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	10/24/2024

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45044 Based on record review, and resident and staff interviews the facility failed to provide written advance directive information and/or an opportunity to formulate an advance directive for 10 of 33 residents reviewed for advance directives (Residents #2, #14, #22, #42, #45, #49, #72, #80, #109, and #427). The findings included: a. Review of Resident #2's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive pulmonary disease, and a history of a stroke. The review revealed a full code Physician order dated 8/23/24. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. b. Review of Resident #14's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included diabetes, heart failure, and kidney failure. The review revealed a full code Physician order dated 10/18/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. c. Review of Resident #22's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and chronic obstructive pulmonary disease. The review revealed a do not resuscitate Physician order dated 7/10/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. d. Review of Resident #42's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included a history of a stroke and diabetes. The review revealed a do not resuscitate Physician order dated 8/24/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Review of Resident #45's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included a history of a stroke, heart failure, and diabetes. The review revealed a full code Physician order dated 7/26/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. f. Review of Resident #49's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included high blood pressure and seizure disorder. The review revealed a do not resuscitate Physician order dated 10/4/24. The was no documentation in the record for education regarding a formulation of an advance directive and/or the opportunity to formulate an advance directive was offered. g. Review of Resident #72's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and diabetes. The review revealed a do not resuscitate Physician order dated 1/17/22. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. h. Review of Resident #80's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease, diabetes, and a history of a stroke. The review revealed a full code Physician order dated 4/12/23. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. i. Review of Resident #109's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and diabetes. The review revealed a do not resuscitate Physician order dated 7/1/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. j. Review of Resident #427's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included heart disease and kidney failure. The review revealed a do not resuscitate Physician order dated 10/9/24. There was no documentation in the record for education regarding the formulation of an advance directive and/or the opportunity to formulate an advance directive was offered. An interview was completed on 10/22/24 at 1:30pm with the facility's Administrator. She revealed at this time the facility only discussed the resident's code status with the resident and/or their responsible party. An interview was completed on 10/23/24 at 11:37am with the facility's Admission's Director. The Admission's Director stated she only discussed code status with the resident and/or their responsible party. An interview was completed on 10/23/24 at 12:07pm with the facility's Social Worker. The Social Worker stated she only reviewed the resident's code status with the resident and/or responsible party. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up interview was completed on 10/24/24 at 11:41am with the facility's Administrator. The Administrator stated the Social Worker was new to the position. She stated the Social Worker was unaware of the requirement for providing education regarding the formulation of an advance directive, not just regarding a resident's code status.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations and staff interviews, the facility failed to maintain a clean and sanitary homelike environment as evidenced by dried substance on the top and front of an oxygen concentrator and dried enteral feeding on the floor for 1 of 4 rooms reviewed for environment (room [ROOM NUMBER]). The findings included: An observation was conducted on 10/21/24 at 11:02 am in room [ROOM NUMBER] the oxygen concentrator was observed to have a dried beige substance on the top and multiple dried lines down the front of the concentrator. The floor had multiple round, dime sized, brown hardened substance on the floor near the feeding tube pole and resident bed. Observations of room [ROOM NUMBER] conducted on 10/22/24 at 1:59 pm