STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF DUNN	711 SUSAN TART ROAD DUNN, NC 28335

(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 A recertification and complaint investigation was conducted onsite from 9/30/24 through 10/4/24. Additional information was obtained remotely on 10/7/24 and 10/8/24. Onsite validation of the immediate jeopardy removal plans was conducted on 10/8/24. Therefore the exit date was 10/8/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #S71J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted onsite from 9/30/24 through 10/4/24. Additional information was obtained remotely on 10/7/24 and 10/8/24. Onsite validation of the immediate jeopardy removal plans was conducted on 10/8/24. Therefore the exit date was 10/8/24. The following intakes were investigated: NC00222770, NC00222520, and NC00221335. 3 of the 5 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/3/24 for F580 and was removed on 10/4/24, and began on 10/3/24 for F600 and was removed on 10/5/24.	F 000		

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

Electronically Signed | 10/31/2024

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F 000	Continued From page 1 An extended survey was conducted.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to	F 578		10/31/24

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F 578	Continued From page 2 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record reviews, the facility failed to ensure a resident's code status election was accurate throughout the medical record for 1 of 2 residents reviewed for advanced directives (Resident #341). The findings included: Resident #341 admitted to the facility on 9/9/24. Resident #341's physician orders dated 9/09/24 through 10/01/24 did not note an order for a code status. In an interview on 10/01/24 02:23 PM, Nurse #2 said thought that Resident #341 had an order for a "Full Code" code status, meaning to attempt all resuscitative measures in case of cardiac arrest. She said she was told in report by another nurse (name not recalled) that he had a full code order. She said in an emergency, she would have looked in the medical record at the orders to see what his code status was. She looked in the resident's chart but was unable to find a code status order. She continued to review the resident's chart and found a hospital note dated 8/25/24 which indicated his code status was "code with limitations." Nurse #2 said she did not know what that meant. She said when a resident was about to be admitted to the facility, the procedure was that the admissions office staff would tell nursing what the code status was. She	F 578	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #341 no longer resides at Carrolton of Dunn. During survey, the facility confirmed that Resident # 341 (or his legal guardians / responsible parties) desired his code status to be DO NOT RESUSCITATE (DNR). His medical record was updated appropriately to reflect his DNR status, and an order was obtained from his physician to support his accurate DNR Status. The order was entered into the electronic medical record on 10/01/24. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected if their medical records do not contain accurate information related to their advanced directives. Actions taken/systems put into place to reduce the risk of future occurrence include: An audit of all medical records was completed on October 28, 202. Utilizing the audit results, a master listing was prepared for each patient reflecting their	

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F 578	Continued From page 3 said because there was no "Do Not Resuscitate" (DNR) order in the chart, Resident #341 would have been treated as as full code order and would have received all measures in case of an emergency. In an interview on 10/01/24 at 3:47 PM, the Admission Director said when a resident was admitted, she met with the resident and the resident's representative (RR). She explained what advanced directives were to the resident or RR. If the resident or RR requested a DNR, the Admissions Director filled out a form with them formally requesting a DNR code status and then provided it to the charge nurse on duty, who would then request an order and complete the DNR notification form. Resident #341's RR made the decision on code status because the resident was unable to make his own wishes known. The RR requested a DNR order and signed the with the Admissions Director. The Admissions Director notified the charge nurse but was not aware of what happened after that notification. She said she did not remember the name of the nurse because the nurse was new at the time but no longer worked at the facility. Resident #341's Do Not Resuscitate Request form dated 9/09/24 revealed the RR signed the form indicating Resident #341 was to have a DNR order. In an interview on 10/01/24 at 4:53 PM, the director of nurses (DON) said Resident #341 did not have a DNR order and said one was obtained and a notification form completed on 10/01/24 after the concern was identified by surveyor.	F 578	desired code status. The master listing was then cross referenced to the medical record to confirm accuracy and to ensure that all supporting documents were present in the medical records to validate the wishes of the patients. MD Orders were then reviewed to determine that the medical record was accurate and contained updated MD orders and reflecting the accurate wishes of the residents. All discrepancies were resolved with residents and their legal guardians to ensure that the medical record reflects accurate documentation. Out of facility transport records were audited to ensure that Golden Rods were present and accurate for each resident in the facility. The audit was completed between the dates of 10/20/24 and 10/30/24 and all discrepancies were resolved immediately. In-servicing was completed by the corporate nurse consultant for the Administrator, Director of Nursing, Social Worker, and Admissions Coordinator on October 28, 2024. The agenda included the regulations and facility policy for Advanced Directives as well as the requirement that medical records accurately reflect the desires of the patient. How the corrective action(s) will be	

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F 578	Continued From page 4	F 578	monitored to ensure the practice will not recur: The corporate nurse consultant (or designee) will review all new admissions once per week for four weeks to determine that the medical record reflects the wishes of the patient (dated and signed). The audit will further review all physician orders for new patients to ensure that the orders reflect the wishes of the patient and that they reconcile with the documents presented by the resident and families declaring their desires related to advanced directives. After four weeks, the corporate nurse consultant will audit 2-3 admissions weekly for 2 additional weeks until compliance is achieved. Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee on a biweekly basis until such time as substantial compliance has been achieved. Corrective action completion date: 10/31/24	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		10/31/24

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74) for an undetermined amount of time and instances. During observations on 10/3/24 Resident #60's and Resident #74's feeding tube pumps (the mechanism that delivers the nutrition) were observed off. Nurse #1 confirmed she turned Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed "their stomach needed a rest". Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician. Deviating from the physician orders by turning off the tube feedings without notifying the physician deprived Resident #60 and Resident #74 of their assessed nutritional needs. Nurse #1 had a history of disciplinary action at the facility for substandard work in July of 2024 and in response she was to be monitored while she was working her shift. This deficient practice was identified for 2 of 2 residents (Resident #60 and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident #74's tube feeding without notifying the physician. Immediate jeopardy was removed on 10/4/24	F 580	Immediate action(s) taken for the resident(s) found to have been affected include: On the morning of 10/3/24, Residents # 60 and # 74 were observed to have their feeding tubes turned to OFF position and the nurse that placed the feeding pumps in the off position did not notify the physician. The same morning, both pumps were turned to the ON position as soon as the Director of Nursing she went immediately to the patient rooms to check all tube feeders and pumps. Upon checking, all feeding pumps were turned on. The physician for both residents, 60 and #74, was notified by the Administrator that the feedings had been stopped and were restarted without notification to him. The physician immediately came to the facility to assess the patients, and no new orders were given. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected when staff members deviate from MD orders for care provision. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 580	Continued From page 7 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. The findings included: Review of Nurse #1's personnel file revealed she was employed in February 2024. Nurse #1's personnel file contained 1 employee disciplinary form from on 7/25/24 when she received a first warning for substandard work. The details of the occurrence documented Nurse #1 was the assigned nurse to supervise the medication aide and multiple medications including seizure medications were not documented as administered. During an interview with the Facility Nurse Consultant, Director of Nursing (DON), and Chief Clinical Officer on 10/4/24 at 12:33 pm, the Chief Clinical Officer stated the nursing supervision and monitoring interventions in place for Nurse #1 after the incident in July 2024 included daily monitoring of essential reports in the electronic medical record (EMR) to assure nurse supervision of medication aides and all medications were completed timely and as ordered by the physician were completed by the Facility Nurse Consultant. The Facility Nurse Consultant did not state the length of time for the monitoring of Nurse #1 and there was no written documentation for this plan of action for monitoring Nurse #1 provided by the facility. The Chief Clinical Officer explained that new nurses hired had a competency evaluation with a nurse skills checklist that was completed during	F 580	The licensed nurse who turned the feeding pumps off is no longer employed. She was suspended and terminated during the survey. All licensed nurses were in-serviced regarding the facility policy for Notification of Changes, Policy 2.16 by the Director of Nursing (DON), Corporate Nurse Consultant, and Chief Clinical Officer. The in-services began on October 3, 2024 and the education continued through October 17 - 18, 2024. The Medical Director joined the education session to teach and educate regarding the importance of following orders and notifying him when deviance from the existing orders is necessary. The orientation agenda was updated to include a review of Carrolton policy 2.16 reminding all licensed new employees of the company requirement to notify the MD when a reason arises for order variance. New employees are taught that the company has zero tolerance for failure to follow orders AND failure to notify the physician of changes in conditions that dictate order deviance. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/Designee will review the 24-hour report, incident reports and grievances daily for three weeks beginning 10/18/24 to ensure compliance with notification of resident changes to the attending physicians.	

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F 580	Continued From page 8 orientation. Nurse #1's competency skills checklist was unable to be located. Review of the nursing assignment sheets from 8/8/24 through 10/3/24 revealed Nurse #1 was assigned to Resident #60's and Resident #74's hall 32 days. The assignment sheet also revealed Nurse #1 shifts worked were double shifts (7:00 am until 3:30 pm and 3:30 pm until 11:30 pm). a. Resident #60 was re-admitted to the facility 8/7/24 with diagnoses which included anoxic brain damage, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, and acute respiratory failure. The Registered Dietician's (RD) nutritional assessment dated 8/21/24 recommended Resident #60 needed 1728 kilocalories (kcal) with 1708 cubic centimeters (cc) free water and 90.4 grams (g) of protein daily from her continuous tube feeding. Review of the RD's progress note for Resident #60 dated 8/21/24 revealed a readmission evaluation on 8/21/24. Resident #60's weight was 268 pounds. The tube feeding order was noted as 50 milliliters per hour (ml/hr) with 135 cc water flushes every 6 hours. No recommendations, tube feeding adequate as ordered, and well tolerated with weight stability. Resident #60's active physician orders related to his tube feeding included the following: - every day and night shift tube feeding at 60 milliliters per hour (ml/hr) continuous (initiated on 9/30/24) An observation on 10/3/24 at 3:08 am revealed	F 580	Audit records will be reviewed by the Quality Assurance Performance Improvement (QAPI) bi-weekly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	

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Resident #60's feeding tube pump was turned off. An empty tube feeding bottle was hanging on the feeding tube pole.

In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #60 on night shift (11:00 pm until 7:30 am). When Nurse #1 was asked why the feeding tube pump was off for Resident #60, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #60 was on continuous tube feeding per physician orders. Nurse #1 stated she did not notify the physician when she turned the feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #60 on 10/3/24.

The following additional observations were made of Resident #60:
- 10/3/24 at 3:53 am Resident #60's feeding tube pump continued to be turned off.
- 10/3/24 at 7:53 am Resident #60's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 5:43 am hanging on the feeding tube pole

In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #60's feeding tube pump off when she "thought her

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stomach needed a rest". Nurse #1 stated "this was not a regular thing" and she did this when she "felt [the resident] needed a break". Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she "turned [the tube feeding pump] off when she thought [the resident's stomach] needed a rest". She revealed she did not notify the physician she turned the tube feeding off on any previous instance.

