STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on record review, observation, and staff and physician interviews, the facility failed to protect the residents' right to be free from neglect when Nurse #1 did not provide the necessary care and services as assessed and ordered by the physician to Resident #60 and Resident #74. On 10/03/24 Nurse #1 turned their continuous tube feedings (nutrition administered through a tube directly into the stomach) off because she believed their stomachs needed a rest. Nurse #1 was aware of the physician's orders, she deliberately disregarded them, and she independently made the decision to deviate from the physician's orders and turn the tube feedings off depriving the residents of their assessed nutritional needs. She revealed this was not a new practice for her and she had done this previously for both residents an undetermined number of times. When staff purposefully disregard physician's orders and make treatment decisions on their own, it places all residents at risk of serious harm and/or death. Nurse #1 had a history of disciplinary action at the facility for substandard work in July of 2024 and in response she was to be monitored while she was working her shift. This deficient practice affected 2 of 2 residents reviewed for neglect (Resident #60 and Resident #74). Immediate jeopardy began on 10/3/24 when Nurse #1 disregarded physician's orders and turned off Resident #60's and Resident #74's tube feeding. Immediate jeopardy was removed on 10/5/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. The findings included: Review of Nurse #1's personnel file revealed she was employed in February 2024. Nurse #1's personnel file documented orientation training of the facility policies and procedures which included written tests on these policies and procedures. Nurse #1's personnel file also contained 1 employee disciplinary form. The first disciplinary action was on 7/25/24 when she received a first warning for substandard work. The details of the occurrence documented Nurse #1 was the assigned nurse to supervise the medication aide and multiple medications including seizure medications were not documented as administered. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Facility Nurse Consultant (FNC), Director of Nursing (DON), and Chief Clinical Officer (CCO) on 10/4/24 at 12:33 pm, the CCO stated the nursing supervision and monitoring interventions in place for Nurse #1 after the incident in July 2024 included daily monitoring of essential reports in the electronic medical record (EMR) to assure nurse supervision of medication aides and all medications were completed timely and as ordered by the physician were completed by the FNC. The FNC did not state the length of time for the monitoring of Nurse #1 and there was no written documentation for this plan of action for monitoring Nurse #1 provided by the facility. The CCO explained that new nurses hired have a competency evaluation with a nurse skills checklist that is completed during orientation. Nurse #1's competency skills checklist was unable to be located. Review of the nursing assignment sheets from 8/8/24 through 10/3/24 revealed Nurse #1 was assigned to Resident #60's and Resident #74's hall 32 days. The assignment sheet also revealed Nurse #1 shifts worked were double shifts (7:00 am until 3:30 pm and 3:30 pm until 11:30 pm). a. Resident #60 was readmitted to the facility 8/7/24 with diagnoses which included anoxic brain damage, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, and acute respiratory failure. Resident #60's care plan dated 4/15/24 revealed a focus for required tube feeding related to dysphagia. The interventions included to monitor, document, report any signs/symptoms of aspiration, fever, shortness of breath (SOB), tube dislodged or tube malfunction. Resident #60 was dependent with tube feeding and water flushes. Review of Resident #60's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Resident #60 had bilateral (left and right) impairment of the upper and lower extremities, completely dependent upon staff for all activities of daily living and coded for a feeding tube. Resident #60's weight on quarterly MDS was 268 pounds. Review of Resident #60's weights revealed the following: - 6/3/24 255.0 pounds - 7/2/24 249.8 pounds - 8/8/24 267.8 pounds - 9/9/24 247.5 pounds Resident #60's active physician orders related to his tube feeding included the following: - every day and night shift tube feeding at 60 milliliters per hour (ml/hr) continuous (initiated on 9/30/24) - every 6 hours flush with 135 cubic centimeters (cc) for water flushes (initiated on 8/7/24) The Registered Dietician's (RD) nutritional assessment dated [DATE] recommended Resident #60 needed 1728 kilocalories (kcal) with 1708 cubic centimeters (cc) free