| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345279 | A. BUILDING ______<br>B. WING ______ | C<br>01/14/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARROLTON OF NASH | 7369 HUNTER HILL ROAD<br>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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint survey was conducted on 1/11/22 through 1/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NZT411. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 1/11/22 through 1/14/22 Event ID# NZT411.<br><br>5 of the 5 complaint allegations were not substantiated. | F 000 | | |
| F 578<br>SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§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.<br><br>§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.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives | F 578 | | 2/11/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/07/2022

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 578 | Continued From page 1<br>and applicable State law.<br>(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.<br>(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.<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to clarify code status orders for 1 of 2 residents reviewed for advanced directives. (Resident #21).<br><br>Findings included:<br><br>Resident #21 was admitted to the facility on 10/5/21 with diagnoses which included dementia.<br><br>Record review of the advanced directive care plan dated 10/6/21 and revised on 10/25/21 revealed Resident #21 was a full code.<br><br>Record review of hard copy code status book revealed Resident #21 had a full code order dated 10/6/21.<br><br>Resident #21 ' s Quarterly Minimum Data Set | F 578 | Resident Affected:<br>The facility failed to clarify code status order for Resident #21. Social Worker was immediately educated and conducted clarification of order and resident choice with resident representative. Resident #21 order was immediately clarified and corrected on 01/13/2022.<br><br>Residents with Potential to be Affected:<br>All residents are at risk for this deficiency.<br><br>All nursing, social work, minimum data set, and medical records staff were educated on the right for a resident to request, refuse, and/or discontinue treatment to formulate an advanced directive. Education was initiated on | |

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**F 578** Continued From page 2

(MDS) Assessment dated 10/29/21 revealed he had severe cognitively impairment.

Record review of MDS Discharge Return Anticipated Assessment dated 12/13/21 revealed Resident #21 was discharged from the facility to an acute hospital.

Record review of MDS Entry Tracking Assessment dated 12/23/21 revealed Resident #21 returned to the facility from an acute hospital.

A physician order dated 12/23/21 for full code was entered in the electronic medical record by Nurse #2.

A physician order dated 12/28/21 for Do Not Resuscitate (DNR) entered in electronic medical record by the Social Worker.

During an interview on 1/13/22 at 8:33 AM Nurse #1 revealed that the Social Worker was responsible to obtain and enter Resident #21 ' s code status in the electronic record and place a paper copy in code status book located at the nursing station. Nurse #1 stated that if a discrepancy of code status orders were found the resident would be a full code until the order was clarified.

During an interview on 1/13/22 at 9:26 AM the Social Worker revealed she confirmed code status with the resident or responsible party (RP) if resident was cognitively impaired upon admission to the facility or when a code status change was requested while a resident. She stated she entered the code status order in the electronic medical record and placed a written copy in the code status book at the nurse station.

**F 578**

01/13/2022 and education was completed on 02/07/2022.

Social Work Supervisor and Minimum Data Set Nurse completed a 100% resident population audit of the resident code status orders on 01/13/2022.

Systemic Changes:
The Social Worker will complete a 100% advanced directive preference audit by 02/11/2022. The Social Worker will complete a code status order audit on new admissions and code status changes 5 days per week for 3 months. Any discrepancies will be immediately corrected. The Director of Nursing will review the audits completed by Social Work Supervisor weekly for 3 months.

Monitoring:
The Director of Nursing or Designee will discuss the audit results during the monthly Performance Improvement Committee, for 3 months, consisting of the Administrator, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services.

