STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. Building B. Wing	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Nash	7369 Hunter Hill Road Rocky Mount, NC 27804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on observation, record review and staff interviews, the facility failed to assess a resident for self-administration of medication for 1 of 1 resident (Resident #47) reviewed for self-administration of medication. The findings included: Resident #47 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease. The resident ' s care plan dated 1/16/23 did not include the self-administration of medication. There was not an assessment for Resident #47 in the medical record to determine if it was safe for the resident to self -administer medication. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively intact. On 3/26/23 at 11:13 AM Resident #47 was observed lying on the bed with a cup containing 7 tablets sitting on the bedside table. Resident #47 was resting on the bed with his eyes closed. An interview was conducted with Medication Aide #1 on 3/26/23 at 11:15 AM. Medication Aide #1 stated she had left Resident #47 ' s medication at the bedside because he was not awake. The Medication Aide stated she had been told by other staff she could leave Resident #47 ' s medication at the bedside and he would take it when he woke up. Further interview with Medication Aide #1 revealed that she had been educated not to leave resident ' s medication at the bedside. During an interview with the Director of Nursing on 3/28/23 at 3:44 PM. The DON stated the Medication Aide should have made sure Resident #47 took his medication or attempted to offer the medication at a later time. The DON stated medication should never be left at a resident ' s bedside.

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

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20710 Based on record review and staff interviews, the facility failed to provide written notification for reason of discharge to hospital to the Resident and/or Responsible Party (RP) for 6 of 6 residents reviewed for hospitalization (Resident #69, Resident #82, Resident #3, Resident #96, Resident #74, and Resident #46). The findings included: 1. Resident #69 was admitted to the facility on [DATE]. The admission Minimum Data Set, dated dated dated [DATE] revealed Resident #69 was cognitively intact. Review of Resident # 69's medical record revealed hospital stays from 1/17/23 through 1/21/23 and 2/5/23 through 2/9/23. No written notice of transfer was documented to have been provided to the resident or her responsible party. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Resident Party (RP). The DON stated the bed hold and transfer/discharge to hospital form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 2. Resident #82 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident # 82 was severely cognitively impaired. Review of Resident #82's medical record revealed she was transferred to the hospital on 11/24/22 through 11/28/22. No written notice of transfer was documented to have been provided to the resident or her responsible party. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold and transfer/discharge to hospital form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 41772 3. Resident #3 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	A Health Status Note dated 9/3/22 revealed Resident #3 was transferred to the emergency department for further evaluation. The medical record indicated Resident #3 was discharged to the hospital on 9/3/22 and returned to the facility on [DATE]. Review of the medical record revealed no evidence that Resident #3 and his Responsible Party received written notification of the reason for transfer to the hospital. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 4. Resident #96 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 had severe cognitive impairment. A Health Status Note dated 1/24/23 revealed Resident #96 was sent to the emergency department for further evaluation. The medical record indicated Resident #96 was discharged to the hospital on 1/24/23 and he returned to the facility on [DATE]. Review of the medical record revealed Resident #96 revealed no evidence the Responsible Party received written notification of the reason for transfer to the hospital. