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 03/29/2023

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 3/26/2023 through 3/29/2023. The facility was found compliant with the requirment CFR 483.73, Emergency preparedness. Event ID#I8CL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/26/23 through 3/29/23. Event ID# I8CL11. The following intakes were investigated NC00194140, NC00194682, NC00197409, NC00198503, NC00199386, and NC00199916. 1 of the 25 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assess a resident for self-administration of medication for 1 of 1 resident (Resident #47) reviewed for self-administration of medication. The findings included: Resident #47 was admitted to the facility on 7/30/21 with diagnoses that included end stage renal disease. The resident ' s care plan dated 1/16/23 did not	F 554	WHAT WE DID FOR RESIDENT : Resident # 47 had an assessment for Self-Administration of medication on 4/17/2023 and was deemed appropriate to self-administer medications by the interdisciplinary team. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected by the alleged deficient practice. All residents with a BIMs score of 13-15 with the capability of	4/26/23

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

Electronically Signed | 04/21/2023

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F 554	Continued From page 1 include the self-administration of medication. There was not an assessment for Resident #47 in the medical record to determine if it was safe for the resident to self -administer medication. A review of the Quarterly Minimum Data Set (MDS) Assessment dated 1/16/23 revealed Resident #47 was cognitively intact. On 3/26/23 at 11:13 AM Resident #47 was observed lying on the bed with a cup containing 7 tablets sitting on the bedside table. Resident #47 was resting on the bed with his eyes closed. An interview was conducted with Medication Aide #1 on 3/26/23 at 11:15 AM. Medication Aide #1 stated she had left Resident #47 ' s medication at the bedside because he was not awake. The Medication Aide stated she had been told by other staff she could leave Resident #47 ' s medication at the bedside and he would take it when he woke up. Further interview with Medication Aide #1 revealed that she had been educated not to leave resident ' s medication at the bedside. During an interview with the Director of Nursing on 3/28/23 at 3:44 PM. The DON stated the Medication Aide should have made sure Resident #47 took his medication or attempted to offer the medication at a later time. The DON stated medication should never be left at a resident ' s bedside.	F 554	self-administering medications will be assessed with the use of Medication Self Administration Safety Screen in PCC by the Nursing Administration team by 4/21/2023. SYSTEMIC CHANGES: The Regional Staff Development Director provided education to the DON, ADON and Unit Managers on Medication Administration related to Self-administration of Medication on 4/17/2023. The DON and ADON will provide education on Medication Administration to all nursing staff to include registered nurses, licensed nurses, and medication aides on 4/17/2023 to include agency personnel. Staff will not be permitted to work until training is completed. MONITORING: The Administrative nursing teams will conduct medication audits 3 times a week x 4 weeks (4/17/2023 through 5/8/2023) to identify any new areas of concern for re-education. This audit will be documented on the Self Administration of Medication Audit Tool. MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. DATE OF COMPLIANCE WILL BE 4/26/2023.	

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F 623 SS=C	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 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	F 623		4/26/23

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F 623	Continued From page 3 (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 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.	F 623		

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F 623	Continued From page 4 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 interviews, the facility failed to provide written notification for reason of discharge to hospital to the Resident and/or Responsible Party (RP) for 6 of 6 residents reviewed for hospitalization (Resident #69, Resident #82, Resident #3, Resident #96, Resident #74, and Resident #46). The findings included: 1. Resident #69 was admitted to the facility on 12/15/22. The admission Minimum Data Set dated 12/22/22 revealed Resident #69 was cognitively intact. Review of Resident # 69's medical record revealed hospital stays from 1/17/23 through 1/21/23 and 2/5/23 through 2/9/23. No written notice of transfer was documented to have been provided to the resident or her responsible party.	F 623	WHAT WE DID WE DO FOR OUR RESIDENTS: Resident #69, #82, #3, #96, #74, #46 or resident representative did not receive a written notice of transfer for the facility after being sent out to the hospital. Discharge dates included 1/17/23 through 1/21/23, 2/5/23 through 2/9/23. A written notification of transfer was mailed to Resident Representative for resident # 69, #82, #3, #96, #74, #46 on 4/25/2023. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All other residents in the facility that have been transferred to the hospital have the potential to be affected by the alleged deficient practice. All documentation of residents that have been transferred to the hospital has been reviewed within the last 30 days by the DON 4/17/2023. Audit	