During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #60 had lost some weight possibly due to being in and out of the hospital. Resident #60 was readmitted from the hospital on 8/7/24. The RD was not aware of Resident #60's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated a continuous tube feeding may be turned off for a short amount of time to perform activities of daily living (ADL's) or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pump, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding.

b. Resident #74 was admitted to the facility on 7/11/24 with diagnoses which included dysphagia (difficulty swallowing), failure to thrive, dementia, and type 2 diabetes mellitus.

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The Registered Dietician's (RD) nutritional assessment dated 7/22/24 recommended Resident #74 needed 1980 kilocalories (kcal) with 1963 cubic centimeters (cc) free water and 83 grams (g) protein daily from her tube feeding for 22 continuous hours.

Resident #74's active physician orders related to his tube feeding included the following orders:
- continuous tube feeding via pump at 55 milliliters per hour (ml/hr) for nutritional support for 22 hours estimated 2 hours (scheduled for 8:00 am until 10:00 am) downtime to allow for activities of daily living (ADL) care (initiated on 7/11/24)

An observation on 10/3/24 at 3:10 am revealed Resident #74's feeding tube pump was turned off. A tube feeding bottle with approximately 100 cubic centimeters (cc) was hanging on feeding tube pole.

In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #74 on night shift (11:00 pm until 7:30 am). When asked Nurse #1 why the feeding tube pump was off for Resident #74, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #74 was on continuous tube feeding per physician orders. Nurse #1 further stated she did not notify the physician when she turned the

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feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #74.

The following additional observations were made of Resident #74:
- 10/3/24 at 3:55 am Resident #74's feeding tube pump continued to be turned off.
- 10/3/24 at 7:55 am Resident #74's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 4:30 am.

In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #74's feeding tube pump off when she "thought her stomach needed a rest". Nurse #1 stated "this was not a regular thing" and she did this when she "felt [the resident] needed a break". Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she "turned [the tube feeding pump] off when she thought [the resident's stomach] needed a rest". She revealed she did not notify the physician she turned the tube feeding off on any previous instance.

During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #74's weight had been stable. The RD was not aware of Resident #74's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated continuous tube feedings may be turned off for a short amount of time to perform activities of daily living or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the

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physician. The RD further indicated Resident #74 had a physician's order for her feeding tube pump to be turned off 2 hours a day to allow downtime for ADL care. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pumps, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding.

In an interview on 10/3/24 at 9:15 am with the Director of Nursing (DON), she stated continuous tube feedings should not be turned off without a physician's order. The DON further stated she was unaware of Nurse #1 turning the feeding tube pumps off for Resident #60 and Resident #74 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed the residents (Resident #60 and Resident #74) and notified the physician of any changes in their condition before making any decisions on her own. The DON indicated she expected the nursing staff to follow the physician's orders and to notify the physician for any significant change that required deviation from the orders.

During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware that Resident #60's and Resident #74's feeding tube pumps were being turned off by Nurse #1. The Physician further stated if there had been a change in the residents' condition such as shortness of breath (SOB), vomiting, or gurgling that could have explained the feeding tube pumps being turned off; however, he was not notified of this for Resident #60 or Resident #74 at all. The

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physician explained one of his concerns with turning off the tube feedings was that Resident #60 and Resident #74 were not receiving the calories and the nutrients provided from the tube feeding. Another concern noted by the physician was the fact that Nurse #1 intentionally turned the feeding tube pumps off without notifying him before taking this action. The Physician indicated he did not like the nurses to make unreasonable decisions on their own without any notification. The Physician indicated that weight loss could happen as a result of the tube feeding pumps being turned off. He further explained Nurse #1's reason for the feeding tube pumps being turned off was not a good enough reason for Nurse #1 to make that decision.

The Administrator was notified of Immediate Jeopardy on 10/4/24 at 6:37 pm.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify recipients who have suffered or are likely to suffer a serious adverse outcome as a result of the non-compliance.

On 10/3/24 the feeding pumps for Residents # 60 and # 74 were observed off for an undetermined amount of time. Both Residents # 60 and # 74 were determined to be at risk for harm based on the actions of Nurse # 1.
Nurse # 1 failed to follow the physician orders for Resident # 60 for continuous tube feeding, 24 hours per day.
Nurse #1 failed to follow the physician orders for Resident #74 for continuous tube feeding, 22 hours per day.
Nurse #1 failed to notify the MD of her deviant

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practice for both residents #60 and #74.
All residents in the facility are deemed to be at risk for serious adverse outcome based on the actions of Nurse #1.
On the morning of 10/3/24, upon notification of the problem, the Director of Nursing went immediately to the rooms of Residents #60 and #74 to assess the tube feeding status. Both residents were found to have feeding pumps that were "on" and both residents were found to have currently dated and timed feedings infusing per MD orders.
The Director of Nursing reviewed the patient medical records for physician notification on the morning of 10/3/24.
There was no evidence of MD notification by Nurse #1.
The physician was notified of the order deviance and behavior of the nurse on 10/3/24. He was notified by the Administrator.

Specify the action the entity will take to alter the system failure to prevent serious adverse outcomes from occurring or recurring.

The facility confirmed that all residents with enteral feedings, including residents # 60 and #74, were resumed and infusing at the rate ordered by the physician. This confirmation was made on the morning of 10/3/24 at approximately 9:00 am by the Director of Nursing.
On 10/3/24 the Director of Nursing and the Chief Clinical Officer called Nurse #1 to the facility for interview. Nurse # 1 was notified of her failure to follow MD orders and she was interviewed about her conversations during the night with the surveyors.
Nurse #1 acknowledged that she did not have a physician order to stop the tube feedings and did

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not notify the physician of the deviant practice.
The Board of Nursing Complaint Evaluation Tool was completed and reviewed with Nurse #1 on the evening of 10/3/24. The employee meeting was conducted by the Administrator, DON, Chief Clinical Officer, and Nurse Clinical Consultant.
Prior to suspension, the DON and Chief Clinical Officer counseled and re-educated Nurse # 1 about her deviant practices.
After consultation with the Chief Clinical Officer and the Chief Operating Officer, she was suspended at approximately 7:30 pm.
Education sessions were begun on 10/3/24 with all licensed nurses and included the following subjects:
" Consult and notify the MD of resident changes and need to alter treatments
" Provision of care to ensure that MD orders are followed at all times, including orders for enteral feedings.
The DON and Corporate Clinical Nurse and Chief Clinical Officer conducted the education sessions.
Education sessions will continue with all staff members until 100% of the licensed nurses have received education.
The Director of Nursing, ADON, and nurse managers will review education session sign ins daily to ensure that all staff have received the material effectively and to ensure that no staff members worked prior to receiving it.
No licensed nurses will be allowed to work until they have received the education.
The Chief Clinical Officer notified the Facility Nurse Consultant on 10/3/24 that new licensed nursing staff will be trained in orientation and education will continue within the facility to ensure understanding of the importance to notify the MD of significant changes in resident's physical, mental, and psychological status, the need to

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F 580	Continued From page 17 alter resident treatments significantly, and our ZERO tolerance position for rogue employees. On 10/3/24 the Chief Clinical Officer notified the Director of Nursing for the need and requirement to complete education prior to employees returning to work. The DON notified the hall nurses at the beginning of shifts that an inservice would be held prior to the shift beginning. These education sessions will continue until 100% of the licensed nurses have been trained. Date of immediate jeopardy removal: 10/4/24 Validation of the immediate jeopardy removal plan was completed on 10/8/24: Interviews confirmed the physician was notified of the tube feedings being turned off on 10/3/24 by the Administrator and that Nurse #1 verified she did not notify the physician when she turned the tube feedings off. A review of Nurse #1's Human Resource (HR) records revealed documentation of her disciplinary forms and a North Carolina Board of Nursing (NCBON) Complaint Evaluation Tool which was completed on 10/3/24. The signed in-service roster and staff interviews of licensed nurses verified education was providing on consulting and notifying the physician of resident changes and need to alter treatments and ensuring that physician orders are followed at all times to include orders for tube feeding. No licensed nurse worked after 10/3/24 without receiving the education. The following residents' tube feeding were observed, and orders checked for accuracy: Resident #s 4, 28, 38, 41, 60, 64, 74, 80, and 341. All tube feedings were running or on hold as ordered. The immediate jeopardy removal date of 10/4/24 was validated.	F 580		
F 600 SS=J	Free from Abuse and Neglect	F 600		10/31/24

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F 600	Continued From page 18 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and physician interviews, the facility failed to protect the residents' right to be free from neglect when Nurse #1 did not provide the necessary care and services as assessed and ordered by the physician to Resident #60 and Resident #74. On 10/03/24 Nurse #1 turned their continuous tube feedings (nutrition administered through a tube directly into the stomach) off because she believed their "stomachs needed a rest." Nurse #1 was aware of the physician's orders, she deliberately disregarded them, and she independently made the decision to deviate from the physician's orders and turn the tube feedings off depriving the residents of their assessed nutritional needs. She revealed this was not a new practice for her and she had done this previously for both residents an undetermined number of times. When staff purposefully disregard physician's orders and make treatment	F 600	Immediate action taken for the residents found to have been affected: On 10/3/24 the feeding pumps for Residents # 60 and # 74 were observed off for an undetermined amount of time. Both Residents # 60 and # 74 were determined to be at risk for neglect based on the actions of Nurse # 1. Nurse #1 was removed from the facility at approximately 7:30 pm on 10/3/24. Nurse #1 was terminated on 10/4/24. The facility will ensure that both Residents # 60 and # 74 are free from neglect at all times. Identification of other residents having the potential to be affected: All residents in the facility are deemed to be at risk for neglect, based on the actions of Nurse #1.	