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 45045 5. Resident # 74 was admitted to the facility on [DATE]. A Nursing Progress Note dated 2/5/23 revealed Resident #74 was sent to the emergency department for further evaluation. The medical record revealed Resident #74 was discharged to the hospital on 2/05/23 and returned to the facility on [DATE]. Review of the medical record revealed no evidence that Resident #74 and/or his Responsible Party (RP) received written notification of the reason for transfer to hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP. 6. Resident #46 was admitted to the facility on [DATE]. A Nursing Progress Note dated 1/20/23 revealed Resident #46 was sent to the emergency department for further evaluation. The medical record revealed Resident #46 was discharged to the hospital on 1/0/23 and returned to the facility on [DATE]. Review of the medical record revealed no evidence that Resident #46 and/or his Responsible Party (RP) received written notification of the reason for transfer to the hospital. During an interview with the Director of Nursing on 3/28/23 at 11:49 AM, she stated when a resident was sent out to the hospital the facility notified the physician and Responsible Party (RP). The DON stated the bed hold policy and discharge/transfer form were sent to the hospital with the resident. She stated that the facility notified the RP by phone but there was no written notification sent to the resident or RP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for 2 of 27 residents whose MDS was reviewed (Resident #67 and Resident #107). Findings included: 1. Resident #67 was admitted to the facility on [DATE] with diagnoses which included stroke and dysphagia (difficulty swallowing). The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #67 was coded as comatose, and he required oxygen, suctioning, and tracheostomy (surgical airway to assist with breathing) care. Resident #67's cognition was not assessed related to him being rarely/never understood. An observation on 3/26/23 at 2:00 pm revealed Resident #67 was awake and alert, did not have oxygen in use, and did not have a tracheostomy. An interview on 3/26/23 at 2:30 pm Nurse #2 revealed Resident #67 was awake and alert with periods of confusion but was able to make his needs known. She stated he did not have a tracheostomy, use oxygen, or require suctioning. Nurse #2 stated she reviewed Resident #67's previous physician orders and documentation and confirmed he was awake and alert since admission and never had a tracheostomy, he never required suctioning, and had not been on oxygen. During an interview on 3/27/23 at 2:53 pm the MDS Nurse reviewed Resident #67's health record and confirmed Resident #67 was not comatose, he did not have a tracheostomy or require oxygen and suctioning. The MDS Nurse stated she coded Resident #67 in error. An interview was conducted on 3/29/23 at 11:26 am with the Director of Nursing (DON) who revealed Resident #67 was never comatose, he never had a tracheostomy, and he did not require suctioning. The DON stated the MDS Nurse was responsible to complete an accurate assessment for Resident #67 based on observation and record review. 2. Resident #107 was admitted to the facility on [DATE] with an unstageable pressure ulcer injury to his sacrum. The Skin/Wound/Treatment note dated 1/25/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum. A physician order dated 1/25/23 for sacrum cleanse with wound cleaner, apply silver alginate (wound treatment) and cover with folded pad secured with tape every evening shift and as needed for unstageable pressure ulcer. The Minimum Data Set (MDS) 5-day admission assessment dated [DATE] revealed Resident #107 had an unstageable pressure ulcer injury which was present upon admission to the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The Weekly Wound Observation Tool dated 2/01/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum. A nursing progress note dated 2/01/23 revealed Resident #107 was sent to the hospital for hematuria (blood in urine) and was admitted . a. The MDS discharge return anticipated assessment dated [DATE] revealed Resident #107 did not have an unstageable pressure ulcer injury. The Skin/Wound/Treatment note dated 2/07/23 revealed Resident #107 returned to the facility and had an unstageable pressure ulcer injury to his sacrum/left buttock. b. The MDS 5-day admission assessment dated [DATE] revealed Resident #107 did not have an unstageable pressure injury. The Weekly Wound Observation Tool dated 2/17/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock. The Weekly Wound Observation Tool dated 2/23/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock. The Skin/Wound/Treatment note dated 2/28/23 revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum/left buttock. A Physician Progress note dated 3/02/23 revealed Resident #107 was sent to the hospital for declining respiratory status and sacral pressure ulcer infection and was admitted . c. The MDS discharge return anticipated assessment dated [DATE] revealed Resident #107 did not have an unstageable pressure ulcer injury. During an interview on 3/27/23 at 3:00 pm the MDS Nurse revealed she completed the wound section based on the weekly wound report provided by the Wound Nurse. The MDS Nurse confirmed Resident #107 had an unstageable pressure ulcer injury on 2/01/23, 2/13/23, and 3/02/23 when she completed the assessments based on the weekly wound report. The MDS Nurse stated she must have just missed it and coded Resident #107 incorrectly regarding his unstageable pressure ulcer injury. An interview was conducted on 3/28/23 at 9:54 am with the Wound Nurse who revealed Resident #107 had an unstageable pressure ulcer injury to his sacrum when he admitted to the facility and received treatment daily. The Wound Nurse stated she provided the MDS Nurse with a weekly wound report and Resident #107 was included on the weekly wound report. During an interview on 3/29/23 at 11:26 am the Director of Nursing (DON) revealed the MDS Nurse was responsible to ensure the assessments were accurate for Resident #107. The DON stated the MDS Nurse was to physically see each resident to confirm the assessment was accurate and if any question regarding the resident status she was able to ask questions before submitting the assessments for Resident #107.