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F 623	Continued From page 5 During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Resident Party (RP). The DON stated the bed hold and transfer/discharge to hospital form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 2. Resident #82 was admitted to the facility on 5/6/20. The quarterly Minimum Data Set dated 12/5/22 revealed Resident # 82 was severely cognitively impaired. Review of Resident #82's medical record revealed she was transferred to the hospital on 11/24/22 through 11/28/22. No written notice of transfer was documented to have been provided to the resident or her responsible party. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold and transfer/discharge to hospital form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 3. Resident #3 was admitted to the facility on 2/15/22. The quarterly Minimum Data Set (MDS) assessment dated 3/8/23 revealed Resident #3 was cognitively intact.	F 623	revealed that residents had not received written notice of transfer/discharge but did receive verbal notification. All residents identified through the audit had notification of transfer mailed to RR or resident by the DON through 4/25/2023. SYSTEMIC CHANGES: The DON will formulate a letter to notify residents or resident representative of transfer to hospital. The DON will educate Social Workers, ADON and Unit Coordinators on the written process of notification of transfers to resident or resident representative on 4/17/2023. MONITORING: Social Workers will conduct a weekly monitoring of written notification to resident and resident representatives on the Transfer/Discharge Audit Tool weekly x 4 weeks (4/17/2023 through 5/8/2023) to identify areas of concern and correct immediately. The Transfer Audit Form will be initiated weekly by the Administrator or DON to follow up with compliance. MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. DATE OF COMPLIANCE IS 4/26/2023.	

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F 623	Continued From page 6	F 623		

A Health Status Note dated 9/3/22 revealed Resident #3 was transferred to the emergency department for further evaluation.

The medical record indicated Resident #3 was discharged to the hospital on 9/3/22 and returned to the facility on 9/7/22.

Review of the medical record revealed no evidence that Resident #3 and his Responsible Party received written notification of the reason for transfer to the hospital.

During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP.

4. Resident #96 was admitted to the facility on 5/24/22.

The quarterly Minimum Data Set (MDS) assessment dated 2/3/23 revealed Resident #96 had severe cognitive impairment.

A Health Status Note dated 1/24/23 revealed Resident #96 was sent to the emergency department for further evaluation.

The medical record indicated Resident #96 was discharged to the hospital on 1/24/23 and he returned to the facility on 1/27/23.

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F 623	Continued From page 7	F 623		

Review of the medical record revealed Resident #96 revealed no evidence the Responsible Party received written notification of the reason for transfer to the hospital.

During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP.

5. Resident # 74 was admitted to the facility on 6/21/19.

A Nursing Progress Note dated 2/5/23 revealed Resident #74 was sent to the emergency department for further evaluation.

The medical record revealed Resident #74 was discharged to the hospital on 2/05/23 and returned to the facility on 2/13/23.

Review of the medical record revealed no evidence that Resident #74 and/or his Responsible Party (RP) received written notification of the reason for transfer to hospital.

