STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRELSON STREET CHERRYVILLE, NC 28021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted from 02/24/25 through 02/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2U3G11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 02/24/25 through 02/27/25. Event ID# 2U3G11. The following intakes were investigated: NC00216269, NC00224270, NC00227138. 5 of 5 complaint allegations did not result in a deficiency.	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.	F 578		3/22/25

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

Electronically Signed | 03/21/2025

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 19 residents reviewed for advanced directives (Resident #62). Findings included: Resident #62 was admitted to the facility on 03/01/2023. Review of Resident #62's electronic medical record revealed a Medical Orders for Scope of Treatment (MOST) form dated 05/02/2023 that indicated her preference for Cardiopulmonary Resuscitation (CPR) to be attempted in the event she had no pulse and was not breathing.	F 578	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiences cited have been or will be completed by the dates indicated. The facility failed to maintain accurate advanced directives throughout the	

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F 578	Continued From page 2 The Code book for 100 hall was observed at the Nurses station. Review of the Code Book revealed Resident #62's a Medical Orders for Scope of Treatment (MOST) form dated 11/01/2023 that indicated her preference for a Do Not Resuscitate (DNR) status in the event she had no pulse and was not breathing. The form was signed by Resident #62's Responsible Party. Further review of Resident #62's electronic medical record revealed a progress note written by the Social Worker dated 11/01/2023 2:42 PM that read in part: Optum NP reviewed plan of care and current MOST form with resident and resident's responsible party. New MOST form completed to indicate Do Not Resuscitate (DNR) order with limited additional interventions, New MOST scanned to residents' chart and copy placed in MOST form book at nursing desk. Review of Resident #62's electronic medical record revealed the following care conference notes from Resident #62's care plan meetings: A note dated 8/1/2024 that read in part: advanced directives discussed and no changes at this time. A note dated 10/17/2024 read in part: Social went over advanced directives and wants resident to remain a Full code. A note dated 1/16/2025 read in part: Social went over advanced directives and wants resident to remain a Full code. The quarterly Minimum Data Set (MDS) dated 01/27/2025 revealed Resident #62 was cognitively intact. During an interview on 02/25/2025 at 10:20 am	F 578	medical record for Resident #62. The Medical Orders for Scope of Treatment (MOST) form in the Code Book for the 100 hall indicated Resident # 62 was a Do Not Resuscitate (DNR) which did not match the electronic medical record that indicated the resident was a Full Code. Current facility residents are at risk of being affected by the deficient practice. The Social Worker (SW) completed an audit on current facility residents to ensure the advanced directives were correct throughout the medical record and Code Books. The audit was completed on 2/27/25. The audit was completed and no concerns were noted. On 2/28/25 an ad hoc QAPI meeting was held to discuss the survey results and implement a plan of correction. By 3/21/25 the Director of Nursing (DON) educated the SW, facility licensed nurses, and the interdisciplinary team (IDT) on ensuring the resident's advanced directives are accurate throughout the resident's medical record and Code Books. The DON will be responsible for ensuring staff have been trained before working their next shift. The DON will ensure the education is added to the new hire SW, licensed nurses and IDT members and completed before they work their first shift. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Director of Nursing or designee will	

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F 578	Continued From page 3 NA #3 stated residents code status could be found in the code book. NA #3 stated the code book is kept at the nurse's desk, and that each unit had a code book. During an interview on 02/25/2025 at 10:44 am Nurse #2 stated the code book is where the resident's code status could be found, and the book was the most updated. Nurse #2 stated it was the Social Worker's responsibility to update the forms in the code book. During an interview on 02/25/2024 at 11:42 am the Social Worker stated advanced directives were discussed with residents upon admission and reviewed at quarterly care plan meetings. The Social Worker stated he was responsible and received completed MOST forms to be scanned and uploaded into the electronic medical record, then placed in the code book. The Social Worker stated the code books had the residents' most up to date code status. The Social Worker stated he normally filled out the MOST forms with the resident or resident representative, but sometimes the Nurse Practitioner from Optum completed the form and then he was responsible to upload the form and place the most updated form into the code book. The Social Worker verified Resident #62's MOST form in the code book did not match the MOST form in the electronic medical record or the status documented in care conference notes. The Social Worker was not sure why the form from 11/01/2023 was not in the electronic medical record. During an interview on 02/25/2025 at 1:27 pm, the Director of Nursing (DON) stated on admission the Nurse Practitioner or nurse fills out	F 578	audit 5 residents medical records/Code Books weekly to ensure their advanced directives are accurate throughout medical record/Code Book weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	