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F 600	Continued From page 19 decisions on their own, it places all residents at risk of serious harm and/or death. Nurse #1 had a history of disciplinary action at the facility for substandard work in July of 2024 and in response she was to be monitored while she was working her shift. This deficient practice affected 2 of 2 residents reviewed for neglect (Resident #60 and Resident #74). Immediate jeopardy began on 10/3/24 when Nurse #1 disregarded physician's orders and turned off Resident #60's and Resident #74's tube feeding. Immediate jeopardy was removed on 10/5/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. The findings included: Review of Nurse #1's personnel file revealed she was employed in February 2024. Nurse #1's personnel file documented orientation training of the facility policies and procedures which included written tests on these policies and procedures. Nurse #1's personnel file also contained 1 employee disciplinary form. The first disciplinary action was on 7/25/24 when she received a first warning for substandard work. The details of the occurrence documented Nurse #1 was the assigned nurse to supervise the medication aide and multiple medications including seizure medications were not documented as administered. During an interview with the Facility Nurse Consultant (FNC), Director of Nursing (DON),	F 600	On the morning of 10/3/24, upon notification of the problem, the Director of Nursing immediately went to the rooms of all tube feeders (9 in total) to assess the pump settings, dates and times of currently hung feedings, that pumps were on appropriately (per MD settings) and that feedings were infusing accurately (based on MD orders). Actions taken / systems put into place to reduce the risk of future occurrence include: On the morning of 10/3/24 at approximately 8:30 am, the surveyors notified the Administrator of the tube feeding problem. All feeding pumps were checked, and no additional feeding pumps were identified to be off. The facility will ensure that all residents, including residents # 60 and #74, are always free from neglect. The Administrator, Director of Nursing (DON), and corporate clinical team will monitor the facility and patient care delivery every shift to ensure that the nutrition and hydration needs of all patients are met based on MD orders and that no patient suffers neglect. The team will utilize our newly hired administrative nurse managers (including Assistant Director of Nursing (ADON), MDS nurses, treatment nurse, and resource nurses) facility management team, and lead CNAs to accomplish the shift to shift rounding. This rounding	

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F 600	Continued From page 20 and Chief Clinical Officer (CCO) on 10/4/24 at 12:33 pm, the CCO stated the nursing supervision and monitoring interventions in place for Nurse #1 after the incident in July 2024 included daily monitoring of essential reports in the electronic medical record (EMR) to assure nurse supervision of medication aides and all medications were completed timely and as ordered by the physician were completed by the FNC. The FNC did not state the length of time for the monitoring of Nurse #1 and there was no written documentation for this plan of action for monitoring Nurse #1 provided by the facility. The CCO explained that new nurses hired have a competency evaluation with a nurse skills checklist that is completed during orientation. Nurse #1's competency skills checklist was unable to be located. Review of the nursing assignment sheets from 8/8/24 through 10/3/24 revealed Nurse #1 was assigned to Resident #60's and Resident #74's hall 32 days. The assignment sheet also revealed Nurse #1 shifts worked were double shifts (7:00 am until 3:30 pm and 3:30 pm until 11:30 pm). a. Resident #60 was re-admitted to the facility 8/7/24 with diagnoses which included anoxic brain damage, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, and acute respiratory failure. Resident #60's care plan dated 4/15/24 revealed a focus for required tube feeding related to dysphagia. The interventions included to monitor, document, report any signs/symptoms of aspiration, fever, shortness of breath (SOB), tube dislodged or tube malfunction. Resident #60 was dependent with tube feeding and water flushes.	F 600	was initiated on 10/3/24. The facility initiated Angel Rounds to be done every day by senior team members to ensure that no residents have been neglected or abused. The daily rounds are documented and reviewed during morning meetings. The Administrator, DON, ADON, and nurse managers will ensure that appropriate and necessary action has been taken to remedy all identified negative findings. The Director of Nursing will ensure that the MD is notified timely of all discrepancies and plans for correction. The Administrator, Director of Nursing, Corporate Nurse Consultant and RN / MDS Nurse conducted education sessions beginning 10/4/24 with all staff that included the following subjects: -Resident rights to be free from abuse and neglect -Reporting abuse and neglect -Carrolton policy # 3.10 Abuse, Neglect, and Exploitation -Definitions of abuse and neglect -Carrolton policies to ensure all residents are free of neglect and rogue employees. Education sessions will continue with all staff members until 100% of the employees have received education. No employee will be allowed to work until they have received the education. All residents will be free from abuse and neglect at all times.	

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F 600	Continued From page 21 Review of Resident #60's quarterly Minimum Data Set (MDS) assessment dated 8/21/24 revealed she was severely cognitively impaired. Resident #60 had bilateral (left and right) impairment of the upper and lower extremities, completely dependent upon staff for all activities of daily living and coded for a feeding tube. Resident #60's weight on quarterly MDS was 268 pounds. Review of Resident #60's weights revealed the following: - 6/3/24 255.0 pounds - 7/2/24 249.8 pounds - 8/8/24 267.8 pounds - 9/9/24 247.5 pounds Resident #60's active physician orders related to his tube feeding included the following: - every day and night shift tube feeding at 60 milliliters per hour (ml/hr) continuous (initiated on 9/30/24) - every 6 hours flush with 135 cubic centimeters (cc) for water flushes (initiated on 8/7/24) The Registered Dietician's (RD) nutritional assessment dated 8/21/24 recommended Resident #60 needed 1728 kilocalories (kcal) with 1708 cubic centimeters (cc) free water and 90.4 grams (g) of protein daily from her continuous tube feeding. Review of the RD's progress note for Resident #60 dated 8/21/24 revealed a readmission evaluation on 8/21/24. Resident #60's weight was 268 pounds. The tube feeding order was noted as 50 ml/hr with 135 cc water flushes every 6 hours. No recommendations, tube feeding	F 600	New hires are trained in orientation, and education will continue within the facility to ensure understanding of abuse and neglect prevention, including our ZERO TOLERANCE position for rogue employees. The Chief Clinical Officer reviewed the general orientation requirements with the Clinical Nurse Consultant. This meeting was held on 10/3/24 the requirement for abuse training was re-enforced. How the corrective action will be monitored to ensure the practice will not recur: Results from the shift-to-shift rounding checking the status of feeding pumps will be reviewed weekly in QAPI. Instances of potential abuse and / or neglect will be analyzed to review root cause analysis and weekly implementation of a plan to ensure the incident is isolated and will not recur. Angel rounds will be reviewed daily by the DON and biweekly by the Quality Assurance Performance Improvement (QAPI) committee for the next 6 weeks to ensure that patients remain free of abuse and neglect at all times. Corrective action completion date: 10/31/24	

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adequate as ordered, and well tolerated with weight stability.

The following observation was made of Resident #60:
- 10/3/24 at 3:08 am Resident #60's feeding tube pump was turned off. An empty tube feeding bottle was hanging on the feeding tube pole

In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #60 from 11:00 pm on 10/02/24 until 7:30 am on 10/03/24 (night shift). When asked Nurse #1 why the feeding tube pump was off for Resident #60, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #60 was on continuous tube feeding per physician orders Nurse #1 stated she did not notify the physician when she turned the feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #60 on 10/3/24.

The following additional observations were made of Resident #60:
- 10/3/24 at 3:53 am Resident #60's feeding tube pump continued to be turned off.
- 10/3/24 at 7:53 am Resident #60's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 5:43 am hanging on the feeding

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tube pole

Review of Resident #60's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1.

Review of Resident #60's October Medication Administration Record (MAR) revealed enteral feed order every day and night shift [name of tube feeding formula] at 60 ml/hr with Nurse #1's initials electronically signed for the night hours (12HR) on 10/2/24.

In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #60's feeding tube pump off when she "thought her stomach needed a rest". Nurse #1 stated "this was not a regular thing" and did this when she "felt they needed a break". Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she "turned them off when she thought their stomachs needed a rest". When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #60's feeding tube pump was turned on when she hung a new bottle of tube feeding at 5:43 am on 10/3/24.

During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #60 had lost some weight possibly due to being in and out of the hospital. Resident #60 was readmitted from the hospital on 8/7/24. The RD was not aware of Resident #60's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding

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tube pump off without notifying the physician. The RD indicated a continuous tube feeding may be turned off for a short amount of time to perform activities of daily living (ADL) or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pump, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding.

Review of the RD's progress note for Resident #60 dated 10/7/24 revealed he increased Resident #60's tube feeding on 9/19/24 due to weight loss. Resident #60's weight was noted to be 255 pounds with prior weight loss and noted weight regain, and IV fluids during hospital stay as attributing to weight fluctuations.

b. Resident #74 was admitted to the facility on 7/11/24 with diagnoses which included dysphagia (difficulty swallowing), failure to thrive, dementia, and type 2 diabetes mellitus.

The Registered Dietician's (RD) nutritional assessment dated 7/22/24 recommended Resident #74 needed 1980 kilocalories (kcal) with 1963 cubic centimeters (cc) free water and 83 grams (g) protein daily from her tube feeding for 22 continuous hours.

Resident #74's care plan dated 8/7/24 revealed a focus for tube feeding for nutrition. The interventions included monitor, document, report any signs/symptoms of aspiration, fever, shortness of breath (SOB), tube dislodged or tube

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malfunction. Resident #74 was dependent with tube feeding and water flushes.

Review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated 8/7/24 revealed she was severely cognitively impaired. Resident #74 required maximum assistance from staff with activities of daily living and coded for a feeding tube.

Review of Resident #74's weights revealed the following weights:
- 7/11/24 154.9 pounds
- 7/22/24 154.9 pounds
- 8/6/24 156.6 pounds
- 9/6/24 160.0 pounds

Resident #74's active physician orders related to his tube feeding included the following orders:
- continuous tube feeding via pump at 55 milliliters per hour (ml/hr) for nutritional support for 22 hours estimated 2 hours (scheduled for 8:00 am until 10:00 am) downtime to allow for activities of daily living (ADL) care (initiated on 7/11/24)
- water flushes every 3 hours of 120 milliliters

The following observation was made of Resident #74:
- 10/3/24 at 3:10 am Resident #74's feeding tube pump was turned off. A tube feeding bottle with approximately 100 cubic centimeters (cc) was hanging on feeding tube pole.

In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #74 from 11:00 pm on 10/02/24 until 7:30 am on 10/03/24 (night shift). When asked Nurse #1 why the feeding tube pump was off for

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Resident #74, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #74 was on continuous tube feeding per physician orders. Nurse #1 further stated she did not notify the physician when she turned the feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #74.

Review of Resident #74's EMR revealed no progress notes which documented turning the feeding tube pump off by Nurse #1.

Review of Resident #74's October Medication Administration Record (MAR) revealed the enteral feed order every shift for nutritional support/supplementation [name of tube feeding formula] at 55 ml/hr with Nurse #1's initials electronically signed for the night hours on 10/2/24.

The following additional observations were made of Resident #74:
- 10/3/24 at 3:55 am Resident #74's feeding tube pump continued to be turned off.
- 10/3/24 at 7:55 am Resident #74's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 4:30 am.

In a second interview on 10/3/24 at 3:26 pm with

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Nurse #1 she stated she turned Resident #74's feeding tube pump off when she "thought her stomach needed a rest". Nurse #1 stated "this was not a regular thing" and did this when she "felt they needed a break". Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she "turned them off when she thought their stomachs needed a rest". When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #74's feeding tube pump was turned on when she hung a new bottle of tube feeding at 10/3/24 at 4:30 am.

During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #74's weight had been stable. The RD was not aware of Resident #74's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated continuous tube feedings may be turned off for a short amount of time to perform activities of daily living or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further indicated Resident #74 had a physician's order for her feeding tube pump to be turned off 2 hours a day to allow downtime for ADL care. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pumps, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding.

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In an interview on 10/3/24 at 9:15 am with the Director of Nursing (DON), she stated continuous tube feedings should not be turned off without a physician's order. The DON further stated she was unaware of Nurse #1 turning the feeding tube pumps off for Resident #60 and Resident #74 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed the residents (Resident #60 and Resident #74) and notified the physician of any changes in their condition before making any decisions on her own. The DON indicated she expected the nursing staff to follow the physician's orders as written as a part of a resident's necessary care and services.