During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility

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F 623	Continued From page 8 notified the RP by phone but there was no written notification sent to the resident or RP. 6. Resident #46 was admitted to the facility on 5/29/18. A Nursing Progress Note dated 1/20/23 revealed Resident #46 was sent to the emergency department for further evaluation. The medical record revealed Resident #46 was discharged to the hospital on 1/0/23 and returned to the facility on 1/22/23. Review of the medical record revealed no evidence that Resident #46 and/or his Responsible Party (RP) received written notification of the reason for transfer to the hospital. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP.	F 623		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §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 record review and staff interviews, the	F 641	WHAT WE DID FOR RESIDENT (#67 &	4/26/23

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F 641	Continued From page 9 facility failed to code the Minimum Data Set (MDS) assessment accurately for 2 of 27 residents whose MDS was reviewed (Resident #67 and Resident #107). Findings included: 1. Resident #67 was admitted to the facility on 6/10/22 with diagnoses which included stroke and dysphagia (difficulty swallowing). The Minimum Data Set (MDS) quarterly assessment dated 1/18/23 revealed Resident #67 was coded as comatose, and he required oxygen, suctioning, and tracheostomy (surgical airway to assist with breathing) care. Resident #67's cognition was not assessed related to him being rarely/never understood. An observation on 3/26/23 at 2:00 pm revealed Resident #67 was awake and alert, did not have oxygen in use, and did not have a tracheostomy. An interview on 3/26/23 at 2:30 pm Nurse #2 revealed Resident #67 was awake and alert with periods of confusion but was able to make his needs known. She stated he did not have a tracheostomy, use oxygen, or require suctioning. Nurse #2 stated she reviewed Resident #67's previous physician orders and documentation and confirmed he was awake and alert since admission and never had a tracheostomy, he never required suctioning, and had not been on oxygen. During an interview on 3/27/23 at 2:53 pm the MDS Nurse reviewed Resident #67's health record and confirmed Resident #67 was not comatose, he did not have a tracheostomy or	F 641	107): Resident # 67 and # 107 received inaccurate documentation on MDS. Resident # 67 was coded as being comatose with oxygen, tracheostomy and required suctioning. Resident # 107 MDS coding of pressure ulcer was inaccurate. Revision of Resident # 67 MDS was completed on 3/27/2023. Revision of Resident # 107 MDS was completed on 3/27/2023. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected by the alleged deficient practice. All Minimum Data Set (MDS) for the last 30 days will be reviewed for accuracy by the MDS nurses and DON. Any noted errors will be corrected immediately. SYSTEMIC CHANGES: The Regional Staff Development Coordinator will educate the MDS nurses and Director of Nursing and Assistant Director of Nursing on conducting an Accurate Resident Assessment on 4/17/2023. MONITORING: The Director of Nursing or Assistant Director of nursing will conduct weekly MDS audits for accuracy twice a week x 4 weeks (4/17/2023 through 5/8/2023) to identify any new areas of concern for re-education or corrections. The audit will be documented on the MDS Assessment Accuracy Audit Tool.	

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F 641	Continued From page 10 require oxygen and suctioning. The MDS Nurse stated she coded Resident #67 in error. An interview was conducted on 3/29/23 at 11:26 am with the Director of Nursing (DON) who revealed Resident #67 was never comatose, he never had a tracheostomy, and he did not require suctioning. The DON stated the MDS Nurse was responsible to complete an accurate assessment for Resident #67 based on observation and record review. 2. Resident #107 was admitted to the facility on 1/25/23 with an unstageable pressure ulcer injury to his sacrum. The Skin/Wound/Treatment note dated 1/25/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum. A physician order dated 1/25/23 for sacrum cleanse with wound cleaner, apply silver alginate (wound treatment) and cover with folded pad secured with tape every evening shift and as needed for unstageable pressure ulcer. The Minimum Data Set (MDS) 5-day admission assessment dated 2/01/23 revealed Resident #107 had an unstageable pressure ulcer injury which was present upon admission to the facility. The Weekly Wound Observation Tool dated 2/01/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum. A nursing progress note dated 2/01/23 revealed Resident #107 was sent to the hospital for hematuria (blood in urine) and was admitted.	F 641	MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. DATE OF COMPLIANCE 4/26/2023	

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F 641	Continued From page 11	F 641		

a. The MDS discharge return anticipated assessment dated 2/1/23 revealed Resident #107 did not have an unstageable pressure ulcer injury.

