

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2021
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF WILLIAMSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC 27892		
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E 000	Initial Comments An unannounced recertification survey was conducted on 06/7/2021 through 06/10/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #05WR11.	E 000			
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/7/21 through 6/10/21. Event ID# 05WR11.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		7/8/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/01/2021

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

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F 550	<p>Continued From page 1 residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to treat residents in a dignified manner as evidenced by staff standing while providing assistance with eating and failed to prevent staff from making inappropriate verbal statemes to residents for 2 of 2 residents (Resident #69 & Resident #59) reviewed for dignity.</p> <p>The findings included:</p> <p>1. Resident #69 was admitted to the facility on 4/26/21 with diagnoses which included dementia.</p> <p>His admission minimum data set assessment dated 5/3/21 assessed him as having severe cognitive impairment.</p>	F 550	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The incident with Resident #69 occurred on May 2, 2021 and was investigated and reported to NCDHHS. As documented and reported, the nursing assistant involved was immediately suspended pending investigation. She was properly terminated on May 5, 2021. Mandatory in-services were conducted for all staff regarding resident rights and treating residents with dignity and respect.</p> <p>Staff members, therapists, and restorative aides will assist Resident #59 from a sitting position only</p>		

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F 550	<p>Continued From page 2</p> <p>Review of a facility reported incident report dated 5/3/21 revealed Nurse Aide #2 was overhead speaking to a resident in a loud voice using profanity.</p> <p>An interview was conducted with Nurse Aide #2 on 6/9/21 at 11:25 PM who stated she was working with Resident #69 on a 1:1 basis. She reported he was walking towards the door when he fell. NA #2 stated she told him, "that is what you get when you get out of bed". She reported that she went and got the nurse to assist with getting him up. NA #2 stated the Director of Nursing at the time came and got her to go to the Administrator's office. She reported she was sent home at that time. NA #2 stated she was terminated on 5/5/21. She further stated other witnesses stated she cursed at Resident #69. NA #2 reported she did not curse at him. She stated she did apologize to him for what she said. NA #2 stated residents can say whatever they want so she felt it was acceptable for her to speak freely to the residents.</p> <p>An interview was conducted with the Therapy Director on 6/9/21 at 11:54 AM who stated she was in a resident's room two doors down from Resident #69. She stated she heard a loud noise coming from his room. The Therapy Director stated she went down to his room and he was on the floor. She stated she overhead NA #2 tell Resident #69, "That's what you get. You need to leave your a** in the f*cking bed". The therapy director stated NA #2 was working 1:1 with Resident #69. She stated NA #1's chair was at his door so he could be observed.</p> <p>An interview was conducted with the Social Worker on 6/9/21 at 12:11 PM who stated she</p>	F 550	<p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>While all residents were at risk for being affected, daily rounds and observations have revealed NO other residents have been affected.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Mandatory in-services were conducted for all staff on June 14 - 18, 2021, to address treating residents in a dignified manner. Staff was educated about the proper way to speak with residents as well as the appropriate way to assist residents while feeding.</p> <p>New Policy Addition: Carrolton Policy # 2.18 Promoting/Maintaining Resident Dignity During Mealtimes was added to outline the company's expectation that each resident is treated with respect and dignity and in a manner that maintains or enhances the quality of his or her life.</p> <p>Specific in services for CNAs were conducted June 28, 2021 - July 1, 2021 and included the following topics:</p> <p>Review of Residents Rights and Facility Expectations of Staff Behavior a. Review of Carrolton Policy # 3.1 Abuse, Neglect and</p>		

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F 550	<p>Continued From page 3</p> <p>was in another resident's room when she heard a crash. She stated she observed NA #2 sitting in a chair at the Resident #69's door. The social worker stated by the time she arrived in the room NA #2 was out of her chair. She reported she overhead NA #2 say that she was not putting up with this mess all day. The social worker stated she could not recall the exact words but stated there were expletives in the statement. She reported that she returned to the other resident's room.</p> <p>An interview was conducted with Resident #69 on 6/9/21 at 1:34 PM who stated he did not recall the incident.</p> <p>A review of the facility incident report dated 5/4/21 included a statement from the former Director of Nursing who stated Resident #69 did not recall the incident.</p> <p>Attempts to contact the former Director of Nursing were unsuccessful.</p> <p>An interview was conducted with Nurse #3 on 6/9/21 at 2:56 PM who stated she assisted Resident #69 from the floor. She stated she was notified of his fall by NA #2. Nurse #3 stated she assessed Resident #69 and he did not appear to have any injuries. She reported she did not observe NA #2 speaking harshly or using profanity with Resident #69.</p> <p>An interview was conducted with the Interim Administrator on 6/10/21 at 8:46 PM who stated NA #2 should not have spoken harshly to the resident or used profanity. She stated NA #2 was terminated from the facility and is not eligible for rehire.</p>	F 550	<p>Exploitation with emphasis on verbal abuse</p> <p>b. Review of Carrolton Policy #2.1 Resident Rights</p> <p>c. Review of Carrolton Policy # 2.4 Promoting- Maintaining Resident Dignity</p> <p>d. Response to Resident Concerns</p> <p>e. Passing ice every shift</p> <p>f. Timely distribution of meals and snacks</p> <p>Maintaining Dignity and Respect During Mealtime</p> <p>a. Review of Carrolton Policy # 2.18</p> <p>b. Feeding Competency Validation</p> <p>A Validation / Competency Checklist was completed for each person whose duties involve feeding assistance to determine if they were performing the procedure correctly. Findings were reviewed with each individual, and corrective action was provided as needed.</p> <p>A facility senior management team meeting was held on June 30, 2021. Members of the CFM corporate clinical team led the meeting and discussed the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>1. The Director of Nursing (DON), or</p>		