During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware of Resident #60's and Resident #74's feeding tube pumps were being turned off. The Physician further stated if there had been a change in the residents' condition such as shortness of breath (SOB), vomiting, or gurgling that could have explained the feeding tube pumps being turned off; however, he was not notified of this for Resident #60 or Resident #74 at all. The physician explained one of his concerns were Resident #60 and Resident #74 not receiving the calories, and the nutrients provided from the tube feeding. Another concern noted by the Physician was the fact that Nurse #1 intentionally turned the feeding tube pumps off without notifying him before taking this action. The Physician indicated he did not like the nurses to make unreasonable decisions on their own without any notification. The Physician indicated that weight loss could happen as a result of the tube feeding pumps being turned off. He further explained Nurse #1's reason for the feeding tube pumps being turned

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off was not a good enough reason for Nurse #1 to make that decision.

The Administrator was notified of Immediate Jeopardy on 10/4/24 at 6:37 pm.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify recipients who have suffered or are likely to suffer a serious adverse outcome as a result of the non-compliance.

On 10/3/24 the feeding pumps for Residents # 60 and # 74 were observed off for an undetermined amount of time. Both Residents # 60 and # 74 were determined to be at risk for neglect based on the actions of Nurse # 1.
Nurse #1 was removed from the facility at approximately 7:30 pm on 10/3/24.
Nurse #1 was terminated on 10/4/24.
All residents in the facility are deemed to be at risk for serious adverse outcome including neglect, based on the actions of Nurse #1.
On the morning of 10/3/24, upon notification of the problem, the Director of Nursing immediately went to the rooms of all tube feeders (9 in total) to assess the pump settings, dates and times of currently hung feedings, that pumps were "on" appropriately (per MD settings) and that feedings were infusing accurately (based on MD orders).

Specify the action the entity will take to alter the system failure to prevent serious adverse outcomes from occurring or recurring.

On the morning of 10/3/24 at approximately 8:30 am, the surveyors notified the Administrator of the

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tube feeding problem.
Within minutes of the state notification, the Administrator notified the DON. The time was approximately 8:40 am. The Director of Nursing went immediately to the rooms of Residents #60 and #74 to assess the tube feeding status. Both residents were found to have feedings pumps that were "on", both residents were found to have currently dated and timed feedings infusing per MD orders.
The facility will ensure that all residents including residents # 60 and #74 are free from neglect - at all times. The Administrator, DON, and Corporate team will monitor the facility and patient care delivery every shift to ensure that the nutrition and hydration needs of all patients are met based on MD orders.
The team will utilize our newly hired administrative nurse managers (including ADON, MDS nurses, treatment nurse, and resource nurses) facility management team, and lead CNAs to accomplish the shift to shift rounding. This rounding was initiated on 10/3/24. As additional personnel is utilized to complete this rounding, they will be educated.
The DON, ADON, and nurse managers will review findings first thing every morning to ensure that appropriate and necessary action has been taken to remedy all identified negative findings.
The Director will ensure that the MD is notified timely of all discrepancies and plans for correction.
The Administrator, Director of Nursing, Corporate Clinical Director and RN / MDS Nurses began education sessions on 10/4/24 with all staff and included the following subjects:
" Resident rights to be free from abuse and neglect
" Reporting abuse and neglect

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F 600	Continued From page 31 " Facility policy on "Abuse, Neglect, and Exploitation" " Definitions of abuse and neglect " Facility policies to ensure all residents are free of neglect and rogue employees. Education sessions will continue with all staff members until 100% of the employees have received education. No employee will be allowed to work until they have received the education. New hires are trained in orientation and education will continue within the facility to ensure understanding of abuse and neglect prevention, including our ZERO TOLERANCE position for rogue employees. The Chief Clinical Officer reviewed the general orientation requirements with the Clinical Nurse Consultant. This meeting was held on 10/3/24 the requirement for abuse training was re-enforced. The Director of Nursing, ADON, and nurse managers will review education session daily to ensure that all staff have received and that no staff members work prior to receiving it. Date of immediate jeopardy removal - 10/5/24 Validation of the credible allegation of IJ removal was completed on 10/8/24: Nurse #1 was suspended from the facility on 10/3/24. Nurse #1 was terminated on 10/4/24. In review of Nurse #1's Human Resource (HR) records revealed documentation of her disciplinary forms and a North Carolina Board of Nursing (NCBON) Complaint Evaluation Tool (CET) which was completed on 10/3/24 with an	F 600		

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F 600	Continued From page 32 appointment scheduled with the Board of Nursing (BON) for Nurse #1 on 10/7/24 at 10 am. There was a signed roster of staff in all departments who participated in in-service for abuse and neglect dated 10/3/24 and 10/4/24. There was a signed roster of nursing staff who participated in in-service for tube feeding and following the physician order dated 10/3/24 and 10/4/24. The in-services were completed by 10/4/24. The following residents' tube feeding were observed, and orders checked for accuracy: Resident #s 4, 28, 38, 41, 60, 64, 74, 80, and 341. All tube feedings were running or on hold as ordered. On 10/8/24 at 11:30 am 2 nurses, 4 nursing assistants, the newly hired Assistant Director of Nursing (second day) and 1 housekeeping staff were interviewed. All staff had participated in abuse/neglect in-service and nursing staff participated in tube feed/following physician orders in-service in addition to the abuse in-service. The Director of Nursing provided documentation of the daily on-going audits of all residents that have an order for tube feeding to evaluate the status of the pump status/infusion rate and type of feed per physician order. The immediate jeopardy removal date of 10/5/24 was validated.	F 600		
F 636 SS=D	Comprehensive Assessments & Timing	F 636		10/31/24

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F 636	Continued From page 33 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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F 636	Continued From page 34 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the admission Minimum Data Set (MDS) assessment within the required timeframe for 1 of 1 newly admitted resident reviewed for MDS assessments (Resident #341). Findings included: Resident #341 was admitted on 9/09/24. Resident #341's admission Minimum Data Set (MDS) dated 9/16/24 had not been completed when reviewed on 10/01/24. During an interview on 10/03/24 at 3:17 pm, MDS Nurse #1 stated she was aware there were MDS	F 636	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #341 was discharged from the facility on 10/14/2024. The MDS Team completed a Comprehensive Assessment for resident # 341 on 10/1/2024. Identification of other residents having the potential to be affected was accomplished by: All residents of this facility have the potential to be affected by this practice. Actions taken/systems put into place to reduce the risk of future occurrence	

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F 636	Continued From page 35 assessments that had not been completed because there had been no full-time MDS staff for approximately 3 months until 9/30/24. The MDS staff were back-tracking to complete all assessments that were not completed. During an interview on 10/04/24 at 1:15 pm, the Administrator stated he was made aware that there were MDS assessments that had not been completed timely. He stated the facility had hired 2 full-time MDS nurses, and remote MDS nurses were helping the facility to get caught up.	F 636	include: The facility hired two Registered Nurses responsible for all MDS processes, including developing Comprehensive Assessments on September 30, 2024. The Chief Operating Officer initiated an audit of MDS processes on October 2, 2024. MDS Coordinators completed a 100% facility audit on outstanding assessments to be completed on October 8, 2024. The Chief Operating Officer and the Chief Clinical Officer met with the MDS team, Director of Nursing and Administrator on October 10, 2024, to review audit results and to discuss the distribution of duties. The MDS team was also re-educated on the importance of completing a timely comprehensive, accurate, standardized reproducible assessment of each residents functional abilities during this meeting. How the corrective action(s) will be monitored to ensure the practice will not recur: The Facility Nurse Consultant or member of the corporate clinical team will audit at random 2 new admissions for timely completion of comprehensive assessments weekly for 4 weeks and then monthly for 2 months. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) until such time consistent substantial compliance has	

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F 636	Continued From page 36	F 636	been achieved as determined by the committee. Corrective action completion date: 10/31/24	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required 14-day timeframe after the Assessment Reference Date (ARD, the last day of the assessment look-back period) for 8 of 21 residents' MDS assessments reviewed (Resident #s 5, 10, 13, 49, 62, 63, 69, and 71). Findings included: a. Resident #49 was admitted on 2/9/21. Resident #49's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 7/19/24 was incomplete when reviewed on 10/3/24. b. Resident #5 was admitted on 12/24/13. Resident #5's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/17/24 was in progress and was incomplete when reviewed on 10/3/24.	F 638	F 638 Qrtly Assessment at Least Every 3 Months SS E Immediate action(s) taken for the resident(s) found to have been affected include: The MDS team completed quarterly assessment on the following residents: -Resident #5 on 10/4/24 -Resident #10 on 9/24/24 -Resident #13 on 10/15/24 -Resident #49 on 10/15/24 -Resident #62 on 10/2/24 -Resident #63 on 10/8/24 -Resident #69 on 10/21/24 -Resident #71 on 10/10/24 The facility□s new MDS nurses have implemented calendars to ensure timely completion of all upcoming quarterly assessements. Identification of other residents having the	10/31/24

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F 638	Continued From page 37 c. Resident #71 was admitted on 5/26/23. Resident #71's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/13/24 was listed as in progress and was incomplete when reviewed on 10/3/24. d. Resident #13 was admitted on 2/1/22. Resident #13's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/16/24 was noted as in progress and was incomplete as of 10/2/24. e. Resident #62 was admitted on 9/7/22. Resident #62's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/29/24 was signed as completed on 10/2/24. f. Resident #63 was admitted on 2/29/24. Resident #63's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/15/24 was signed as completed on 9/24/24. g. Resident #69 was admitted on 12/22/22. Resident #69's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/17/24 was signed as completed on 9/24/24. h. Resident #10 was admitted to the facility on 9/25/23. Resident #10's quarterly MDS assessment with an Assessment Reference Date (ARD, the last	F 638	potential to be affected was accomplished by: All residents of this facility have the potential to be affected by this practice. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility hired two Registered Nurses responsible for all MDS processes, including developing Comprehensive Assessments on September 30, 2024. The Chief Operating Officer initiated an audit of MDS processes on October 2, 2024. MDS Coordinators completed a 100% facility audit on outstanding assessments to be completed on October 8, 2024. The Chief Operating Officer and the Chief Clinical Officer met with the MDS team, Director of Nursing and Administrator on October 10, 2024 to review audit results and to discuss the distribution of duties. The MDS team was also re-educated on the importance of assessing residents using the quarterly review instrument specified by the State and approved by CMS no less than once every three months during this meeting. How the corrective action(s) will be monitored to ensure the practice will not recur: The Corporate Nurse Consultant or member of the corporate clinical team will audit at random 5 resident records for timely completion of quarterly	