The Skin/Wound/Treatment note dated 2/07/23 revealed Resident #107 returned to the facility and had an unstageable pressure ulcer injury to his sacrum/left buttock.

b. The MDS 5-day admission assessment dated 2/13/23 revealed Resident #107 did not have an unstageable pressure injury.

The Weekly Wound Observation Tool dated 2/17/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock.

The Weekly Wound Observation Tool dated 2/23/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock.

The Skin/Wound/Treatment note dated 2/28/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock.

A Physician Progress note dated 3/02/23 revealed Resident #107 was sent to the hospital for declining respiratory status and sacral pressure ulcer infection and was admitted.

c. The MDS discharge return anticipated assessment dated 3/02/23 revealed Resident #107 did not have an unstageable pressure ulcer injury.

During an interview on 3/27/23 at 3:00 pm the MDS Nurse revealed she completed the wound

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F 641	Continued From page 12 section based on the weekly wound report provided by the Wound Nurse. The MDS Nurse confirmed Resident #107 had an unstageable pressure ulcer injury on 2/01/23, 2/13/23, and 3/02/23 when she completed the assessments based on the weekly wound report. The MDS Nurse stated she must have just missed it and coded Resident #107 incorrectly regarding his unstageable pressure ulcer injury. An interview was conducted on 3/28/23 at 9:54 am with the Wound Nurse who revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum when he admitted to the facility and received treatment daily. The Wound Nurse stated she provided the MDS Nurse with a weekly wound report and Resident #107 was included on the weekly wound report. During an interview on 3/29/23 at 11:26 am the Director of Nursing (DON) revealed the MDS Nurse was responsible to ensure the assessments were accurate for Resident #107. The DON stated the MDS Nurse was to physically see each resident to confirm the assessment was accurate and if any question regarding the resident status she was able to ask questions before submitting the assessments for Resident #107.	F 641		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		4/26/23

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F 656	Continued From page 13	F 656		

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

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F 656	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan that addressed Hospice services for 2 of 2 sampled residents reviewed for Hospice services (Resident #102 and Resident #56). Findings included: 1. Resident #102 was admitted to the facility on 11/28/22. A review of Resident #102's medical record revealed the Resident's family signed the consent for hospice services to begin on 12/19/22. The quarterly Minimum Data Set (MDS) assessment dated 3/3/23 revealed Resident #102 was coded as receiving Hospice services. A review of the Resident #102's comprehensive care plan most recently reviewed on 3/27/23 revealed no identification or incorporation of Hospice services. An interview was completed on 3/29/23 at 8:40am with the MDS Coordinator. She confirmed Resident #102 was receiving hospice services. The comprehensive care plan was reviewed with the MDS Coordinator, and she confirmed there was no inclusion of the Resident's hospice services in her care plan. The MDS Coordinator stated hospice services should have been included in Resident #102's comprehensive care plan. An interview was completed on 3/29/23 at	F 656	WHAT WE DID FOR RESIDENT (# 102 & # 56): Resident # 102 and Resident # 56 were both receiving hospice. Resident # 102 was admitted to hospice on 12/19/23 and resident # 56 was admitted to hospice on 9/27/22. There was no documentation of hospice with interventions on the comprehensive care plan. The care plans for residents # 102 and 56 were updated on 3/23/2023 by the MDS nurse to reflect Hospice services. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All residents receiving hospice services have the potential to be affected by the alleged deficient practice. Comprehensive care plans for all residents receiving hospice were reviewed and updated by the MDS nurses to reflect accurate information on 3/27/2023. SYSTEMIC CHANGES: The Regional Staff Development Coordinator educated MDS nurses, DON ADON, Unit Managers and Social Workers on 4/17/2023 related to Comprehensive Care Plans, Care plan Revisions upon status change to include Hospice and coordination of Hospice services. MONITORING: The DON, ADON and Unit Managers will conduct 3 random Care plan audits utilizing the Care Plan Audit Tool weekly x	