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F 550	Continued From page 4 2. Resident #59 was admitted to the facility on 1/11/2018 with diagnoses that included Alzheimer's disease. Resident #59's care guide initiated on 3/6/2018 revealed physical assistance with eating and usually eats 25 percent or less daily. The quarterly Minimum Data Set (MDS) dated 4/19/2021 revealed Resident #59 was severely cognitively impaired and required limited assistance with meals. A care plan last reviewed on 4/19/2021 revealed a plan for potential for less than adequate intake related to a decreased appetite. The interventions included provide assistance with meals as indicated. An observation on 6/7/2021 at 12:38 pm revealed Restorative aide (RA) #1 stood beside Resident #59's bed while assisting the resident with the lunch meal. RA #1 stood beside Resident #59's bed throughout the meal. During an interview with RA #1 on 6/7/2021 at 3:23 pm she stated she was unaware that she could not stand while assisting Resident #59 with her meal. She stated she had never been given that information. On 6/7/2021 at 3:30 pm during an interview with the Rehabilitation Manager she stated she did not know that the staff could not stand while assisting with a meal. She said she could see how it may be a dignity issue.	F 550	designee, will conduct random observations of staff during the next three (3) months to ensure staff are promoting and maintaining resident dignity in accordance with our facility's practice guidelines and regulatory requirements. 2. Facility Managers will conduct staff observations daily during mealtimes over the next three (3) months to ensure staff promotes and maintains resident dignity during mealtimes following our facility practice guidelines and regulatory requirements. 3. Observation reports and validation checklists will be reviewed by the Carrolton Facility Management (CFM) Compliance Team monthly until such time consistent and substantial compliance has been achieved as determined by CFM. 4. The Administrator, or designee, will review the results of observation reports and any corrective measures taken with the Resident/Family Group Council during their monthly meetings for comments and suggestions. 5. Routine monitoring regarding promoting and maintaining resident dignity has been added to the facility QAPI plan.		

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F 550	Continued From page 5 An interview was conducted on 6/10/2021 at 10:45 am with the Administrator and Director of Nursing (DON). The Administrator stated normally the staff should be seated when assisting a resident with a meal. The DON stated she was new at the position and did not know what the rules were at that time.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		7/8/21	

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F 565	<p>Continued From page 6</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews with Resident Council members, staff interviews and review of Resident Council minutes the facility failed to resolve concerns voiced by the Resident Council members during the previous 4 of 6 monthly meetings.</p> <p>The findings included:</p> <p>Resident Council Meeting minutes from December 2020, January 2021, February 2021, March 2021, April 2021, and May 2021 were reviewed.</p> <p>A review of Resident Council minutes dated 1/19/21 indicated residents voiced concerns regarding not receiving ice as requested. The Resident Council minutes from February 2021, April 2021, and May 2021 indicated residents are not receiving ice.</p> <p>An interview was conducted on 6/9/21 at 2:00 PM with the facility's resident council. There were 8 residents present. During the meeting residents expressed a concern with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation as to why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. Residents</p>	F 565	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The daily assignment sheets were changed to include distribution of ice and water by specific individuals every day / every shift.</p> <p>Resident council minutes were reviewed for concerns and grievances to ensure that specific concerns and grievances were followed up on appropriately.</p> <p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address resident/family group and response as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to have been affected, however, NO other residents have been identified to be affected.</p> <p>Carrolton Facility Management (CFM)</p>		

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F 565	<p>Continued From page 7</p> <p>stated they have repeatedly requested ice be provided. Residents stated a staff member was present at the Resident Council meetings and communicated their concerns to Administration.</p> <p>An interview was conducted with the Activities Assistant on 6/9/21 at 4:09 PM. She reported she is present during monthly Resident Council meetings and recorded resident concerns. She indicated she completed grievance forms each month and submitted them to the appropriate Department Head. The Activities Assistant reported when she received the grievance form back from the applicable Department Head, she would save it to review with the Resident Council at the next meeting. She stated sometimes she did not receive the forms back. The Activities Assistant stated she did not receive grievances forms back regarding ice being passed. She stated she gave them to the former Director of Nursing.</p> <p>An interview was conducted with the interim Director of Nursing (DON) on 6/9/21 at 4:27 PM. She stated she had noticed that ice was not being passed as requested. The interim DON stated she was working with staff to ensure this was being done. She stated she had been employed at the facility for two weeks and she was unaware that grievances had been submitted by Resident Council.</p> <p>An interview was conducted with the interim Administrator on 6/10/21 at 8:46 AM who stated she was unaware that ice was a concern voiced by Resident Council members. She stated the grievances filed about ice were not mentioned in the morning report. The interim Administrator stated ice should be passed to residents as</p>	F 565	<p>Corporate clinical staff has reviewed all resident council minutes for the past six (6) months and determined that there no outstanding grievances.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>New policy addition: Carrolton Policy # 2.19 Resident Council Meetings was added to provide guidance, promote structure, and outline company expectations of Resident Council Meetings. A single template for council minutes, grievances, and follow-up will be used throughout the company.</p> <p>Social Work and Activity Staff manage the resident council meetings as allowed by the resident council members. As such, the social workers and activity staff members were in-serviced on June 28, 2021, by Carrolton Facility Management Corporate Staff regarding the following:</p> <p>A. Resident/Family Group Meetings and Appropriate Response / follow up within 48 hours</p> <p>B. Policy Review including: ~Review of Carrolton Policy # 2.19 Resident Council Meetings ~ Review of Resident Council Forms (Minutes, Sign-in sheets etc.) ~ Review of Carrolton Policy # 2.3 Resident and Family Grievances</p>		