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F 638	Continued From page 38 day of the assessment look-back period) of 8/13/24 was signed as completed on 9/24/24. During an interview with the Resource Nurse on 10/3/24 at 5:06 pm, she explained that quarterly MDS assessments were not completed within the 14 day time frame prior to 9/30/24 because there were no consistent MDS staff at the facility to complete the assessments except a part-time MDS nurse who worked twice a week. She further explained that the Administrator was aware the completion of quarterly MDS assessments were backed up and on 9/3/24 the administration asked her to help the MDS department to get caught up. During an interview with MDS Nurse #1 on 10/3/24 at 4:57 pm, she stated she started to work at the facility on 9/30/24. She explained there were several quarterly MDS assessments discovered on 9/30/24 which were incomplete, and they were working to complete these assessments. She further explained that quarterly MDS assessments were to be completed within fourteen days of the ARD. During an interview with the Clinical Nurse Consultant on 10/3/24 at 4:46 pm, she stated the quarterly MDS assessments should have been completed within the fourteen day regulation time frame. During an interview with the Administrator on 10/3/24 at 4:50 pm, he stated the quarterly MDS assessments needed to be completed within the regulatory fourteen day time frame. In a follow up interview on 10/4/24 at 1:15 pm, he explained when he started at the facility on 8/30/2024 he was aware the facility was behind in completing	F 638	assessments biweekly for 8 weeks and then monthly for 2 months. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	

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F 638	Continued From page 39 quarterly MDS assessments. He stated the facility had hired two MDS nurses and remote MDS nurses to help the facility catch up in completing the quarterly MDS assessments	F 638		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that a resident with diagnoses of mental disorders had received a Level 2 Preadmission Screening and Resident Review (PASRR) after admission to the facility for 1 of 2 residents reviewed for PASRR (Resident #26). Findings included:	F 644	Immediate action(s) taken for the resident(s) found to have been affected include: A Level II Preadmission Screening and Resident Review (PASARR) was submitted for Resident # 26 on 10-02-24 however the request contained an error. A representative from North Carolina Medical Orders for Scope of Treatment (NC MOST) deleted the request on	10/31/24

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F 644	Continued From page 40 A PASRR Level 1 dated 6/22/2015 indicated Resident #26 did not meet the federal definition for mental illness and mental retardation. Resident #26 was admitted to the facility on 8/2/24 with diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel and behave) and bipolar disorder (a serious mental illness characterized by extreme mood swings). A physician order dated 8/2/24 recorded Resident #26 was ordered Haloperidol (an antipsychotic medication) 2 milligrams twice a day for paranoid schizophrenia. The admission Minimum Data Set (MDS) assessment dated 8/9/24 noted Resident #26 was not currently considered by the state level II PASRR process to have a serious mental illness. Resident #26's care plan dated 8/18/24 included the use of antipsychotic medications related to schizophrenia. Interventions included administering antipsychotic medications as physician ordered and monitoring for effectiveness. A psychiatric physician note dated 8/26/24 recorded Resident #26 had a history of paranoid schizophrenia and a bipolar disorder and reported Resident #26's history of behaviors included hallucinations, the refusal of foods, agitation and verbal aggression. The psychiatric physician plan for treatment consisted of no change in Resident #26's medication regimen. A quarterly MDS assessment dated 9/4/24 indicated Resident #26 was cognitively intact and	F 644	10-31-24 and a new, corrected Level II PASARR was submitted. A new Minimum Data Set (MDS) Assessment will be completed immediately when the PASARR Level II is approved. The new assessment will note his diagnoses correctly as well as his medications. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be negatively affected. Actions taken/systems put into place to reduce the risk of future occurrence include: An audit was completed on October 30 of all the PASARRs to ensure that the PASARRs are accurate and coordinated with MDS assessments appropriately. A new notebook was implemented with the PASARRs printed in alphabetical order by patient in order such that a weekly audit can be completed based on all new admissions. The PASARR process will be managed by the Social Worker from this point forward. How the corrective action(s) will be monitored to ensure the practice will not recur: Corporate nurse consultant completed educated the Dunn senior leadership on 10-26-24 regarding the importance of PASARR definitions, the PASARR Level II process, the audit, and the newly implemented PASARR management	

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F 644	Continued From page 41 received antipsychotic medications on a routine basis. A review of the September 2024 and October 2024 Medication Administration Record documented Resident #26's refusal of medications as a behavior. Haloperidol 2 milligrams was recorded as given daily as ordered. During a phone interview with the Social Worker on 10/3/24 at 4:25 pm, she explained Resident #26 was admitted prior to her employment at the facility at the end of September 2024. She stated she had not reviewed Resident #26's diagnoses since starting at the facility and this should have been reviewed on admission. She explained Resident #26's PASRR Level 1 determination was only valid for thirty days from the time of hospitalization. She further explained she had started the process for a PASRR Level 2 screening on 10/2/24 after there had been an inquiry regarding Resident #26's PASRR status. During an interview with the Clinical Nurse Consultant with the Administrator present on 10/3/24 at 4:31 pm, she stated the Social Worker should have submitted a PASRR Level 2 for Resident #26 due to Resident #26's admitting diagnoses of schizophrenia and bipolar disorder. The Clinical Nurse Consultant and the Administrator were unable to explain why a PASRR Level 2 had not been submitted for Resident #26.	F 644	protocol. Corporate nurse consultant will complete a weekly audit to ensure that all new admissions have accurate PASARRs based on patient specific medications and diagnoses. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		10/31/24

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F 655	Continued From page 42	F 655		

Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting

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F 655	Continued From page 43 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to create a baseline care plan within 48 hours of a resident's admission for 1 of 2 residents (Resident #341) reviewed for baseline care plans. The findings included: Resident #341 was admitted to the facility on 9/9/24 with diagnoses including nontraumatic intracerebral hemorrhage (brain bleed) and dysphagia (trouble swallowing). Resident #341's Minimum Data Set (MDS) assessment dated 9/16/24 noted he had no speech, could rarely or was unable to understand others, was unable to participate in the assessment, and had an unhealed Stage IV wound (a wound down to the bone). There was no documentation in the electronic medical record of a baseline care plan for Resident #341. In an interview on 10/03/24 at 4:54 PM, the Director of Nursing (DON) confirmed there was no baseline care plan completed for Resident #341. She said the baseline care plan should have been completed by the charge nurse within 48 hours of admission.	F 655	Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 341 discharged from the facility on 10/14/2024. His comprehensive care plan initiated on 9/10/24 was completed on 9/18/24 by the MDS nurse. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility hired two Registered Nurses responsible for all MDS processes, including developing baseline care plans on September 30, 2024. Interdisciplinary care plan team members responsible for completing baseline care plans were re-educated on the facility's policy and procedure for developing Baseline Care Plans, by the Chief Operating Officer and the Chief Clinical Officer on October 10, 2024. A 100% audit of all residents admitted in the last 14 days was initiated the week of October 27, 2024, by the Chief Clinical	

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F 655	Continued From page 44	F 655	Officer to ensure that base line care plans are completed within 48 hours of admission to the facility. All baseline care plans had been completed timely. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Corporate Nurse Consultant or designee will conduct a weekly audit of admissions to ensure that baseline care plans have been completed within 48 hours of admission to the facility and summaries are provided to residents/resident representatives. The Corporate Nurse Consultant will send any discrepancies found to the Director of Nursing and Administrator for immediate follow-up. This review will continue weekly for four (4) consecutive weeks. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		10/31/24

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F 677	Continued From page 45 by: Based on record review, observation, resident representative interview, and staff interviews, the facility failed to provide incontinence care to a resident that was dependent on staff for activities of daily living (ADL) for 1 of 1 resident reviewed (Resident #20). Findings included: Resident #20 was admitted to the facility on 3/15/21 with diagnoses included non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/25/24 indicated the resident was moderately cognitively impaired and was frequently incontinent of urine and stool. The quarterly MDS indicated Resident #20 required partial assistance with toileting. Resident #20's care plan that was last reviewed on 8/3/24 stated Resident #20 was at risk for a not performing ADL due to impaired mobility and impaired cognition. Interventions included staff providing extensive assistance with toileting needs. Resident #20's care plan also included a focus for bowel and bladder incontinence. Interventions included staff monitoring Resident #20 for incontinence of urine and stool and cleaning the perineum (space between the anus and genitals) with each incontinent episode. On 10/2/24 at 11:20 am in an interview with Resident #20's Resident Representative, Resident #23 (who was also Resident #20's roommate), Resident #23 stated Resident #20's adult brief had not been changed since 9:00 pm on 10/1/24. Resident #23 stated no one had been	F 677	Immediate action(s) taken for the resident(s) found to have been affected include: Incontinence care was immediately provided for resident # 20 in the presence of the surveyor. The Chief Clinical Officer met with the Director of Nursing, Facility Nurse Consultant and Lead Nursing Assistant to review the nursing assistant assignments for 10/2/24. Nursing Assistant assignments were revised to accommodate for new admissions on the 400 hall. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Nursing Supervisors instituted a daily review of nursing assistant assignments to assure that the distribution of residents is accurate and conducive to the provision of timely care, including timely incontinence care. In-service education was conducted by the Director of Nursing Services October 14 -18, 2024 for all certified nursing assistants addressing the importance of proper and timely incontinence care.	

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F 677	Continued From page 46 into their room (Resident #20's and Resident #23's room) except to assist Resident #20 to eat breakfast. Resident #23's quarterly MDS assessment dated 7/12/24 indicated he was cognitively intact and he was observed during interviews alert and oriented to person, place, time and situation. On 10/2/24 at 11:25 am an interview was conducted with Resident #20. When Resident #20 was asked if her adult brief needed changing, she stated she did not think she was wet. Resident #20 agreed for nursing staff to check the adult brief for incontinence. On 10/2/24 at 11:26 am upon request of the surveyor, Nurse Aide (NA) #2 was observed checking Resident #20's adult brief for incontinence. Resident #20's adult brief was observed saturated with dark amber colored urine at the top of the adult brief. NA #2 stated Resident #20's adult brief was soaked and the pad underneath the resident was wet with urine also. There was no redness observed to Resident #20's skin. NA #2 was observed providing incontinent care to Resident #20, applying a clean adult brief and a new pad under Resident #20. On 10/02/24 at 11:30 am in an interview with NA #2, she explained NA #3 was the assigned nurse aide for Resident #20. On 10/2/24 at 11:33 am in an interview with NA #3, she stated at that time she had not checked Resident #20 for incontinence of urine or stool since she began her shift at 7:15 am. She stated she had only assisted Resident #20 with her breakfast meal and had informed Resident #20 she would come back. NA #3 stated she was to	F 677	Newly hired nursing assistants will receive training the provision of timely incontinence care by the DON/ADON/Facility Nurse Consultant during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Department Heads will round daily for 4 weeks to assigned halls to assure that timely incontinence care is being provided. Monday- Friday, management team members will interview all residents on assigned halls who are able to interview about the provision of incontinence care and report any concerns to the hall nurse immediately. Weekend Managers on Duty (MOD) will interview 3 residents per hall on Saturday and Sunday about the provision of incontinence care and report any concerns to the hall nurse immediately. DON/ADON will review daily interview sheets for 4 weeks and act on any negative findings. DON/ADON/management team nurses will randomly spot check residents that are unable to complete interviews, 5 residents a week for 4 weeks to check for the provision of timely incontinence care. Audit results will be reviewed biweekly by	