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F 656	Continued From page 15 12:22pm with the Director of Nursing (DON). The DON indicated Resident #102's comprehensive care plan included a terminal illness care plan, and it should have been customized to include hospice services. 2.Resident #56 was admitted to the facility on 5/12/22. A Significant Change in Status Minimum Data Set (MDS) Assessment dated 9/27/22 revealed Resident #56 was admitted to Hospice care. A review of Resident #56's comprehensive care plan last reviewed 3/10/23 did not reveal a care plan related to Hospice services. During an interview with MDS Coordinator on 3/29/23 at 9:40 AM she confirmed Resident #56 was receiving hospice services. A review of the comprehensive care plan with the MDS Coordinator revealed there were no hospice services included in Resident #56's care plan. The MDS Coordinator stated hospice care should have been included in the Resident's care plan. An interview was conducted with the Director of Nursing (DON) on 3/29/23 at 1:30 PM. The DON stated Resident #56's comprehensive care plan should have included a hospice care plan. She further stated the care plan should have been customized to include hospice services.	F 656	4 weeks (4/17/2023 through 5/8/2023) to identify any new areas of concern for re-education or corrections. The audit will be documented on the Care Plan Audit Tool. MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. Date of Compliance is 4/26/2023.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		4/26/23

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F 695	Continued From page 16 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, staff interviews, and Nurse Practitioner interview, the facility failed to obtain physician orders for supplemental oxygen (Resident #74) and tracheostomy care and suctioning (Resident #82) for 2 of 5 residents reviewed for respiratory care. Findings included: 1. Resident #74 was re-admitted to the facility on 2/05/23 and had cumulative diagnoses which included asthma, low blood oxygen, and stroke. Record review of the hospital discharge record dated 2/13/23 revealed Resident #74 was diagnosed with COVID-19, acute hypoxic (low blood oxygen) failure, and he did not have an order for supplemental oxygen upon discharge. The care plan dated 2/15/23 revealed Resident #74 had a care plan for oxygen therapy related to respiratory illness with intervention to provide oxygen 2 L via nasal canula (NC) continuous humidified. The Minimum Data Set (MDS) annual assessment dated 2/20/23 revealed Resident #74 had severe cognitive impairment and was coded for oxygen use.	F 695	WHAT WE DID FOR RESIDENT (#74 and #82): Resident #74 had oxygen at 3 liter/min in use but did not have a physician order in the system to reflect oxygen use. Resident # 82 did not have a physician's order for tracheostomy care and suctioning. Orders received for both residents #74 and #82 on 3/28/2023 and entered into the electronic medical record. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All residents receiving oxygen therapy, tracheostomy care and suctioning have the potential to be affected by the alleged deficient practice. An audit was conducted by the nurse leadership team to audit all residents receiving oxygen, tracheostomy care and suctioning to assure that proper physician orders were obtained and entered into the electronic medical record on 3/28/2023. SYSTEMIC CHANGES: The Director of Nursing provided education to all Licensed Nursing staff to include RN, LPN and Medications aides on the physician orders required for oxygen therapy, tracheostomy care and	