and 10/23/24 at 9:38 am revealed the oxygen concentrator was observed to have multiple dried, beige, substance on the top and dried in lines down the front of the concentrator. The floor had multiple round in shape, dime sized, brown hardened substance on the floor near the feeding tube pole and resident bed. An observation and interview were conducted with the Housekeeping Manager on 10/23/24 at 11:22 am. The Housekeeping Manager revealed that all resident rooms were cleaned daily using the 5 and 7 step method which included sweeping, mopping, wiping outer surfaces of furniture and equipment used such as the concentrator and wheelchair. The Housekeeping Manager confirmed the oxygen concentrator was something that should have been wiped down daily by the housekeeping staff and the floor where the dried enteral feeding was observed was to be mopped every day. The Housekeeping Manager stated he did random checks of resident rooms to ensure the cleaning was being completed, but he had not checked room [ROOM NUMBER] to ensure it was done properly. During an interview on 10/23/24 at 11:39 am with Housekeeper #1 who confirmed she was assigned to room [ROOM NUMBER] on 10/20/24, 10/22/24, and 10/23/24. Housekeeper #1 stated she cleaned room [ROOM NUMBER] on 10/20/24 but was unable to get the dried substance off the floor in the room, but she did not see the concentrator was dirty. She stated she did not notify the manager regarding room [ROOM NUMBER]'s floor, but she stated she should have reported that she was unable to get the floor clean. Housekeeper #1 stated she went into room [ROOM NUMBER] on 10/22/24 to clean but did not clean the room because the nurses were doing something with the tube feeding. She stated she should have gone back to room [ROOM NUMBER] to clean later but she never went back. Housekeeper #1 stated she told the resident when she went in the room today (10/23/24) that she would be back later to clean the room but had not been to room [ROOM NUMBER] to clean yet. An interview was conducted on 10/24/24 at 12:10 pm with the Interim Administrator who stated resident rooms were to be cleaned daily.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45045 Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of a resident transfer for 2 of 5 residents reviewed for hospitalization (Resident #2 and Resident #42). The findings included: 1a. Resident #2 was admitted to the facility on [DATE]. The nursing progress note dated 7/02/24 at 3:00 pm revealed Resident #2 was transferred to the hospital for evaluation of change in mental status. Resident #2 was discharged from the facility on 7/02/24 and returned to the facility on [DATE]. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #2's 7/02/24 transfer to the hospital on 10/23/24. b. The nursing progress note dated 8/12/24 at 3:38 pm revealed Resident #2 was transferred to the hospital for evaluation of altered mental status. Resident #2 was discharged from the facility on 8/12/24 and returned to the facility on [DATE]. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #2's 8/12/24 transfer to the hospital on 10/23/24. 2a. Resident #42 was admitted to the facility on [DATE]. The nursing progress note dated 7/21/24 at 9:00 am revealed Resident #42 was transferred to the hospital for evaluation. Resident #42 was discharged from the facility on 7/21/24 and returned to the facility on [DATE]. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #42's 7/21/24 transfer to the hospital on 10/23/24. b. The physician progress note dated 8/20/24 revealed Resident #42 was transferred to the hospital for further evaluation. Resident #42 was discharged from the facility on 8/20/24 and returned to the facility on [DATE]. Record review of the Ombudsman Discharge and Transfer report provided by the facility revealed the Ombudsman was notified of Resident #42's 8/20/24 transfer to the hospital on 10/23/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 10/23/24 at 03:29 pm with the Ombudsman who revealed she had not received written notification of hospitalization discharges for the last 6 months. An interview was conducted with Social Worker #1 on 10/23/24 at 3:49 pm who revealed she started working at the facility in April 2024 and she was educated at that time to send the transfers and discharges to the Ombudsman. Social Worker #1 stated she had not sent any discharge and transfer information to the Ombudsman since she started at the facility because she forgot the information was to be sent monthly. Social Worker #1 reported it was her fault that she had not sent the information to the Ombudsman prior to today (10/23/24). During an interview on 10/24/23 at 10:24 am with the Interim Administrator she revealed she was not sure why Social Worker #1 had not sent any information to the Ombudsman. The Interim Administrator stated Social Worker #1 was educated upon hire, but she felt Social Worker #1 just forgot to send the lists to the Ombudsman monthly.