STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jesse Helms Nursing Center	**1411 Dove Street , Monroe, North Carolina, 28111**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey conducted on 8/11/2025 through 8/14/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D30#9-H1.	E0000		09/14/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/11/2025 through 8/14/2025. Event ID # 1D30E9-H1. The following intakes were investigated: 2566487 and 761795. 1 of the 5 allegations resulted in deficiency.	F0000		09/11/2025
F0580 SS = D	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 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	F0580	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F580 On 6/23/25, Resident #67 was transferred to the hospital and did not return to the facility. On 8/19/25, the Director of Nursing conducted nursing education with nursing staff, including Nurse #2 and Nurse #3, on expectations for reporting resident change in condition to physicians. Clinical Supervisor to conduct 100% audit of the 24-hour reports, for the period between 8/18/25 through 8/25/25, validating that follow-up was completed for reports of resident change in condition. One opportunity identified during the audit was addressed with the nurse. Provider was then notified with all concerns resolved.	09/11/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = D	Continued from page 1 (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 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 record review, and physician and staff interviews, the facility failed to notify the physician immediately of a change in condition for 1 of 3 residents reviewed for change of status (Resident #67). The findings included: Resident #67 was admitted to the facility 5/14/25 with diagnoses including congestive heart failure and diabetes. The admission Minimum Data Set assessment dated 5/17/25 assessed Resident #67 to be cognitively intact. The medical record was reviewed and vital signs for Resident #67 revealed the following: 6/22/25 at 7:07 PM temperature 103.1 Fahrenheit (F) (normal 98.6), pulse 137 (normal 60-100), blood pressure 147/135 (normal 120/70).	F0580	Continued from page 1 By 9/11/25, the Nurse Educator will provide in-services to nursing staff on the new Interact Change in Condition tool for reporting to physicians. The in-service will include to document physician notification on the 24-hour report. Any staff members who do not receive the training by 9/11/25 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 9/15/25, the Clinical Supervisor or designee will audit five 24-hour report entries weekly times 12 weeks, for compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 9/11/25.	

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F0580 SS = D	Continued from page 2 Review of the nursing schedule for 6/22/25 revealed Nurse #3 was assigned to Resident #67 on 6/22/25 for the 7:00 AM to 7:00 PM shift. Review of the electronic documentation system revealed no nursing note written by Nurse #3 regarding the elevated temperature, pulse, or blood pressure had been communicated to the physician. The medical record documented a recheck of the vital signs on 6/22/25 at 7:40 PM: temperature 102.8 F, pulse 124, blood pressure 101/41. A phone interview was conducted with nursing assistant (NA) #1 on 8/13/25 at 4:20 PM. NA #1 reported she arrived early for her 7:00 PM to 7:00 AM shift on 6/22/25 and she started taking vital signs on her assigned residents. NA #1 reported that when she got the abnormal vital signs on Resident #67, she reported to Nurse #3, and Nurse #3 told her to recheck the vitals signs. NA #1 explained that because she told Nurse #3 about the abnormal vital signs, when she rechecked Resident #67's vital signs at 7:40 PM and the vital signs were still abnormal, she did not report to Nurse #2 because she thought Nurse #3 would have reported to Nurse #2 at change of shift. NA #1 reported that Resident #67 said she was "ok", but Resident #67 was very sweaty and "looked bad". A phone interview was conducted with Nurse #3 on 8/13/25 at 2:47 PM. Nurse #3 reported she worked on 6/22/25, but she did not recall if she was assigned to Resident #67 or anything about Resident #67, nor did she recall NA #1 reporting abnormal vital signs to her. Nurse #2 was interviewed by phone on 8/13/25 at 12:29 PM. Nurse #2 reported she was assigned to Resident #67 from 7:00 PM on 6/22/25 to 7:00 AM on 6/23/25. Nurse #2 reported when she received report from Nurse #3, nothing was said about Resident #67's abnormal vital signs. Nurse #2 reported she started her medication pass and in the middle of it, Nurse #4 came to her to report the family member of Resident #67 had called expressing concern about Resident #67 "not acting like herself." Nurse #2 reported when she was given this information, she looked up vital signs for Resident #67 and discovered that Resident #67 had an abnormal temperature, pulse, and blood pressure. Nurse #2 reported she checked the vital signs for Resident #67 again at 8:59 PM and called the on-call provider with report. An interview was conducted by phone with Nurse #4 on	F0580		