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F 578	Continued From page 4 the MOST form with residents. The DON stated the Social Worker made sure the MOST forms were correct and was responsible to upload the MOST form into the electronic medical record and to make sure the completed MOST form was placed into the code book at the nurse's station. The DON stated she expected the resident's code status to match throughout the electronic chart and the Code Book. During an interview 02/25/2025 at 1:27 pm the Administrator stated advanced directives were completed and discussed with residents on admission and at quarterly care plan meetings. The Administrator stated Optum Nurse Practitioners could complete the MOST forms with the residents. The Administrator stated completed forms were given to the Social Worker to be uploaded to the electronic medical record and placed into the code book at the nurse's station. The Administrator expected the code status to match throughout the resident record.	F 578		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		3/21/25

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F 623	Continued From page 5	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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F 623	Continued From page 6	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 7 relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and responsible party (RP) interviews the facility failed to notify the resident and the Responsible Party in writing of transfers to the hospital for 2 of 2 residents reviewed for facility initiated discharge (Resident #6 and Resident #55). The findings included: 1. Resident #6 was admitted to the facility on 12/09/2024. Review of Resident #6's facility face sheet dated 12/09/2024 revealed Resident #6 was her own responsible party. Review of the Nurse Practitioner's (NP) order dated 12/19/2024 at 10:52 AM revealed Resident #6 was sent to the hospital for evaluation and treatment. Review of Resident #6's discharge Minimum Data Set (MDS) assessment dated 12/19/2024 revealed the discharge was coded as an unplanned discharge to hospital with return anticipated. Review of Resident #6's electronic medical record revealed no written notification was given to Resident #6 of her transfer to the hospital. Resident #6 returned to the facility on 12/24/2024. An interview was conducted with Resident #6 on 02/27/2025 at 8:10 AM. Resident #6 stated she	F 623	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. On 2/27/25 it was discovered by the Director or Regulatory Compliance that the facility failed to notify the residents or the Responsible Party in writing of transfers to the hospital. On 2/27/25 the Administrator completed an audit of resident hospital transfers occurring during previous two weeks (2/14/25 - 2/27/25) for evidence of timely written notice to Resident/Representative. All residents without written notices had a written transfer form completed by the Admissions Coordinator or Marketing Director by 3/17/25. On 2/28/25, the Director of Regulatory Compliance provided education to the Administrator on the federal regulation to send written transfer notice with the resident or Responsible party when they are transferred out of the facility. On 3/3/25 the Administrator provided	

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F 623	Continued From page 8 did not receive any notification in writing prior to being transferred to the hospital in December 2024. An interview was conducted with the Social Worker (SW) on 02/27/2025 at 9:15 AM. The SW stated that the facility did not notify residents or their responsible parties (RPs) in writing regarding transfers to the hospital. The SW also stated that the facility had never notified residents or their RPs in writing about hospital transfers and he was not aware of the regulation. The Administrator was interviewed on 02/27/2025 at 10:30 AM. The Administrator stated he did not notify residents or their RPs in writing of transfers to the hospital. The Administrator also stated that the facility did not have a process for written notification of transfers. The Administrator also stated that he was aware of the regulation, but the facility was not meeting the regulation. 2. Resident #55 was admitted to the facility on 6/30/23. Review of Resident #55's facility face sheet dated 6/30/23 revealed Resident #55 had a designated responsible party (RP). Review of the Nurse Practitioner's (NP) order dated 2/11/25 at 8:21 PM revealed Resident #55 was sent to the hospital for evaluation and treatment. Review of Resident #55's discharge Minimum Data Set (MDS) assessment dated 2/11/25 revealed the discharge was coded as an unplanned discharge to hospital with return anticipated.	F 623	education to the Admissions/Marketing staff and DON on the requirements of the facility to notify the resident and/or the residents representative(s) prior to any transfer and the reasons for the move in writing and in a language and manner they understand. The nurse or Admissions/Marketing staff will be responsible for providing written notices prior to transfer or as soon as practical. The admission staff will maintain a transfer Notice log with date and method written notices are provided. On 3/3/25 the DON or designee provided education to all Licensed Practical Nurses and Registered Nurses and Administrative staff that a written notice of transfer is to be given to the resident/responsible party prior to transfer or as soon as practical. The DON will be responsible for ensuring that nursng staff do not work until education has been completed. The Administrator informed the DON on 3/11/25 the education would be added to the new hire education for nursing staff and Admissions Staff and would have to be completed before they work their first shift. The Administrator or DON will complete quality assurance monitoring of transfers for accurate, timely notifications. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI	

