hours 2.49 - 2/24/24, Saturday: RN hours logged 3:01 A.M. to 10:42 A.M. and 3:23 P.M. to 11:20 P.M./ total RN hours 7.41 and 7.57 - 2/26/24, Monday: DON hours logged 8:48 A.M. to 5:10 P.M./ total DON hours 8.22 - 2/27/24, Tuesday: DON hours logged 9:30 A.M. to 4:52 P.M./ total DON hours 7.22 - 2/28/24, Wednesday: DON hours logged 8:37 A.M. to 3:00 P.M., RN hours logged 3:01 P.M. to 11:25 P.M. / total DON hours 6.23, total RN hours 8.24 Review of the DON time punches for the week of 2/29/24 through 3/6/24 showed the DON worked 37.02 hours in the DON role. - 2/29/24, Thursday: DON hours logged 9:44 A.M. to 5:27 P.M./ total DON hours 7.43 - 3/2/24, Saturday: DON hours logged 3:14 P.M. to 8:57 P.M. / total DON hours 5.43 - 3/3/24, Sunday: DON hours logged 3:08 P.M. to 12:07 A.M./ total DON hours 8.59 - 3/6/24, Wednesday: DON hours logged 4:55 P.M. to 8:52 P.M./ total DON hours 15.57 During the week of 2/29/24 through 3/6/24 the DON was on the schedule with a resident assigned on 3/2/24 during the shift from 3:00 P.M. -11:00 P.M. and 3/3/24 during the shift from 3:00 P.M. - 11:00 P.M. The facility had a census greater than 60 residents.	F 727	have been set up for the week of April 10, 2024 and a means to conduct orientation on site via proctored video has been made available. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Chief Operating Officer educated the senior leadership April 1, 2024 on the importance of knowing the daily and weekly schedules always. 2. Chief Operating Officer educated the NHA, DON, Department heads, Unit Manager, and Scheduler on the importance of knowing that an RN is present 7 days per week, 8 hours per day. 3. NHA, DON, and Unit Manager will review schedules daily to ensure 24 hour assignments include RN coverage 8 hours per day / 7 days per week. 4. Nursing hours worksheet and assignments sheets are being submitted to the Compliance Line for review on a daily basis for two weeks; 3 times per week for 2 weeks; and weekly for the next month. 5. Schedule results will be reviewed in the daily afternoon stand down meeting. 6. Audit results will be brought to the QAPI team by the NHA and DON at the weekly meeting. QAPI meetings have been increased to weekly for 2 months. Immediate corrections will be made to system failures that present to ensure that the coverage is maintained. A member of the corporate clinical team will participate in the weekly QAPI	

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F 727	Continued From page 39 An interview was conducted on 3/13/24 at 12:30 P.M. with Scheduler #2 who stated she was aware an RN was to be scheduled for 8 consecutive hours each day. She indicated the facility no longer had agency staff working at the building and she was not always able to find a RN available to work. The Scheduler explained when she was unable to find the RN coverage, she filled the schedule with other licensed nurses to meet resident needs. During the interview, Scheduler #2 explained the Administrator and the Director of Nursing were aware of the lack of RN coverage because they reviewed the schedule weekly when it was created. An interview was conducted on 3/13/24 at 4:54 P.M. with the Director of Nursing (DON) who stated when the schedule was completed, she reviewed it to ensure the schedule had enough staff to meet resident needs. The DON indicated she was unaware of the requirement that the facility needed a RN for eight consecutive hours a day. The DON explained the facility only had one RN other than herself, and they had been unsuccessful at hiring additional RNs. The DON explained the facility does not work with agency staff at this time. During the interview, the DON indicated when staff called out, she tried to find coverage and when she was unable to find any coverage, she worked on the medication cart to meet resident needs. She further explained she had also been assigned the medication cart, typically on the evening 3:00 P.M. to 11:00 P.M. shift, when no one else was available. The DON stated she tried to complete her responsibilities as DON any time she had a free minute, no matter if she was working in the DON role or as a nurse on the medication cart. The DON indicated	F 727	meeting. Corrective action completion date: 4/12/24	

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F 727	Continued From page 40 when she was assigned to a medication cart with a resident assignment, she had gotten pulled away by staff to handle DON responsibilities. During the interview, the DON indicated the facility census had been approximately 102 since she started in January 2024. An interview was conducted on 3/13/24 at 1:08 P.M. with the Administrator who stated she was aware of the requirement a RN worked eight consecutive hours in a day and to her knowledge the facility had a RN scheduled to meet these needs. The Administrator stated she was not aware a RN had not worked a scheduled shift until the shift had already passed. The Administrator indicated she had a limited number of RNs employed at her facility and this made it difficult to cover the RN hour requirements. During the interview, the Administrator stated the facility had one RN hired full time, one RN hired part time, and the DON assisted on the floor as needed. The Administrator explained the facility did not have any agency staff working at this time and there were no waivers in place. The Administrator stated she was aware the DON was unable to serve as a charge nurse if the facility census was greater than 60 and she stated the DON was picking up the 3:00 P.M. to 11:00 P.M shift after her DON responsibilities were completed. During the interview, the Administrator further indicated if she had been made aware the DON responsibilities were not being completed, she would pull staff from a sister facility to provide assistance.	F 727		
F 729 SS=E	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification.	F 729		4/12/24

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F 729	Continued From page 41 Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 5 of 47 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry	F 729	1. Immediate action(s) taken for the resident(s) found to have been affected include: All NAs with expired certifications to include, # 6, #9, #4, and #8 were	

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F 729	Continued From page 42 with an active Nurse Aide I certification (NA #6, NA #9, NA #4, NA #1,and NA #8). Findings included: 1. On 3/11/2024 at 8:12 a.m., NA #6, who was a Medication Aide, was observed passing medications to Resident #59. A review of NA #6's employment record reported a hired date as 9/12/2022, and NA #6's verification report listed the NA I expiration date as 1/31/2024 for the NC Nurse Aide Registry, and the NC Medication Aide Registry listed an expiration date of 3/31/2025. A review of daily nursing assignment schedules since 1/31/2024 listed NA #6 assigned as a medication aide on the following dates: * 2/3/2024 7am-3pm; 8pm and 5am on the Skills and Sparks Unit. * 2/5/2024 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * 2/6/2024 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * 2/7/2024 3pm-11pm on the Skills and Sparks Unit. * 2/9/2024 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * 2/11/2024 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * 2/12/2024 3 pm- 11pm on the Skills and Sparks Unit. * 2/19/2024 7am-3 pm on the Skills and Sparks Unit. * 2/20/2024 3pm-11pm on the Skills and Sparks Unit. * 2/21/2024 3pm-11pm on the Martin Unit. * 2/23/2024 7am-3 pm and 5am on the Martin	F 729	suspended from work, placed on administrative leave and removed from the hall immediately upon learning of the NA lapsed certifications. The facility performed a complete audit of all NA certification files during the week of March 10-13, 2024, to determine the status of all working NAs. A complete audit was executed specifically to determine certification expiration dates. NAs found to have expired certifications (including # 6, #9, #4 and #8) and were placed on unpaid administrative leave and removed from the facility. 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 however there is no knowledge of negative impact to the patients. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Carrolton policy “Credentialing/Nurse License and Nursing Assistant Certification Verification” was revised on March 30, 2024, to include additional corporate oversite of licensure and verification by the Carrolton Facility Management (CFM) Human Resources Department. Corporate will prepare a report monthly and will validate every facility and staff listing to determine that all certifications	

