STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/21/24 through 10/24/24. The facility was found compliant with the requirment CFR 483.73, Emergency preparedness. Event ID# VXLK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/21/24 through 10/24/24. Event ID# VXLK11. The following intakes were investigated: NC00203700, NC00204810, NC00209972, NC00210919, NC00212353, NC00212698, NC00212937, NC00213411, NC00213664, NC00219536, NC00221536, NC00221561, and NC00222631. 4 of the 29 complaint allegations resulted in deficiency.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		11/21/24

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

Electronically Signed | 11/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to provide written advance directive information and/or an opportunity to formulate an advance directive for 10 of 33 residents reviewed for advance directives (Residents #2, #14, #22, #42, #45, #49, #72, #80, #109, and #427). The findings included: a. Review of Resident #2's medical record revealed the Resident was admitted to the facility on 10/01/05 with diagnoses that included heart failure, chronic obstructive pulmonary disease,	F 578	Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to provide written advance directive information for Residents #2, #14, #22, #42, #45, #49, #72, #80, #109, and #427. Medical Orders for Scope of Treatment (MOST) forms are now in place for residents #22, #42, #45, #49, #72, #80, #109, and #427. Residents #2 and #14 have been discharged from the facility. Social Workers were immediately educated by the facility Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 578	Continued From page 2	F 578		

and a history of a stroke. The review revealed a full code Physician order dated 8/23/24. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.

b. Review of Resident #14's medical record revealed the Resident was admitted to the facility on 2/8/19 with diagnoses that included diabetes, heart failure, and kidney failure. The review revealed a full code Physician order dated 10/18/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.

c. Review of Resident #22's medical record revealed the Resident was admitted to the facility on 1/8/11 with diagnoses that included heart disease and chronic obstructive pulmonary disease. The review revealed a do not resuscitate Physician order dated 7/10/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.

d. Review of Resident #42's medical record revealed the Resident was admitted to the facility on 10/27/16 with diagnoses that included a history of a stroke and diabetes. The review revealed a do not resuscitate Physician order dated 8/24/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.

e. Review of Resident #45's medical record

regarding the use of the MOST Form along with Code status verification during Advanced Care planning Meetings.

Identification of other residents having the potential to be affected was accomplished by:
The Social Work Supervisor and Minimum Data Set (MDS) Coordinator completed a 100% resident population audit of the resident code status orders to include MOST Forms. This audit was concluded by November 14, 2024.
Facility Social Workers completed a 100% advanced directive preference audit that concluded by November 14, 2024.
All residents of this facility have the potential to be affected by this practice.

Actions taken/systems put in place to reduce the risk of future occurrence include:
All nursing, social work, and medical records staff were in-service by the Administrator on Residents Rights to request, refuse, and/or discontinue treatment to formulate an advanced directive. This education was initiated and completed on November 7, 2024.
Facility Social Workers have initiated the introduction of MOST forms during all Care plan Meetings beginning November 7, 2024.

How the corrective action(s) will be monitored to ensure the practice will not recur:
Facility Social Workers will complete a 100% code status order audit using the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 578	Continued From page 3 revealed the Resident was admitted to the facility on 5/29/18 with diagnoses that included a history of a stroke, heart failure, and diabetes. The review revealed a full code Physician order dated 7/26/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. f. Review of Resident #49's medical record revealed the Resident was admitted to the facility on 10/4/24 with diagnoses that included high blood pressure and seizure disorder. The review revealed a do not resuscitate Physician order dated 10/4/24. The was no documentation in the record for education regarding a formulation of an advance directive and/or the opportunity to formulate an advance directive was offered. g. Review of Resident #72's medical record revealed the Resident was admitted to the facility on 10/29/21 with diagnoses that included heart disease and diabetes. The review revealed a do not resuscitate Physician order dated 1/17/22. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. h. Review of Resident #80's medical record revealed the Resident was admitted to the facility on 5/26/20 with diagnoses that included heart disease, diabetes, and a history of a stroke. The review revealed a full code Physician order dated 4/12/23. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.	F 578	Advanced Directive Audit Tool for all new admissions three (3) times a week for four (4) weeks, then monthly for two (2) months beginning November 11, 2024. Any discrepancies noted will be immediately corrected. The Director of Nursing (DON) or Designee will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 578	Continued From page 4	F 578		

i. Review of Resident #109's medical record revealed the Resident was admitted to the facility on 6/28/23 with diagnoses that included heart disease and diabetes. The review revealed a do not resuscitate Physician order dated 7/1/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.

j. Review of Resident #427's medical record revealed the Resident was admitted to the facility on 10/9/24 with diagnoses that included heart disease and kidney failure. The review revealed a do not resuscitate Physician order dated 10/9/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive was offered.

An interview was completed on 10/22/24 at 1:30pm with the facility's Administrator. She revealed at this time the facility only discussed the resident's code status with the resident and/or their responsible party.

An interview was completed on 10/23/24 at 11:37am with the facility's Admission's Director. The Admission's Director stated she only discussed code status with the resident and/or their responsible party.