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F 565	Continued From page 8 requested and resident council grievances should be followed up on.	F 565	<p>~ Use of the Grievance Officer</p> <p>~ Grievance Resolution</p> <p>~ Review of the facility Corrective Action Plan related to Resident/Family Group Response</p> <p>A facility management meeting was held July 1, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <ol style="list-style-type: none"> The Administrator, or designee, will monitor Resident/Family Group Council minutes, grievances and follow up to assure timely resolution (48 hours). Management team daily rounds will be used to communicate with residents about follow-up, concern identification, and resolution. Resident Council minutes, grievances and follow up to all grievances will be reviewed by the Carrolton Facility Management (CFM) Compliance Team monthly to assure that compliance is maintained. The monitoring will continue for six (6) months. Routine monitoring regarding Resident/Family Group and Response has been added to the facility QAPI plan. 		

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F 565	Continued From page 9	F 565			
F 582 SS=B	<p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p>	F 582	<p>Corrective action completion date: July 8, 2021</p>	7/8/21	

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F 582	<p>Continued From page 10</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #15 and Resident #48).</p> <p>The findings included:</p> <p>1. Resident #15 was admitted to the facility on 6/28/19 with diagnoses including coronary artery disease. He was admitted to Medicare Part A skilled services on 1/29/21.</p> <p>Resident #15's Medicare Part A skilled services ended on 2/5/21. He remained in the facility.</p>	F 582	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #15 and #48 have not had any additional changes in status or services that required the presentation of an ABN.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has reviewed all payor changes occurring over the past six months to identify any residents without the required discharge documentation. None of the reviews have revealed charges for services that were not covered by Medicare / Medicaid.</p>		

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F 582	<p>Continued From page 11</p> <p>Record review revealed that neither Resident #15 nor his resident representative were given the SNF ABN.</p> <p>The SNF ABN reviewed had Resident #15's name, the date services were to end, and the estimated cost of the services. There was no signature on the form, date on the form and there were no options checked for the decision made about continuing Medicare Part A services.</p> <p>An interview was conducted with the Interim Administrator on 6/8/21 at 2:48 PM. She stated the SNF ABN should have been signed by Resident #15's resident representative. The Interim Administrator further stated the form should have been mailed to the representative after the Social Worker had a discussion with the representative. She stated that if a conversation was held with the resident representative it should have been documented on the SNF ABN.</p> <p>An interview was conducted with the facility social worker on 6/9/21 at 12:11 PM who stated she did speak with the resident representative on 2/3/21 based on the notes she wrote on the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). She stated that when she spoke to the resident representative on the phone, she did not document the conversation on the SNF ABN form. She stated that she kept the form until the resident representative visited the facility and would get a signature at that time. The social worker stated Resident #15's resident representative does not visit the facility as they live out of town. She stated she does not mail the forms to the resident representative because she may not get it returned.</p>	F 582	<p>New Policy Addition: Carrolton Policy # 2.20 "Advanced Beneficiary Notices" was added to outline to outline the process for completing Advanced Beneficiary Notices.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <ol style="list-style-type: none"> 1. Carrolton Policy # 2.20 Advanced Beneficiary Notices was added to outline the process for completing Advanced Beneficiary Notices. 2. The facility social worker and business office staff were in-serviced on July 1, 2021, by Carrolton Facility Management Corporate Staff. Topics covered in this in-service included the following: Advanced Beneficiary Notices <ol style="list-style-type: none"> A. Review of Carrolton Policy # 2.20 Advanced Beneficiary Notices <ol style="list-style-type: none"> a. Importance of accuracy, signatures and b. Timely filing of documents B. Review of corrective action plan regarding Advanced Beneficiary Notices <ol style="list-style-type: none"> a. A 10% random sample of advanced beneficiary notices will be audited by Carrolton Facility Management (CFM) on monthly basis for three (3) months. 3. A facility management meeting was held on July 1, 2021, to discuss the 		