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F 677	Continued From page 47 check residents every two hours and had been providing ADL care to other residents and was planning to address Resident #20's bath and incontinent needs next. In a follow up interview with NA #3 on 10/2/24 at 2:27 pm, she stated 10/2/24 was the first time caring for Resident #20 since she was readmitted to the facility. She explained before hospitalization, Resident #20 would inform the nursing staff when her adult brief needed to be changed. She explained Resident #20 informed her (NA #3) her adult brief did not need changed after assisting Resident #20 with feeding her breakfast. NA #3 stated she did not check Resident #20 at that time. NA #3 admitted Resident #20's ADL needs had changed since returning to the facility included assisting Resident #20 with feeding and the need to provide incontinent care because the resident wasn't able to walk to the bathroom and wasn't using her call light to communicate incontinent needs. On 10/2/24 at 3:45 pm in a phone interview with NA #1, she stated she had worked the 7:00 pm to 7:00 am shift on 10/1/24 and was assigned to Resident #20. She admitted she provided incontinent care to Resident #20 on 10/1/24 at approximately 10:00 pm and did not recheck Resident #20 for incontinent care needs the remaining time of her shift because Resident #23 (Resident #20's representative and roommate) had told her (NA #1) not to worry about checking on Resident #20 until day shift. NA #1 stated NA #4, who was assisting her with Resident #20's incontinent care, overheard Resident #23 requesting not to check Resident #20 during the night. NA #1 explained Resident #20 had not	F 677	the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	

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F 677	Continued From page 48	F 677		

verbalized the need for incontinent care during her night shift. She reported there was a change in Resident #20's ADL abilities as she was no longer able to walk to the bathroom and use the call bell to verbalize incontinent needs since readmission to the facility. NA #1 said she did not notify the nurse or nurse aide reporting for the day shift on 10/2/24 that Resident #20 had not been checked or changed during the night because NA #3, who was assigned to Resident #20 on 10/2/24, had not reported to work before she left the facility.

On 10/2/24 at 4:40 pm in an interview with NA #4, he stated he had helped NA #1 changed Resident #20's adult brief on the evening of 10/1/24. NA #4 recalled seeing NA #1 and Resident #23 (Resident #20's representative and roommate) talking and stated he did not recall hearing Resident #23 telling NA #1 not to check Resident #20 for ADL care during the night of 10/1/24. NA #4 stated nurse aides were to check all residents every 2-3 hours and as needed.

On 10/2/24 at 4:43 pm in a follow up interview with Resident #23, he stated no one entered the room of Resident #20 and Resident #23 during the night of 10/1/24 and stated he did not tell NA #1 not to come into the room during the night to check on Resident #20 or that the morning nursing staff would change Resident #20.

On 10/2/24 at 11:47 am in an interview with the Director of Nursing she stated nurse aides were to check Resident #20 every two hours entering Resident #20's room to check for incontinent needs. The DON stated since readmission to the facility due to a change in her health, Resident #20 required the nurse aides to check her for

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F 677	Continued From page 49 incontinent needs every two hours.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct and document an admission screening assessment to identify and communicate any changes in the resident's cognitive and functional levels after an hospitalization for 1 of 1 resident reviewed for activities of daily living (Resident #20). Findings included: Resident #20 was admitted to the facility on 3/15/21, with diagnoses that included non-Alzheimer's dementia. Resident #20 was discharged from the facility on 9/23/24 and re-admitted to the facility on 9/27/24 with a diagnosis that included a fracture to right hip. The significant change Minimum Data Set (MDS) assessment dated 10/3/24 was reported as in progress and was not complete. The quarterly MDS dated 7/25/24 indicated resident #20 was moderately cognitively impaired and required assistance setting up her meal for eating, and	F 684	Immediate action(s) taken for the resident(s) found to have been affected include: The nursing admission assessment for resident # 20 was completed on October 2, 2024, by the facility resource nurse. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents admitted to the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: In-service education programs were conducted by the Director of Nursing on October 14-15, 2025, with all licensed nurses to address the importance of completing nursing assessments in a timely manner.	10/31/24

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F 684	Continued From page 50 supervision for mobility and transfers and partial assistance with toileting. The MDS also indicated Resident #20 was frequently incontinent of urine and stool. There was no nursing documentation since Resident #20's re-admission to the facility communicating the cognitive state and level of function of Resident #20 in the electronic medical record There was no admission screening assessment (an assessment that would determine changes in Resident #20's cognitive and functional levels) located in Resident #20's electronic medical record since her readmission on 09/27/24. In an interview with the Director of Nursing (DON) on 10/2/24 at 11:47 am, she stated on readmission to the facility, Resident #20 "was not able to recognize her incontinent needs, and staff would need to check on Resident #20 every 2 hours." In an follow up interview with the DON on 10/2/24 at 4:34 pm, she stated Resident #20's admission screening assessment that would identify and communicate changes in Resident #20 when she was re-admitted to the facility after hospitalization should have been completed for Resident #20 within 24 to 48 hours after returning to the facility. The DON further stated she was the nurse assigned to Resident #20's on 9/27/24 when Resident #20 returned to the facility, and she did not complete the admission screening assessment. The DON stated she left a packet with Resident #20's admission screening assessment inside at the nurses station and did not verbally inform Nurse #5, who was working	F 684	The following items were discussed: -Carrolton PCC Admission Checklist (detailing assessments due within 2 to 48 hours) -Importance of communicating any assessments not competed to the oncoming shift. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON), or designee, will monitor all facility admissions to ensure that assessments have occurred as scheduled using the Carrolton PCC Admission Checklist. The Corporate Nurse Consultant or designee will conduct a daily audit of admissions from the preceding day to ensure that all admission assessments have been completed in a timely manner. The FNC will send any discrepancies found to the Director of Nursing for immediate follow-up. This review will begin the week of 10/27/24 and continue daily for four (4) consecutive weeks. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	

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F 684	Continued From page 51 7:00pm to 7:00 am (night shift) on 9/27/24 of the need to complete Resident #20's admission screening assessment. In an interview with Nurse #5 on 10/3/24 at 3:20 am, she stated she worked from 7:00 pm to 7:00 am (night shift) on 9/27/24. She explained if Resident #20 returned to the facility at 6:00pm on 9/27/24, the DON assigned to Resident #20 was responsible for completing the admission screening assessment. Nurse #5 stated no one reported to her on 9/27/24 upon reporting to work that Resident #20 needed the admission screening assessment completed, and she had not seen a packet for Resident #20 with the admission screening assessment at the nurse's station. In an interview with the Clinical Nurse Consultant on 10/3/24 at 4:35 pm, she stated when Resident #20 was re-admitted to the facility on 9/27/24, the DON assigned to Resident #20 should have started Resident #20's admission screening assessment to determine cognitive and functional changes. She explained if the DON was not able to complete Resident #20's admission screening assessment, the DON should have communicated the need for Resident #20's admission screening assessment to be completed to Nurse #5 who was working the night shift on 9/27/24.	F 684		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		10/31/24

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F 692	Continued From page 52 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to administer tube feedings via a gastrostomy tube as ordered by the physician for 3 of 3 residents reviewed for nutrition maintenance (Resident #60, Resident #74, and Resident #341). The findings included: 1. Resident #60 was re-admitted to the facility 8/7/24 with diagnoses which included anoxic brain damage, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, and acute respiratory failure. Review of Resident #60's Minimum Data Set (MDS) dated 8/21/24 revealed she was severely cognitively impaired. Resident #60 and completely dependent upon staff for all activities of daily living (ADL) and was coded for a feeding	F 692	Immediate action(s) taken for the resident(s) found to have been affected include: All residents with enteral feedings, including residents #60, #74 and #341, were checked to assure that tube feedings were infusing at the rate ordered by the physician. Nurse #1 was suspended on October 3, 2024, pending the outcome of the investigation and consultation with the North Carolina Board of Nursing (NCBON). Nurse #1 was terminated on October 4, 2024, and subsequently reported to the NCBON. Identification of other residents having the potential to be affected was accomplished by:	

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F 692	Continued From page 53 tube. Resident #60's active physician orders related to her tube feeding included the following: - every day and night shift tube feeding at 60 milliliters per hour (ml/hr) continuous (initiated on 9/30/24) - every 6 hours flush with 135 cubic centimeters (cc) for water flushes (initiated on 8/7/24) The Registered Dietician's (RD) nutritional assessment dated 8/21/24 recommended Resident #60 needed 1728 kilocalories (kcal) with 1708 cubic centimeters (cc) free water and 90.4 grams (g) of protein daily from her continuous tube feeding. Review of the RD's progress note for Resident #60 dated 8/21/24 revealed completed a readmission evaluation on 8/21/24 and noted no new recommendations, the tube feeding was adequate as ordered, and well tolerated with weight stability. The following observation was made of Resident #60: - 10/3/24 at 3:08 am Resident #60's feeding tube pump was turned off. An empty tube feeding bottle was hanging on the feeding tube pole. Review of Resident #60's weights revealed the following weights: - 6/3/24 255.0 pounds - 7/2/24 249.8 pounds - 8/8/24 267.8 pounds - 9/9/24 247.5 pounds In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for	F 692	Weights for all residents on enteral feedings were reviewed for the past three months to identify any trends in weight loss or residents needing interventions related to weight loss. No negative trends were noted. The facility has determined that all residents that receive enteral feedings have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Education for Licensed Nurses: All licensed nurses were in-serviced by the Director of Nursing (DON)/Corporate Nurse Consultant (October 3-4, 2024), regarding the facilities expectations for providing enteral feedings as ordered, including: -Following MD orders (tube feeding type, rates, flushes and treatment duration) -Notifying the MD of any resident concerns regarding tube feeding or resident change in condition. -Tube feedings are not to be held without a MD order to do so. Education for Certified Nursing Assistants: All certified nursing assistants will be in-serviced by the DON/Corporate Nurse Consultant/Nursing Supervisors (October 4-5) regarding the following: -If a feeding pump is noted to be off, or the alarm is sounding, the nurse is to be notified immediately. -All residents with enteral feedings should be positioned with the head of bed	

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F 692	Continued From page 54 Resident #60. When asked Nurse #1 why the feeding tube pump was off for Resident #60, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #60 was on continuous tube feeding per physician orders which is part of Resident #60's necessary care and services. Review of Resident #60's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1. The following additional observations were made of Resident #60: - 10/3/24 at 3:53 am Resident #60's feeding tube pump continued to be turned off. - 10/3/24 at 7:53 am Resident #60's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 5:43 am. In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #60's and feeding tube pump off when she "thought her stomach needed a rest". Nurse #1 stated she did this "now and then" but did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #60's feeding tube pump was turned on when she hung a new bottle of tube feeding at 5:43 am on 10/3/24.	F 692	elevated at least 45 degrees. Newly hired licensed nurses and medication aides will receive training on enteral feeding a/ monitoring by the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Corporate Nurse Consultant during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Nursing Supervision: The DON/ADON are responsible for all nursing staff including the charge nurses for all shifts, licensed nursed and unlicensed nursing personnel. The DON/ADON will continue to monitor the nursing staff by: -Daily monitoring of essential reports in the Point Click Care (PCC) electronic medical record (EMR): 24-hour report Missing and late medication reports Incident reports -Unannounced visits to 7p to 7a shift to observe nursing practice: Unannounced visits will include 1 visit per week for 4 weeks, 1 visit per month for 2 months (at a minimum). These unannounced visits will be made by the DON/ADON/FNC or CCO. Observation will include general nursing practice, medication administration and the administration of enteral feedings.	