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F 623	Continued From page 9 Review of Resident #55's electronic medical record revealed no written notification was given to Resident #55 or her RP of her transfer to the hospital. Resident #55 returned to the facility on 2/14/25. Attempted to contact Resident #55's RP and was unable to be reached. An interview was conducted with the Social Worker (SW) on 02/27/2025 at 9:15 AM. The SW stated that the facility did not notify residents or their responsible parties (RP) in writing regarding transfers to the hospital. The SW also stated that the facility had never notified residents or their RPs in writing about hospital transfers and he was not aware of the regulation. The Administrator was interviewed on 02/27/2025 at 10:30 AM. The Administrator stated he did not notify residents or their RP's in writing of transfers to the hospital. The Administrator also stated that the facility did not have a process for written notification of transfers. The Administrator also stated that he was aware of the regulation, but the facility was not meeting the regulation.	F 623	meetings and will make changes to the plan as necessary to maintian compliance with notice requirements before transfer/discharge.	
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:	F 644		3/21/25

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F 644	Continued From page 10 §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 a Preadmission Screening and Resident Review (PASRR), level II was completed after a readmission with mental health diagnoses for 1 of 3 residents (Resident #40) reviewed for PASRR. The findings include: Review of Resident #40's medical record revealed the resident was admitted to the facility on 3/05/21 and a PASRR level I was completed. The resident was diagnosed with other schizoaffective disorder on 4/13/21, anxiety disorder on 4/13/21, and mood affective disorder on 06/03/21. Resident #40 was readmitted to the facility on 1/25/24. No PASRR level II was completed. During an interview on 2/27/25 at 10:05 AM with the Social Worker (SW) he revealed a PASRR level II should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. He stated	F 644	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility failed to ensure PASARR level II was completed after readmission with mental health diagnosis on Resident #40. Resident #40's PASARR was submitted for review on 2/27/25. A 100% audit was completed on 2/27/25 by the Social Worker and Administrator to identify any residents with newly diagnosed mental disorders, intellectual disabilities, related conditions, or with a significant change in assessment for a	

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F 644	Continued From page 11 in December 2023 and January 2024 he and the Administrator completed a PASRR audit for all residents with mental health diagnosis including Resident #40 but could not locate her current PASRR letter to show if a level II PASRR had been completed. During an interview on 2/27/25 at 11:40 AM with the Administrator he revealed PASRR level II should be completed in a timely manner upon the admission of a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated in December 2023 and January 2024 he and the SW completed a PASRR audit for all residents with mental health diagnosis and PASRR level II referrals were sent into the PASRR office for any resident found to have a mental health diagnosis with no level II PASRR. He revealed this included Resident #40 and according to the PASRR audit documentation, Resident #40's name was checked off and labeled addressed for a level II referral being completed. The Administrator stated Resident #40's current PASRR letter could not be located to show if a level II PASRR had been completed.	F 644	level II PASARR review. Any residents identified with needing a level II PASARR screening were reviewed and new FL2s and Screening Tools will be completed and submitted to NCMUST for review by 3/21/25. Admissions Coordinator, Marketing Director, Social Worker and the MDS Coordinators were educated on 2/27/25 by the Administrator on resident assessments and the requirements for PASARR screenings. A three-step identification process was implemented on 2/27/25 to ensure all new admission residents and readmissions will be reviewed to ensure they have a correct PASARR. The three-step process includes the following: 1. The Admissions/Marketing staff will review new admit PASARRs, 2. Social Worker will monitor all residents receiving psych visits/services for new diagnosis and ensuring the admission PASARRs have correct listed diagnosis, 3. MDS will notify the Social Worker of significant changes on resident assesssment. Any significant changes in assessment, residents receiving visits from psych services, or diagnosis of mental disorders, intellectual disabilities, or related conditions will be audited and a new PASARR screening will be conducted if applicable. The Administrator will be responsible for ensuring staff do not work until education has been completed. The Administrator to add the education to the new hire education for Admissions/Marketing staff, Social Workers, and MDS Coordinators. The Social Worker will conduct an audit of	