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F 582	<p>Continued From page 12</p> <p>2. Resident #48 was admitted to the facility on 10/3/20 with diagnoses that included diabetes mellitus. He was admitted to Medicare Part A skilled services on 4/12/21.</p> <p>Resident #48's Medicare Part A skilled services ended on 5/21/21.</p> <p>Record review revealed that neither Resident #48 nor his resident representative were given the SNF ABN. The SNF ABN reviewed had Resident #48's name and the date services were to end. There was no signature on the form, date on the form and there were no options checked for the decision made regarding continuing Medicare Part A skilled services.</p> <p>An interview was conducted with the Interim Administrator on 6/8/21 at 2:48 PM. She stated the SNF ABN should have been signed by Resident #48's resident representative. The Interim Administrator further stated the form should have been mailed to the representative after the Social Worker had a discussion with the representative. She stated that if a conversation was held with the resident representative it should have been documented on the SNF ABN.</p> <p>An interview was conducted with the facility social worker on 6/9/21 at 12:11 PM who stated she did speak with the resident representative on 5/19/21 based on the notes she wrote on the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). She stated that when she spoke to the resident representative on the phone, she did not document the conversation on the SNF ABN form. The social worker further stated she should have completed the form completely. She stated she kept the form until</p>	F 582	<p>corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>Meetings were held with the Business Office Manager and the Social Worker on Wednesday, June 30, 2021 for the purpose of re-educating them on the regulations for NOMNCs and ABNs.</p> <p>All residents will be provided ABNs or NOMNCs in the event the circumstances call for such.</p> <p>All patients will be notified, in writing, at the time of admission to the nursing facility of the items and services that are included in the nursing facility services under the State plan and which the resident might be charged.</p> <p>All patients will be informed at the time of admission of services available and charges for those services, including any charges for services not covered under Medicare / Medicaid, or by the facility's per diem rate.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>1. The Administrator, or designee, will monitor Advanced Beneficiary Notices to assure they are completed accurately and</p>		

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F 582	Continued From page 13 the resident representative visited the facility and would get a signature at that time. She stated she does not mail the forms to the resident representative because she may not get it returned.	F 582	timely. 2. Carrolton Facility Management (CFM) will conduct a 10% audit of Advanced Beneficiary audits to assure accuracy for a period of three (3) months. 3. Routine monitoring regarding Advanced Beneficiary Notices has been added to the facility QAPI plan.		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a	F 622		7/8/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 622	<p>Continued From page 14</p> <p>resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)</p>	F 622			

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F 622	<p>Continued From page 15</p> <p>(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician assistant interviews the facility failed to complete physician discharge documentation for 1 of 2 residents reviewed for discharge. (Resident #84)</p> <p>Findings included:</p> <p>Resident #84 was admitted to the facility on 2/25/21. Her active diagnoses included chronic obstructive pulmonary disease, muscle weakness, difficulty walking, and hyperlipidemia.</p> <p>A review of Resident #84's care plan dated 2/25/21 revealed she was care planned to return home after stay. The interventions included to make arrangements with required community resources to support independence post-discharge.</p>	F 622	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Resident #84 discharged home prior to the survey and a call to the resident by the Social Worker revealed no additional needs identified for continuance of care.</p> <p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address transfer and discharge requirements as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished</p>		

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F 622	Continued From page 16 A review of Resident #84's physician and physician assistant notes revealed the last note was dated 3/29/21 and was a physician's assistant progress note. The physician's assistant note did not indicate the resident was going to discharge. A review of her discharge minimum data set assessment dated 4/3/21 revealed Resident #84 was assessed as cognitively intact. She required extensive assistance with bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene. She required supervision with eating. She was discharged to the community on 4/3/21. A review of the facility discharge summary and instruction form for Resident #84 dated 4/1/21 as well as Resident #84's medical record revealed there was no discharge documentation completed by the physician. A review of a nursing note dated 4/3/21 revealed Resident #84 was discharged home with the power of attorney. Resident #84 was stable with no shortness of breath or pain noted. All belongings were packed and sent with resident During an interview on 6/9/21 At 11:15 AM Nurse Manager #1 stated there was no physician or physician's assistant documentation or summary of Resident #84's discharge. She further stated they contacted Physician's Assistant #1 who saw Resident #84 last on 3/29/21 and she indicated at that time, she did not know Resident #84 was going to discharge and did not complete discharge documentation. She concluded there should have been documentation about the	F 622	by: The corporate clinical team reviewed 10% of discharges in the previous 6 months to identify patterns for educational opportunity. The facility social worker called every discharged patient to ensure that all their needs are met and services are in place to ensure adequate care delivery in their new location. Actions taken/systems put into place to reduce the risk of future occurrence include: New Policy Addition: Carrolton Policy # 6.6 Discharge Planning Process was updated to specify that the discharge summary will be completed by the MD or midlevel practitioner at least 48 hours prior to planned discharges. Facility Nurses were in-serviced June 27 <input type="checkbox"/> July 1, 2021. Topics covered in these in-services included the following: 1. Transfer and Discharge Requirements ~ Review of Discharge Forms (Electronic Medical Record) ~ Home Medication Reconciliation ~ Physician Discharge Summary 2. Accuracy of Assessments and Care Plan Timing and Revision ~ Importance of accurate assessments,		