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| F 578 | Continued From page 3<br>The Social Worker reported she reviewed the physician orders in the electronic record before she entered the code status order, but she did not remember seeing the full code order when she entered the DNR order on 12/28/21. The Social Worker was unable to state how she missed the full code order for Resident #21.<br><br>During an interview on 1/13/22 at 9:59 AM the Director of Nursing (DON) revealed the Social Worker was responsible for confirmation and electronic order entry of code status. She stated Resident #21 ' s RP had considered hospice care and a DNR order was discussed but RP decided not to pursue hospice care and the code status was not changed. The DON was unable to state how Resident #21 ' s conflicting code status orders were missed.<br><br>During an interview on 1/14/22 at 11:19 AM the Administrator revealed the Social Worker was responsible to obtain the code status order and enter in electronic medical record. She stated the Social Worker was expected to ensure the code status was correct and if discrepancy to clarify before entering a new code status order. | F 578 | | |
| F 695<br>SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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. | F 695 | | 2/11/22 |

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| F 695 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, resident interview, and staff interviews, the facility failed to obtain a physician order for the use of supplemental oxygen for 1 of 4 residents reviewed for oxygen. (Resident #38).<br><br>Findings included:<br><br>Resident #38 was admitted to the facility on 9/11/18 with diagnoses which included obstructive sleep apnea and chronic respiratory failure.<br><br>Resident #38 ' s Annual Minimum Data Set (MDS) Assessment dated 11/12/21 revealed he was cognitively intact and was on oxygen.<br><br>Record review of care plan dated 10/23/18 with revisions on 3/4/19, 8/23/19, and 2/6/20, revealed care plan for ineffective breathing pattern related to chronic respiratory failure and obstructive sleep apnea.<br><br>Record review of physician orders revealed Resident #38 did not have a physician order for oxygen.<br><br>During an observation on 1/11/22 at 3:10 PM Resident #38 with oxygen via nasal cannula at 2 Liters and oxygen in use sign on resident door.<br><br>Record review of Oxygen Saturation Summary Report for the month of January revealed resident had oxygen saturation levels between 96%-99% with oxygen via nasal cannula.<br><br>During an interview on 1/13/22 at 8:33 AM Nurse #1 revealed that Resident #38 was on oxygen | F 695 | Resident Affected:<br>Resident #38 was observed to be receiving oxygen without written documentation reflecting physician order for the use of supplemental oxygen. Facility obtained written documentation from physician on 01/13/2022 and written order was recorded in resident #38 medical record.<br><br>Residents with Potential to be Affected:<br>All residents are at risk for this deficiency. All licensed nursing staff were educated on requirement of documentation for written order for the use of supplemental oxygen. Education was initiated on 01/13/2022 and education was completed on 02/07/2022.<br>Minimum Data Set Nurse immediately completed a 100% resident room round for residents with oxygen concentrators and 100% resident chart audit documentation of written physician order for use of supplemental oxygen on 01/13/2022 with no additional concerns identified.<br><br>Systemic Changes:<br>The Administrator will conduct a 100% resident room round for residents with oxygen concentrators two times per week for 3 months. Nursing Administrative Staff will conduct a 100% resident chart audit documentation of written physician order for use of supplemental oxygen two times per week for 3 months. Any discrepancies noted, the facility will obtain written | |

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| F 695 | Continued From page 5<br>and that a physician order was required for the oxygen. Nurse #1 reported that orders were entered by floor nurse or the unit nurse. She was unable to state why the physician order for oxygen was not entered for Resident #38.<br><br>During an interview on 1/13/21 at 8:36 AM Nurse Aide (NA) #2 revealed that Resident #38 was on oxygen.<br><br>During an interview on 1/13/22 at 1:39 PM NA #1 revealed that Resident #38 was on oxygen, and he would put on and take off as he wanted.<br><br>During an interview on 1/13/22 at 9:56 AM the Director of Nursing (DON) revealed that Resident #38 required a physician order for oxygen. She stated that the orders were entered by the floor or unit nurse. She stated physician orders were reviewed in the clinical meeting but was unable to state how the oxygen order was missed for Resident #38.<br><br>During an interview on 1/14/22 at 11:15 AM the Administrator revealed the DON or unit nurse were responsible to confirm orders were entered. She stated physician orders were reviewed in clinical meeting and was unable to state why the order was missed for Resident #38. | F 695 | physician order and place in resident medical record. Director of Nursing or Designee will audit all residents to include new admissions receiving supplemental oxygen for written physician order documentation in medical record weekly for 3 months.<br><br>Monitoring:<br>The Director of Nursing or Designee will discuss the audit results during the monthly Performance Improvement Committee, for 3 months, consisting of the Administrator, Director of Nursing, Pharmacist, Social Worker, Minimum Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services. | |
| F 814 SS=E | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to maintain the area surrounding the | F 814 | Resident Affected:<br>The District Dietary Manager and | 2/11/22 |