water and 90.4 grams (g) of protein daily from her continuous tube feeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the RD's progress note for Resident #60 dated 8/21/24 revealed a readmission evaluation on 8/21/24. Resident #60's weight was 268 pounds. The tube feeding order was noted as 50 ml/hr with 135 cc water flushes every 6 hours. No recommendations, tube feeding adequate as ordered, and well tolerated with weight stability. The following observation was made of Resident #60: - 10/3/24 at 3:08 am Resident #60's feeding tube pump was turned off. An empty tube feeding bottle was hanging on the feeding tube pole In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #60 from 11:00 pm on 10/02/24 until 7:30 am on 10/03/24 (night shift). When asked Nurse #1 why the feeding tube pump was off for Resident #60, she replied she intentionally turned the feeding tube pump off because she thought her stomach needed a rest. Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just thought her stomach needed a rest. Nurse #1 explained she made the decision on her own to turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest. Nurse #1 indicated she was aware Resident #60 was on continuous tube feeding per physician orders Nurse #1 stated she did not notify the physician when she turned the feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #60 on 10/3/24. The following additional observations were made of Resident #60: - 10/3/24 at 3:53 am Resident #60's feeding tube pump continued to be turned off. - 10/3/24 at 7:53 am Resident #60's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 5:43 am hanging on the feeding tube pole Review of Resident #60's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1. Review of Resident #60's October Medication Administration Record (MAR) revealed enteral feed order every day and night shift [name of tube feeding formula] at 60 ml/hr with Nurse #1's initials electronically signed for the night hours (12HR) on 10/2/24. In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #60's feeding tube pump off when she thought her stomach needed a rest. Nurse #1 stated this was not a regular thing and did this when she felt they needed a break. Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she turned them off when she thought their stomachs needed a rest. When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #60's feeding tube pump was turned on when she hung a new bottle of tube feeding at 5:43 am on 10/3/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #60 had lost some weight possibly due to being in and out of the hospital. Resident #60 was readmitted from the hospital on 8/7/24. The RD was not aware of Resident #60's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated a continuous tube feeding may be turned off for a short amount of time to perform activities of daily living (ADL) or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pump, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding. Review of the RD's progress note for Resident #60 dated 10/7/24 revealed he increased Resident #60's tube feeding on 9/19/24 due to weight loss. Resident #60's weight was noted to be 255 pounds with prior weight loss and noted weight regain, and IV fluids during hospital stay as attributing to weight fluctuations. b. Resident #74 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), failure to thrive, dementia, and type 2 diabetes mellitus. The Registered Dietician's (RD) nutritional assessment dated [DATE] recommended Resident #74 needed 1980 kilocalories (kcal) with 1963 cubic centimeters (cc) free water and 83 grams (g) protein daily from her tube feeding for 22 continuous hours. Resident #74's care plan dated 8/7/24 revealed a focus for tube feeding for nutrition. The interventions included monitor, document, report any signs/symptoms of aspiration, fever, shortness of breath (SOB), tube dislodged or tube malfunction. Resident #74 was dependent with tube feeding and water flushes. Review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Resident #74 required maximum assistance from staff with activities of daily living and coded for a feeding tube. Review of Resident #74's weights revealed the following weights: - 7/11/24 154.9 pounds - 7/22/24 154.9 pounds - 8/6/24 156.6 pounds - 9/6/24 160.0 pounds Resident #74's active physician orders related to his tube feeding included the following orders: - continuous tube feeding via pump at 55 milliliters per hour (ml/hr) for nutritional support for 22 hours estimated 2 hours (scheduled for 8:00 am until 10:00 am) downtime to allow for activities of daily living (ADL) care (initiated on 7/11/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- water flushes every 3 hours of 120 milliliters The following observation was made of Resident #74: - 10/3/24 at 3:10 am Resident #74's feeding tube pump was turned off. A tube feeding bottle with approximately 100 cubic centimeters (cc) was hanging on feeding tube pole. In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #74 from 11:00 pm on 10/02/24 until 7:30 am on 10/03/24 (night shift). When asked Nurse #1 why the feeding tube pump was off for Resident #74, she replied she intentionally turned the feeding tube pump off because she thought her stomach needed a rest. Nurse #1 explained the tube feeding formula was thick and sometimes clogged the feeding tubes and she just thought her stomach needed a rest. Nurse #1 explained she made the decision on her own to turn the tube feeding pump off for 2 to 3 hours to give her stomach a rest. Nurse #1 indicated she was aware Resident #74 was on continuous tube feeding per physician orders. Nurse #1 further stated she did not notify the physician when she turned the feeding tube pump off for Resident #60 because there was no significant change in her condition. Nurse #1 did not remember what time she turned the feeding tube pump off for Resident #74. Review of Resident #74's EMR revealed no progress notes which documented turning the feeding tube pump off by Nurse #1. Review of Resident #74's October Medication Administration Record (MAR) revealed the enteral feed order every shift for nutritional support/supplementation [name of tube feeding formula] at 55 ml/hr with Nurse #1's initials electronically signed for the night hours on 10/2/24. The following additional observations were made of Resident #74: - 10/3/24 at 3:55 am Resident #74's feeding tube pump continued to be turned off. - 10/3/24 at 7:55 am Resident #74's feeding tube pump was on with a new bottle of tube feeding dated 10/3/24 at 4:30 am. In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #74's feeding tube pump off when she thought her stomach needed a rest. Nurse #1 stated this was not a regular thing and did this when she felt they needed a break. Nurse #1 did not give a specific answer as to how many times she had turned the feeding tube pump off or when she first began turning off the feeding tube pump. She stated she turned them off when she thought their stomachs needed a rest. When Nurse #1 was asked when she turned the feeding tube pump back on, Nurse #1 indicated Resident #74's feeding tube pump was turned on when she hung a new bottle of tube feeding at 10/3/24 at 4:30 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Registered Dietician (RD) on 10/3/24 at 9:00 am, he stated Resident #74's weight had been stable. The RD was not aware of Resident #74's feeding tube pump being turned off and did not understand why Nurse #1 intentionally turned the feeding tube pump off without notifying the physician. The RD indicated continuous tube feedings may be turned off for a short amount of time to perform activities of daily living or due to a change in condition, but not for 2 to 3 hours at a time unless ordered by the physician. The RD further indicated Resident #74 had a physician's order for her feeding tube pump to be turned off 2 hours a day to allow downtime for ADL care. The RD further explained Nurse #1 needed a physician's order to turn off the feeding tube pumps, and he had not recommended this to the physician. The RD further stated turning the feeding tube pump off could have caused weight loss; however, his concern was the loss of calories and nutrients provided by the tube feeding. In an interview on 10/3/24 at 9:15 am with the Director of Nursing (DON), she stated continuous tube feedings should not be turned off without a physician's order. The DON further stated she was unaware of Nurse #1 turning the feeding tube pumps off for Resident #60 and Resident #74 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed the residents (Resident #60 and Resident #74) and notified the physician of any changes in their condition before making any decisions on her own. The DON indicated she expected the nursing staff to follow the physician's orders as written as a part of a resident's necessary care and services. During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware of Resident #60's and Resident #74's feeding tube pumps were being turned off. The Physician further stated if there had been a change in the residents' condition such as shortness of breath (SOB), vomiting, or gurgling that could have explained the feeding tube pumps being turned off; however, he was not notified of this for Resident #60 or Resident #74 at all. The physician explained one of his concerns were Resident #60 and Resident #74 not receiving the calories, and the nutrients provided from the tube feeding. Another concern noted by the Physician was the fact that Nurse #1 intentionally turned the feeding tube pumps off without notifying