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F 622	<p>Continued From page 17</p> <p>discharge by a physician or physician's assistant.</p> <p>During an interview on 6/9/21 at 11:17 AM Social Worker #1 stated the physician or physician's assistant did not complete any discharge documentation or summary for Resident #84 and there should have been some clinical documentation by the physician or physician's assistant on Resident #84.</p> <p>During an interview on 6/09/21 at 11:24 AM Physician's Assistant #1 stated she did not know Resident #84 was leaving when she last saw the resident on 3/29/21 and so she completed a regular progress note on Resident #84. She further stated neither herself or Physician #1 were in the facility again prior to Resident #84's discharge and they did not write a discharge summary when they found out she was discharging.</p> <p>During an interview on 6/9/21 at 11:58 AM the Administrator stated there should have been a discharge summary and assessment for Resident #84 by the physician or physician's assistant prior to discharge.</p>	F 622	<p>coding, and care planning</p> <p>~ Nurse role in assuring accuracy of assessments, coding, and care planning</p> <p>3. A facility management meeting was held on July 1, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>4. A meeting was held with the medical director by Carrolton Facility Management Corporate Team Representatives and the facility Director of Nursing on July 1, 2021, to discuss facility expectations regarding timeliness of discharge summary completion and documentation in the electronic medical record.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>1. The Director of Nursing (DON) or designee, will review all discharge paperwork for accuracy and completeness prior to resident discharge for the next three (3) months. Records found to be out of compliance will be corrected and the appropriate action will be taken to council or re-train staff as needed.</p> <p>2. All transfers and discharges will be audited by Carrolton Facility Management (CFM) for the next three (3) months to ensure that all transfer and discharge</p>		

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F 622	Continued From page 18	F 622	requirements are met.		
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to accurately complete the minimum data set assessment (MDS) in the area of physical restraints for 2 of 39 residents whose MDS was reviewed. (Resident #74 and Resident #13)</p> <p>Findings included:</p> <p>1. Resident #74 was admitted to the facility on 02/17/2009 with a diagnoses of Alzheimer's dementia (a progressive disease that destroys memory and other important mental functions).</p> <p>A review of the annual MDS for Resident #74 dated 05/07/021 indicated she was severely impaired for daily decision making. It further indicated she required the extensive assistance of one person for bed mobility. Transfer out of bed was not assessed during the look back period. Resident #74 had no impairment of her upper or lower extremities. She had no falls. Bed rails were used daily as a restraint.</p> <p>On 06/07/2021 at 12:35 PM Resident #74 was</p>	F 641	<p>3. Routine monitoring regarding Transfer and Discharge Requirements have been added to the facility QAPI plan.</p> <p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #74 and #13 have updated care plans that reflect the use of side rails and half rails as positioning devices. They are not restraints, they have never been restraints for these two residents, and they are not coded as such.</p> <p>Meetings were held with the MDS nurses to educate about the definitions of restraints and to discuss the requirement to maintain an accurate assessment.</p> <p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address Accuracy of Assessments and Care Plan Timing and Revision as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished</p>	7/8/21	

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F 641	<p>Continued From page 19</p> <p>observed in bed with half rails on both sides raised at the head. She was resting quietly. The bed rails were not observed to impair Resident #74's access to her body or restrict her movement.</p> <p>On 06/08/2021 at 2:11 PM an interview with nursing assistant (NA) #1 indicated Resident #74 required total assistance of staff to get out of bed. NA #1 stated Resident #74 used her bed rails to help with turning in bed. She went on to say Resident #74 did not try to get out of bed by herself.</p> <p>On 06/09/2021 at 10:18 AM an interview with Nurse #2 indicated Resident #74 required total assistance of staff to transfer out of bed. She stated Resident #74 used her bed rails to assist with turning in bed. Nurse #2 went on to say Resident #74's bed rails did not restrain her in any way.</p> <p>A review of the most recent bed rail assessment for Resident #74 dated 06/09/2021 indicated half bed rails were used to assist with positioning.</p> <p>On 06/09/2021 at 11:41 AM an interview with an occupational therapist (OT) #1 indicated she was the rehabilitation director. She stated she was familiar with Resident #74 and assisted with her care. OT #1 stated Resident #74 used her bed rails to assist with turning in bed. She further indicated the bed rails did not restrain Resident #74 in any way.</p> <p>On 06/09/2021 at 2:13 PM an interview with MDS nurse #1 indicated bedrails used daily as a restraint was an error on Resident #74's MDS dated 05/07/2021. She further indicated she had</p>	F 641	<p>by:</p> <p>Team meetings, facilitated by Carrolton Facility Management Staff were held with MDS nurse, floor nurses and floor CNAs to review and update each residents' care plan June 28 through July 4, 2021. Care plans were updated as needed.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>1. Facility MDS Nurses were in-serviced June 28, 2021.</p> <p>Topics covered in this in-service included the following:</p> <p>A. Accuracy of Assessments Review of Carrolton Policy # 5.2 Conducting and Accurate Assessment</p> <p>B Care Plan Timing and Revision Review of Carrolton Policy # 5.3 Assessment Frequency/Timeliness</p> <p>C. Corrective Action Plan for Assessments and Care Plan Revisions ~ Review audits completed and issues identified (siderails). ~ Discuss plan for team meetings with floor</p>		