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on observation, record reviews, staff interviews, the facility failed to ensure there was a physician's order in place for the size of an indwelling urinary catheter and frequency to change the indwelling urinary catheter for 1 of 1 resident reviewed for catheters (Resident #49). The findings included: Resident #49 was admitted to the facility on [DATE] with diagnoses that included disorder of kidney and ureter. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident had severe cognitive impairment with no behaviors present. He was coded as dependent on staff for toileting and had an indwelling urinary catheter. A review of a care plan dated 10/5/24 revealed Resident #49 was care planned for an indwelling urinary catheter. The goal was for Resident #49 to be/remain free from catheter-related trauma and have no signs and symptoms of urinary tract infection through review date. The interventions included monitor and document sign and symptoms of infection. Review of a physician's order revealed an order dated 10/7/24 for a size 20 French (FR) urinary indwelling catheter. Review of a physician progress note dated 10/8/24 revealed Resident #49 had a chronic catheter and was admitted to the hospital for possible infection. Review of a health status note dated 10/17/24 revealed Resident #49 was out to a urology appointment and returned with no new orders. A review of the consultation progress notes for urology dated 10/17/24 revealed an order to change 16 FR indwelling urinary catheter every month and call office with issues. A review of the electronic health record revealed no order in place for 16 FR indwelling urinary catheter change every month. An observation was conducted of Resident #49 with Nurse Aide #4 on 10/23/24 at 09:45 AM. Resident #49 had a 16 French indwelling urinary catheter that was connected to a urinary drainage bag. An interview was conducted with Unit Manager #2 on 10/23/24 at 03:39 PM. She stated Medical Records was out during the week of October 17th. The Unit Manager stated she was responsible for taking off the orders. She reported that Medical Records Clerk normally scanned in the information from consults and would either call on the phone to let her know to review or she would bring her a stack of consults for her to review. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Medical Records Clerk on 10/23/24 at 3: 48 PM. She stated she reviewed the information from consults when a resident returned for an appointment. The Medical Record Clerk stated she scanned the consults into the electronic medical records then gave the hard copy of the consult to the unit manager. An interview was conducted on 10/23/24 at 3:59 PM. The Interim Administrator verified the medical records clerk scanned the consults into the system. The Administrator stated the unit managers were responsible for entering the orders into the electronic medical record when the residents returned from appointments.

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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, and staff, resident, Respiratory Therapist, and Nurse Practitioner interviews, the facility failed to obtain a physician order for liters of oxygen and the fraction of inspired oxygen (FiO2) for a resident with a tracheostomy for 1 of 1 resident reviewed for respiratory care (Resident #112). The findings included: Review of the hospital speech therapy consultation provided by the facility dated 9/05/24 revealed Resident #112 had a tracheostomy (a surgical opening through the front of the neck into the windpipe for an air passage to help breathe) and was on a trach collar (a soft plastic mask that fits over the tracheostomy) with 5 liters of oxygen with 28% FiO2 (percentage of oxygen in the air that a person inhales). Review of the hospital discharge summary dated 9/08/24 revealed no orders were noted for Resident #112's oxygen or FiO2 settings. Resident #112 was readmitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypercapnia (carbon dioxide retention), pneumonia, and tracheostomy. Review of the nursing progress note dated 9/08/24 at 11:08 am by Nurse #3 revealed Resident #112 was scheduled to return to the facility from the hospital in the afternoon. Nurse #3 further noted that Resident #112 had a tracheostomy and would be returning to the facility on 5 liters of oxygen at 28% FiO2. An attempt to interview Nurse #3 on 10/24/24 at 12:30 pm was unsuccessful. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #112 had clear speech and was cognitively intact. Resident #112 was coded for oxygen therapy, suctioning, and tracheostomy. The care plan dated 9/21/23 and last reviewed on 10/03/24 revealed Resident #112 had a care plan in place for tracheostomy related to impaired breathing mechanics with an intervention of oxygen settings via trach at 5 liters continuous with 28% humidity. A record review conducted on 10/21/24 of the physician orders revealed no orders for oxygen or FiO2 settings for Resident #112's tracheostomy. An observation and interview conducted with Resident #112 on 10/21/24 at 10:45 am revealed Resident #112's oxygen concentrator (a machine that gives extra oxygen) was set to 5 liters and the compressor's (machine that pushes air through a bottle of water to pick up moisture) FiO2 was set to 35%. The oxygen tubing was noted to be connected to the concentrator water humidification bottle which was connected to the tracheostomy tubing and Resident#112's trach collar. Resident #112 was observed in bed with no respiratory distress noted. Resident #112 stated she had the tracheostomy for about one year and had just been in the hospital. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 2:01 pm with Medication Aide #1 she revealed she was assigned to Resident #112's hall but she was not able to do the respiratory care since she was not a nurse. Medication Aide #1 stated Unit Manager #2 was responsible for Resident #112's care due to the tracheostomy. An observation of Resident #112's room with Unit Manager #2 was conducted on 10/22/24 at 2:07 pm. Resident #112 was noted to be in bed with the trach collar in place. Unit Manager #2 confirmed Resident #112's oxygen was set to 5 liters and the FiO2 was set to 35%. An interview with Unit Manager #2 was conducted on 10/22/24 at 2:18 pm. Unit Manager #2 revealed Resident #112's settings for the oxygen at 5 liters and 35% FiO2 were her normal settings since returning from the hospital, and the physician order should be in the computer. Unit Manager #2 confirmed no physician orders were in place for Resident #112's 5 liters of oxygen or 35% FiO2 for the tracheostomy. She stated she recalled being told in report from the hospital that Resident #112 was coming back to the facility with 5 liters of oxygen and the FiO2 was at 35% but she would have to look for the discharge information to review and confirm. Unit Manager #2 stated she was responsible for entering Resident #112's physician orders and was unable to state why the oxygen and FiO2 orders were not put back in place when Resident #112 returned to the facility from the hospital. An interview was conducted on 10/24/24 at 9:27 am with the Nurse Practitioner (NP) who revealed the provider did not determine the settings required for Resident #112's tracheostomy. The NP stated it was the facility's standard practice to obtain Resident #112's tracheostomy oxygen and FiO2 settings when she returned to the facility and once obtained the provider would confirm and sign the order. A telephone interview was conducted on 10/24/24 at 9:52 am with the Respiratory Therapist (RT) who revealed she last saw Resident #112 on 10/09/24 for a tracheostomy change only and she did not review any orders at that time. The RT stated Resident #112's settings would normally come from the hospital discharge record or if needed she could provide. The RT stated she was fine with the setting of 35% for the FiO2 for Resident #112 because the FiO2 setting was for humidification purpose only. The RT stated when a trach collar was used for Resident #112's tracheostomy, the oxygen order and FiO2 settings were needed. An interview was conducted with the previous Director of Nursing (DON) on 10/24/24 at 9:06 am who revealed Resident #112's oxygen and FiO2 settings would have been received by the hospital or given in report from the hospital. The previous DON stated Unit Manager #2 was responsible to obtain Resident #112's orders and confirm the orders with the NP. The previous DON stated admission orders were reviewed during the clinical meetings, and she stated the missed orders for Resident #112's oxygen and FiO2 settings should have been identified when reviewed during the clinical meeting. The previous DON was unable to state how the orders for Resident #112 were missed for so long.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41772 Based on observation, staff interviews, the facility failed to dispose/discard expired medications in 2 of 4 medication carts (200 Hall, 700 Hall medication cart) observed for medication storage. The findings included: 1a. An observation was conducted of the 700 Hall medication cart on 10/22/24 at 11:43 AM. One opened bottle of Simethicone 80 milligrams (mg) had an expiration date of July 2024. An interview was conducted with Medication Aide #2. Mediation Aide #2 stated the medication should have been discarded. Medication Aide #2 stated the medication aide/nurse assigned to the cart was responsible for checking for expired medications each shift. 