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F 729	Continued From page 43 Unit. * 2/25/2024 3pm-11pm on the Skills and Sparks Unit. * 2/26/2024 7am-3 pm on the Martin Unit. * 2/27/2024 7am-3 pm and 3 pm- 11pm on the Martin Unit. * 2/28/2024 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * 3/1/2024 3pm-11pm on the Peele Unit. * 3/4/2024 3pm-11pm on the Peele Unit. * 3/5/2024 3pm-11pm on the Peele Unit. * 3/8/2024 7am-3 pm and 3 pm- 11pm on the Peele Unit. * 3/9/2024 3pm-11pm on the Skills and Sparks Unit. * 3/10/2024 7am-3 pm on the Skills and Sparks Unit and 3 pm- 11pm on the Peele Unit. * 3/11/2024 7am-3 pm on the Peele Unit and 3 pm- 11p NA #6 was removed from schedule. On 3/11/2024 at 1:30 p.m., a review of the electronic NC Nurse Aide I Registry listed NA #6's NA I certification expired as of 1/31/2024, and the NC Medication Aide Registry listed NA #6's expiration date as 3/31/2025. A review of NA #6's employee timesheet since 3/1/2024 listed NA #6 working the following dates: * On 3/1/2024 at 5:06 pm to 11:22pm as Cerified Nurse Aide (CNA) I Medication Aide. * On 3/4/2024 at 3:19pm to 8:04am on 3/5/2024 as CNA I Medication Aide. * On 3/5/2024 at 3:45pm to 10:07 pm as CNA I Medication Aide. * On 3/6/2024 at 7:50 am to 10:03 pm as CNA I Medication Aide. * On 3/7/2024 at 9:39 am to 3:21 pm as CNA I Medication Aide. * On 3/8/2024 at 7:19am to 10:02 pm as CNA	F 729	are current, active, and valid. The facility Administrator, Director of Nursing, and payroll clerk were re-educated on April 8, 2024, by the facility Chief Clinical Officer regarding Carrolton policy “Credentialing/Nurse License and Nursing Assistant Certification Verification”. The Administrator and DON are fully responsible for ensuring that only currently certified NAs are working with our patients. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator will complete random weekly licensure and certification audits for 5 nursing assistants for 4 consecutive weeks and 5 nursing assistants monthly for 2 months to ensure that licenses and certifications have not expired. The CFM Human Resource Department will run licensure and verification reports for all Carrolton facilities, including Carrolton of Williamston, monthly to ensure that all licensed nurses and certified nursing assistants are maintaining current licensure and or certification. Monthly certification audit reports will be presented to the weekly QAPI committee for four weeks. After 4 weeks the audit will become standardized on a monthly rotation. Audit records will be reviewed by	

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F 729	Continued From page 44 I Medication Aide. * On 3/9/2024 at 8:53 am to 10:08 pm as CNA I Medication Aide. * On 3/10/2024 at 8:33 am to 7:11pm as CNA I Medication Aide. * On 3/11/2024 at 7:01am to 4:55 pm as CNA I Medication Aide. In an interview with NA #6 on 3/11/2024 at 4:20 pm, he stated he had been a NA I since 2014 and a Medication Aide since 2020, and his assignments mainly consisted of being a medication aide due to the shortage of nurses in the facility. He said the Administrator informed him at 2:45 pm that day his NA I certification was expired, and he was removed from his assignment to go home. He explained he knew he had to have a NA I certification to work as a medication aide and thought the past DON had sent the information into the NC Nurse Aide Registry for renewal of his NA I certification. He stated no one at the facility had mentioned his NA I certification had expired before that day. In an interview with the Administrator on 3/11/2024 at 4:34 pm, she stated medication aides had to have a current NA I certification to practice as a medication aide, and the Director of Nursing (DON) was responsible for monitoring nursing certification/licensure for expirations and renewals. She explained there had been six different DONs in the facility over the last year, and NA #6's NA I certification expiration had "fell through the cracks". She further stated the facility was conducting an immediate audit to ensure all Nurse Aide certifications had not expired from the NC Nurse Aide Registry. In an interview with the Director of Nursing (DON)	F 729	the Quality Assurance Committee until such time as consistent substantial compliance has been achieved and confirmed by the committee. Compliance Date: April 12, 2024	

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on 3/13/2024 at 11:04 am, she stated she had been slowly learning the role of DON since starting in the role as DON on 1/8/2024. She explained no one had informed her to track/monitor nurse aide certifications for expirations, and she did not know who was responsible for the task prior to this week. She further stated she was not aware NA #6's NA I certification had expired and a NA I certification was required with a medication aide certification.

2. a. On 3/12/2024 at 5pm, a review of the audit conducted by the facility on 3/11/2024 to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #9's NA I certification expired on 12/31/2023.

A review of NA #9's employment timesheet since 2/29/2024 reported she worked as a nurse aide of the following dates:

* On 2/29/2024 from 8:29 am to 3:04 pm.
* On 3/2/2024 from 7:05 am to 3:10 pm.
* On 3/03/2024 from 7:12 am to 7:00 pm.
* On 3/04/2024 from 7:38 am to 3:01 pm.
* On 3/05/2024 from 7:26 am to 3:11 pm.
* On 3/07/2024 from 7:12 am to 3:05 pm.
* On 3/08/2024 from 9:19 am to 3:01 pm.

b. On 3/12/2024 at 5pm, a review of the audit conducted by the facility on 3/11/2024 to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #4's NA I certification expired on 2/29/2024.

A review of NA #4's employment timesheet since 2/29/2024 reported she worked as a Nurse Aide II of the following dates:

* On 3/1/2024 from 3:05 pm to 7:17 am on 3/2/2024.

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* On 3/4/2024 from 3:48 pm to 7:08 am on 3/5/2024.
* On 3/5/2024 from 3:41 pm to 7:16 am on 3/6/2024.
* On 3/6/2024 from 3:09 pm to 7:15 am on 3/7/2024.
* On 3/7/2024 from 3:21 pm to 7:25 am on 3/8/2024.
* On 3/9/2024 from 3:22 pm to 7:13 am on 3/10/2024.
* On 3/10/2024 from 3:04 pm to 7:10 am on 3/11/2024.
* On 3/11/2024 from 3:26 pm to 5:00 pm

c. On 3/12/2024 at 5pm, a review of the audit conducted by the facility on 3/11/2024 to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #1's NA I certification expired on 2/29/2024.

A review of NA #1's employment timesheet sine 2/29/2024 reported she worked as a Nurse Aide/Medication Aide of the following dates:
* On 3/4/2024 from 7:39 am to 10:21 pm.
* On 3/5/2024 from 7:33 am to 2:48 pm.
* On 3/6/2024 from 7:31am to 2:35 pm.
* On 3/8/2024 from 7:29 am to 2:42 pm.
* On 3/9/2024 from 7:29 am to 11:08 pm.
* On 3/10/2024 frp, 7:38 am to 3:04 pm.
* On 3/12/2024 from 7:44 am to 8:15am.

d. On 3/12/2024 at 5pm, a review of the audit conducted by the facility on 3/11/2024 to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA)#8's NA I certification expired on 2/29/2024.

A review of NA #8's employment timesheet reported he working as a nurse aide of the

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following dates:
* On 3/1/2024 from 2:59 pm to 11:07 pm.
* On 3/9/2024 from 2:52 pm to 11:08 pm.
* On 3/10/2024 from 2:55 pm to 11:13 pm.

In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:04 am, she explained she started in the role of DON on 1/8/2024, and she was slowly learning the role and duties of the DON. She explained she was not aware NA #9's, NA #4's, NA #1's and NA #8's NA I certifications had expired from the NC Nurse Aide Registry until the Administrator conducted an audit conducted on all nurse aides on 3/11/2024 to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry. She explained Accounts Payable Personnel was responsible for verifying NA I certifications when new nurse aides were hired, and she did not know that she was responsible for monitoring NA I certification for expiration on the NC Nurse Aide Registry until this week.

In an interview with the Administrator on 3/13/2024 at 4:44 pm, she stated the Director of Nursing was responsible for monitoring NA I certifications for expiration and renewal on the NC Nurse Aide Registry, and it was in the DON job description. The Administrator further stated she wasn't sure the DON was aware of her responsibility to monitor the certifications of the nurse aides due to limited time of orientation. She explained on 3/11/2024, NA #9, NA #4, NA #1 and NA #8 were sent home if working and removed from daily nursing assignments. She explained they would not be allowed to work until their NA I certification was renewed and posted on the NA Nurse Aide Registry as active.