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F 641	Continued From page 20 corrected this. On 06/10/2021 at 9:20 AM an interview with the administrator indicated Resident #74's MDS should be coded to accurately reflect her care and conditions. 2. Resident #13 was admitted to the facility on with diagnoses that included diabetes mellitus. A review of Resident #13's care plan dated 12/30/20 revealed no intervention related to restraints. A review of Resident #13's Minimum Data Set (MDS) assessment dated 3/30/21, a quarterly assessment revealed Resident #13 was assessed to use a limb restraint less than daily. An interview was conducted with MDS Nurse #1 on 6/9/21 at 12:49 PM who reported the 3/30/21 assessment was incorrect. She stated it was a coding error and the facility does not utilize limb restraints. An interview was conducted with the Administrator on 6/10/21 at 8:49 AM who indicated the facility does not use limb restraints and the 3/30/21 assessment should have been coded to reflect Resident #13 does not require limb restraints.	F 641	nurses and CNAs to assure accuracy of coding and care plans. ~ 3. All care plans will be updated and corrected by July 4, 2021. 2. A facility management meeting was held on July 1, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. A 10% random sample of facility care plans will be audited by Carrolton Facility Management (CFM) for the next three (3) months to ensure that assessment are accurate and care plan revisions are timely. Auditing will continionue. 2. Routine monitoring regarding Accuracy of Assessments and Care Plan Timing and Revision have been added to the facility QAPI plan.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		7/8/21	

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F 657	<p>Continued From page 21</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review the facility failed to update a care plan for siderails for 1 of 2 residents (resident #59) reviewed for activities of daily living.</p> <p>Findings included:</p> <p>Resident #59 was admitted to the facility on 1/11/2018 with diagnoses that included Alzheimer's disease and chronic kidney disease.</p> <p>The Minimum Data Set (MDS) dated 4/19/2021 revealed Resident #59 was severely cognitively impaired.</p>	F 657	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #74 and #13 have updated care plans that reflect the use of side rails and half rails as positioning devices. They are not restraints, they have never been restraints for these two residents, and they are not coded as such.</p> <p>Meetings were held with the MDS nurses to educate about the definitions of restraints and to discuss the requirement to maintain an accurate assessment.</p>		

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F 657	<p>Continued From page 22</p> <p>Review of Resident #59's care plan last reviewed on 4/19/2021 revealed a risk for falls plan related to a history of falls. The interventions included side rails as an enabler for mobility, positioning, and transferring.</p> <p>An observation on 6/9/2021 at 8:30 am revealed no side rails were attached to Resident #59's bed.</p> <p>During an interview with MDS #1 on 6/9/2021 at 2:00 pm she stated the siderails was discontinued in August 2020. She said the care plan should have been updated when Resident #59 no longer needed side rails on her bed. She stated the update just was not done.</p> <p>On 6/10/2021 at 10:40 am an interview was conducted with the Administrator, and she stated the MDS Nurse should have updated Resident #59's care plan when the side rails were discontinued.</p>	F 657	<p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address Accuracy of Assessments and Care Plan Timing and Revision as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>Team meetings, facilitated by Carrolton Facility Management Staff were held with MDS nurse, floor nurses and floor CNAs to review and update each residents <input type="checkbox"/> care plan June 28 <input type="checkbox"/> July 4, 2021.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>1. Facility MDS Nurses were in-serviced June 28, 2021. Topics covered in this in-service included the following:</p> <p>Accuracy of Assessments a. 1. Review of Carrolton Policy # 5.2 Conducting and Accurate Assessment</p> <p>Care Plan Timing and Revision a. Review of Carrolton Policy # 5.3 Assessment Frequency/Timeliness</p> <p>Corrective Action Plan for Assessments and Care Plan Revisions a. Review audits completed and</p>		

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F 657	Continued From page 23	F 657	<p>issues identified (siderails).</p> <p>b. Discuss plan for team meetings with floor nurses and CNAs to assure accuracy of coding and care plans.</p> <p>c. All care plans will be updated and corrected by July 4, 2021.</p> <p>2. A facility management meeting was held on June 30, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>1. A 10% random sample of facility care plans will be audited by Carrolton Facility Management (CFM) for the next three (3) months to ensure that assessment are accurate and care plan revisions are timely. Auditing will continioue&&.</p> <p>2. Routine monitoring regarding Accuracy of Assessments and Care Plan Timing and Revision have been added to the facility QAPI plan.</p> <p>Corrective action completion date: July 8, 2021</p>		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		7/8/21	

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F 758	<p>Continued From page 24</p> <p>but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic</p>	F 758			

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F 758	<p>Continued From page 25</p> <p>drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, Physician, Pharmacist, staff interviews, and record reviews the facility failed to provide a stop date for an antianxiety medication order for 1 of 5 residents (Resident #32) reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>Resident #32 was admitted to the facility on 12/4/2020 with diagnoses that included major depressive disorder.</p> <p>The Minimum Data Set (MDS) dated 4/9/2021 revealed Resident #32 was moderately cognitively impaired and received an antianxiety medication 2 days out of the 7-day assessment period.</p> <p>A physician order for Resident #32 dated 12/7/2020 revealed Lorazepam 0.5 mg one tablet by mouth every 4 hours as needed for anxiety or agitation.</p> <p>A pharmacy recommendation dated 12/11/2020 requested a rational and stop date for the Lorazepam. Physician #1 agreed with the recommendation, added a duration of 180 days, and rationale of anxiety on 12/23/2020.</p> <p>Physician order for Resident #32 dated 3/8/2021 Lorazepam 0.5 mg one by mouth every 4 hours as needed for anxiety. Pharmacist to dispense 50 tablets with 5 refills.</p>	F 758	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The physician has updated the Lorazepam order for Resident #32 to include a stop date. There was a stop date on the original order, however, this continuation order failed to pull the stop date forward.</p> <p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address Psychotropic Drugs and end dates as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The Regional Clinical Pharmacy Manager performed s 100% audit of all active PRN psychotropic orders for residents at the facility to ensure appropriate indication, rationale and duration were in place. No orders were found to be out of compliance.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p>		