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F 692	Continued From page 55 During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #60 had lost some weight possibly due to being in and out of the hospital. Resident #60 was readmitted from the hospital on 8/7/24. The RD was not aware of Resident #60's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated a continuous tube feeding may be turned off for a short amount of time to perform activities of daily living (ADL) or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pump, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding. In an interview on 10/3/24 at 9:15 am with the Director of Nursing (DON), she stated continuous tube feedings should not be turned off without a physician's order. The DON further stated she was unaware of Nurse#1 turning the feeding tube pump off for Resident #60 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed Resident #60 and notified the physician of any changes in her condition before making any decisions on her own. The DON indicated she expected the nursing staff to follow the physician's orders as written as a part of a resident's necessary care and services. During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware of	F 692	-A nursing skills fair/competency assessment will be conducted for all licensed nurses beginning October 10, 2024, to verify basic nursing skills to include, but not limited to: Enteral Feeding- skills verification to be completed by 10/30/24 Trach Care Wound Care Medication and IV Administration Additional Monitoring: The DON/ADON will amend the weekly wound and weight meeting to include weekly monitoring of weights for all residents receiving enteral feedings. This monitoring will occur weekly for the next eight weeks, and at least monthly thereafter. This plan will be amended to more frequent monitoring and additional interventions for any noted weight loss. The DON/ADON/FNC are responsible for reviewing reports, monitoring trends and ensuring timely corrective action is taken as needed for all negative findings. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	

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Resident #60's feeding tube pump being turned off. The Physician further stated if there had been a change in the residents' condition such as shortness of breath (SOB), vomiting, or gurgling that could have explained the feeding tube pump being turned off; however, he was not notified at all. The Physician explained one of his concerns was Resident #60 not receiving the calories, and the nutrients provided from the tube feeding. Another concern noted by the Physician was the fact that Nurse #1 intentionally turned the feeding tube pump off without notifying him before taking this action. The Physician indicated he did not like the nurses to make unreasonable decisions on their own without any notification. The Physician indicated that weight loss could happen as a result of the tube feeding pump being turned off. He further explained Nurse #1's reason for the feeding tube pump being turned off was not a good enough reason for Nurse #1 to make that decision.

2. Resident #74 was admitted to the facility on 7/11/24 with diagnoses which included dysphagia (difficulty swallowing), failure to thrive, dementia, and type 2 diabetes mellitus.

The Registered Dietician's (RD) nutritional assessment dated 7/22/24 recommended Resident #74 needed 1980 kilocalories (kcal) with 1963 cubic centimeters (cc) free water and 83 grams (g) protein daily from her tube feeding for 22 continuous hours.

Review of Resident #74's Minimum Data Set (MDS) dated 8/7/24 revealed she was severely cognitively impaired. Resident #74 required maximum assistance from staff with activities of daily living (ADL) and was coded for a feeding

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tube.

Resident #74's active physician orders related to her tube feeding included the following orders:
- continuous tube feeding via pump at 55 milliliters per hour (ml/hr) for nutritional support for 22 hours estimated 2 hours (scheduled for 8:00 am until 10:00 am) downtime to allow for activities of daily living (ADL) care (initiated on 7/11/24)
- water flushes every 3 hours of 120 milliliters

The following observation was made of Resident #74:
- 10/3/24 at 3:10 am Resident #74's feeding tube pump was turned off. A tube feeding bottle with approximately 100 cubic centimeters (cc) was hanging on feeding tube pole.

Review of Resident #74's weights revealed the following weights:
- 7/11/24 154.9 pounds
- 7/22/24 154.9 pounds
- 8/6/24 156.6 pounds
- 9/6/24 160.0 pounds

In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #74. When asked Nurse #1 why the feeding tube pump was off for Resident #74, she replied she intentionally turned the feeding tube pump off because she "thought her stomach needed a rest". Nurse #1 explained she made the decision on her own to "turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest." Nurse #1 indicated she was aware Resident #74 was on continuous tube feeding per physician orders which is part of Resident #74's necessary care and services.

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Review of Resident #74's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1.

The following additional observations were made of Resident #74:
- 10/3/24 at 3:55 am Resident #74's feeding tube pump continued to be turned off.
- 10/3/24 at 7:55 am Resident #74's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 4:30 am.

In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #74's feeding tube pump off when she "thought her stomach needed a rest". Nurse #1 stated she did this "now and then" but did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #74's feeding tube pump was turned on when she hung a new bottle of tube feeding at 4:30 am on 10/3/24.

During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #74's weight had been stable. The RD was not aware of Resident #74's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated continuous tube feedings may be turned off for a short amount of time to perform activities of daily living (ADL) or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by

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the physician. The RD further indicated Resident #74 had a physician's order for her feeding tube pump to be turned off 2 hours a day (2hrs/day) to allow downtime for ADL care. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pumps, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding.

During an interview with the Facility Nurse Consultant, Director Of Nursing, and Chief Clinical Officer on 10/4/24 at 12:33 pm, revealed the nursing supervision and monitoring interventions in place for Nurse # 1 after the incident in July 2024, included daily monitoring of essential reports in the electronic medical record (EMR) to assure nurse supervision of medication aides and all medications were completed timely and as ordered by the physician, and random unannounced facility visits which included evening, night, and weekend shifts. There was no written documentation for the plan of action for monitoring Nurse #1 provided by the facility. The Chief Clinical Officer explained that new nurses hired have a competency evaluation with a nurse skills checklist that is completed during orientation. Nurse #1's competency skills checklist was unable to be located.

In an interview on 10/3/24 at 9:15 am with the Director of Nursing (DON), she stated continuous tube feedings should not be turned off without a physician's order. The DON further stated she was unaware of Nurse#1 turning the feeding tube pump off for Resident #74 which disregarded the physician's order. The DON further stated Nurse

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#1 should have assessed Resident #74 and notified the physician of any changes in their condition before making any decisions on her own. The DON indicated she expected the nursing staff to follow the physician's orders as written as a part of a resident's necessary care and services.

During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware of Resident #74's feeding tube pump being turned off. The Physician further stated if there had been a change in the residents' condition such as shortness of breath (SOB), vomiting, or gurgling that could have explained the feeding tube pumps being turned off; however, he was not notified at all. The Physician explained one of his concerns was Resident #74 not receiving the calories, and the nutrients provided from the tube feeding. Another concern noted by the physician was the fact that Nurse #1 intentionally turned the feeding tube pump off without notifying him before taking this action. The Physician indicated he did not like the nurses to make unreasonable decisions on their own without any notification. The Physician indicated that weight loss could happen as a result of the tube feeding pump being turned off. He further explained Nurse #1's reason for the feeding tube pump being turned off was not a good enough reason for Nurse #1 to make that decision.

3. Resident #341 admitted to the facility on 9/9/24 with diagnoses including nontraumatic intracerebral hemorrhage (brain bleed), dysphagia (trouble swallowing), and had a gastrostomy tube (a g-tube, feeding tube into the stomach) and tracheostomy (breathing tube into the trachea).

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Resident #341's Minimum Data Set (MDS) dated 9/16/24 noted he was unable to participate in the assessment, had an altered level of consciousness, had a tracheostomy, and he had a g-tube and consumed more than 51% of his calories and more than 501 cubic centimeters (cc) of fluids through the g-tube. The MDS indicated he had an unhealed Stage IV wound (a wound down to the bone).

Resident #341's physician orders dated 9/12/24 noted he was to receive tube feeding 1.5 calorie formula at 50 cc an hour and a water flush at a rate of 200 ml every 6 hours.

Observation on 9/30/24 at 11:24 AM revealed Resident #341 was laying in bed with his eyes closed. He did not respond to any questions. The resident had a g-tube pump with a bottle of tube feeding 1.5 calorie formula and a bag of fluids hanging with formula infusing into the resident's g-tube. The pump settings were set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. There was approximately 250 cc remaining in the bottle. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach.

Observation on 09/30/24 at 3:47 PM revealed Resident #341 was laying in bed with his eyes closed. He did not respond to any questions. The resident had a g-tube pump with an almost full bottle of tube feeding 1.5 calorie formula and a bag of fluids hanging with formula infusing into the resident's g-tube. The pump settings were set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. The formula bottle was labeled as being started on 9/30 at

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1:55 PM. There were no nurse's name or initials to indicate who had started the formula. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach.

Observation on 10/01/24 at 2:17 PM revealed Resident #341's g-tube pump settings were still set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach. The formula bottle was labeled as being started on 9/30 at 1:55 PM and there was less than 200 cc left in the bottle. The bag of fluids were dated 9/30/24 and was approximately half full.

In an interview on 10/01/24 02:23 PM, Nurse #2 said she had started Resident #341's g-tube formula on 9/20/24. She said she wrote down the formula and fluid rate based on what was already programmed into the pump but had not confirmed the rate with the orders. She said she had not seen any coughing, residual, reflux, or distress when she had worked with him that week that would cause her to reduce the rate of the feeding. She said one of the night shift nurses (name not recalled) told her the resident had been coughing a few days ago and thought the rate may have been reduced by the night nurse. She was not sure if the doctor was notified about the coughing. She looks for the most current order and confirmed the pump should have been set to infuse the formula at 50 cc an hour and for the fluids to be set to 200 ml every 6 hours. She was unable to find any other orders in the resident's chart.