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| F 814 | Continued From page 6<br>dumpster free of debris for 2 of 2 dumpsters observed.<br>The findings included:<br><br>During an observation of the dumpster area on 1/11/22 at 10:46 AM, 2 disposable gloves were observed behind dumpster # 1, assorted papers, and a jelly cup were between dumpster #1 and dumpster # 2. Broken glass from a fluorescent light bulb was observed between dumpster #2 and the grease disposal container.<br><br>During a second observation on 1/13/22 at 9:54 AM 2 disposable gloves were behind dumpster # 2, a jelly cup and clear broken glass were between dumpster #1 and dumpster # 2. Broken glass from a fluorescent light bulb was observed between dumpster #2 and the grease disposal container.<br><br>A third observation of the dumpster area on 1/14/22 at 9:26 AM 4 disposable gloves and assorted papers were observed on the ground behind dumpster # 2. a jelly cup and clear broken glass were between dumpster #1 and dumpster # 2. Broken fluorescent light bulb was observed between dumpster #2 and the grease disposal container.<br><br>An observation of the dumpster area was conducted with the regional dietary manager on 1/14/22 at 10:17 AM revealed the dumpster area to be in the same condition.<br><br>During an interview 1/14/22 at 10:19 AM the regional dietary manager stated all departments, including dietary used the dumpster every day and the kitchen staff did their part to keep the area clean. She indicated she would get the area | F 814 | Environmental Services Director immediately corrected identified concerns of disposing garbage and refuse properly upon notification by surveyor on 01/14/2022.<br><br>Residents with Potential to be Affected:<br>All residents have the potential to be affected. A 100% audit on 01/14/2022 was completed by the Administrator to ensure that all garbage and refuse items were disposed of properly, that dumpster lids were closed, and that the dumpster area was in sanitary compliance.<br><br>Systemic Changes:<br>The Dietary Manager and Dietary departmental staff, Environmental Services Manager and departmental staff, and Maintenance Staff were educated on 01/14/2022 regarding regulatory requirements for closure of dumpster lids and proper disposal of garbage and refuse around dumpster area. Education for all departmental staff was initiated on 01/13/2022 and education was completed on 02/07/2022<br><br>The Dietary Manager or Designee, and Environmental Services Director or Designee, will each complete an individual dumpster area walk through audit for proper lid closure and disposal of garbage and refuse 2 times daily for 7 days a week for 2 weeks, once daily for 5 days a week for 4 weeks, then 3 times per week for 6 weeks. Identified concerns will be corrected immediately and reported to Administrator. The Administrator will | |

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| F 814 | Continued From page 7<br>cleaned up.<br><br>In an interview on 1/14/22 at 10:22 AM the housekeeping manager stated the garbage truck driver should have cleaned up the area. He indicated they would no longer rely on the garbage truck driver and his staff would sweep and clean the area daily.<br><br>In an interview on 1/14/22 at 12:01 PM the administrator indicated staff would begin making daily rounds to check and clean the dumpster area. | F 814 | complete a dumpster area walk through audit for proper disposal of garbage and refuse weekly for 3 months. Any identified concerns will be corrected immediately.<br><br>Monitoring:<br>The Administrator or Designee will discuss the audit results during the monthly Performance Improvement, for 3 months, consisting of the Administrator, Director of Nursing, Pharmacist, Social Worker, Minimal Data Set Coordinator, and Medical Director will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services. | |