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F 730	Continued From page 48	F 730		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete a performance review every 12 months for 4 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #4, NA #7, NA #6, and NA #5). Findings included: 1. NA (Nurse Aide) #4's personnel file was reviewed and revealed a date of hire of 10/1/20. The personnel file for NA #4 did not include evidence a performance review had been completed since the NA's date of hire. Attempts were made to reach NA #4 for an interview were unsuccessful. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual	F 730	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility reviewed the personnel files for all NAs including NA # 4, #7, #6 and #5 on Friday April 5, 2024 and scheduled performance reviews for all NAs (18) found to be out of compliance with this standard. 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: Carrolton Facility Management (CFM) revised the staff development program to include policy #22.5 “Nurse Aide Training Program” on March 30, 2024. The policy outlines the basic components of the NA training program including responsible persons for program implementation and	4/12/24

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F 730	Continued From page 49 training to NA #4 based on the outcome of her performance evaluation. An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no performance evaluations in NA #4's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error. 2. NA #7's personnel file was reviewed and revealed a date of hire of 10/1/20. The personnel file for NA #7 did not include evidence a performance review had been completed since the NA's date of hire. Attempts were made to reach the NA for an interview were unsuccessful. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA#7 based on the outcome of her performance evaluation. An interview was conducted on 3/13/24 at 5:10	F 730	the process for providing education based on the NAs areas of weakness. The facility Administrator, Director of Nursing (DON) and payroll clerk were educated on April 8, 2024, by the Chief Clinical Officer on Carrolton policy # 22.5 “Nurse Aide Training Program”. NA performance evaluations were completed by the Director of Nursing during the week of April 8, 2024, for all NAs found to be past due with performance evaluations. Areas of weakness were noted, and a plan to provide education/re-education will be provided in accordance with agency policy. All other performance evaluations for nursing assistants will be performed as scheduled to ensure compliance with this standard. The personnel clerk is responsible for monitoring anniversary dates for NAs and providing this list to the Director of Nursing. The Director of Nursing is also responsible for annual NA performance evaluations. Nurse aide education will be tracked by the Director of Nursing monthly to ensure that all nursing assistants complete at least 12 hours of in-service education annually. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 730	Continued From page 50 P.M. with the Administrator who stated there were no performance evaluations in NA #7's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error. 3. NA #6's personnel file was reviewed and revealed a date of hire of 9/7/22. The personnel file for NA #6 did not include a performance review for September 2023. . An interview was conducted on 3/12/24 at 1:29 P.M. with NA #6. During an interview with NA #6, he stated the facility had not completed a performance review in the past twelve months and he was unable to recall if the facility had ever evaluated his work during his employment at the facility. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA #6 based on the outcome of his performance evaluation. An interview was conducted on 3/13/24 at 5:10	F 730	recur: The Administrator will audit the performance evaluations completed by the DON the week of April 8, 2024, to assure that all past dew evaluations have been completed and areas of weakness have been identified. The Administrator will complete a monthly audit of all nursing assistants scheduled for evaluation for the next 3 months to assure performance evaluations and education in the NAs areas of weakness are completed as scheduled. CFM Clinical Compliance Team will review and monitor the results of these audits monthly for three months or until such time consistent substantial compliance has been achieved as determined. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Compliance Date: April 12, 2024	

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P.M. with the Administrator who stated there were no performance evaluations in NA #6's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error.

4. NA #5's personnel file was reviewed and revealed a date of hire of 10/4/22. The personnel file for NA #5 did not include a performance review for October 2023.

An interview was conducted on 3/12/24 at 1:00 P.M. with NA #5. During an interview with NA #5, she stated the facility had not completed a performance review in the past twelve months and she was unable to recall if the facility had ever evaluated her work during her employment at the facility.

An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA #5 based on the outcome of her performance evaluation.

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F 730	Continued From page 52 An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there was no performance evaluation in NA #5's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and the responsibilities from this position fell to the DON to complete. The Administrator stated the DON was aware of her job responsibilities of training and performance evaluations for NA to be completed and tracked. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732		4/12/24

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F 732	Continued From page 53 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to display accurate daily nursing staffing information, the resident census on each shift, and/or maintain the daily nurse staff posting on file for 39 out of 39 days from February 2024 and March 2024 reviewed for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) for February 1, 2024, through March 10, 2024, was conducted. The staffing posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nursing Assistance (NAs) and Medication Assistant, the census (number of residents in the facility), a column for actual hours worked and a column for staffing total.	F 732	Immediate action(s) taken for the resident(s) found to have been affected include: Facility will ensure that the daily nursing staffing information is posted daily for all the sheets. The posting will be accurate and complete prior to posting. Identification of other residents having the potential to be affected was accomplished by: All residents have the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: 1. The Administrator, DON and Unit Manager were re-educated by the Chief Operating Officer on March 19, 2024, and April 8, 2024 on several topics	

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F 732	Continued From page 54 The number of unlicensed and licensed staff and actual hours worked during the evening shift, the night shift, and the facility census were not documented during the evening shift and night shift for the following days: 2/1/24, 2/2/24, 2/5/24, 2/6/24. 2/7/24, 2/12/24, 2/13/24, 2/16/24, 2/19/24, 2/20/24, 2/23/24, 2/24/24, 2/25/24, 2/26/24, 2/27/24, 2/28/24, 3/1/24, 3/4/24, 3/5/24, and 3/7/24. The number of unlicensed and licensed staff and actual hours worked during the night shift and the facility census were not documented for the following days: 2/9/24, and 2/10/24. Review of the Daily Nursing Staff sheet dated 3/10/24 showed the resident census was not completed for the evening shift and night shift. The facility was unable to provide staffing sheets for 2/3/24, 2/4/24, 2/8/24, 2/11/24, 2/14/24, 2/15/24, 2/17/24, 2/18/24, 2/21/24, 2/22/24, 3/2/24, 3/3/24, 3/6/24, 3/8/24, and 3/9/24. An interview was conducted on 3/12/23 at 10:09 A.M. with Front Desk Staff #1 who stated she filled out the daily nursing staff sheet for the shifts she was assigned to work at the front desk. The Front Desk Staff #1 indicated when she arrived in the morning for her shift, either the Scheduler took her the schedule for that day, or she went to the Scheduler to get the schedule. She used the information on the daily schedule to complete the daily nursing staff sheet. During the interview, the Front Desk Staff #1 indicated when her shift ended prior to the start of the 3:00 P.M. shift, her replacement was responsible for completing the daily nurse staffing sheet for the evening shift.	F 732	surrounding the March 10-13, 2024 survey to include maintaining sufficient staffing and accurate posting of staffing information. 2. The scheduler is responsible for completing the staffing sheets accurately. 3. The NHA, DON, and Unit Manager will ensure that the daily nurse staffing information is posted and is inclusive of all staff and all shifts. 4. Posting will appear on the interior glass door of the entrance. 5. Staffing sheets will be reviewed and approved with an initial by NHA/DON daily. 6. Results of the staff posting review will be discussed during the morning meeting to ensure the staffing for the next day is / was sufficient and covered. 7. All facility leadership team members (department heads) were educated on the importance of reviewing the staffing worksheet every time they enter the building April 8, 2024. 8. Call outs will be promptly handled by the facility leadership team (DON, Unit Manager, and scheduler) to secure replacement staffing at the time the call out is received. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Chief Operating Officer educated the senior leadership April 1, 2024 on the importance of posting the staffing as required. 2. Chief Operating Officer educated the senior leadership April 1, 2024 on the	

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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 732	Continued From page 55 The Front Desk Staff #1 was unsure who completed the daily nurse staffing sheet for the night shift. An interview was conducted on 3/12/24 at 5:25 P.M. with the Front Desk Staff #2. During the interview Front Desk Staff #2 stated the individual assigned to work the front desk during the first shift was responsible for completing the daily nursing staff posting sheet and she explained the sheet was completed prior to her arriving for her shift. The Front Desk Staff #2 indicated she had not completed the daily nursing staff sheet and did not review the daily nursing staff sheet when she started her work shift. An interview was conducted on 3/12/24 at 10:05 A.M. with the Administrator. During the interview, the Administrator stated the individual assigned to work the front desk was responsible for filling out the daily nursing staff sheet and posting the completed sheet on the window at the front entrance of the building. The Administrator indicated the daily nursing staff sheet should have been completed for each shift and then posted in the window where it was visible for anyone entering the building.	F 732	importance of knowing that the posted staffing worksheets are accurate and timely. 3. Audit results will be discussed by the QAPI team at the weekly meetings. 4. A member of the corporate clinical team will participate in the weekly QAPI meeting. Corrective action completion date: 4/12/24	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, staff interviews and a Physician interview, the facility failed to administer	F 760	1. Immediate action(s) taken for the resident(s) found to have been affected include:	4/12/24

