

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Carolina Care Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Harrelson Street Cherryville, NC 28021	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142</p> <p>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).</p> <p>Findings included:</p> <p>Resident #62 was admitted to the facility on [DATE].</p> <p>Review of Resident #62's electronic medical record revealed a Medical Orders for Scope of Treatment (MOST) form dated [DATE] that indicated her preference for Cardiopulmonary Resuscitation (CPR) to be attempted in the event she had no pulse and was not breathing.</p> <p>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 [DATE] 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.</p> <p>Further review of Resident #62's electronic medical record revealed a progress note written by the Social Worker dated [DATE] 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.</p> <p>Review of Resident #62's electronic medical record revealed the following care conference notes from Resident #62's care plan meetings:</p> <p>A note dated [DATE] that read in part: advanced directives discussed and no changes at this time.</p> <p>A note dated [DATE] read in part: Social went over advanced directives and wants resident to remain a Full code.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A note dated [DATE] read in part: Social went over advanced directives and wants resident to remain a Full code.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #62 was cognitively intact.</p> <p>During an interview on [DATE] at 10:20 am 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.</p> <p>During an interview on [DATE] 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.</p> <p>During an interview on [DATE] 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 [DATE] was not in the electronic medical record.</p> <p>During an interview on [DATE] at 1:27 pm, the Director of Nursing (DON) stated on admission the Nurse Practitioner or nurse fills out 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.</p> <p>During an interview [DATE] 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.</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006</p> <p>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).</p> <p>The findings included:</p> <p>1. Resident #6 was admitted to the facility on [DATE].</p> <p>Review of Resident #6's facility face sheet dated 12/09/2024 revealed Resident #6 was her own responsible party.</p> <p>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.</p> <p>Review of Resident #6's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the discharge was coded as an unplanned discharge to hospital with return anticipated.</p> <p>Review of Resident #6's electronic medical record revealed no written notification was given to Resident #6 of her transfer to the hospital.</p> <p>Resident #6 returned to the facility on [DATE].</p> <p>An interview was conducted with Resident #6 on 02/27/2025 at 8:10 AM. Resident #6 stated she did not receive any notification in writing prior to being transferred to the hospital in December 2024.</p> <p>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.</p> <p>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.</p> <p>45380</p> <p>2. Resident #55 was admitted to the facility on [DATE].</p> <p>Review of Resident #55's facility face sheet dated 6/30/23 revealed Resident #55 had a designated responsible party (RP).</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Review of Resident #55's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the discharge was coded as an unplanned discharge to hospital with return anticipated.</p> <p>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.</p> <p>Resident #55 returned to the facility on [DATE].</p> <p>Attempted to contact Resident #55's RP and was unable to be reached.</p> <p>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.</p> <p>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.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380</p> <p>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.</p> <p>The findings include:</p> <p>Review of Resident #40's medical record revealed the resident was admitted to the facility on [DATE] 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 [DATE]. No PASRR level II was completed.</p> <p>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 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.</p> <p>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.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217</p> <p>Based on observations, record review, and staff interviews, the facility failed to provide toenail care to 1 of 2 residents (Resident #82) who were dependent on staff for assistance with activities of daily living (ADL).</p> <p>Findings included:</p> <p>Resident #82 was admitted on [DATE] with diagnoses that included muscle wasting and atrophy.</p> <p>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.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] 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.</p> <p>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.</p> <p>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 (mm) beyond the tip of his toes. The right big toenail was cracked with sharp edges and brownish substances were visible underneath this toenail.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>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.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142</p> <p>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).</p> <p>The findings included:</p> <p>Resident #83 was admitted to the facility on [DATE] with diagnoses that included Metabolic encephalopathy, cognitive communication deficit, unspecified dementia, and anxiety disorder.</p> <p>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.</p> <p>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.</p> <p>12/14/2024- 1 dose</p> <p>12/30/2024- 1 dose</p> <p>1/3/2025- 1 dose</p> <p>1/6/2025- 1 dose</p> <p>1/14/2025- 1 dose</p> <p>1/15/2025- 1 dose</p> <p>1/23/2025- 1 dose</p> <p>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 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.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142</p> <p>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).</p> <p>The findings included:</p> <p>Resident #83 was admitted to the facility on [DATE] with diagnoses that included Metabolic encephalopathy, cognitive communication deficit, unspecified dementia, and anxiety disorder.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #83 with severe cognitive impairment and indicated she had received antianxiety medications in the 7-day assessment period.</p> <p>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 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.</p> <p>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.</p> <p>12/14/2024- 1 dose</p> <p>12/30/2024- 1 dose</p> <p>1/3/2025- 1 dose</p> <p>1/6/2025- 1 dose</p> <p>1/14/2025- 1 dose</p> <p>1/15/2025- 1 dose</p> <p>1/23/2025- 1 dose</p> <p>On 02/24/25 at 11:49 AM an attempt to interview Resident #83 was unsuccessful. She was unable to engage in the interview.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>During an interview conducted on 02/27/25 at 09:48 AM, the Nurse Practitioner (NP) stated that 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		