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F 758	<p>Continued From page 26</p> <p>The electronic physician orders) revealed an order for Lorazepam 0.5 mg one by mouth every 4 hours as needed. The order was dated 5/6/2021 with an end date of indefinitely.</p> <p>The physician orders revealed no order for as needed Lorazepam dated 5/6/2021.</p> <p>An electronic Medication Administration Record (MAR) for the month of June 2021 revealed Lorazepam tablet 0.5 mg take one tablet by mouth every four hours as needed for anxiety. The order on the MAR was dated 3/8/2021.</p> <p>An observation on 6/9/2020 at 11:25 am with Nurse #1 revealed Resident #32 had 49 Lorazepam in the medication cart.</p> <p>An interview with Nurse #1 on 6/9/2021 at 11:31 am revealed when a nurse had an order for Lorazepam without a stop date, the nurse should call the physician to get a clarification order. She stated she did not call the physician for a clarification order for Resident #32 ' s Lorazepam.</p> <p>An interview with the Pharmacist on 6/9/2021 at 11:45 am revealed the last Lorazepam order was received on 3/8/2021 and last refilled on 5/6/2021. He stated the prescription did not have a stop date on it.</p> <p>The pharmacy recommendations for March 10, 2021, April 21, 2021, and May 24, 2021 revealed pharmacy review was completed with no recommendations.</p> <p>During an interview with Physician #1 on 6/10/2021 at 8:45 am he stated he was very</p>	F 758	<ol style="list-style-type: none"> 1. Facility Nurses were in-serviced on June 22 and 23, 2021. Topics covered in this in-service included the following: <ol style="list-style-type: none"> a. Psychotropic Medications b. Medication Utilization c. PRN Medication Orders 2. A facility management meeting was held on July 1, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey. 3. A meeting was held with the medical director by Carrolton Facility Management Representatives and the Director of Nursing on July 1, 2021, to discuss survey findings and end dates for psychotropic medications. 4. The Carrolton Facility Management Representatives also spoke with the psychiatric providers to discuss survey findings as related to end dates for psychotropic medications. <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <ol style="list-style-type: none"> 1. The facility consultant pharmacist will conduct a 100% monthly audit for three (3) months of all active PRN psychotropic orders for of all residents at the facility to assure appropriate indication, rationale and duration are in place. 		

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F 758	Continued From page 27 much aware the Lorazepam order needed a stop date. An interview was conducted with the Administrator and Director of Nursing (DON) on 6/10/2021 at 10:40 am. The Administrator said Resident #32 ' s Lorazepam needed to have a firm stop date. She stated the nurses should have made the physician aware of the need for a stop date for the Lorazepam as soon as possible.	F 758	2. Routine monitoring regarding Psychotropic Medications/PRN use has been added to the facility QAPI plan.		
F 761 SS=E	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		7/8/21	

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F 761	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to discard expired medications on one of three medications carts (Martin hall) and one of one medication storage rooms (Skill hall) reviewed for medication storage, failed to monitor the temperature of a medication storage refrigerator (Skill hall) containing medications for one of one medication storage refrigerators reviewed, and failed to lock an unattended medication storage cart (Split hall) for one of five medication carts observed.</p> <p>Findings included:</p> <p>1. On 06/08/2021 at 11:30 AM an observation of the Martin hall medication storage cart with Nurse #5 revealed 39 Meclizine (an anti-nausea medication) 12.5 milligram (mg) tablets with an expiration date of 11/2020. An interview with Nurse #5 at that time indicated the medication was expired and should have been discarded.</p> <p>On 06/08/2021 at 12:59 PM an interview with the interim Director of Nursing (DON) indicated there should be no expired medication present on any medication carts. She stated nurses should be going through the carts daily looking for any expired medications and immediately discarding them.</p> <p>2. On 06/08/2021 at 1:06 PM an observation of the Skill hall medication room with the DON indicated five 473 milliliter (ml) bottles of Tylenol (an anti-fever and pain medication) 160 mg per 5 ml with an expiration date of 05/2021. An interview with the DON at that time indicated the medication was expired and should have been</p>	F 761	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>No residents were found to be affected. The med rooms have been cleaned and all expired medications have been removed. Only one medication room is in use at this time.</p> <p>General In-services were held during all-staff meetings conducted June 14 - 18, 2021, to address Labeling and Storage of Drugs and Biologicals as well as other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility Director of Nursing (DON) and other Carrolton Facility Management Representatives completed an inspection of all medication storage rooms, refrigerators, and medication carts and removed all expired medications found.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>1. Facility Nurses were in-serviced on June 22 and 23, 2021. Topics covered in this in-service included the</p>		