1b. An observation of the 200 Hall medication cart on 10/22/24 at 11:43 AM revealed an open bottle of Moxifloxacin 0.5% eye drops with a prescription filled date of 9/20/24 and had an open date of 9/20/24. The bottle was labeled by the pharmacy: Administer 3 drops to right eye 3 times a day for 3 days. The manufacturer's package insert indicated any unused ophthalmic moxifloxacin should be discarded 30 days after you first opened the bottle to avoid getting another eye infection. The moxifloxacin medication was outdated and not discarded from the medication cart. An interview was conducted with Medication Aide # 3. Medication Aide #3 stated the medication should have been discarded once the resident completed the doses. Medication Aide #3 stated the medication aide/nurse assigned to the cart was responsible for checking for expired medications each shift An interview was conducted with the Interim Director of Nursing and Interim Administrator on 10/22/24 at 3:28 PM. The interim Administrator stated the medication aides and nurses assigned to the medication cart were responsible for checking carts for expired medication. The Administrator stated expired medications were to be removed from the cart immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45789 Based on record review and staff interviews, the facility failed to sign off documentation for physician orders of cleansing area to right ankle and applying Calcium Alginate and Cleanse left lateral ankle and apply Santyl ointment daily, in the Treatment Administration Records (TAR) for 1 of 2 reviewed residents for treatment (Resident #94). Resident #94's TAR had blanks where staff were to indicate if treatment was administered or an indication that the treatment was not administered with an explanation on the reverse side of the TAR for 1 of 2 residents reviewed for documentation (Resident #94). The findings included: Physician orders for Resident #94 dated 9/20/24 revealed orders for cleansing area to right lateral ankle and applying of calcium alginate with silver cover with superabsorbent gelling fiber with silicone border to promote wound healing daily. Physician orders for Resident #94 dated 9/27/24 revealed an order for cleansing left lateral ankle and apply Santyl ointment to plain calcium alginate daily. During a telephone interview with Nurse #1 on 10/24/24 at 8:10 A.M. she revealed she provided care to Resident #94 regularly but was not aware she did not sign off on the TAR on 10/3/24, 10/5/24, 10/6/24, 10/10/24, 10/13/2024, 10/19/24, and10/20/24. During an interview with Nurse #2 on 10/24/2024 at 8:17 A.M. She revealed she provided Resident #94's wound care on 10/19/24 at 10 P.M. but could not remember why she did not document the treatment on the TAR. A telephone interview with Unit Manager #1 on 10/24/24 at 8:30 A.M. revealed she was not sure why nursing staff failed to document wound care provided to Resident #94 on the TAR on 10/3/24, 10/5/24, 10/6/24, 10/10/24, 10/13/2024, 10/19/24, and10/20/24. She further stated nursing staff are required to document whether Resident #94 agreed to or declined care. In an interview with the Director of Nursing (DON) on 10/24/24 at 9:11 A.M. she revealed nursing staff were required to document medication administration even when there is a refusal. During an interview with the Administrator on 10/24/24 at 9:15 A.M. she stated that nursing staff are required to document the care provided to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45045

Based on observations, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when 1) Unit Manager #2 failed to wear a gown and did not perform hand hygiene between glove changes while performing tracheostomy care for a resident on Enhanced Barrier Protection (EBP) (Resident #112), 2) when the Wound Treatment Nurse failed to perform hand hygiene between glove changes during the observation of wound treatment (Resident #115), and 3) when Nurse Aide #1 was observed carrying uncontained dirty linen in the hallway. The facility also failed to implement its hand hygiene policy when Nurse Aide #1 failed to perform hand hygiene and remove gloves before entering and exiting 2 of 2 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER]) observed for infection control practices.

The findings included:

The facility's Infection Prevention and Control Program policy last updated 10/01/23 indicated all staff should assume that all residents were potentially infected or colonized with an organism that could be transmitted while providing resident care services. The policy stated hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. The policy further noted all staff shall use personal protective equipment (PPE) according to the established policy governing the use of PPE. Further review of the Infection Prevention and Control Program policy revealed in part soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled linen room.