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F 760	Continued From page 56 significant medications of a resident's medication regimen in the scheduled time frame that caused the resident to remain in bed for fear of falling due to feeling dizzy for 1 of 1 resident reviewed for administration of significant medications (Resident #211). Findings included: Resident #211 was admitted to the facility on 2/29/2024 with diagnoses including hypertension, atrial fibrillation, epilepsy (seizures), anxiety and pain. Resident #211's care plan dated 2/29/2024 included a focus for hypertension and atrial fibrillation, and interventions included giving antihypertensive medications as physician ordered and monitoring for side effects. Resident #211's care plan also included the use of anti-anxiety and seizure medications. Interventions included administering the medications as ordered by the physician, monitoring for side effects and effectiveness of the medications and seizure precautions. The admission Minimum Data Set (MDS) assessment dated 3/7/2024 indicated Resident #211 was cognitively intact and received anti-anxiety medications, opioids (pain relief medications) and antiplatelets (medications that prevent the blood to clot). A review of physician's orders indicated Resident #211 was ordered the following significant medications in her medication regimen on 2/29/2024: * Metoprolol Tartrate oral tablet 25 milligrams (mg) two tablets by mouth two times a day for	F 760	Resident #211 did not receive her morning medication in the allotted time. The Medical Director was notified and an order was received to give her morning medications at 11:09 am on 3/12/24. Resident was discharged as previously planned from the facility 3/12/24 at 3pm. No other medication were late for this resident on 3/12/24. 2. Identification of other residents having the potential to be affected was accomplished by: The facility leadership team which included the DON, Administrator, Corporate Clinical Team reviewed the medication administration times for all residents in the facility. No further negative outcomes were noted. 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: Medication Aide #7, Nurses #1, #3 were counseled and re-educated on medication administration including timeliness during the survey and again the week of April 8, 2024. Senior DON, Medication Aide Instructor will provide mandatory education to licensed nurses and medication aides. The education was provided 4/10/24. Education included the following: timely administration of medications, following physician’s orders and notifying the	

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F 760	Continued From page 57 hypertension. * Lorazepam oral tablet 0.5 mg one tablet by mouth two times a day for anxiety. * Lisinopril oral tablet 20 mg one tablet by mouth one time a day for hypertension. * Levetiracetam oral tablet 500 mg one tablet by mouth two times a day for seizure. * Dronedarone HCl oral tablet 400mg one tablet by mouth two times a day for heart failure. * Aspirin Enteric Coated Tablet Delayed Release 81mg one tablet by mouth two times a day for coronary artery disease/atrial fibrillation. A review of Resident #211's March Medication Administration Record (MAR) reported Metoprolol Tartrate, Lorazepam, Lisinopril, Dronedarone HCL and Aspirin were scheduled for administration at 8:30 a.m. daily and given. A review of Resident #211's medication audit report from 3/1/2024 to 3/12/2024 reported Resident #211 received her scheduled 8:30 a.m. medications after the one-hour time frame for administration on the following dates: * On 3/2/2024, Nurse #1 recorded medications were administered at 10:55 a.m. * On 3/3/2024, NA (Medications Aide) #7 recorded medications were recorded administered between 10:13am and 10:19 a.m. * On 3/4/2024. Nurse #3 recorded medications were administered at 11:06 a.m. * On 3/8/2024, NA (Medications Aide) #7 recorded medications were administered between 10:56 a.m. and 11:00 a.m. * On 3/12/2024, NA (Medications Aide) #7 recorded medications were administered between 10:57 a.m. and 11:02 a.m. A review of Resident #211's blood pressure	F 760	physician of any deviations from the orders. Licensed nurses and medication aides were not allowed to work until this training was completed. Daily review of medication administration times beginning April 7, 2024, via the "Medication Admin Audit Report" was initiated by DON. The facility nursing leaders (DON, Unit Manager) adjusted medication administration times April 8-12, 2024 for better compliance with timely medication administration. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON will monitor the medication administration performed by the nurses or medication aides for all residents to ensure medications are administered within the allotted timeframe using the "Medication Admin Audit Report" in the electronic medical record. Any deviations from the schedule will be communicated to the physician and will result in immediate corrective action. Monitoring will continue daily for 2 weeks and then weekly for 1 month. The DON will report the audit findings to the QAPI team weekly for 4 weeks or until QAPI team deems compliance. Corrective action completion date: 4/12/24	

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readings indicated a slight elevation on 3/3/2024 at 4:46 a.m. with a reading of 140/86, 3/3/2024 at 3:21 a.m. with a reading of 138/85, and on 3/11/2024 at 1:01 a.m. 142/74.

On 3/10/2024 at 10:34 a.m. in an interview with Resident #211, she said the nursing staff usually administered her medications between 8:00 am and 9:00 a.m., and there was one day since admission she received her scheduled morning medications at 11:00 a.m. She explained the morning she received her morning medications at 11:00 a.m., she was feeling dizzy by the time her medications were administered. She said she spoke to the nurse about receiving her morning medications earlier in the morning. She was unable to recall the date when her medications were given at 11:00 a.m. and the name of the nurse she had spoken with about receiving her medications earlier in the morning.

On 3/12/2024 at 8:21 a.m. in a follow up interview with Resident #211, she explained she didn't take her medications at home late in the morning and would experience dizziness, trembling and jitters when her medications were administered later in the morning around 11:00 a.m. She stated the dizziness, trembling and jitters disappeared after receiving her morning medications.

On 3/12/2024 at 9:27 a.m. NA (medications Aide) #7 was observed exiting the sparks unit with a medications cart and moving to the skills unit medication cart to begin the scheduled morning medications.

In an interview with NA (medications Aide) #7 on 3/12/2024 at 9:27 a.m., she explained she was assigned both medications carts for the sparks

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unit and the skills unit, and Nurse #6 and the Director of Nursing (DON) knew she was assigned both medications carts. She said had the keys to both medication carts since reporting to work at 7:00 a.m., and no one had been to get the keys for the skills medication cart to start the scheduled morning medications for the residents. She stated medications were to be administered one hour before or after the scheduled time, and due to starting the skills hall medication administration at this time, she would not be able to administered the residents' their scheduled morning medications on time.

On 3/12/2024 at 11:05 a.m., NA (medications Aide) #7 was observed in Resident #211 room and the skills unit medication cart outside the Resident #211 door. NA (medications Aide) #7 stated she had just administered Resident #211 her scheduled morning medications.

In an interview with Resident #211 on 3/12/2024 at 11:08 a.m., she stated she had asked three times for her scheduled morning medications and had just received her medications. She stated that due to feeling dizzy she had stayed in the bed so she wouldn't fall. Resident #211 denied needing to get out of bed while waiting to receive her medications and stated the dizziness would go away now that she had been administered her scheduled morning meds.

In an interview with Nurse #4 on 3/13/2024 at 2:44 p.m., he stated he couldn't recall why the medications were given after the scheduled time frame on 3/2/2024 to Resident #211. He explained usually there was one nurse or medication aide assigned to both the sparks unit medication cart and the skills unit medication

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cart, and it was not unusual for residents' medications to be administered medications after the scheduled time frame. He further stated on 3/2/2024 he did not inform the physician Resident #211's mediations were administered after the scheduled time frame and was not a usual practice.

Attempts to interview Nurse #3 were unsuccessful.

In an interview with Nurse #6 on 3/13/2024 at 2:35 p.m., she stated as unit manager she notified the physician when medications were administered after the scheduled time frame and called the physician on 3/12/2024. She stated she was not aware on 3/2/2024, 3/3/2024, 3/4/2024 and 3/8/2024 Resident #211 received her medications after the scheduled time frame. She explained on 3/12/2024 NA (Medication Aide) #7 was assigned the medication cart for the sparks and skills unit because there were only four nurses/medication aides scheduled and there were five medication carts in the facility. She stated she did not work the medication cart often, and the Director of Nursing (DON) made the decision when the unit manager worked a medication cart if not enough staff. She said on 3/12/2024, the DON made decision for her to not work a medication cart.

In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:15 a.m., she explained scheduled medications were to be administered one hour before or after the scheduled time, and Resident #211 receiving her scheduled morning medications after 11:00 a.m. was not acceptable. The DON explained usually with one medication aide and a nurse covering the hall, residents'

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F 760	Continued From page 61	F 760		

medications were administered in the scheduled allotted time frame. She explained on 3/13/2024 due to a scheduled medication aide calling out, NA (Medication Aide) #7 was assigned both the sparks unit and skills unit medication cart. She stated Nurse #6 was assigned to the cover sparks unit and skills unit for nursing tasks and it would had been best if she had been assigned one of the medication carts for administration of medications in the scheduled time frame for Resident #211.