An interview was completed on 10/23/24 at 12:07pm with the facility's Social Worker. The Social Worker stated she only reviewed the resident's code status with the resident and/or responsible party.

A follow-up interview was completed on 10/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 578	Continued From page 5 at 11:41am with the facility's Administrator. The Administrator stated the Social Worker was new to the position. She stated the Social Worker was unaware of the requirement for providing education regarding the formulation of an advance directive, not just regarding a resident's code status.	F 578		
F 584 SS=B	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 resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 584	Continued From page 6 §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 observations and staff interviews, the facility failed to maintain a clean and sanitary homelike environment as evidenced by dried substance on the top and front of an oxygen concentrator and dried enteral feeding on the floor for 1 of 4 rooms reviewed for environment (Room #602). The findings included: An observation was conducted on 10/21/24 at 11:02 am in Room #602 the oxygen concentrator was observed to have a dried beige substance on the top and multiple dried lines down the front of the concentrator. The floor had multiple round, dime sized, brown hardened substance on the floor near the feeding tube pole and resident bed. Observations of Room #602 conducted on 10/22/24 at 1:59 pm and 10/23/24 at 9:38 am revealed the oxygen concentrator was observed to have multiple dried, beige, substance on the top and dried in lines down the front of the concentrator. The floor had multiple round in shape, dime sized, brown hardened substance on the floor near the feeding tube pole and resident	F 584	Immediate action(s) taken for the resident(s) found to have been affected include: The oxygen concentrator, feeding pump pole, resident bed, and floor in room #602 were cleaned and sanitized by the facility housekeeping team on October 22, 2024. Identification of other residents having the potential to be affected was accomplished by: A 100 % audit of the resident facility rooms was completed on October 22, 2024, by the housekeeping manager and maintenance staff members to identify and correct other problem areas. All findings were immediately addressed. All residents of this facility have the potential to be affected by this practice. Actions taken/systems put in place to reduce the risk of future occurrence include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 584	Continued From page 7 bed. An observation and interview were conducted with the Housekeeping Manager on 10/23/24 at 11:22 am. The Housekeeping Manager revealed that all resident rooms were cleaned daily using the 5 and 7 step method which included sweeping, mopping, wiping outer surfaces of furniture and equipment used such as the concentrator and wheelchair. The Housekeeping Manager confirmed the oxygen concentrator was something that should have been wiped down daily by the housekeeping staff and the floor where the dried enteral feeding was observed was to be mopped every day. The Housekeeping Manager stated he did random checks of resident rooms to ensure the cleaning was being completed, but he had not checked Room #602 to ensure it was done properly. During an interview on 10/23/24 at 11:39 am with Housekeeper #1 who confirmed she was assigned to Room #602 on 10/20/24, 10/22/24, and 10/23/24. Housekeeper #1 stated she cleaned Room #602 on 10/20/24 but was unable to get the dried substance off the floor in the room, but she did not see the concentrator was dirty. She stated she did not notify the manager regarding Room #602's floor, but she stated she should have reported that she was unable to get the floor clean. Housekeeper #1 stated she went into Room #602 on 10/22/24 to clean but did not clean the room because the nurses were doing something with the tube feeding. She stated she should have gone back to Room #602 to clean later but she never went back. Housekeeper #1 stated she told the resident when she went in the room today (10/23/24) that she would be back later to clean the room but had not been to Room	F 584	All housekeeping staff members were re-educated on the steps for cleaning and sanitizing rooms daily and deep cleaning of patient rooms post resident discharge on October 23, 2024, by the Housekeeping District Manager. Facility staff were educated to wipe up spills immediately and notify housekeeping for further cleaning by the Administrator the week of November 11, 2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The housekeeping supervisor will monitor five (5) random rooms daily and document on a deep clean list. The administrator will monitor five (5) random rooms daily to include residents with special equipment (feeding pumps, oxygen concentrators) two (2) times a week x four (4) weeks for areas of deficiency. The Administrator will notify the housekeeping staff immediately for corrections as needed. Audits will be documented on a daily census sheet. Audit records will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 584	Continued From page 8 #602 to clean yet. An interview was conducted on 10/24/24 at 12:10 pm with the Interim Administrator who stated resident rooms were to be cleaned daily.	F 584	Corrective action completion date: 11/21/24	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9	F 623		