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F 644	Continued From page 12	F 644	any residents receiving psych services and newly admitted residents and the Admission/Marketing staff will review PASARR screenings prior to a new admission to the facility ensuring PASARR has been done and obtaining a number. The audits will be completed as follows: Weekly for 4 Weeks, then every 2 weeks for 4 weeks, and then monthly for 1 month. The Administrator will bring findings of audits to he Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate effectiveness of training to determine if continued auditing is necessary to maintain compliance.	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide toenail care to 1 of 2 residents (Resident #82) who were	F 687	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged	3/21/25

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F 687	Continued From page 13 dependent on staff for assistance with activities of daily living (ADL). Findings included: Resident #82 was admitted on 11/13/23 with diagnoses that included muscle wasting and atrophy. The care plan for ADL that initiated on 11/14/23 revealed Resident #82 required ADL assistance related to impaired mobility and muscle weakness. The goal was to reach his highest level of independence with ADL through the next review date. Interventions included using clear and simple instructions or cues when providing care, and monitoring, documenting and reporting declines in functions to the physician as indicated. The quarterly Minimum Data Set (MDS) assessment dated 12/31/24 coded Resident #82 with severely impaired cognition. He needed supervision or touching assistance for personal hygiene, and partial to moderate assistance for putting on or taking off footwear and shower. Resident #82 did not exhibit behavior of rejecting evaluation or care during the 7-day assessment period. A review of Resident #82's shower records revealed he was scheduled to receive shower twice weekly on Wednesday and Saturday during the first shift. The shower records indicated that he received a shower provided by Nurse Aide (NA) #2 last Saturday on 02/22/25. An observation conducted on 02/24/25 at 12:47 PM revealed all of Resident #82's bilateral toenails were extended between 4-5 millimeters	F 687	deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiences cited have been or will be completed by the dates indicated. On 2/25/25 Resident #82 had his toenails cleaned and trimmed based off his request by the Licensed Practical Nurse (LPN). On 3/11/25, 100% of all in house residents were observed for nail care deficits to include cleanliness, length and filing needs by the Licensed Nurses and Certified Nursing Assistants on each unit. Any resident who had long, unclean, or jagged nails were corrected on 3/11/25 based on the residents preference at that time. Education was initiated on 3/12/25 by Director of Nursing (DON) or Designee for all current nursing department staff including certified nursing assistants, medication aides, licensed practical nurses, and registered nurses on cleaning and trimming nails per resident needs and choice. All residents will have their nails trimmed and cleaned based on observation and resident choice during showers and as needed. The education included asking the resident at the time of observation regarding nail care regardless of past refusals. Any nursing department staff member who did not receive this	

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F 687	Continued From page 14 (mm) beyond the tip of his toes. The right big toenail was cracked with sharp edges and brownish substances were visible underneath this toenail. During an interview conducted on 02/24/25 at 12:49 PM, Resident #82 stated he was not diabetic. He could not trim his toenails as he had difficulty reaching his lower extremities. He did not know how long it had been since his toenails had been trimmed and indicated the staff did not offer to trim them when he received showers in the past week. He wanted his toenails to be trimmed immediately as it bothered him, especially when wearing his cowboy boots. A subsequent observation conducted on 02/25/25 at 1:14 PM revealed Resident #82's bilateral toenails remained untrimmed. The right big toenail was cracked with sharp edges and dirty. During a joint observation conducted on 02/25/25 at 3:15 PM with NA #1 and Nurse #1, Resident #82's toenails remained untrimmed with both big toenails cracked with sharp edges. Brownish substances were seen underneath the right big toenail. An interview was conducted with NA #1 on 02/25/25 at 3:18 PM. She stated she had provided care for Resident #82 frequently, but she did not notice his long, cracked, dirty toenails. She added Resident #82's toenails needed to be trimmed to ensure comfort and safety. During an interview conducted on 02/25/25 at 3:20 PM, Nurse #1 explained she did not provide care for Resident #82 frequently and was not aware of his long, cracked, and dirty toenails. She	F 687	education by 3/21/25 will not be allowed to work until completed. This education will be included in the new hire orientation. The DON or Nurse Administration designee will audit 10 residents toenails weekly times 4 weeks, then 5 resident observations weekly times 4 weeks, and then 3 resident observations weekly times 4 weeks. The DON or Nurse Administration Designee will bring the audit results to the Quality Assurance Committee monthly times 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