In a phone interview with Physician #1 on 3/13/2024 at 1:54 p.m., he stated Resident #211's scheduled morning medications should be administered in the allotted time frame. He explained the nursing staff informed him on 3/12/2024 there was a delay in administering Resident #211's medications and noted the reason was due to staffing. He stated Resident #211 receiving her scheduled morning medications two hours after the allotted scheduled time frame was not acceptable and should not cause any harm. He explained that Resident #211 not receiving the Metoprolol Tartrate (a medication for high blood pressure) medication timely could have caused some slight dizziness. Physician #1 said he was not notified of Resident #211 not receiving her morning scheduled medications in the allotted time frame on 3/2/2024, 3/3/2024, 3/4/2024 and 3/8/2024, and the facility needed to improve in administering scheduled medications in a timely manner.

In an interview with the Administrator on 3/13/2024 at 4:27 p.m., she explained that due to residents' complaints of receiving medications late, the nursing staff received an in-service in

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F 760	Continued From page 62 administering medications in a timely manner one to two months ago. She stated Resident #211 should have received her medications one hour before or after the scheduled time.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed secure the keys for a medication cart when Medication Aide #7 left the medication cart keys for the skilled-hall medication cart in	F 761	1. Immediate action(s) taken for the resident(s) found to have been affected include: The keys to the Skilled Hall medication	4/12/24

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F 761	Continued From page 63 Resident #211's room. This deficient practice was for 1 of 5 medication carts in the facility. Findings included: On 3/12/2024 at 11:05 a.m., Medication Aide #7 was observed locking the skilled-hall medication cart and positioning the medication cart against the wall outside Resident #211's door before walking down the hall away from Resident #211's door. On 3/12/2024 at 11:08 a.m., during an interview with Resident #211, she picked up a double ring key chain and stated the Medication Aide #7 had left the keys in her room after administering her medications. Three keys were observed on one ring and four keys were observed on the other ring. On 3/12/2024 at 11:11a.m., when Medication Aide #7 returned to Resident #211's room, Resident #211 was observed holding up the double ring key chain and stating, "You forgot these." Medication Aide #7 with a surprise facial gesture stated, "Oh" and gathered the keys from Resident #211. Medication Aide #7 explained the keys were to the skilled-hall medication cart. On 3/12/2024 at 11:13 a.m. in an interview with Medication Aide #7, she stated the keys were to the skilled-hall medication cart positioned outside Resident #211's room and should always be kept in her possession. In a follow up interview with Medication Aide #7 on 3/13/2024 at 3:05 p.m., she stated she had laid the keys to the medication cart down in Resident #211's room to administer her medications, and Resident #211 had some questions about her discharge	F 761	cart were returned within minutes to the Med Aide. All medication cart keys were accounted for and in the possession of the authorized employees assigned to the carts. The Med Aide was counseled and re-educated on medication cart safety during the survey by the Director of Nursing. Carrolton Senior DON reviewed a medication pass to include safe medication cart safety and handling of the cart keys. The Carrolton Sr. DON found the medication aide to be competent to pass medications safely on April 10, 2024. 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 however, none were negatively impacted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nurses and Medication Aides were educated on medication storage safety in a mandatory in-service April 8-11, 2024, by the DON. All licensed nurses and medication aides were not allowed to work until attending the in-service. Education included: locked compartments	

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F 761	Continued From page 64 medications. She explained when she left Resident #211's room to address her questions, she forgot to get the keys to the skilled-hall medication cart. On 3/13/2024 at 12:10 p.m. in an interview with the Director of Nursing, she stated keys to the skilled hall medication cart were to remain in Medication Aide #7 as all times and leaving the keys in Resident #211's room was not acceptable practice.	F 761	for all drugs and biologicals, only authorized personnel will have access to the keys to the locked compartments, and the keys will not be left unattended at any time by authorized personnel. Newly hired licensed nurses and medication aides will be educated on medication administration by the DON or designee, to include medication cart safety and safe handling of the keys as a part of orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON will monitor medication cart safety 3 times a week for 2 weeks and then weekly for 4 weeks to ensure the medication cart and keys are always secure. Audit results will be presented by the DON and discussed by the QAPI team at the weekly meetings for 4 weeks or until compliance is achieved. Corrective action completion date: 4/12/24	
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F 805		4/12/24

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F 805	Continued From page 65 Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide a pureed food item with a smooth consistency. This failure had the potential to affect 9 of 105 residents with diet orders for a pureed diet texture. The findings included: A review of the Diet Order Report dated 3/12/24 revealed 9 residents with diet orders for a pureed diet texture. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. A continuous observation of the lunch meal tray line on 3/12/24 from 11:43 AM - 11:56 AM revealed Cook #1 recorded the internal temperature of the food items stored on the tray line intended for the lunch meal service, including pureed egg noodles. The pureed egg noodles were observed with a lumpy consistency smaller than pea-sized when the food was stirred. Cook #1 stated she intended to serve the pureed egg noodles as it was. The District Manager observed the lumpy consistency and told Cook #1: "There are chunks in there but all squishy." The District Manager removed the pureed egg noodles from the tray line to further blend. The pureed egg noodles were a smooth pureed consistency. Cook #1 was interviewed on 3/12/24 at 12:44 PM. She stated that puree consistency was supposed	F 805	Immediate action(s) taken for the resident(s) found to have been affected include: Dietary Staff and Dietary Manager were in-serviced by the Dietary Regional Manager on proper puree consistency during meal service from April 5th through April 11th. Identification of other residents having the potential to be affected was accomplished by: All residents who have a pureed food or a mechanical soft diet have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: 1. Audit Tool will be utilized by the Cook verifying that all items during meal service are served at the correct consistency at breakfast, lunch, and dinner. If the consistency is not correct the food will not be served until the correct consistency is obtained. 2. Dietary manager will ensure by visualization that patients are served food at the correct consistency by completed reviews daily for 4 weeks. 3. RD will monitor the serving line weekly by observation to determine accuracy of diet consistency for 4 weeks. 4. HSG District manager will review the audit tools weekly to ensure accuracy of food consistency and foods served. 5. HSG District Manager will review and monitor the serving line 3 times per week to ensure that food consistency is	

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F 805	Continued From page 66 to look like baby food, smooth, and no chunks. Cook #1 stated she had learned how to prepare the pureed food on her own from previous work experience. She revealed that she did not pay attention to the pureed egg noodles before placing on the tray line because she was not the one who prepared it. She indicated that the puree foods were prepared the day before, but she did not know by whom. An interview was conducted with the Dietary Manager on 3/12/24 at 12:46 PM. She revealed that Dietary Aide #1 had prepared the pureed egg noodles. The DM indicated that puree consistency was supposed to be like pudding. She stated that Dietary Aides participate in the preparation of pureed food and other parts of the meal. She further stated that Cook #1 should have inspected the pureed food before placed on the tray line. The DM revealed that Dietary Aide #1 was re-hired 2 weeks ago, and training/education was provided upon rehire. An interview was conducted on 3/12/24 at 12:48 PM with the District Manager. She confirmed that there were lumps in the pureed egg noodles. The Speech Therapist (ST) was interviewed on 3/12/24 at 4:06 PM. She revealed she began at the facility in January 2023 as needed. The ST stated she had not seen pureed foods that caused concern or to question the consistency. However, she normally visited the facility twice weekly. If pureed foods were lumpy, they could be a choking hazard and could lead to aspiration pneumonia. The ST indicated that the expected consistency of puree foods should be like baby food. If a food was modified with a machine, it should have a uniform consistency, which can be	F 805	accurate. 6. All new dietary staff will be trained on providing food in the consistency ordered. How the corrective action will be monitored to ensure the practice will not recur: 1. HSG team audits will be provided to the administrator for signature upon completion. 2. Results of the above detailed audits will be reviewed in the weekly QAPI meeting 4 weeks and longer if the deficient practice is not deemed corrected. Corrective action completion date: 4/12/24	