this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of a resident transfer for 2 of 5 residents reviewed for hospitalization (Resident #2 and Resident #42). The findings included: 1a. Resident #2 was admitted to the facility on 10/01/05. The nursing progress note dated 7/02/24 at 3:00 pm revealed Resident #2 was transferred to the hospital for evaluation of change in mental status.	F 623	Immediate action(s) taken for the resident(s) found to have been affected include: Residents #2 and #42 were reviewed and per progress notes were discharged from the facility to the hospital. The facility failed to notify the Ombudsman of discharge or transfer information for the last 6 months. The social worker immediately notified the Ombudsman of the last 6 months of discharges and transfers to include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 Resident #2 was discharged from the facility on 7/02/24 and returned to the facility on 7/08/24. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #2's 7/02/24 transfer to the hospital on 10/23/24. b. The nursing progress note dated 8/12/24 at 3:38 pm revealed Resident #2 was transferred to the hospital for evaluation of altered mental status. Resident #2 was discharged from the facility on 8/12/24 and returned to the facility on 8/23/24. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #2's 8/12/24 transfer to the hospital on 10/23/24. 2a. Resident #42 was admitted to the facility on 10/27/16. The nursing progress note dated 7/21/24 at 9:00 am revealed Resident #42 was transferred to the hospital for evaluation. Resident #42 was discharged from the facility on 7/21/24 and returned to the facility on 7/25/24. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #42's 7/21/24 transfer to the hospital on 10/23/24. b. The physician progress note dated 8/20/24 revealed Resident #42 was transferred to the	F 623	residents #2 and #42. Identification of other residents having the potential to be affected was accomplished by: The Administrator conducted a 100% audit of the resident discharge/transfers for the last 6 months on November 11, 2024. Any discrepancies noted were immediately sent to the Ombudsman. All residents of this facility have the potential to be affected by this practice. Actions taken/systems put in place to reduce the risk of future occurrence include: All social workers were educated by the Administrator on the requirement for the facility to notify the Ombudsman of any discharges or transfers. This education was initiated and completed on November 11, 2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The discharge/transfer list will be monitored by the Administrator monthly for three (3) months (November, December, January) using the Discharge/Transfer Summary Form to ensure that the Ombudsman is notified monthly of discharges and transfers. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 hospital for further evaluation. Resident #42 was discharged from the facility on 8/20/24 and returned to the facility on 8/23/24. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #42's 8/20/24 transfer to the hospital on 10/23/24. A telephone interview was conducted on 10/23/24 at 03:29 pm with the Ombudsman who revealed she had not received written notification of hospitalization discharges for the last 6 months. An interview was conducted with Social Worker #1 on 10/23/24 at 3:49 pm who revealed she started working at the facility in April 2024 and she was educated at that time to send the transfers and discharges to the Ombudsman. Social Worker #1 stated she had not sent any discharge and transfer information to the Ombudsman since she started at the facility because she forgot the information was to be sent monthly. Social Worker #1 reported it was her fault that she had not sent the information to the Ombudsman prior to today (10/23/24). During an interview on 10/24/23 at 10:24 am with the Interim Administrator she revealed she was not sure why Social Worker #1 had not sent any information to the Ombudsman. The Interim Administrator stated Social Worker #1 was educated upon hire, but she felt Social Worker #1 just forgot to send the lists to the Ombudsman monthly.	F 623	Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 13 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews, the facility failed to ensure there was a	F 690	Immediate action(s) taken for the resident(s) found to have been affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 14 physician's order in place for the size of an indwelling urinary catheter and frequency to change the indwelling urinary catheter for 1 of 1 resident reviewed for catheters (Resident #49). The findings included: Resident #49 was admitted to the facility on 10/4/24 with diagnoses that included disorder of kidney and ureter. Review of the admission Minimum Data Set (MDS) assessment dated 10/4/24 revealed resident had severe cognitive impairment with no behaviors present. He was coded as dependent on staff for toileting and had an indwelling urinary catheter. A review of a care plan dated 10/5/24 revealed Resident #49 was care planned for an indwelling urinary catheter. The goal was for Resident #49 to be/remain free from catheter-related trauma and have no signs and symptoms of urinary tract infection through review date. The interventions included monitor and document sign and symptoms of infection. Review of a physician's order revealed an order dated 10/7/24 for a size 20 French (FR) urinary indwelling catheter. Review of a physician progress note dated 10/8/24 revealed Resident #49 had a chronic catheter and was admitted to the hospital for possible infection. Review of a health status note dated 10/17/24 revealed Resident #49 was out to a urology appointment and returned with no new orders.	F 690	include: The facility failed to ensure that resident #49 had physician orders in place for the size of the indwelling catheter and frequency to change the catheter. The facility immediately clarified these orders with the physician and added them to the medical record of Resident #49. Identification of other residents having the potential to be affected was accomplished by: All residents with indwelling catheters have the potential to be affected by this practice. Actions taken/systems put in place to reduce the risk of future occurrence include: All licensed nursing staff (Registered Nurses and Licensed Practical Nurses) were educated by the Director of Nursing (DON) and the facility Administrator from November 11 through November 13, 2024, regarding indwelling catheters. This education included: - The importance of residents receiving appropriate treatment and services to prevent urinary tract infections and the restore continence to the extent possible. - The proper way to add physician orders to the Medication Administration Record (MAR) to include changes in medications and treatments, including orders for indwelling catheters. New licensed nursing staff will be educated regarding these practices by the DON and administrative nurses during the orientation process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 15 A review of the consultation progress notes for urology dated 10/17/24 revealed an order to "change 16 FR indwelling urinary catheter every month and call office with issues". A review of the electronic health record revealed no order in place for 16 FR indwelling urinary catheter change every month. An observation was conducted of Resident #49 with Nurse Aide #4 on 10/23/24 at 09:45 AM. Resident #49 had a 16 French indwelling urinary catheter that was connected to a urinary drainage bag. An interview was conducted with Unit Manager #2 on 10/23/24 at 03:39 PM. She stated Medical Records was out during the week of October 17th. The Unit Manager stated she was responsible for taking off the orders. She reported that Medical Records Clerk normally scanned in the information from consults and would either call on the phone to let her know to review or she would bring her a stack of consults for her to review. An interview was conducted with the Medical Records Clerk on 10/23/24 at 3: 48 PM. She stated she reviewed the information from consults when a resident returned for an appointment. The Medical Record Clerk stated she scanned the consults into the electronic medical records then gave the hard copy of the consult to the unit manager. An interview was conducted on 10/23/24 at 3:59 PM. The Interim Administrator verified the medical records clerk scanned the consults into	F 690	How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrative Nurses (Unit Managers, Treatment Nurses) will conduct audits using the Indwelling Catheter Audit Tool on all residents with indwelling catheters weekly for four (4) weeks, then monthly for two (2) months to ensure that all orders to care for the indwelling catheters are complete and documented in the resident□s medical record. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 16 the system. The Administrator stated the unit managers were responsible for entering the orders into the electronic medical record when the residents returned from appointments.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident, Respiratory Therapist, and Nurse Practitioner interviews, the facility failed to obtain a physician order for liters of oxygen and the fraction of inspired oxygen (FiO2) for a resident with a tracheostomy for 1 of 1 resident reviewed for respiratory care (Resident #112). The findings included: Review of the hospital speech therapy consultation provided by the facility dated 9/05/24 revealed Resident #112 had a tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe) and was on a trach collar (a soft plastic mask that fits over the tracheostomy) with 5 liters of oxygen with 28% FiO2 (percentage of oxygen in the air that a person inhales).	F 695	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #112 was observed to be receiving oxygen at 5 liters per minute and 35% Fi02 by tracheostomy. Per hospital discharge Resident #112 should have been receiving 5liters of oxygen per minute and 28% Fi02. The facility received and implemented clarification orders for resident #112 from the physician and respiratory therapist on October 24, 2024. Identification of other residents having the potential to be affected was accomplished by:	11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 695	Continued From page 17 Review of the hospital discharge summary dated 9/08/24 revealed no orders were noted for Resident #112's oxygen or FiO2 settings. Resident #112 was readmitted to the facility on 9/08/24 with diagnoses which included acute respiratory failure with hypercapnia (carbon dioxide retention), pneumonia, and tracheostomy. Review of the nursing progress note dated 9/08/24 at 11:08 am by Nurse #3 revealed Resident #112 was scheduled to return to the facility from the hospital in the afternoon. Nurse #3 further noted that Resident #112 had a tracheostomy and would be returning to the facility on 5 liters of oxygen at 28% FiO2. An attempt to interview Nurse #3 on 10/24/24 at 12:30 pm was unsuccessful. The Minimum Data Set (MDS) annual assessment dated 9/13/24 revealed Resident #112 had clear speech and was cognitively intact. Resident #112 was coded for oxygen therapy, suctioning, and tracheostomy. The care plan dated 9/21/23 and last reviewed on 10/03/24 revealed Resident #112 had a care plan in place for tracheostomy related to impaired breathing mechanics with an intervention of oxygen settings via trach at 5 liters continuous with 28% humidity. A record review conducted on 10/21/24 of the physician orders revealed no orders for oxygen or FiO2 settings for Resident #112's tracheostomy. An observation and interview conducted with Resident #112 on 10/21/24 at 10:45 am revealed	F 695	Unit Managers immediately completed a 100% resident room audit for residents with oxygen concentrators and 100% resident chart audit documentation of written physician orders for use of supplemental oxygen on 11/11/2024 with no additional concerns identified. All residents with orders for oxygen therapy have the potential to be affected by this practice. Actions taken/systems put in place to reduce the risk of future occurrence include: All licensed nursing staff including Registered Nurses and Licensed Practical Nurses, were in-serviced on documentation requirements for written orders, including orders for supplemental oxygen from November 11 through November 13, 2024 by the Director of Nursing and the Administrator. New licensed nursing staff will be educated regarding these practices by the DON and administrative nurses during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Administrative Nurses (Unit Managers) will conduct a 100% resident room audits for residents with oxygen concentrators two (2) times per week for four (4) weeks, then monthly for two (2) months. This audit will include comparing oxygen concentrator settings with written orders in the residents medical records. The Oxygen Audit Tool will be utilized to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 695	Continued From page 18 Resident #112's oxygen concentrator (a machine that gives extra oxygen) was set to 5 liters and the compressor's (machine that pushes air through a bottle of water to pick up moisture) FiO2 was set to 35%. The oxygen tubing was noted to be connected to the concentrator water humidification bottle which was connected to the tracheostomy tubing and Resident#112's trach collar. Resident #112 was observed in bed with no respiratory distress noted. Resident #112 stated she had the tracheostomy for about one year and had just been in the hospital. During an interview on 10/22/24 at 2:01 pm with Medication Aide #1 she revealed she was assigned to Resident #112's hall but she was not able to do the respiratory care since she was not a nurse. Medication Aide #1 stated Unit Manager #2 was responsible for Resident #112's care due to the tracheostomy. An observation of Resident #112's room with Unit Manager #2 was conducted on 10/22/24 at 2:07 pm. Resident #112 was noted to be in bed with the trach collar in place. Unit Manager #2 confirmed Resident #112's oxygen was set to 5 liters and the FiO2 was set to 35%. An interview with Unit Manager #2 was conducted on 10/22/24 at 2:18 pm. Unit Manager #2 revealed Resident #112's settings for the oxygen at 5 liters and 35% FiO2 were her normal settings since returning from the hospital, and the physician order should be in the computer. Unit Manager #2 confirmed no physician orders were in place for Resident #112's 5 liters of oxygen or 35% FiO2 for the tracheostomy. She stated she recalled being told in report from the hospital that Resident #112 was coming back to the facility	F 695	ensure that orders for supplemental oxygen are being followed as ordered. Any discrepancies noted will be immediately addressed. The Director of Nursing or Designee will review all audits for accuracy. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 695	Continued From page 19	F 695		