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F 687	Continued From page 15 confirmed Resident #82 was not a diabetic and his toenails could be trimmed by a NA. She stated Resident #82 was dependent on the staff for nail care and acknowledged that his toenails needed to be trimmed immediately. An interview was conducted with NA #2 on 02/26/25 at 10:54 AM. She stated she was a member of the shower team and recalled giving a shower to Resident #82 last Saturday on 02/22/25. She did not notice Resident #82 with long, cracked, and dirty toenail during the shower. Otherwise, she would have offered to trim and clean his toenails. During a joint interview conducted on 02/26/25 at 11:44 AM, the Director of Nursing and the Administrator expected all the nursing staff to be more attentive to residents' skin conditions including toenails when providing care or shower and offer nail care as indicated. It was their expectation for all the dependent residents to receive nail care as needed or indicated in a timely manner.	F 687		
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,	F 756		3/21/25

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F 756	Continued From page 16 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 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, and interviews with staff, Consultant Pharmacist, and Nurse Practitioners, the facility failed to respond to identified drug irregularities related to the use of as needed (PRN) psychotropic drug (drug that affects mental state) and provide follow up recommendations for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #83). The findings included:	F 756	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers	

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F 756	Continued From page 17 Resident #83 was admitted to the facility on 12/26/2023 with diagnoses that included Metabolic encephalopathy, cognitive communication deficit, unspecified dementia, and anxiety disorder. A physician's order dated 10/25/2024 indicated Lorazepam one (1) milligram (mg) by mouth three times a day PRN (as needed) for anxiety/agitation, hold for sedation was ordered for Resident #83. The order did not contain a stop date. Rationales for extended therapy beyond 14 days were not found in Resident #83's medical records. A review of the October, November and December 2024 and January 2025 medication administration record (MAR) revealed Resident #83 had received no doses of PRN Lorazepam in October and November of 2024, and Resident #83 received 2 doses of PRN Lorazepam in December 2024 and received 5 doses of PRN Lorazepam in January 2025. 12/14/2024- 1 dose 12/30/2024- 1 dose 1/3/2025- 1 dose 1/6/2025- 1 dose 1/14/2025- 1 dose 1/15/2025- 1 dose 1/23/2025- 1 dose A review of Resident #83's medical record revealed the Consulting Pharmacist had conducted a medication regimen review (MRR) for Resident #83 on 11/29/2024. The Consulting Pharmacist sent a recommendation to the provider on 11/29/2024 that read: "Resident has a	F 756	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility failed to respond to identified drug irregularities related to the use of as needed (PRN) psychotropic drug and provide follow up recommendations. Resident #83's physician's order was written for Lorazepam one milligram by mouth three times a day as needed on 10/25/2024. The order did not contain a stop date. Resident #83's Lorazepam was discontinued on 2/14/2025. All residents with orders for PRN psychotropic medications have the potential to be affected. On 2/27/25, the Director of Nursing (DON) completed an audit of all PRN psychotropic medications. All PRN psychotropic medications had a 14 day stop date or documentation provided in the medical record as to why the 14 day stop date was not recommended. On 2/27/25 an Adhoc QAPI meeting was held to discuss the survey results and implement a plan of correction. On 2/27/25 the Administrator educated the PHyarmacy Consultant on the guidelines for making recommendations to the physician for any resident recieving PRN anti-psychotic medications and ensuring there was a 14 day stop date or documented reason from the physician to continue the medication. On 2/27/25 the Director of Nursing (DON) provided education to all Licensed nurses regarding the need for a 14 day stop date on all PRN psychotropic medications initially and correct documentation to	