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F 692	Continued From page 63 Attempts to interview the nurse who worked on 9/28-9/30/24 were not successful. In an interview on 10/03/24 at 10:43 AM, the Registered Dietitian (RD) said Resident #341's formula rate had been increased to provide extra nutrients for the resident's Stage IV wound. He said the resident would still be getting enough calories for the wound, but it was important for the resident to receive the ordered nutrients. In an interview on 10/03/24 at 12:06 PM, Resident #341's Physician said the resident needed to receive the ordered rate of formula for wound healing. The Physician said the resident was getting approximately 300 fewer calories, which was not enough to help heal his wound. The Physician was not notified by any staff that Resident #341 had been coughing or that he had any symptoms that would indicate a need to reduce the feeding rate. He said nurses should not be changing the resident's feeding rate without consulting him first. In an interview on 10/03/24 at 2:14 PM, the Director of Nursing (DON) said Resident #341 should have received the ordered feeding rate and she had not been notified of him being in distress which would indicate a need to turn the rate lower.	F 692		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		10/31/24

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F 727	Continued From page 64 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5:30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present as required on 8/3/24, 8/18/24, and 9/15/24. The schedule only had licensed practical nurses and medication aides scheduled due to a lack of registered nurses available at the time. The facility had offered overtime and bonuses to the existing staff to cover. On 10/3/24 at 5:40 pm an interview was conducted with the Administrator. He stated he	F 727	Immediate action(s) taken for the resident(s) found to have been affected include: The facility will ensure than an RN will be assigned to work 7 days per week, 8 hours per day every day - not including the Director of Nursing (DON). Three RNs have been hired and have completed orientation. The Chief Operating Officer educated the Administrator, DON, Scheduler, and Unit Manager on the RN coverage requirements 8 hrs per day / 7 days per week. Education was completed on Monday, October 12, 2024. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be negatively affected; however, none have been negatively impacted. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 727	Continued From page 65 was not aware of the lack of registered nurses for the 3 dates.	F 727	Staffing and assignments will be reviewed by the Administrator, DON, and scheduler daily during the morning meeting to ensure the staffing for the next day is sufficient and covered. Sponsored ads have been placed for additional staff members to hire to ensure sufficient staffing is available. Three RNs have been hired to work in the facility on a full-time basis. Additional orientation sessions will be set up to ensure that new staff members are oriented as quickly as possible. Chief Clinical Officer educated the senior leadership on 10-05-24 regarding the importance of knowing the daily and weekly schedules always. Chief Operating Officer educated the NHA, DON, Department heads, Unit Manager, and Scheduler on the importance of knowing that an RN is present 7 days per week, 8 hours per day and that the presence of the RN is documented on the daily assignment sheet. This was completed on 10-05-24. How the corrective action(s) will be monitored to ensure the practice will not recur: NHA, DON, and Unit Manager will review schedules daily to ensure 24-hour assignments include RN coverage 8 hours per day / 7 days per week. They	

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F 727	Continued From page 66	F 727	will initial the daily assignment sheets every day to acknowledge review. Schedule results will be reviewed in the daily afternoon stand-down meeting. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		10/31/24

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F 756	Continued From page 67 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and Consultant Pharmacist interview, the facility failed to address recommendations made by the Consultant Pharmacist for 1 of 5 residents reviewed for unnecessary medications (Resident #84). Findings included: Resident #84 was admitted to the facility on 8/14/24 with diagnoses including dementia and Alzheimer's disease. A physician order dated 8/14/24 for Resident #84 to receive the following medications: Quetiapine Fumerate (an antipsychotic/neuroleptic medication) 50 milligrams (mg) twice a day for dementia. The 5-day admission Minimum Data Set (MDS)	F 756	Immediate action(s) taken for the resident(s) found to have been affected include: A review of the medication regimen and identified recommendations was conducted by the Director of Nursing for resident(s) #84 on October 3, 2024. Irregularities included the need to complete an Abnormal Involuntary Movement Scale (AIMS) for resident #84. The AIMS assessment was completed by the facility resource nurse on October 3, 2023. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.	

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F 756	Continued From page 68 assessment dated 8/21/24 indicated Resident #84 was severely cognitively impaired and received antipsychotic medications on a routine daily basis. A review of Resident #84's EMR reported monthly Medication Regimen Reviews (MRR) were conducted on 8/16/24 and 9/26/24. The Consultant Pharmacist wrote a nursing recommendation each month for an AIMS assessment due to Resident #26 receiving an antipsychotic for monitoring the side effects associated with antipsychotic drug therapy. There was no written response to the pharmacy recommendation for an AIMS assessment on the Nursing Recommendations from Pharmacist forms dated 8/16/24 and 9/26/24. There was no abnormal Involuntary Movement Scale (AIMS) assessment (an assessment to assess the severity of tardive dyskinesia, abnormal involuntary movements, in patients receiving antipsychotic/neuroleptic medications) in Resident #84 electronic medical record (EMR). A review of the September 2024 and October 2024 Medication Administration Record (MAR) recorded Resident #84 received the Quetiapine Fumerate 50 mg as ordered. In a phone interview with the Consultant Pharmacist on 10/4/24 at 2:00 pm, she explained in July 2024 that she identified a concern with AIMS assessments not being completed for residents on antipsychotics/neuroleptic medications and emailed the Administrator, Director of Nursing (DON) and the facility's corporate office about the concern. She stated	F 756	The Director of Nursing reviewed and took action on the current pharmacy report, dated September 27, 2024 (including all outstanding medication regimen review recommendations) from October 3 through October 7, 2024. Actions taken/systems put into place to reduce the risk of future occurrence include: A facility procedure regarding the timely review and action taken on identified medication regimen review recommendations was developed on October 9, 2024, by the Carrolton Facility Management Chief Clinical Officer (CCO) and the Scriptworx, LLC Consulting Pharmacist. The CCO reviewed the Carrolton Policy # 12.5, Addressing Medication Regimen Review Irregularities/Recommendations, with the Director of Nursing (DON), Corporate Nurse Consultants on October 10, 2024. The Director of Nursing reviewed the guidelines with the staff nurses and nurse managers on October 10, 2024. Newly hired nurses and medication aides will receive training on medication regimen review by the DON/Assistant Director of Nursing/Corporate Nurse Consultant during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur:	

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F 756	Continued From page 69 Resident #84 nursing recommendation for an AIMS assessment was initially written in August 2024 when admitted and was re-requested in the MMR for September 2024 since the AIMS assessment had not been conducted. She stated she was unsure if the new DON had seen the September pharmacy recommendation for Resident #82's AIMS assessment and did not recall reaching out to the Interim DON in August 2024 since Resident #84 was a new admission. In an interview with the Clinical Nurse Consultant (Interim DON) on 10/3/24 at 4:32 pm, she stated she was the Interim DON in August 2024. She stated she was unable to recall whether she received Resident #84's pharmacy nursing recommendation dated 8/16/24 for an AIMS assessment. She explained AIMS assessments were to be completed on admission and quarterly to assess for side effects of antipsychotics/neuroleptic medications, and the nursing staff would have been verbally informed to conduct Resident #84's AIMS assessment. She further stated she was unable to recall informing the nursing staff to complete the AIMS assessment on Resident #84. In an interview with the DON on 10/3/24 at 3:15 pm, she stated she started as the DON in September 2024. She stated she had received the pharmacy recommendations for September 2024 and had not addressed the pharmacy's nursing recommendation dated 9/26/24 to conduct an AIMS assessment on Resident #84. The DON was unable to provide a reason why the nursing recommendation had not been addressed.	F 756	Nurse Managers will address any irregularities/recommendations identified in the medication regimen review within 7 days of receipt of the pharmacy report. Documentation will be provided of action taken for each irregularity/recommendation noted. Physician recommendations will be scanned to the medical record within 15 days of the report date. The Director of Nursing will audit the pharmacy report and corresponding documentation for (3) months to ensure compliance with all pharmacy recommendations. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		10/31/24

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F 761	Continued From page 70 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to discard an expired insulin aspart flex pen from 1 of 4 medication carts observed for medication storage (300-hall medication cart). Findings included: An observation of the 300-hall medication cart on 10/3/24 at 3:42 pm was conducted in the	F 761	Immediate action(s) taken for the resident(s) found to have been affected include: The expired insulin found on the 300-hall medication cart was immediately discarded when found by the surveyor on 10/3/2024. Identification of other residents having the potential to be affected was accomplished	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 10/08/2024

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F 761	Continued From page 71 presence of Medication Aide #1. An insulin aspart (fasting acting insulin) flex pen with a label attached to the insulin aspart flex pen dated opened 8/23 was observed on the top drawer of the 300-hall medication cart. The expiration date on the insulin aspart flex pen was 8/31/26. The 300-hall medication cart was observed locked by Medication Aide #1 without the removal of the insulin aspart flex pen discarded Manufacturer information on the insulin aspart flex pen recommended to throw away the insulin aspart flex pen 28 days after opening. In an interview with Medication Aide #1 on 10/3/24 at 3:42 pm, she stated she did not know when the insulin aspart flex pen would have expired based on the label opened 8/23 because insulin medications had different expiration time periods after the medication was opened. A second observation of the 300-hall medication cart on 10/3/24 at 3:51pm was conducted in the presence of the Director of Nursing (DON). The insulin aspart flex pen was observed with 50 units of insulin in the syringe with a label attached to the flex pen dated open 8/23. The DON was observed removing and discarding the insulin aspart flex pen from the 300-hall medication cart. In an interview with the DON on 10/3/24 at 3:52 pm, she stated insulin aspart flex pen expired twenty eight days after the opening date of 8/23 and should have been discarded on 9/19/24. She stated she checked the 300-hall medication cart earlier in the week for expirations and was unable to explain why the expired insulin aspart flex pen was on the 300-hall medication cart.	F 761	by: The facility has determined that 100% of residents have the potential to be affected, including all residents that receive insulin. All medication carts were checked for expired medications, including insulin, on October 9, 2024, by the Director of Nursing (DON). Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel (RNs, LPNs and Medication Aides) were in-serviced on October 15-16, 2024, by the Pharmacy Nurse Consultant/ Director of Nursing (DON)/Assistant Director of Nursing (ADON). The in-services included the following information: Medication Administration: -Rights of Medication Administration Medication Storage: -Medication Carts -Checking for expired medications, including insulin -Medication Disposal Newly hired licensed nurses and medication aides will receive training on Medication Administration and Medication Storage by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) /Corporate Nurse Consultant during the orientation process.	

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F 761	Continued From page 72 In an interview with the Chief Clinical Officer on 10/7/24 at 4:00 pm, she stated medication carts were checked frequently for medication expirations by the nursing staff prior to administering medications, by the pharmacy staff monthly and by the nursing administration staff at the facility randomly for audits. She said expired medications should be discarded from the 300-hall medication cart when medications were observed expired.	F 761	How the corrective action(s) will be monitored to ensure the practice will not recur: The ADON/administrative nurses will complete weekly random medication storage audits using the Medication Storage/Observation Weekly Inspection tool weekly for 4 weeks. Medication Storage/Observation Weekly Inspection and Medication Pass Worksheet tools will be reviewed weekly by the Director of Nursing for 4 weeks. Medication Storage monthly audits will continue by the pharmacy nurse consultant. Audit results will be reviewed biweekly by the Quality Assurance Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 10/31/24	