with 5 liters of oxygen and the FiO2 was at 35% but she would have to look for the discharge information to review and confirm. Unit Manager #2 stated she was responsible for entering Resident #112's physician orders and was unable to state why the oxygen and FiO2 orders were not put back in place when Resident #112 returned to the facility from the hospital.

An interview was conducted on 10/24/24 at 9:27 am with the Nurse Practitioner (NP) who revealed the provider did not determine the settings required for Resident #112's tracheostomy. The NP stated it was the facility's standard practice to obtain Resident #112's tracheostomy oxygen and FiO2 settings when she returned to the facility and once obtained the provider would confirm and sign the order.

A telephone interview was conducted on 10/24/24 at 9:52 am with the Respiratory Therapist (RT) who revealed she last saw Resident #112 on 10/09/24 for a tracheostomy change only and she did not review any orders at that time. The RT stated Resident #112's settings would normally come from the hospital discharge record or if needed she could provide. The RT stated she was fine with the setting of 35% for the FiO2 for Resident #112 because the FiO2 setting was for humidification purpose only. The RT stated when a trach collar was used for Resident #112's tracheostomy, the oxygen order and FiO2 settings were needed.

An interview was conducted with the previous Director of Nursing (DON) on 10/24/24 at 9:06 am who revealed Resident #112's oxygen and FiO2 settings would have been received by the hospital or given in report from the hospital. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 695	Continued From page 20 previous DON stated Unit Manager #2 was responsible to obtain Resident #112's orders and confirm the orders with the NP. The previous DON stated admission orders were reviewed during the clinical meetings, and she stated the missed orders for Resident #112's oxygen and FiO2 settings should have been identified when reviewed during the clinical meeting. The previous DON was unable to state how the orders for Resident #112 were missed for so long.	F 695		
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.	F 761		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 761	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, the facility failed to dispose/discard expired medications in 2 of 4 medication carts (200 Hall, 700 Hall medication cart) observed for medication storage. The findings included: 1a. An observation was conducted of the 700 Hall medication cart on 10/22/24 at 11:43 AM. One opened bottle of Simethicone 80 milligrams (mg) had an expiration date of July 2024. An interview was conducted with Medication Aide #2. Mediation Aide #2 stated the medication should have been discarded. Medication Aide #2 stated the medication aide/nurse assigned to the cart was responsible for checking for expired medications each shift. 1b. An observation of the 200 Hall medication cart on 10/22/24 at 11:43 AM revealed an open bottle of Moxifloxacin 0.5% eye drops with a prescription filled date of 9/20/24 and had an open date of 9/20/24. The bottle was labeled by the pharmacy: Administer 3 drops to right eye 3 times a day for 3 days. The manufacturer's package insert indicated any unused ophthalmic moxifloxacin should be discarded 30 days after you first opened the bottle to avoid getting another eye infection. The moxifloxacin medication was outdated and not discarded from the medication cart. An interview was conducted with Medication Aide # 3. Medication Aide #3 stated the medication should have been discarded once the resident completed the doses. Medication Aide #3 stated	F 761	Immediate action(s) taken for the resident(s) found to have been affected include: During observation and interview with Medication Aide #2 the surveyor noted an expired medication on the 700-hall medication cart. During a second observation with Medication Aide #3 the surveyor noted expired eye drops on the 200-medication cart. The facility had failed to discard these expired medications. Both medications were immediately discarded. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected, including all residents that receive eye drops and over the counter medications. Actions taken/systems put in place to reduce the risk of future occurrence include: Nursing staff including Registered Nurses, Licensed Practical Nurses and Medication Aides were in-serviced November 11 through November 13, 2024, by the Director of Nursing (DON) and Unit Managers. The in-services included the following information: -Medication Administration -Medication storage related to expired medication -Disposal of expired medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 761	Continued From page 22 the medication aide/nurse assigned to the cart was responsible for checking for expired medications each shift An interview was conducted with the Interim Director of Nursing and Interim Administrator on 10/22/24 at 3:28 PM. The interim Administrator stated the medication aides and nurses assigned to the medication cart were responsible for checking carts for expired medication. The Administrator stated expired medications were to be removed from the cart immediately.	F 761	New licensed nursing staff and medication aides will be educated regarding these practices by the DON and administrative nurses during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing and Administrative Nurses will complete weekly random medication storage audits using the Medication Storage Audit Form for four (4) weeks, then monthly for two (2) months. The Pharmacy Nurse Consultant will continue completing the monthly Medication Storage Audits as scheduled. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	
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	F 842		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 842	Continued From page 23	F 842		