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F 756	Continued From page 18 PRN (as needed) Lorazepam order on MAR. Per guidelines, this medication would need to have a 14 day stop date added or a progress note to document a longer duration on MAR. Whichever is appropriate." Review of the November recommendations to provider form revealed on 12/04/2024 the facility Nurse Practitioner (NP) wrote "continue" under the section Physician response to recommendation. Review of medication regimen reviews dated 12/29/2024 and 01/24/2025 revealed the Consulting Pharmacist made no recommendations. During an interview conducted on 02/27/25 at 9:48 AM, the Nurse Practitioner (NP) stated that the Psychiatric NP usually wrote the orders for psychotropic medications and that the orders normally had a 14 day stop date, then the orders would have to be renewed. The NP verified she had signed the November pharmacist recommendation form for Resident #83 and wrote "Continue" under the rationale section. NP stated the Psychiatric NP normally completed the pharmacy recommendation forms for antipsychotic and psychotropic medications and could not explain why she had addressed the recommendation and not the Psychiatric NP. During a telephone interview on 02/27/25 at 12:02 PM, the Consulting Pharmacist verified he had completed the MMR for Resident #83 on 11/29/24. The Consulting Pharmacist verified he had sent a recommendation to the provider that read: "Resident has a PRN (as needed) Lorazepam order on MAR. Per guidelines, this medication would need to have a 14 day stop date added or a progress note to document a longer duration on MAR. Whichever is appropriate." The Consulting Pharmacist verified	F 756	continue after the initial 14 day order. Education will be provided to all Licensed Nurses upon hire during orientation period. The Director of Nursing and or designee will ensure that the pharmacist will review all residents monthly that have psychoactive medications. All new admits and or readmissions will also be reviewed. Director of Nursing or designee will audit each months pharmacy reviews to ensure completion by facility provider. This audit will be communicated to the Director of Nursing and then to they physician. The results will be reported to the Quality Assurance Performance Improvement (QAPI) committee on a monthly basis. The committee will evaluate the effectiveness and amend as needed.	

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F 756	Continued From page 19	F 756		

the response from the provider was "continue". The Consulting Pharmacist stated the response of "continue" received from the Nurse Practitioner on the pharmacist recommendation form was sufficient since his recommendation had been acknowledged and a response was sent. The consulting pharmacist stated he would have followed up with it again in a couple months if needed.

During a telephone interview on 02/27/25 at 12:55 PM the Psychiatric Nurse Practitioner (NP) stated she was familiar with Resident #83 and was aware she had an order for Lorazepam. The Psychiatric NP stated if she had received the pharmacy recommendation form from 11/29/24, regarding the Lorazepam order written 10/25/24 and known the resident had not received any Lorazepam she would have discontinued the order. The Psychiatric NP stated she normally responded to all the pharmacy recommendations regarding antipsychotic or psychotropic medications, but sometimes the facility NP or Medical Director received and responded to the pharmacy recommendation forms.

An interview was conducted with the Director of Nursing (DON) on 02/27/2025 at 10:08 AM and the DON expected PRN psychotropic medications to be written for 14 days, or for the provider to write the specific rationale for why the order needed to be extended for more than 14 days, which the DON verified is part of the facility psychotropic policy.

During an interview on 02/27/2025 at 10:59 AM the Administrator stated he expected orders for PRN psychotropic medications to be written per the facility policy.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		3/21/25

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F 758	Continued From page 21 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff and Nurse Practitioners, the facility failed to ensure physician's orders for as needed (PRN) psychotropic drug (drug that affects mental state) was time limited in duration and provided rationales for therapy exceeding 14 days for 1 of 5 sampled residents reviewed for unnecessary medications (Residents #83). The findings included: Resident #83 was admitted to the facility on 12/26/2023 with diagnoses that included Metabolic encephalopathy, cognitive communication deficit, unspecified dementia, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 01/06/2025 assessed Resident #83 with severe cognitive impairment and indicated she had received antianxiety medications in the 7-day assessment period. Review of Resident #83's medical record revealed a physician's order dated 10/25/2024 that indicated Lorazepam 1mg (milligram) three times a day PRN (as needed) for Anxiety/Agitation, Hold for sedation was ordered	F 758	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility failed to respond to identified drug irregularities related to the use of as needed (PRN) psychotropic drug and provide follow up recommendations. Resident #83's physician's order was written for Lorazepam one milligram by mouth three times a day as needed on 10/25/2024. The order did not contain a stop date. All residents with orders for PRN psychotropic medications have the potential to be affected. On 2/27/25, the Director of Nursing (DON) completed an audit of all PRN	