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F 805	Continued From page 67 achieved by liquids or corn starch or bread or milk. The Administrator stated in an interview on 3/13/24 at 8:16 AM that whatever the diet order said in the medical record was the expected consistency. She stated that the kitchen staff should have further blended the pureed egg noodles immediately, and it should have never touched the tray line with a lumpy consistency.	F 805		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, North Carolina Board of Nursing Registry, observations, resident interviews, staff interviews and a Physician interview, the facility failed to provide effective leadership and oversight to ensure the Director of Nursing (DON) implemented her responsiblities in these areas: sufficiently staffing the facility to administer medications in a timely manner, having a registered nurse work eight consecutive hours daily and a DON who worked full time and only serves as a charge nurse when census was less than 60 residents, monitoring and tracking expiration of nursing licenses (Nurse #3) and nurse aide certifications (NA #9, NA # 4, NA #1, and NA #8), completing yearly performance evaluations for nurse aides (NA #4, NA #7, NA #6 and NA #5) and providing and monitoring 12	F 835	Immediate action(s) taken for the resident(s) found to have been affected include: Chief Operating Officer counseled and educated NHA and DON about the required changes for systems and accountability within the facility at all levels. Initial meeting occurred on Monday, March 28, 2024 and subsequent daily calls and weekly face to face meetings have been held since. Carrolton of Williamston will receive daily management oversight from Carrolton Facility Management by the Chief Operating Office, Corporate Nurse Consultant, and Chief Clinical Officer to	4/12/24

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F 835	Continued From page 68 hours of annual training for nurse aides (NA #4, NA #7, NA #6 and NA #5). This deficient practice had the potential to affect 105 of 105 facility residents. Findings included: This tag is cross reference to: F725: Based on observations, record review, resident interview, staff interviews and a Physician interview, the facility failed to provide sufficient nursing staff to ensure a resident was administered morning scheduled medications in the allotted time frame for 1 of 1 resident reviewed for significant medications (Resident #211). Resident #211 not receiving her scheduled morning medications in the allotted time frame caused Resident #211 to remain in bed for fear of falling due to feeling dizzy. F727: Based on record reviews and staff interviews, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days a week, to designate a director of nursing (DON) who worked on a full-time basis, and to have the DON only serve as a charge nurse when the average daily census was 60 residents or less for 23 of 39 days reviewed for staffing. F729: Based on observation, record review and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 5 of 47 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry with an active Nurse Aide I certification (NA #6, NA #9, NA #4, NA #1,and NA #8).	F 835	ensure NHA and DON responsibilities are implemented in the following areas: 1. Sufficient nursing staffing daily to ensure timely med administration 2. RN coverage 7 days per week / 8 hours per day 3. No DON floor coverage as charge nurse while census is over 60 patients 4. Tracking of nurse licensure and expiration 5. Nurse Aide Competency 6. Annual evaluations 7. Inservice hours for CNAs completed and documented equal to 12 hours Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by system failure occurring from the above mentioned items. One resident was identified during the survey to be impacted by late medication times. No others were negatively impacted. Actions taken/systems put into place to reduce the risk of future occurrence include: 1. Chief Operating Officer met with the nursing administrative nurses to discuss the survey plan of corrections, deficiencies, and plans for correction. 2. Chief Operating Officer and Chief Clinical Officer met with the Administrator on April 4, 2024 to discuss the survey plan of corrections, deficiencies, and plans for correction. 3. Aggressive recruitment plans have been established and implemented for	

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F 835	Continued From page 69 F730: Based on staff interviews and record reviews, the facility failed to complete a performance review every 12 months for 4 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #4, NA #7, NA #6, and NA #5). F839: Based on observations, record review, North Carolina Board of Nursing (NCBON) verification registry and staff interviews, the facility failed to ensure Nurse #3, who was observed providing resident care at the facility, maintained a current and active professional nursing licenses with the NCBON for 1 of 12 nurses reviewed. F947: Based on record review and staff interviews, the facility failed to ensure at least 12 hours of annual training to include dementia and areas of weakness as determined in the nursing aides' performance reviews were completed for 4 Nursing Assistants (NA #4, NA #7, NA #6, and NA #5) of 5 reviewed for staffing. In an interview with the Administrator on 3/13/2024 at 6:00 p.m., she explained in June 2023 the corporate office made the decision not to use agency nursing staff in the facility, and due to the location of the facility in the non-healthcare community, she was finding it hard to recruit nurses to the facility. She explained the Director of Nursing had only had a few days with another sister facility's Director of Nursing (DON) since her employment date 1/8/2023 and the facility could not locate the DON's competency worksheets since her employment. She explained that due to her (the Administrator) nursing background, she helped to ensure resident care	F 835	more staff. 4. Sponsored ads have been placed for additional staff members to hire to ensure sufficient staffing is available. 5. A campaign to re-recruit former nursing staff members was initiated on April 1, 2024 and is ongoing. 6. Electronic system was implemented to manage certifications and licenses to ensure only licensed personnel are working in the facility. 7. Annual servicing plan was implemented by CFM to ensure that one hour of inservice training is provided monthly (calendar year) assuring that the 12 hours required education is obtained. 8. Memorandum was provided to the NHA and DON from Chief Operating Officer outlining the expectations change within the facility for all areas impacted in survey. 9. Appropriate remediation will be provided and managed for the Administrator and Director of Nursing to ensure skill development related to all survey deficiencies, regulations, and effective leadership. These will be managed as personnel issues confidentially. 10. In the event remediation is not effective, the Chief Operating Officer and Chief Clinical Officer to take action immediately to change leadership in an effort to ensure patient needs are met. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Staffing worksheets will be provided	

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F 835	Continued From page 70 was provided and assisted with Minimum Data Set (MDS) assessments as needed. She stated she needed a staff development position in the facility to minimize workload of the DON and herself, and there had been an increase the nursing pay scale in attempt to attract nurses to the facility.	F 835	to the corporate compliance team daily for a period of four weeks to ensure that RN coverage is provided in accordance with regulations for 4 weeks. Compliance team members will review and provide notification to the Operation and Clinical Team of disparities. 2. Assignment sheets will be provided to the corporate compliance team daily for a period of four weeks to ensure that RN coverage is provided in accordance with regulations for 4 weeks. Compliance team members will review and provide notification to the Operation and Clinical Team of disparities. 3. Weekly meetings will be held with the Administrator and Director of Nursing to review staffing, communication, and scheduling for a period of 4 weeks and then bi-weekly until complete resolution has been attained. 4. Audit results will be discussed by the QAPI team at the weekly meetings for 8 weeks. 5. A member of the corporate clinical team will participate in the weekly QAPI meeting. Corrective action completion date: 4/12/24	
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.	F 839		4/12/24

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F 839	Continued From page 71 §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observations, record review, North Carolina Board of Nursing (NCBON) verification registry and staff interviews, the facility failed to ensure Nurse #3, who was observed providing resident care at the facility, maintained a current and active professional nursing licenses with the NCBON for 1 of 12 nurses reviewed. Finding included: A review of the nursing licensure audit conducted by the facility on 3/11/2024 reported Nurse #3's license expired on 2/29/2024. The electric NCBON Registry listed Nurse #3's license with an expiration date of 2/29/2024. A review of the employee time sheet for Nurse #3 indicated she had worked at the facility since 2/29/2024 on the following dates: * 3/1/2024 from 7:22 a.m. to 3:25 p.m. * 3/4/2024 from 7:02 a.m. to 3:00 p.m. * 3/5/2024 from 7:12 a.m. to 7:34 p.m. * 3/6/2024 from 7:19 a.m. to 3:33 p.m. * 3/7/2024 from 7:25 a.m. to 3:08 p.m. * 3/9/2024 from 7:36 a.m. to 3:24 p.m. * 3/10/2024 from 7:15 a.m. to 3:23 p.m. * 3/11/2024 from 7:00 a.m. to 3:25 p.m. On 3/10/2024 at 10:30 a.m., Nurse #3 was observed working on the Skills Unit (the hall that housed residents that were admitted for rehabilitation therapy).	F 839	1. Immediate action(s) taken for the resident(s) found to have been affected include: Nurse #3 was suspended from work and removed from the hall immediately upon learning of the nurse licensure lapse. The facility performed a complete audit of all nurse certification files during the March 10-13, 2024, to determine the licensure status of all working nurses. A complete audit was executed specifically to determine licensure expiration dates. Nurse #3 was the only nurse with an expired license. 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 but there are no known negative impacts to any resident. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Carrolton policy “Credentialing/Nurse License and Nursing Assistant Certification Verification” was revised on March 30, 2024, to include additional corporate oversite of licensure and verification by the Carrolton Facility Management (CFM) Human Resources	