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45044 Based on record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan that addressed Hospice services for 2 of 2 sampled residents reviewed for Hospice services (Resident #102 and Resident #56). Findings included: 1. Resident #102 was admitted to the facility on [DATE]. A review of Resident #102's medical record revealed the Resident's family signed the consent for hospice services to begin on 12/19/22. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #102 was coded as receiving Hospice services. A review of the Resident #102's comprehensive care plan most recently reviewed on 3/27/23 revealed no identification or incorporation of Hospice services. An interview was completed on 3/29/23 at 8:40am with the MDS Coordinator. She confirmed Resident #102 was receiving hospice services. The comprehensive care plan was reviewed with the MDS Coordinator, and she confirmed there was no inclusion of the Resident's hospice services in her care plan. The MDS Coordinator stated hospice services should have been included in Resident #102's comprehensive care plan. An interview was completed on 3/29/23 at 12:22pm with the Director of Nursing (DON). The DON indicated Resident #102's comprehensive care plan included a terminal illness care plan, and it should have been customized to include hospice services. 41772 2.Resident #56 was admitted to the facility on [DATE]. A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was admitted to Hospice care. A review of Resident #56's comprehensive care plan last reviewed 3/10/23 did not reveal a care plan related to Hospice services. During an interview with MDS Coordinator on 3/29/23 at 9:40 AM she confirmed Resident #56 was receiving hospice services. A review of the comprehensive care plan with the MDS Coordinator revealed there were no hospice services included in Resident #56's care plan. The MDS Coordinator stated hospice care should have been included in the Resident's care plan. (continued on next page)

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 3/29/23 at 1:30 PM. The DON stated Resident #56's comprehensive care plan should have included a hospice care plan. She further stated the care plan should have been customized to include hospice services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations, record review, staff interviews, and Nurse Practitioner interview, the facility failed to obtain physician orders for supplemental oxygen (Resident #74) and tracheostomy care and suctioning (Resident #82) for 2 of 5 residents reviewed for respiratory care. Findings included: 1. Resident #74 was readmitted to the facility on [DATE] and had cumulative diagnoses which included asthma, low blood oxygen, and stroke. Record review of the hospital discharge record dated 2/13/23 revealed Resident #74 was diagnosed with COVID-19, acute hypoxic (low blood oxygen) failure, and he did not have an order for supplemental oxygen upon discharge. The care plan dated 2/15/23 revealed Resident #74 had a care plan for oxygen therapy related to respiratory illness with intervention to provide oxygen 2 L via nasal canula (NC) continuous humidified. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #74 had severe cognitive impairment and was coded for oxygen use. Observations on 3/26/23 at 10:51 am and 3/27/23 at 1:51 pm revealed Resident #74 had oxygen at 3 L via NC in use. A record review conducted on 3/27/23 of the physician orders revealed no order for supplemental oxygen use for Resident #74. During an interview on 3/27/23 at 2:50 pm Nurse #2 confirmed Resident #74 had oxygen at 3 LNC in place. She stated a physician order was required for Resident #74's oxygen but she was unable to find the order. Nurse #2 was unable to state why the order for Resident #74's supplemental oxygen was not in place. An interview was conducted on 3/29/23 at 9:20 am with Nurse #3, who was assigned to Resident #74 upon return from hospital, revealed she completed Resident #74's readmission and was given in report from the transportation staff that Resident #74 was on oxygen at 2L via NC. She stated she was unable to state why the order for supplemental oxygen for Resident #74 was not entered but stated the oxygen did require a physician order. During an interview on 3/28/23 at 12:30 pm the Nurse Practitioner (NP) revealed she was not aware Resident #74 was on supplemental oxygen, but she stated a physician order was required. An