The facility's Enhanced Barrier Precautions (EBP) policy dated 4/01/24 revealed EBP was an infection control intervention designed to reduce transmission of multidrug-resistant organisms that used targeted gown and glove use during high contact resident care. The policy further stated EBP would be initiated for any resident with indwelling medical devices (such as tracheostomy tubes and feeding tubes) and wounds (such as pressure ulcers). The policy noted that personal protective equipment (PPE) for EBP was only necessary when performing high-contact care activities which included wound care and device care such as tracheostomy care.

Review of the facility's Hand Hygiene policy last updated 10/01/22 indicated hand hygiene was to be conducted before resident care procedures, before and after handling clean or soiled linens, before applying and after removing personal protective equipment (PPE), including gloves.

1a. Resident #112 had signage posted on the door that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gown for the following high-contact resident care activities which included device care or use including tracheostomy. A large double door cabinet was observed in the hall stocked with PPE, which included disposable gowns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continuous observation was conducted on 10/23/24 from 9:48 am through 10:35 am of tracheostomy care for Resident #112. Unit Manager #2 was observed to enter Resident #112's room, perform hand hygiene with hand sanitizer, and prepare supplies for tracheostomy care. Unit Manager #2 was observed to perform hand hygiene, don sterile gloves and began tracheostomy care for Resident #112 without a disposable gown in place. Unit Manager #2 was observed to touch the sterile supplies with her dirty glove and stopped tracheostomy care, removed supplies, removed gloves, completed hand hygiene, and left Resident #112's room to obtain more supplies. At 10:02 am Unit Manager #2 returned to Resident #112's room with additional supplies, performed hand hygiene, donned gloves, and prepared supplies. Unit Manager #2 was observed to perform hand hygiene, donned sterile gloves, and began tracheostomy care for Resident #112 without a disposable gown in place. #2 Unit Manager #2 completed Resident #112's tracheostomy care at 10:35 am, which included suctioning, without a disposable gown in place throughout the observation. An interview was conducted with Unit Manager #2 on 10/23/24 at 3:05 pm. Unit Manager #2 confirmed Resident #112 was on EBP for the tracheostomy, and staff were required to wear a disposable gown when tracheostomy care and suctioning were performed for Resident #112. She stated she did not realize she did not wear one until she was asked by this surveyor if Resident #112 was on EBP. Unit Manager #2 stated disposable gowns were readily available for use and it should have been used during the tracheostomy care observation. An interview was conducted with the Infection Preventionist (IP) on 10/24/23 at 8:55 am who revealed all staff, which included Unit Manager #2, had been educated on the use of proper PPE for residents on EBP. The IP stated PPE supplies including disposable gowns were available outside of Resident #112's room and the gown should have been on when Unit Manager #2 performed tracheostomy care. b. A continuous observation was conducted on 10/23/24 from 9:48 am through 10:35 am of tracheostomy care for Resident #112. At 10:23 am Unit Manager #2 was observed to place a sterile suction kit on Resident 112's overbed table, perform hand hygiene, open the sterile kit and attempt to don the sterile gloves. Unit Manager #2 was unable to don the sterile gloves fully and removed the sterile gloves and placed the gloves in the trash. Unit Manager #2 then opened Resident #112's bottom dresser drawer and obtained a new sterile suction kit and placed the kit on the overbed table. Unit Manager #2 was observed to open the sterile suction kit and place the sterile gloves from inside the kit onto her hands without performing hand hygiene after obtaining supplies from Resident #112's drawer. Unit Manager #2 was observed to complete Resident #112's tracheostomy care and suctioning, removed gloves and performed hand hygiene. During an interview on 10/23/24 at 3:05 pm with Unit Manager #2 she revealed she was required to perform hand hygiene between glove changes when she performed Resident #112's tracheostomy care. Unit Manager #2 stated she changed the gloves so often during the observation that she just forgot to do hand hygiene after getting more supplies from the drawer and before she put on the sterile gloves to suction Resident #112's tracheostomy. An interview was conducted with the Infection Preventionist (IP) on 10/24/23 at 8:55 am who revealed all staff, which included Unit Manager #2, had received education on hand hygiene and the education was completed yearly and as needed. She stated hand hygiene was to be completed before gloves were donned and again when gloves were removed. The IP stated Unit Manager #2 was required to perform hand hygiene before donning the sterile gloves from the suction kit when tracheostomy care was provided to Resident #112. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/24 at 10:48 am with the Interim Administrator she revealed all staff were required to follow the facility's infection prevention and control program policies. 2. During a continuous observation of a pressure ulcer treatment on 10/23/24 at 3:39 pm through 3:54 pm the Wound Treatment Nurse was observed to perform hand hygiene, don clean gloves, and remove Resident #115's soiled dressing from the right hip. The Wound Treatment Nurse then removed the soiled gloves, and donned clean gloves without performing hand hygiene. The Wound Treatment Nurse then cleansed the right hip wound bed with gauze and normal saline and prepared and placed the wound dressing on Resident #115's right hip wound. The Wound Treatment Nurse did not remove the dirty gloves or perform hand hygiene after cleansing the wound bed or before preparing and placing the wound treatment dressing on Resident #115's right hip wound. Resident #115 then turned onto the right side and the Wound Treatment Nurse removed the soiled dressing from the left hip. The Wound Treatment Nurse then removed the soiled gloves and without performing hand hygiene, donned clean gloves and cleansed the left hip wound with gauze and normal saline. The Wound Treatment Nurse prepared the new dressing and placed the dressing on Resident #115's left hip without removing the dirty gloves or performing hand hygiene after cleansing the wound bed and before placing the new wound dressing on Resident #115's left hip. The Wound Treatment Nurse then removed the soiled gloves and performed hand hygiene. An interview was conducted on 10/23/24 at 3:55 pm with the Wound Treatment Nurse who revealed the dirty gloves should have been removed after the wound bed was cleansed and hand hygiene should have been completed between the glove changes. The Wound Treatment Nurse stated she just realized that she did not change gloves and perform hand hygiene in between glove changes during the observation. The Wound Treatment Nurse was unable to say why she did not change her gloves when moving from dirty to clean or perform hand hygiene between glove changes, but she confirmed she had received education on proper PPE use and handwashing. During an interview on 10/24/24 at 9:03 am with the Infection Preventionist (IP) she stated hand hygiene education was completed for all staff annually and as needed. The IP stated the Wound Treatment Nurse was educated to complete hand hygiene between glove changes and to change gloves when moving from dirty to clean tasks. During an interview on 10/24/24 at 10:48 am with the Interim Administrator she revealed all staff were required to follow the facility's infection prevention and control program policies. 41772 3. A continuous observation was conducted on 10/24/24 at 9:01 AM. Nurse Aide #1 was observed to exit room [ROOM NUMBER] with gloved hands. Nurse Aide #1 removed the gloves and walked across the hall to room [ROOM NUMBER] without performing hand hygiene. Nurse Aide #1 returned to room [ROOM NUMBER] without performing hand hygiene. Nurse Aide #1 was observed exiting room [ROOM NUMBER] with gloved hands and carrying dirty linen that was not contained in a plastic bag. Nurse Aide #1 was observed to walk down the 700 hall and turn the doorknob to the dirty laundry room door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse Aide #1 on 10/24/24 at 9:07 AM. Nurse Aide #1 stated she was aware that she was supposed to carry dirty linen in a plastic bag and remove her gloves when exiting a resident's room. Nurse Aide #1 stated she did not have any plastic bags, so she carried the linen to the dirty laundry room with her gloves on. Nurse Aide #1 stated she was unaware that she had not performed hand hygiene after removing her gloves and before entering room [ROOM NUMBER]. An interview was conducted with the Director of Nursing (DON) on 10/24/24 at 9:32 AM. The DON stated Nurse Aide #1 should have had plastic bags available, taken off her gloves and immediately washed her hands before leaving the room. The DON further stated Nurse Aide #1 should have performed hand hygiene between resident rooms.