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;
(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 842	Continued From page 24 §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 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 and staff interviews, the facility failed to sign off documentation for physician orders of cleansing area to right ankle and applying Calcium Alginate and Cleanse left lateral ankle and apply Santyl ointment daily, in the Treatment Administration Records (TAR) for 1 of 2 reviewed residents for treatment (Resident #94). Resident #94's TAR had blanks where staff were to indicate if treatment was administered or an indication that the treatment was not administered with an explanation on the reverse side of the TAR for 1 of 2 residents reviewed for documentation (Resident #94). The findings included: Physician orders for Resident #94 dated 9/20/24	F 842	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #94 was noted to have omissions in documentation on the treatment record on 10/3/2024, 10/5/2024, 10/6/2024, 10/10/2024, 10/13/2024, 10/19/2024 and 10/2024. Interviews with Nurse #1, Nurse #2 and Unit Manager #1 revealed that wound care was provided for some days and the resident had refused some days, but the treatment record had not been signed. The facility failed to document wound care or refusal of wound care in treatment records according to physician orders. Nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 842	Continued From page 25 revealed orders for cleansing area to right lateral ankle and applying of calcium alginate with silver cover with superabsorbent gelling fiber with silicone border to promote wound healing daily. Physician orders for Resident #94 dated 9/27/24 revealed an order for cleansing left lateral ankle and apply Santyl ointment to plain calcium alginate daily. During a telephone interview with Nurse #1 on 10/24/24 at 8:10 A.M. she revealed she provided care to Resident #94 regularly but was not aware she did not sign off on the TAR on 10/3/24, 10/5/24, 10/6/24, 10/10/24, 10/13/2024, 10/19/24, and10/20/24. During an interview with Nurse #2 on 10/24/2024 at 8:17 A.M. She revealed she provided Resident #94's wound care on 10/19/24 at 10 P.M. but could not remember why she did not document the treatment on the TAR. A telephone interview with Unit Manager #1 on 10/24/24 at 8:30 A.M. revealed she was not sure why nursing staff failed to document wound care provided to Resident #94 on the TAR on 10/3/24, 10/5/24, 10/6/24, 10/10/24, 10/13/2024, 10/19/24, and10/20/24. She further stated nursing staff are required to document whether Resident #94 agreed to or declined care. In an interview with the Director of Nursing (DON) on 10/24/24 at 9:11 A.M. she revealed nursing staff were required to document medication administration even when there is a refusal. During an interview with the Administrator on 10/24/24 at 9:15 A.M. she stated that nursing	F 842	were immediately counseled regarding this practice. Identification of other residents having the potential to be affected was accomplished by: All residents of this facility have the potential to be affected by this practice, including all residents receiving wound care. Actions taken/systems put in place to reduce the risk of future occurrence include: All nursing staff, including Registered Nurses, Licensed Practical Nurses and Medication Aides were in-serviced on the requirements to document all care provided to include refusals of care on the treatment records as ordered by physician and in accordance with physician orders November 11 through November 13, 2024, by the Director of Nursing and Administrative Nurses. New licensed nursing staff will be educated regarding these practices by the DON and administrative nurses during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: The treatment nurses will audit documentation of the treatment records two (2) times a week for four (4) weeks and monthly for two (2) months to monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 842	Continued From page 26 staff are required to document the care provided to residents.	F 842	for omissions. These audits will be documented on the Treatment Record Documentation Audit Tool. Any omissions will be immediately reported to the Director of Nursing and physician. The Director of Nursing or Designee will review all audits for accuracy. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 27	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 28 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when 1) Unit Manager #2 failed to wear a gown and did not perform hand hygiene between glove changes while performing tracheostomy care for a resident on Enhanced Barrier Protection (EBP) (Resident #112), 2) when the Wound Treatment Nurse failed to perform hand hygiene between glove changes during the observation of wound treatment (Resident #115), and 3) when Nurse Aide #1 was observed carrying uncontained dirty linen in the hallway. The facility also failed to implement its hand hygiene policy when Nurse Aide #1 failed to perform hand hygiene and remove gloves before entering and exiting 2 of 2 resident rooms (Room 701, Room 702) observed for infection control practices. The findings included: The facility's Infection Prevention and Control Program policy last updated 10/01/23 indicated all staff should assume that all residents were potentially infected or colonized with an organism that could be transmitted while providing resident care services. The policy stated hand hygiene	F 880	Immediate action(s) taken for the resident(s) found to have been affected include: During observation the State Surveyor noted Unit Manager #2 failed to wear a gown or use