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F 839	Continued From page 72 On 3/11/2024 at 8:49 a.m., Nurse #3 was observed conducting a medication pass to Resident #211 on the Skills Unit. Attempts to reach Nurse #3 for an interview were unsuccessful. In an interview with Accounts Payable Personnel on 3/13/2024 at 4:21 p.m., she stated she was responsible for only verifying nursing licensure before conducting background checks on new employees and was not responsible for keeping a record of when nursing licenses expired. She explained she provided the DON with a list of the licensure dates when new nurses were employed, and the DON was responsible for keeping up when Nurse #3's license expired. She stated the last DON kept a record of when each nurses' license expired and was unsure if the new DON was aware she was responsible to monitor expiration of Nurse #3's license. In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:04 a.m., she explained she was not aware Nurse #3's license had expired on 2/29/2024 until the Administrator informed her on 3/12/2024. She stated Nurse #3 last worked at the facility on 3/11/2024, and she had not been able to contact Nurse #3 per phone. She further explained there had been no changes in Nurse #3 responsibilities as a nurse at the facility since the expiration date. The DON stated she started at the facility as the DON on 1/8/2024 and had not been tracking nursing licenses for expirations because she had not been informed it was her responsibility. The DON further stated she had not reported to the NCBON that Nurse #3 had worked without an active nursing license.	F 839	Department. Corporate will prepare a report monthly and will validate every facility and staff listing to determine that all nurse licenses are current, active, and valid. The facility Director of Nursing and payroll clerk were re-educated on April 8, 2024, by the facility Chief Clinical Officer regarding Carrolton policy "Credentialing/Nurse License and Nursing Assistant Certification Verification". The Administrator and DON are fully responsible for ensuring that only currently licensed nurses are working with our patients. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator will complete random weekly licensure and certification audits for 3 nurses for 4 consecutive weeks and 3 nurses monthly for 2 months to ensure that licenses and certifications have not expired. The CFM Human Resource Department will run licensure and verification reports for all Carrolton facilities, including Carrolton of Williamston, monthly to ensure that all licensed nurses are maintaining current licensure and or certification. Monthly licensure audit reports will be presented to the weekly QAPI committee for four weeks. After 4 weeks the audit will become standardized on a monthly rotation.	

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F 839	Continued From page 73 In an interview with the Administrator on 3/13/2024 at 1:01 p.m., she stated when she conducted a licensure audit for all nursing staff on 3/11/2024, she discovered Nurse #3's license expired on 2/29/2024. She explained initially Accounts Payable did the verification of nursing licensure for new employees before providing the licensure information to the DON, and the DON was responsible for monitoring expiration of Nurse #3's license. The Administrator stated since the new DON's employment, she had reviewed the DON job description with the DON and was unsure if the DON had the information needed to monitor expiration of Nurse #3's license. The Administrator further stated she had not reported Nurse #3 to the NCBON for working without a license but would notify the agency that day.	F 839	Audit records will be reviewed by the Quality Assurance Committee until such time as consistent substantial compliance has been achieved and confirmed by the committee. Compliance Date: April 12, 2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		4/12/24

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F 842	Continued From page 74	F 842		

(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services

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F 842	Continued From page 75 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record related to documentation of the treatment for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #19). Findings included: Resident #19 was admitted to the facility on 10/27/2023. Physician orders dated 2/29/2024 included an order to cleanse the right heel with wound cleaner, to apply collagen particles before applying calcium silver alginate and a foam heel dressing and to secure the dressing with kerlix (a wrap to hold primary and secondary dressings in place) every other day for wound healing. A review of the March 2024 Treatment Administration Record (TAR) for Resident #19 indicated Nurse #3 recorded providing treatment of the right heel pressure ulcer on 3/11/2024. During observation of wound care to Resident #19's right heel pressure ulcer on 3/12/2024 at 10:05 a.m., the old foam dressing to the right heel was observed dated 3/9/2024 with Nurse Aide #6	F 842	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 3/12/24 an order was obtained to change the dressing to the resident # 19 right heel. Resident #19 dressing to the right heel was changed on 3/12/24. The documentation on resident #19 3/11/24 TAR has been corrected. 2. Identification of other residents having the potential to be affected was accomplished by: The DON and Chief Clinical Officer reviewed all scheduled treatments, wound specialist (QSM) recommendations and documentation on the treatment administration records (TARs) 4/7/24 through 4/9/24. The facility has determined that all residents with wounds have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 842	Continued From page 76 initials. On 3/12/2024 at 10:12 a.m. in an interview with the Director of Nursing (the nurse who provided Resident #19's wound care on 3/12/202), she stated Nurse #3 had documented on 3/11/2024 changing the pressure ulcer dressing to the right heel on Resident #19's TAR. She stated obviously based on the date (3/9/2024) and initials (Nurse Aide #6) on the right heel dressing when she changed Resident #19's right heel dressing, Nurse #3 did not change the right heel dressing on 3/11/2024. The Director of Nursing explained Nurse Aide #6 was a Medication Aide and Nurse Aide II who had been trained to help the Wound Care Nurse with Stage I and Stage II dressing changes. The Director of Nursing further explained due to the absence of the Wound Care Nurse, she had informed Nurse #3 on 3/11/2024 she was responsible for Resident #19's wound care, and Nurse #3 assured her she had performed Resident #19's wound care. Attempts to interview Nurse #3 were unsuccessful. In another interview with the Director of Nursing (DON) on 3/13/2024 at 11:35 a.m., she explained Nurse #3 falsified documentation on Resident #19's TAR by documenting wound care to the right heel was performed on 3/11/2024. She stated Nurse #3 had not answered her calls to discuss the documentation of wound care, and documentation should be accurate on Resident #19's TAR. In an interview with the Administrator on 3/13/2024 at 5:04 p.m., she stated documentation on Resident #19's TAR should reflect adequate	F 842	Licensed nurses, Treatment Nurses, and Treatment Aides were educated on documentation requirements 4/8/24-4/11/24. The education included documentation will be timely, factual, accurate and complete, and documentation prior to the task being completed is not allowed. Licensed nurses will not be allowed to work if this education ash not been completed. New nurses will be educated on documentation requirements in orientation by the Facility Nurse Consultant, DON, or designee. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON or designee will audit 5 TARs for accurate documentation weekly for 4 weeks, then monthly for 2 months to ensure the documentation is accurate. The DON will report the audit results to the facility QAPI committee for 3 months or until the QAPI committee deems that compliance has been met. Corrective action completion date: 4/12/24	

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F 842	Continued From page 77 documentation that treatments were recorded correctly.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §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,	F 867		4/12/24

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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.

§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

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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.

§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 observation, resident interview, Wound

1. Immediate action(s) taken for the

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F 867	Continued From page 80 Care Physician Assistant interview, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee following the recertification and complaint investigation surveys of 6/10/21 and 11/18/22 and the complaint investigation surveys of 2/27/23 and 9/7/23. This was for 6 deficiencies that were recited on the current recertification and complaint investigation survey of 3/13/24 in the areas of Resident Rights (F550), Environment (F584),Treatment and Services for Pressure Sores (F686), Supervision to Prevent Accidents (F689), Medication Storage (F761), and Complete/Accurate Medical Records (F842). The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F550: Based on record review and staff interviews, the facility failed to ensure staff communicated to a resident in a respectful and dignified manner for 1 of 2 resident reviewed for dignity (Resident #93). The reasonable person concept was applied to this deficiency as individuals have the expectation to be addressed by staff using language and tone that portrays respect and dignity. During the recertification and complaint investigation survey of 6/10/21, the facility was cited for failing to ensure residents were spoken to in an appropriate manner and for staff to sit while feeding residents.	F 867	resident(s) found to have been affected include: The Administrator and members of the Clinical Corporate Team met with NHA, DON, and department heads immediately following the survey to review QAPI opportunities and failures. All deficiencies mentioned in the exit conference were discussed in great detail. Plans of correction were discussed. Education needs were discussed and schedule was determined. An Ad-HOC QAPI meeting will be held 4/8/24 to discuss POCs submitted for the survey conducted March 10th through March 13th, 2024. QAPI schedule was changed from monthly to weekly for the next 2 months. 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 however no residents have been negatively impacted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Corporate Clinical Team provided education to the Administrator and DON on QAPI requirements the week of 4/8/24. The education included QAPI requirements, root cause analysis process, definitions, using data to impact outcomes, and maintaining ongoing monitoring until compliance is achieved. Audits were assigned to all department	