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F0580 SS = D	Continued from page 3 8/13/25 at 4:05 PM. Nurse #4 reported she had answered a phone call from Resident #67's family member and the family member had expressed concern that Resident #67 was "not acting like herself." Nurse #4 explained she went to Nurse #2 and told her about the phone call and that's when Nurse #2 reviewed the charting for Resident #67 and discovered the abnormal vital signs. Nurse #4 described Resident #67 as sweating, and her blood pressure was very low. Nurse #4 reported Nurse #3 should have reported the abnormal vital signs to the on-call physician. Nurse #4 reported the on-call provider was called about 9:00 PM with report and orders were received. The Physician was interviewed on 8/14/25 at 11:57 AM. The Physician reported the on-call physician had not received notification of the change in Resident #67's status until about 9:00 PM on 6/22/25. The Physician conveyed the off going shift should have reported the abnormal vital signs to the on-call physician when the vital signs were obtained, but the delay in care of about 2 hours had not adversely affected Resident #67. During an interview with the Director of Nursing (DON) on 8/13/25 at 4:35 PM, she reported she was notified on 6/23/25 that Nurse #3 had not notified the on-call physician of the change in Resident #67's status. The DON reported she provided education to the nursing staff about reporting resident changes in condition but had not implemented a corrective action plan. The Administrator was interviewed on 8/14/25 at 11:22 AM and he reported that he expected any change in condition to be communicated to the physician.	F0580		
F0684 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, physician, and staff interviews, the facility failed to ensure a Resident's abnormal vital signs were reported to the on-coming	F0684	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F684 On 6/23/25, Resident #67 was transferred to the hospital and did not return to the facility. On 8/19/25, the Director of Nursing conducted nursing education with nursing staff, including Nurse #2 and Nurse #3, on expectations for reporting resident change	09/11/2025

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F0684 SS = D	Continued from page 4 shift. This was for 1 of 3 residents reviewed for quality of care (Resident #67). The findings included: Resident #67 was admitted to the facility 5/14/25 with diagnoses including congestive heart failure and diabetes. The admission Minimum Data Set assessment dated 5/17/25 assessed Resident #67 to be cognitively intact. The medical record was reviewed and vital signs for Resident #67 were as followed: 6/22/25 at 7:07 PM temperature 103.1 Fahrenheit (F) (normal 98.6), pulse 137 (normal 60-100), blood pressure 147/135 (normal 120/70). 6/22/25 at 7:40 PM temperature 102.8 F, pulse 124, blood pressure 101/41. 6/22/25 at 8:59 PM temperature 99.1 F, pulse 112, blood pressure 89/39. Review of the nursing schedule for 6/22/25 revealed Nurse #3 was assigned to Resident #67 on 6/22/25 for the 7:00 AM to 7:00 PM shift. A phone interview was conducted with NA #1 on 8/13/25 at 4:20 PM. NA #1 reported she arrived early for her 7:00 PM to 7:00 AM shift on 6/22/25 and she started taking vital signs on her assigned residents. NA #1 reported that when she got the abnormal vital signs on Resident #67, she reported to Nurse #3, and Nurse #3 told her to recheck the vital signs. NA #1 explained that because she told Nurse #3 about the abnormal vital signs, when she rechecked Resident #67's vital signs at 7:40 PM and the vital signs were still abnormal, she did not report to Nurse #2 because she thought Nurse #3 would have reported to Nurse #2 at change of shift. A phone interview was conducted with Nurse #3 on 8/13/25 at 2:47 PM. Nurse #3 reported she worked on 6/22/25, but she did not recall if she was assigned to Resident #67 or anything about Resident #67, nor did she recall NA #1 reporting abnormal vital signs to her. A nursing note dated 6/22/25 at 11:56 PM written by Nurse #2 documented that the nurse was notified by the Nursing Assistant (NA) #1 that Resident #67 had a temperature of 102.8 F, and her blood pressure was low at 7:45 PM. Nurse #2 documented she administered acetaminophen (an analgesic pain medication used to	F0684	Continued from page 4 in condition between nursing shifts. Clinical Supervisor to conduct 100% audit of the 24-hour reports, for the period between 8/18/25 through 8/25/25, validating that follow-up was completed for reports of resident change in condition. One opportunity identified during the audit was addressed with the nurse. Provider was then notified with all concerns resolved. By 9/11/25, the Nurse Educator will provide in-services to nursing staff on the new Interact Abnormal Value labeling system for shift-to-shift reporting of residents with change in condition. Any staff members who do not receive the training by 9/11/25 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 9/15/25, the Clinical Supervisor or designee will audit five 24-hour report entries weekly times 12 weeks, for compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 9/11/25. DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	

