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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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). 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 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 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 (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