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F 867	Continued From page 81 During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to ensure residents were spoken to in a dignified manner when a staff member scolded a resident. F584: Based on observation and staff interviews, the facility failed to ensure bathrooms (Room #57, #60, #61, #65, #67/69, #70) on the locked unit were free of fecal matter or black/brown matter on various surfaces for 6 of 10 bathrooms reviewed for clean and homelike living environment. During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to ensure the walls and lighting fixtures on 3 of 4 units were maintained in good repair. F686: Based on record review, observations, staff interviews and interviews with Wound Care Physician Assistant (PA), the facility failed to (1) perform wound care to a pressure ulcer per physician's order (Resident #19), (2) set the alternating pressure air mattress at the correct setting based on the resident's weight (Resident #104), and (3) change the treatment for a pressure ulcer when ordered by the Wound Care PA (Resident #77) for 3 of 4 residents reviewed for pressure ulcers. During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to update a physician's order for wound treatment and failed to apply to correct treatment to the wound.	F 867	managers as well as audit schedules and content. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Nursing consultant/corporate designee will review the participate in the QAPI/QAA meeting minutes monthly for 2 months to ensure ongoing compliance with state regulations for an effective QAPI system. Successes and failures of the audits will be brought through the facilities monthly QAPI meeting monthly x 3 months to evaluate the need for resolution or need for continued monitoring. Corrective action completion date: 4/12/24	

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F689: Based on record review, resident interview, and staff interviews, the facility failed to implement effective interventions to prevent a severely cognitively impaired resident (Resident #46) from hitting another resident (Resident #31) in the face two days after he initially exhibited physically aggressive behaviors directed toward another resident (Resident #55). Resident #31 sustained a scratch to the face as a result of the incident. This was for 1 of 4 residents reviewed for accidents (Resident #46).

During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing ensure an outlet with exposed wiring was not accessible to residents.

During a complaint investigation survey on 2/27/23, the facility failed to provide care in a safe manner resulting in a hematoma and a left ankle fracture for a resident.

F761: Based on observations and staff interviews, the facility failed secure the keys for a medication cart when Medication Aide #7 left the medication cart keys for the skilled-hall medication cart in Resident #211's room. This deficient practice was for 1 of 5 medication carts in the facility.

During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to keep medications locked in an unattended treatment cart.

During a recertification and complaint investigation survey on 6/10/21, the facility failed to discard expired medications, to monitor the temperature for refrigerated medications, and to

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F 867	Continued From page 83 ensure unattended medications carts were locked. F842: Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record related to documentation of the treatment for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #19). During a complaint investigation survey on 9/7/23, the facility failed to accurately document wound treatments provided to residents. In an interview on 03/13/24 at 06:25 PM, the Administrator said the QAA Committee monitored issues that were cited on previous surveys but only for a short length of time relative to the issue and were not reviewed again.	F 867		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		4/12/24

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F 947	Continued From page 84 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure at least 12 hours of annual training to include dementia and areas of weakness as determined in the nursing aides' performance reviews were completed for 4 Nursing Assistants (NA #4, NA #7, NA #6, and NA #5) of 5 reviewed for staffing. Findings included: a) NA (Nursing Aide) #4's date of hire was 10/1/20. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. b) NA # 7's date of hire was 10/1/20. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. c) NA #6's date of hire was 9/7/22. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. d) NA #5's date of hire was 10/4/22. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. Review of a dementia in-service training dated	F 947	1. Immediate action(s) taken for the resident(s) found to have been affected include: An audit was completed on 4.1.24 to determine the in-service hours needed by each CNA. Thorough review revealed inservice hours inadequate for all staff. No resident was negatively impacted by the insufficient training hours. In-services (mandatory) for all nursing staff were conducted on April 9, 10, and 11, 2024. The facility reviewed the personnel files for all NAs including NA # 4, #7, #6 and #5 and scheduled performance reviews for all NAs found to be out of compliance with this standard. 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, however, no resident has been negatively affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Carrolton Facility Management (CFM) revised the staff development program to include policy #22.5 “Nurse Aide Training	

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F 947	Continued From page 85 1/23/24 showed NA #5 had not signed the attendance roster. No other in-service was provided to show NA #5 had completed dementia training. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated the NA performance reviews had not been completed due to high turnover in the DON position. The DON explained she had conducted training with staff through in-services for dementia and abuse, but she had not provided individual training to the NAs based on the outcome of their performance evaluations. The DON did not provide a reason why NA #5 had not completed the dementia training. An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no annual training logs kept showing the courses the NAs had completed. The Administrator indicated the in-services completed by staff in January 2024 did not provide the length of hours for each in-service and she was unable to determine how many hours the training lasted. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON. The Administrator stated the DON was aware her job responsibilities included completing annual training on all staff. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error.	F 947	Program" on March 30, 2024. The policy outlines the basic components of the NA training program including responsible persons for program implementation and the process for providing education based on the NAs areas of weakness. The Director of Nursing (DON) is responsible for ensuring that the nursing staff members receive education and have in-service hours monthly. The Administrator is responsible for ensuring that DON has provided and required staff attendance at mandatory in-services. The facility Administrator, Director of Nursing (DON) and payroll clerk were educated on April 8, 2024, by the Chief Clinical Officer on Carrolton policy # 22.5 "Nurse Aide Training Program". The Payroll / HR Clerk ensure the last week of the month that no licenses or certifications have expired before allowing staff members to be scheduled by the nursing department. NA performance evaluations will be completed by the Director of Nursing the week of April 8, 2024, for all NAs found to be past due with performance evaluations. Areas of weakness will be noted, and education/re-education will be provided in accordance with agency policy. All NAs, including NA # 4, #7, #6 and #5, have been scheduled to complete 4 hours	

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of in-service education including Dementia Management/Care of the Cognitively Impaired and Resident Abuse Prevention prior to April 12, 2024.

The facility NA training calendar was revised in accordance with policy # 22.5 to assure that all NAs will complete no less than 12 hours of education each year.

The DON or designee will ensure that monthly in-services are carried out as scheduled on-going.

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

The Administrator will audit the NA education records to assure that all NAs have completed 4 hours of in-service education including Dementia Management/Care of the Cognitively Impaired and Resident Abuse Prevention prior to April 12, 2024.
The administrator will complete a monthly audit of 5 random NA records for the next 3 months to assure that NAs are completing in-services as scheduled (including education in areas noted as areas of weakness in the NAs performance review). CFM Clinical Compliance Team will monitor the results of these audits.
Corporate HR Director will monitor in-service hour provision to be certain all employees are trained and certified.

Audit records will be reviewed by the

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F 947	Continued From page 87	F 947	Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Compliance Date: April 12, 2024	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 636	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345145	A. BUILDING: _____ B. WING _____	3/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to complete a comprehensive assessment within the required timeframe for 1 of 41 residents reviewed for comprehensive Minimum Data Set (MDS) assessments (Resident #29).

Findings included:

Resident #29 was admitted to the facility on 1/13/2014.

Review Resident #29's annual MDS dated 12/19/23 showed the assessment was signed as completed on 1/8/24. The annual MDS assessment was also noted as transmitted and accepted on 1/11/24.

Resident #29's annual MDS dated 12/19/23 was not found in the CMS (Centers for Medicare & Medicaid Servies) database as having been transmitted or accepted.

During an interview with the MDS Nurse on 3/13/24 at 8:25 A.M she indicated she was aware of the timeline requirements for completion of the MDS assessments. She explained she had been out of the office when Resident #29's annual MDS assessment was due, and she was unsure when it had been transmitted.

An interview was conducted with the Administrator on 3/13/24 at 1:01 P.M. The Administrator stated she had identified late MDS assessments during a spot check and worked to get them caught up. She stated she was aware of the required completion date had been missed and stated the deadline shouldn't have been missed.