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F 695	Continued From page 17 Observations on 3/26/23 at 10:51 am and 3/27/23 at 1:51 pm revealed Resident #74 had oxygen at 3 L via NC in use. A record review conducted on 3/27/23 of the physician orders revealed no order for supplemental oxygen use for Resident #74. During an interview on 3/27/23 at 2:50 pm Nurse #2 confirmed Resident #74 had oxygen at 3 LNC in place. She stated a physician order was required for Resident #74's oxygen but she was unable to find the order. Nurse #2 was unable to state why the order for Resident #74's supplemental oxygen was not in place. An interview was conducted on 3/29/23 at 9:20 am with Nurse #3, who was assigned to Resident #74 upon return from hospital, revealed she completed Resident #74's readmission and was given in report from the transportation staff that Resident #74 was on oxygen at 2L via NC. She stated she was unable to state why the order for supplemental oxygen for Resident #74 was not entered but stated the oxygen did require a physician order. During an interview on 3/28/23 at 12:30 pm the Nurse Practitioner (NP) revealed she was not aware Resident #74 was on supplemental oxygen, but she stated a physician order was required. An interview was conducted on 3/29/23 at 11:29 am with the Director of Nursing (DON) who revealed the supplemental oxygen for Resident #74 required a physician order. The DON stated Resident #74's supplemental oxygen order was just missed.	F 695	suctioning through 4/18/2023. No nurse to include contract or agency staff, will work until education is complete. MONITORING: The DON/ADON/Unit Managers will conduct 3 random audits weekly x 4 weeks to monitor residents to for potential missing physician orders for Oxygen therapy, tracheostomy care and suctioning. These audits will be placed on the New Admission Audit and Tracheostomy Audit Tools. MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. Compliance Date is 4/26/2023.	

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F 695	Continued From page 18	F 695		

2. Resident #82 was readmitted on 11/28/22 with diagnoses that included chronic respiratory failure, coronary artery disease, and tracheostomy status.

Review of the quarterly Minimum Data Set completed on 12/5/22 revealed Resident # 82 was severely cognitively impaired. The MDS coded the resident as receiving oxygen use, suctioning and tracheostomy care.

The care plan dated 5/27/20 and updated on 10/8/22 revealed Resident #82 had a care plan for tracheostomy care related to respiratory illness with intervention to provide suctioning and change tracheostomy inner cannula every day.

Record review of the physician orders dated 6/22/22 revealed Resident #82 had an order to suction the tracheostomy every shift for respiratory distress/ increased secretion. The order was discontinued on 11/25/22.

Record review of the physician orders revealed an order dated 8/24/22. Review of the order revealed Resident #82 had an order to change tracheostomy inner cannula every day every evening shift. The order was discontinued on 11/25/22.

A record review conducted on 3/28/23 of the physician orders revealed no order for suctioning tracheostomy for Resident #82.

A record review conducted on 3/28/23 of the physician orders revealed no order for provide trach care for Resident #82.

An interview was conducted on 3/29/23 at 11:02

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F 695	Continued From page 19 AM with the Director of Nursing (DON) who revealed the Nurse managers would read over the physician orders and treatments from the Discharge Summary orders and put the orders into the record. She revealed if there were no physician orders the nurse manager should call the physician or hospital to get their discharge orders. She indicated Resident #82 should have orders for tracheostomy care and suctioning.	F 695		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the area surrounding the grease bin free of grease buildup and debris. This included 1 of 1 grease bin observed. The findings included. During an observation of the dumpster area on 3/27/23 at 9:45 AM the grease bin was observed. The 4 foot lip of the grease bin was observed with grease dripping down and the ground was soiled with thick black layers of grease buildup. On 3/28/23 at 3:37 PM an observation was conducted with the Dietary Manager and the grease bin was observed to be in the same condition. An interview was conducted with the District Dietary Manger on 3/28/23 at 4:11 PM. She revealed the maintenance director had removed the grease and would pressure wash the area.	F 814	WHAT WE DID TO CORRECT THIS PROBLEM: The grease bin was noted to have grease dripping down to the ground with a thick black layer of grease build up. The grease bin and surrounding area was cleaned on 3/29/23 by the facility maintenance director and the bin was replaced on 3/29/2023 by DAR-Pro Solutions due to a noted leak. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected by the alleged deficient practice. The Maintenance Director shoveled up the grease and power washed the area of grease build up. The grease bin was replaced on 3/29/2023. SYSTEMIC CHANGES:	4/26/23