interview was conducted on 3/29/23 at 11:29 am with the Director of Nursing (DON) who revealed the supplemental oxygen for Resident #74 required a physician order. The DON stated Resident #74's supplemental oxygen order was just missed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20710 2. Resident #82 was readmitted on [DATE] with diagnoses that included chronic respiratory failure, coronary artery disease, and tracheostomy status. Review of the quarterly Minimum Data Set completed on 12/5/22 revealed Resident # 82 was severely cognitively impaired. The MDS coded the resident as receiving oxygen use, suctioning and tracheostomy care. The care plan dated 5/27/20 and updated on 10/8/22 revealed Resident #82 had a care plan for tracheostomy care related to respiratory illness with intervention to provide suctioning and change tracheostomy inner cannula every day. Record review of the physician orders dated 6/22/22 revealed Resident #82 had an order to suction the tracheostomy every shift for respiratory distress/ increased secretion. The order was discontinued on 11/25/22. Record review of the physician orders revealed an order dated 8/24/22. Review of the order revealed Resident #82 had an order to change tracheostomy inner cannula every day every evening shift. The order was discontinued on 11/25/22. A record review conducted on 3/28/23 of the physician orders revealed no order for suctioning tracheostomy for Resident #82. A record review conducted on 3/28/23 of the physician orders revealed no order for provide trach care for Resident #82. An interview was conducted on 3/29/23 at 11:02 AM with the Director of Nursing (DON) who revealed the Nurse managers would read over the physician orders and treatments from the Discharge Summary orders and put the orders into the record. She revealed if there were no physician orders the nurse manager should call the physician or hospital to get their discharge orders. She indicated Resident #82 should have orders for tracheostomy care and suctioning.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 20710 Based on observations and staff interviews, the facility failed to maintain the area surrounding the grease bin free of grease buildup and debris. This included 1 of 1 grease bin observed. The findings included. During an observation of the dumpster area on 3/27/23 at 9:45 AM the grease bin was observed. The 4 foot lip of the grease bin was observed with grease dripping down and the ground was soiled with thick black layers of grease buildup. On 3/28/23 at 3:37 PM an observation was conducted with the Dietary Manager and the grease bin was observed to be in the same condition. An interview was conducted with the District Dietary Manger on 3/28/23 at 4:11 PM. She revealed the maintenance director had removed the grease and would pressure wash the area. In an interview on 3/29/23 at 9:08 AM, the Maintenance Director indicated he had noticed the grease bin and planned to contact the company to replace it. He revealed he had shoveled up the grease, power washing was unable to clean the stain off the cement pad and he would find a compatible chemical to clean the area. An interview was conducted with the Interim Administrator on 3/28/23 at 4:24 PM. He revealed they would get the area cleaned up.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45044 Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 1/14/22 complaint and recertification survey. This was for a recited deficiency on the current recertification survey in the area of respiratory/tracheostomy care and suctioning and dispose garbage and refuse properly. The continued failure during two federal surveys shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F814 Based on observations and staff interviews, the facility failed to maintain the area surrounding the grease bin free of grease buildup and debris. This included 1 of 1 grease bin observed. During the recertification and complaint survey on 1/14/22 the facility was cited for failure to maintain the area around the dumpster free of debris. F695 Based on observations, record review, staff interviews, and Nurse Practitioner interview, the facility failed to obtain physician orders for supplemental oxygen (Resident #74) and tracheostomy care and suctioning (Resident #82) for 2 of 5 residents reviewed for respiratory care. During the recertification and complaint survey on 1/14/22 the facility was cited for failure to obtain a Physician's order for use of supplemental oxygen. An interview was completed on 3/29/23 at 1:45pm with the Director of Nursing (DON) and Administrator. The DON indicated the QAA committee meets monthly to discuss the facility's ongoing performance improvement plans. The DON revealed there were no ongoing performance improvement plans regarding respiratory care or maintaining the cleanliness of the area surrounding the dumpster. The DON and Administrator stated it was their expectation that the facility identify deficient practice and create performance improvement plans to correct the deficient practice.