hand hygiene in Resident #112 room during care of her Tracheostomy. Resident #112 was on Enhanced Barrier Precautions. Treatment nurse failed to use correct hand hygiene will performing wound care for Resident #115. The surveyor also noted Nurse aide #1 failed to discard soiled linen properly and did not practice proper hand hygiene after discarding gloves. The facility failed to practice infection control according to the facilities Infection Prevention and Control Program. Unit Manager #2 and Nurse Aide #1 were both immediately counselled regarding these actions. Identification of other residents having the potential to be affected was accomplished	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 29 shall be performed in accordance with the facility's established hand hygiene procedures. The policy further noted all staff shall use personal protective equipment (PPE) according to the established policy governing the use of PPE. Further review of the Infection Prevention and Control Program policy revealed in part "soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled linen room". The facility's Enhanced Barrier Precautions (EBP) policy dated 4/01/24 revealed EBP was an infection control intervention designed to reduce transmission of multidrug-resistant organisms that used targeted gown and glove use during high contact resident care. The policy further stated EBP would be initiated for any resident with indwelling medical devices (such as tracheostomy tubes and feeding tubes) and wounds (such as pressure ulcers). The policy noted that personal protective equipment (PPE) for EBP was only necessary when performing high-contact care activities which included wound care and device care such as tracheostomy care. Review of the facility's Hand Hygiene policy last updated 10/01/22 indicated hand hygiene was to be conducted before resident care procedures, before and after handling clean or soiled linens, before applying and after removing personal protective equipment (PPE), including gloves. 1a. Resident #112 had signage posted on the door that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gown for the following high-contact resident care activities which	F 880	by: All residents of this facility have the potential to be affected by this practice, including all residents on enhanced barrier precautions. Actions taken/systems put in place to reduce the risk of future occurrence include: All staff (Nursing, Housekeeping, Dietary, Rehabilitation) were in-serviced November 11 through November 13, 2024, by the Infection Control Preventionist on the following items: -Proper Handwashing -Use of personal protective equipment (PPE) for residents on Enhanced Barrier Precautions -How to properly dispose of soiled linen Nursing staff including Registered Nurses and Licensed Practical Nurses were in-serviced by the Director of Nursing and Infection Preventionist November 11 through November 13, 2024. The in-service included: -Proper tracheostomy and wound care techniques -Hand Hygiene -Enhanced Barrier Precautions New staff will be educated regarding these practices by the DON and administrative nurses during the orientation process. How the corrective action(s) will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 30 included device care or use including tracheostomy. A large double door cabinet was observed in the hall stocked with PPE, which included disposable gowns. A continuous observation was conducted on 10/23/24 from 9:48 am through 10:35 am of tracheostomy care for Resident #112. Unit Manager #2 was observed to enter Resident #112's room, perform hand hygiene with hand sanitizer, and prepare supplies for tracheostomy care. Unit Manager #2 was observed to perform hand hygiene, don sterile gloves and began tracheostomy care for Resident #112 without a disposable gown in place. Unit Manager #2 was observed to touch the sterile supplies with her "dirty" glove and stopped tracheostomy care, removed supplies, removed gloves, completed hand hygiene, and left Resident #112's room to obtain more supplies. At 10:02 am Unit Manager #2 returned to Resident #112's room with additional supplies, performed hand hygiene, donned gloves, and prepared supplies. Unit Manager #2 was observed to perform hand hygiene, donned sterile gloves, and began tracheostomy care for Resident #112 without a disposable gown in place. #2 Unit Manager #2 completed Resident #112's tracheostomy care at 10:35 am, which included suctioning, without a disposable gown in place throughout the observation. An interview was conducted with Unit Manager #2 on 10/23/24 at 3:05 pm. Unit Manager #2 confirmed Resident #112 was on EBP for the tracheostomy, and staff were required to wear a disposable gown when tracheostomy care and suctioning were performed for Resident #112. She stated she did not realize she did not wear	F 880	monitored to ensure the practice will not recur: The Administrative Nurses will complete random infection control audits (including hand hygiene, enhanced barrier precautions, the use of PPE) during wound and tracheostomy care. Audits will be documented on the Infection Control Audit Tool and occur weekly for four (4) weeks and monthly for two (2) months. Any negative findings will be immediately reported to the Director of Nursing and corrective action will occur. The Director of Nursing or Designee will review all audits for accuracy. The Corporate Infection Control Director will preform random infection control audits monthly for two (2) months to monitor hand hygiene and compliance with enhanced barrier precautions. The Administrator or The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 11/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 31	F 880		