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F0684 SS = D	Continued from page 5 reduce fevers) (time not specified, nor dosage) and she checked Resident #67's blood pressure getting a result of 92/44 and a pulse of 103. The nurse documented Resident #67 was sweating profusely but denied pain or discomfort. Resident #67's blood sugar was 201 (normal 70-120). Vital signs were checked after 1 hour and the on-call physician was notified. The on-call physician ordered STAT (immediate) labs to be drawn and intravenous fluids to be given. Labs were returned with elevated white blood cells (34.8; normal 4.5-11). The on-call physician was notified, and he ordered Resident #67 to be sent to the hospital for evaluation. Nurse #2 was interviewed by phone on 8/13/25 at 12:29 PM. Nurse #2 reported she was assigned to Resident #67 from 7:00 PM on 6/22/25 to 7:00 AM on 6/23/25. Nurse #2 reported when she received report from Nurse #3, nothing was said about Resident #67's abnormal vital signs. Nurse #2 reported she started her medication pass and in the middle of it, Nurse #4 came to her to report the family member of Resident #67 had called expressing concern about Resident #67 "not acting like herself." Nurse #2 reported when she was given this information, she looked up vital signs for Resident #67 and discovered that Resident #67 had an abnormal temperature, pulse, and blood pressure. Nurse #2 reported she checked the vital signs for Resident #67 again at 8:59 PM and called the on-call provider with report. An interview was conducted by phone with Nurse #4 on 8/13/25 at 4:05 PM. Nurse #4 reported she had answered a phone call from Resident #67's family member and the family member had expressed concern that Resident #67 was "not acting like herself." Nurse #4 explained she went to Nurse #2 and told her about the phone call and that's when Nurse #2 reviewed the charting for Resident #67 and discovered the abnormal vital signs. Nurse #4 reported Nurse #3 should have reported to Nurse #2 the abnormal vital signs at the change of shift. Nurse #4 reported the on-call provider was called about 9:00 PM with report and orders were received. The Physician was interviewed on 8/14/25 at 11:57 AM. The Physician conveyed the off going shift should have reported to the oncoming shift the abnormal vital signs, but the delay in care of about 2 hours had not adversely affected Resident #67. Review of the hospital records for Resident #67 revealed she was admitted with a urinary tract infection and sepsis on 6/22/25. Lab work for Resident #67 included a complete blood count, with white blood cells of 32.24 (normal 3.6-11.7), red blood cells 2.87	F0684		

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F0684 SS = D	Continued from page 6 (normal 3.72-5.24), and a blood culture result positive for pseudomonas aeruginosa (a bacteria that causes infection). A urinalysis collected on 6/23/25 resulted that Resident #67 had 100 proteins in her urine (normal is none), 0.5 blood in her urine (normal is none), and many white blood cell clumps, as well as bacteria. The hospital note documented that the source of infection was Resident #67's urine. Two different antibiotics were started, as well as intravenous fluids. Resident #67 was admitted to the hospital 6/22/25 and discharged on 7/1/25 to another facility. During an interview with the Director of Nursing (DON) on 8/13/25 at 4:35 PM, she reported she was notified on 6/23/25 the oncoming night shift had not received a report of the change in condition on Resident #67 from the off-going shift. The DON reported she provided education to the nursing staff about reporting resident changes in condition but had not implemented a corrective action plan. The Administrator was interviewed on 8/14/25 at 11:22 AM and he reported that he expected any change in condition to be communicated between the nursing shifts.	F0684		