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F 761	<p>Continued From page 29</p> <p>discarded. She stated it was her responsibility to check the medication rooms for expired medication and discard it, but she had been busy and had not had a chance to do it.</p> <p>On 06/10/2021 at 9:22 AM an interview with the administrator indicated there should not be any expired medication present on medication carts or in medication rooms.</p> <p>3. A review of the facility policy titled "Storage of Refrigerated Medications" dated 06/2020 read in part, "The temperature of all refrigerators containing medication shall be maintained between 36 degrees Fahrenheit (F) to 46 degrees F".</p> <p>On 06/08/2021 at 1:29 PM an observation of the Skill hall medication storage refrigerator with the DON indicated the temperature in the refrigerator was 38 degrees F. The medication refrigerator was observed to contain Humalog Kwikpen 3 ml (an injectable diabetic medication) labeled as delivered 5/27/2021 with instructions to "keep refrigerated", Vancomycin (an intravenous antibiotic medication) 250 ml labeled as delivered 6/7/2021 with instructions to "keep refrigerated", and Lispro Kwikpen 3ml labeled as delivered 6/7/2021 with instructions to "keep refrigerated".</p> <p>No medication refrigerator temperature monitoring log was observed to be present in the Skill hall medication room.</p> <p>On 06/08/2021 at 1:36 PM an interview with the DON indicated there was no temperature monitoring log for the Skill medication refrigerator to indicate staff had been monitoring the temperature of the refrigerator. She stated this</p>	F 761	<p>following:</p> <ol style="list-style-type: none"> a. Removal of Expiring Medications b. Maintaining Refrigerator Temperatures and Logs Daily c. Assuring Medication Carts are Locked When Unattended d Labeling and Storage of Drugs and Biologicals <p>2. A facility management meeting was held on July 1, 2021, to discuss the corrective action plan for this and all other issues identified from the June 7-10, 2021, DHHS Survey.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <ol style="list-style-type: none"> 1. The Director of Nursing (DON) or designee, will conduct weekly medication storage audits for a minimum of three (3) months to assure that all expired medications are removed timely and medication temperatures are maintained. 2. The Director of Nursing (DON), or designee, will conduct random observations of staff during over the next three (3) months to ensure staff are complying with locking medication carts when unattended. 3. The facility consultant pharmacist will provide monthly medication storage audits for a minimum of three (3) months and periodically as determined by the QAPI 		

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F 761	<p>Continued From page 30</p> <p>should be done each night shift to ensure the refrigerator was functioning properly and maintaining the proper temperature for the storage of medication.</p> <p>On 06/08/2021 at 4:09 PM an interview with Nurse Manager #1 indicated the facility did not normally use the medication refrigerator on the Skill Hall. She stated she did not know how long the medication had been in the Skill hall medication refrigerator. She went on to say she did not know which staff member placed it there. She further indicated if a medication refrigerator contained medication staff should be monitoring and recording the temperature of the refrigerator twice daily to ensure the refrigerator was functioning and maintaining the required temperature.</p> <p>On 06/08/2021 at 4:40 PM a telephone interview with Nurse #6 indicated he received the medication labeled as being delivered 6/7/2021 from the pharmacy and placed it in the Skill medication refrigerator on that date. He stated he noted at that time the temperature in the refrigerator was 38 degrees F, but he did not write it down. He further indicated there was no temperature monitoring log in the Skill hall medication room. He went on to say the Humalog Kwikpen and the Tubersol were already present in the Skill hall medication refrigerator. Nurse #6 stated he did not know how long it had been there. He further indicated he was assigned to the Skill hall on 6/5/2021 and 6/6/2021 but he did not check the medication refrigerator on those dates as he did not know it contained medication until 6/7/2021 when he received a delivery from the pharmacy.</p>	F 761	<p>committee.</p> <p>4. Routine monitoring regarding Psychotropic Medications/PRN use has been added to the facility QAPI plan.</p>		

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NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF WILLIAMSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	<p>Continued From page 31</p> <p>On 06/10/2021 at 9:22 AM an interview with the administrator indicated medications requiring refrigeration needed to be stored at between 36 degrees F and 46 degrees F. She stated staff should be monitoring and recording the temperature of all medication refrigerators containing medication twice daily. She went on to say if there was no log to indicate staff had done this, there was no way to know if the Skill medication refrigerator had maintained the proper storage temperature of the medication it contained.</p> <p>4. During observation on 6/7/21 at 10:24 AM the Split Hall Medication Cart was observed to be unlocked and unattended on the zone 3 hallway. At 10:25 AM a housekeeping staff member walked past the unlocked medication cart and at 10:26 AM a nurse aide was observed to walk past the unlocked medication cart. At 10:26 AM Medication Aide #1 returned to the medication cart from the nurse's station.</p> <p>During an interview on 6/7/21 at 10:26 AM Medication Aide #1 stated the split hall medication cart was her medication cart. She further stated medication carts were to be locked when unattended and she should have locked the medication cart but did not prior to leaving it unattended.</p> <p>During an interview on 6/7/21 at 2:50 PM Nurse #1 stated medications carts were to be locked when unattended. She concluded Medication Aide #1 should not have left the medication cart unlocked and unattended.</p> <p>During an interview on 6/7/21 at 3:57 PM the</p>	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2021
NAME OF PROVIDER OR SUPPLIER THE CARROLTON OF WILLIAMSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 32 Interim Director of Nursing stated medication carts were to be locked when unattended. She concluded Medication Aide #1 should have locked the medication cart prior to leaving the cart unattended.	F 761		