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F 758	Continued From page 22 for Resident #83. The order did not contain a stop date. This order was discontinued on 02/14/2025 due to non-use, and the rationales for extended therapy beyond 14 days were not found in Resident #83's medical records. A review of the December 2024 and January 2025 medication administration record (MAR) revealed Resident #83 had received 7 doses of PRN Ativan in December 2024 and January 2025. 12/14/2024- 1 dose 12/30/2024- 1 dose 1/3/2025- 1 dose 1/6/2025- 1 dose 1/14/2025- 1 dose 1/15/2025- 1 dose 1/23/2025- 1 dose On 02/24/25 at 11:49 AM an attempt to interview Resident #83 was unsuccessful. She was unable to engage in the interview. During an interview on 02/27/25 at 9:33 AM Nurse #3 stated she just recently became a nurse. Nurse #3 knew there was a policy regarding PRN (as needed) psychotropic medications. Nurse #3 did know recall the specific policy but knew she could get help finding it from the nurses in administration. During an interview on 02/27/25 at 9:44 AM Nurse #4 stated she was aware of the facility's policy for psychotropic medication use and stated that PRN orders for psychotropics had to have a 14 day stop date. During an interview conducted on 02/27/25 at 09:48 AM, the Nurse Practitioner (NP) stated that	F 758	psychotropic medications. All PRN psychotropic medications had a 14 day stop date or documentation provided in the medical record why the 14 day stop date was not recommended. On 2/28/25 an Adhoc QAPI meeting was held to discuss the survey results and implement a plan of correction. On 2/27/25 the Administrator provided education to the Consultant Pharmacist, the Medical Director, the Nurse Practitioner, and the Psychiatric Nurse Practitioner on the need for a stop date on any PRN psychotropic medications. They were also educated on the need for rationale to continue a PRN psychoaction medciation after the 14 day stop date and to document rationale in the medical record and on the pharmacy recommendation. On 2/27/25 the Director of Nursing (DON) or designee educated all licensed nurses that PRN psychoactive medications require a 14 day stop date and if there is not a stop date to contact the provider for further direction. The DON will ensure staff do not work until education has been recieved. All new hire licensed nurses will be educated upon hire during orientation period. The DON educated the clinical management staff that all psychoactive PRN medications require a 14 day stop date order will be reviewed daily Monday through Friday for any new PRN psychoactive medications to ensure a stop date is in place. The DON or designee will audit PRN psychoactive medications 5 times a week	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 23 the Psychiatric NP usually writes the orders for Psychotropic medications and that the orders normally have 14 day stop date, then the orders have to be renewed. During a telephone interview on 02/27/25 at 12:55 PM the Psychiatric Nurse Practitioner (NP) stated she was familiar with Resident #83 and was aware she had an order for Lorazepam. The Psychiatric NP stated if she had received the pharmacy recommendation form from 11/29/24, regarding the Lorazepam order written 10/25/24 and known the resident had not received any Lorazepam she would have discontinued the order. An interview was conducted with the Director of Nursing (DON) on 02/27/2025 at 10:08 AM and the DON expected orders for PRN psychotropic medications to be written for 14 days, which the DON verified was part of the facility psychotropic medication policy. During an interview on 02/27/2025 at 10:59 AM the Administrator stated he expected orders for PRN psychotropic medications to be written per the facility policy.	F 758	times 4 weeks, then 3 times a week for 4 weeks, and then 1 time a week times 4 weeks to ensure 14 day stop dates or documented rationale are in place. The DON or nurse administration designee will bring audit results to the Quality Assurance Committee monthly times 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345255	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	**111 HARRELSON STREET CHERRYVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the discharge status on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for closed record review (Resident #98). Resident #98 was admitted to the facility on 01/07/2025. The discharge MDS dated 01/28/2025 for Resident #98 revealed he was discharged to a short-term general hospital. Review of the progress note written by Nurse #2 dated 01/28/2025 at 2:02 PM revealed the resident was discharged home on that day. During an interview with the MDS Coordinator on 02/26/2025 at 3:11 PM she verified the progress note dated 01/28/2025 that revealed Resident #98 was discharged home was correct. The MDS Coordinator stated she coded the discharge MDS in error, it should have been coded that Resident #98 discharged back to his home. An interview with the Administrator on 02/27/2025 at 8:46 AM revealed he would expect the MDS coding to accurately reflect the discharge location.

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

The above isolated deficiencies pose no actual harm to the residents