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F 814	Continued From page 20 In an interview on 3/29/23 at 9:08 AM, the Maintenance Director indicated he had noticed the grease bin and planned to contact the company to replace it. He revealed he had shoveled up the grease, power washing was unable to clean the stain off the cement pad and he would find a compatible chemical to clean the area. An interview was conducted with the Interim Administrator on 3/28/23 at 4:24 PM. He revealed they would get the area cleaned up.	F 814	The Maintenance Director and Maintenance assistant were educated by the Administrator on 4/18/2023 related to upkeep of the grease bin by the Regional Maintenance Director. The Maintenance Director educated dietary staff on 4/18/2023 to report any issues with grease bins for needed repairs. MONITORING: The Maintenance Director will monitor grease bin 3 times a week for 4 weeks (4/17/2023 through 5/8/2023) to ensure that there is no need to clean, empty, replace or repair the grease bin. This monitoring will be documented on the Refuse property audit tool. MONITORING/SUBSTAIN COMPLIANCE: The results of the audit will be brought through the facilities monthly QAPI meeting monthly x3 months (April, May, June) to evaluate the need for resolution or continued monitoring. Date of Compliance is 4/26/2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		4/26/23

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F 867	Continued From page 21 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).

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F 867	Continued From page 23 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 1/14/22 complaint and recertification survey. This was for a recited deficiency on the current recertification survey in the area of respiratory/tracheostomy care and suctioning and dispose garbage and refuse properly. The continued failure during two federal surveys shows a pattern of the facility's inability to sustain an effective QAA program. The findings included:	F 867	WHAT WE DID FOR RESIDENT INVOLVED: The facility held an Ad-HOC QAPI on 4-17-23 with the Regional Staff Development Director in attendance. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED All residents have the potential to be affected by the alleged deficient practice. SYSTEMIC CHANGES: The Facility Nursing Consultant/designee reviewed the last 6 months of facility QAPI meetings for signs of Program feedback,	

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 03/29/2023

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

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F 867	Continued From page 24 This tag is cross referenced to: F814 Based on observations and staff interviews, the facility failed to maintain the area surrounding the grease bin free of grease buildup and debris. This included 1 of 1 grease bin observed. During the recertification and complaint survey on 1/14/22 the facility was cited for failure to maintain the area around the dumpster free of debris. F695 Based on observations, record review, staff interviews, and Nurse Practitioner interview, the facility failed to obtain physician orders for supplemental oxygen (Resident #74) and tracheostomy care and suctioning (Resident #82) for 2 of 5 residents reviewed for respiratory care. During the recertification and complaint survey on 1/14/22 the facility was cited for failure to obtain a Physician's order for use of supplemental oxygen. An interview was completed on 3/29/23 at 1:45pm with the Director of Nursing (DON) and Administrator. The DON indicated the QAA committee meets monthly to discuss the facility's ongoing performance improvement plans. The DON revealed there were no ongoing performance improvement plans regarding respiratory care or maintaining the cleanliness of the area surrounding the dumpster. The DON and Administrator stated it was their expectation that the facility identify deficient practice and create performance improvement plans to correct the deficient practice.	F 867	data systems and monitoring per state regulation/guidelines on 4/18/2023. The Administrator provided education to the QAPI committee on the QAPI/QAA system on 4-18-23. The DON/designee will educate all staff through 4-28-23 on QAPI/QAA and what the performance improvement plans that the facility currently has in place. MONITORING: The Nursing consultant/designee will review the monthly QAPI/QAA meeting minutes monthly x 4 months to ensure ongoing compliance with state regulations for an effective QAPI system. MONITORING/SUSTAIN COMPLIANCE The results of the audit will be brought through the facilities monthly QAPI meeting weekly x 4 weeks, twice a month x 1 month and then monthly x 1 month (April, May, June) to evaluate the need for resolution or need for resolution or continued monitoring (4/17/2023 to 6/15/2023). Date of Compliance is 4/26/2023.	