one until she was asked by this surveyor if Resident #112 was on EBP. Unit Manager #2 stated disposable gowns were readily available for use and it should have been used during the tracheostomy care observation.

An interview was conducted with the Infection Preventionist (IP) on 10/24/23 at 8:55 am who revealed all staff, which included Unit Manager #2, had been educated on the use of proper PPE for residents on EBP. The IP stated PPE supplies including disposable gowns were available outside of Resident #112's room and the gown should have been on when Unit Manager #2 performed tracheostomy care.

b. A continuous observation was conducted on 10/23/24 from 9:48 am through 10:35 am of tracheostomy care for Resident #112. At 10:23 am Unit Manager #2 was observed to place a sterile suction kit on Resident 112's overbed table, perform hand hygiene, open the sterile kit and attempt to don the sterile gloves. Unit Manager #2 was unable to don the sterile gloves fully and removed the sterile gloves and placed the gloves in the trash. Unit Manager #2 then opened Resident #112's bottom dresser drawer and obtained a new sterile suction kit and placed the kit on the overbed table. Unit Manager #2 was observed to open the sterile suction kit and place the sterile gloves from inside the kit onto her hands without performing hand hygiene after obtaining supplies from Resident #112's drawer. Unit Manager #2 was observed to complete Resident #112's tracheostomy care and suctioning, removed gloves and performed hand hygiene.

During an interview on 10/23/24 at 3:05 pm with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 32	F 880		

Unit Manager #2 she revealed she was required to perform hand hygiene between glove changes when she performed Resident #112's tracheostomy care. Unit Manager #2 stated she changed the gloves so often during the observation that she just forgot to do hand hygiene after getting more supplies from the drawer and before she put on the sterile gloves to suction Resident #112's tracheostomy.

An interview was conducted with the Infection Preventionist (IP) on 10/24/23 at 8:55 am who revealed all staff, which included Unit Manager #2, had received education on hand hygiene and the education was completed yearly and as needed. She stated hand hygiene was to be completed before gloves were donned and again when gloves were removed. The IP stated Unit Manager #2 was required to perform hand hygiene before donning the sterile gloves from the suction kit when tracheostomy care was provided to Resident #112.

During an interview on 10/24/24 at 10:48 am with the Interim Administrator she revealed all staff were required to follow the facility's infection prevention and control program policies.

2. During a continuous observation of a pressure ulcer treatment on 10/23/24 at 3:39 pm through 3:54 pm the Wound Treatment Nurse was observed to perform hand hygiene, don clean gloves, and remove Resident #115's soiled dressing from the right hip. The Wound Treatment Nurse then removed the soiled gloves, and donned clean gloves without performing hand hygiene. The Wound Treatment Nurse then cleansed the right hip wound bed with gauze and normal saline and prepared and placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 33	F 880		

wound dressing on Resident #115's right hip wound. The Wound Treatment Nurse did not remove the dirty gloves or perform hand hygiene after cleansing the wound bed or before preparing and placing the wound treatment dressing on Resident #115's right hip wound. Resident #115 then turned onto the right side and the Wound Treatment Nurse removed the soiled dressing from the left hip. The Wound Treatment Nurse then removed the soiled gloves and without performing hand hygiene, donned clean gloves and cleansed the left hip wound with gauze and normal saline. The Wound Treatment Nurse prepared the new dressing and placed the dressing on Resident #115's left hip without removing the dirty gloves or performing hand hygiene after cleansing the wound bed and before placing the new wound dressing on Resident #115's left hip. The Wound Treatment Nurse then removed the soiled gloves and performed hand hygiene.

An interview was conducted on 10/23/24 at 3:55 pm with the Wound Treatment Nurse who revealed the dirty gloves should have been removed after the wound bed was cleansed and hand hygiene should have been completed between the glove changes. The Wound Treatment Nurse stated she just realized that she did not change gloves and perform hand hygiene in between glove changes during the observation. The Wound Treatment Nurse was unable to say why she did not change her gloves when moving from dirty to clean or perform hand hygiene between glove changes, but she confirmed she had received education on proper PPE use and handwashing.

During an interview on 10/24/24 at 9:03 am with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 34	F 880		

the Infection Preventionist (IP) she stated hand hygiene education was completed for all staff annually and as needed. The IP stated the Wound Treatment Nurse was educated to complete hand hygiene between glove changes and to change gloves when moving from dirty to clean tasks.

During an interview on 10/24/24 at 10:48 am with the Interim Administrator she revealed all staff were required to follow the facility's infection prevention and control program policies.

3. A continuous observation was conducted on 10/24/24 at 9:01 AM. Nurse Aide #1 was observed to exit room 701 with gloved hands. Nurse Aide #1 removed the gloves and walked across the hall to room 702 without performing hand hygiene. Nurse Aide #1 returned to room 701 without performing hand hygiene.

Nurse Aide #1 was observed exiting room 701 with gloved hands and carrying dirty linen that was not contained in a plastic bag. Nurse Aide #1 was observed to walk down the 700 hall and turn the doorknob to the dirty laundry room door.

An interview was conducted with Nurse Aide #1 on 10/24/24 at 9:07 AM. Nurse Aide #1 stated she was aware that she was supposed to carry dirty linen in a plastic bag and remove her gloves when exiting a resident's room. Nurse Aide #1 stated she did not have any plastic bags, so she carried the linen to the dirty laundry room with her gloves on. Nurse Aide #1 stated she was unaware that she had not performed hand hygiene after removing her gloves and before entering room 702.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF NASH	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 35 An interview was conducted with the Director of Nursing (DON) on 10/24/24 at 9:32 AM. The DON stated Nurse Aide #1 should have had plastic bags available, taken off her gloves and immediately washed her hands before leaving the room. The DON further stated Nurse Aide #1 should have performed hand hygiene between resident rooms.	F 880		