him before taking this action. The Physician indicated he did not like the nurses to make unreasonable decisions on their own without any notification. The Physician indicated that weight loss could happen as a result of the tube feeding pumps being turned off. He further explained Nurse #1's reason for the feeding tube pumps being turned off was not a good enough reason for Nurse #1 to make that decision. The Administrator was notified of Immediate Jeopardy on 10/4/24 at 6:37 pm. The facility provided the following credible allegation of immediate jeopardy removal: Identify recipients who have suffered or are likely to suffer a serious adverse outcome as a result of the non-compliance. On 10/3/24 the feeding pumps for Residents # 60 and # 74 were observed off for an undetermined amount of time. Both Residents # 60 and # 74 were determined to be at risk for neglect based on the actions of Nurse # 1. Nurse #1 was removed from the facility at approximately 7:30 pm on 10/3/24. Nurse #1 was terminated on 10/4/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All residents in the facility are deemed to be at risk for serious adverse outcome including neglect, based on the actions of Nurse #1. On the morning of 10/3/24, upon notification of the problem, the Director of Nursing immediately went to the rooms of all tube feeders (9 in total) to assess the pump settings, dates and times of currently hung feedings, that pumps were on appropriately (per MD settings) and that feedings were infusing accurately (based on MD orders). Specify the action the entity will take to alter the system failure to prevent serious adverse outcomes from occurring or recurring. On the morning of 10/3/24 at approximately 8:30 am, the surveyors notified the Administrator of the tube feeding problem. Within minutes of the state notification, the Administrator notified the DON. The time was approximately 8:40 am. The Director of Nursing went immediately to the rooms of Residents #60 and #74 to assess the tube feeding status. Both residents were found to have feedings pumps that were on, both residents were found to have currently dated and timed feedings infusing per MD orders. The facility will ensure that all residents including residents # 60 and #74 are free from neglect - at all times. The Administrator, DON, and Corporate team will monitor the facility and patient care delivery every shift to ensure that the nutrition and hydration needs of all patients are met based on MD orders. The team will utilize our newly hired administrative nurse managers (including ADON, MDS nurses, treatment nurse, and resource nurses) facility management team, and lead CNAs to accomplish the shift to shift rounding. This rounding was initiated on 10/3/24. As additional personnel is utilized to complete this rounding, they will be educated. The DON, ADON, and nurse managers will review findings first thing every morning to ensure that appropriate and necessary action has been taken to remedy all identified negative findings. The Director will ensure that the MD is notified timely of all discrepancies and plans for correction. The Administrator, Director of Nursing, Corporate Clinical Director and RN / MDS Nurses began education sessions on 10/4/24 with all staff and included the following subjects: Resident rights to be free from abuse and neglect Reporting abuse and neglect Facility policy on Abuse, Neglect, and Exploitation Definitions of abuse and neglect Facility policies to ensure all residents are free of neglect and [NAME] employees. Education sessions will continue with all staff members until 100% of the employees have received education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No employee will be allowed to work until they have received the education. New hires are trained in orientation and education will continue within the facility to ensure understanding of abuse and neglect prevention, including our ZERO TOLERANCE position for [NAME] employees. The Chief Clinical Officer reviewed the general orientation requirements with the Clinical Nurse Consultant. This meeting was held on 10/3/24 the requirement for abuse training was re-enforced. The Director of Nursing, ADON, and nurse managers will review education session daily to ensure that all staff have received and that no staff members work prior to receiving it. Date of immediate jeopardy removal - 10/5/24 Validation of the credible allegation of IJ removal was completed on 10/8/24: Nurse #1 was suspended from the facility on 10/3/24. Nurse #1 was terminated on 10/4/24. In review of Nurse #1's Human Resource (HR) records revealed documentation of her disciplinary forms and a North Carolina Board of Nursing (NCBON) Complaint Evaluation Tool (CET) which was completed on 10/3/24 with an appointment scheduled with the Board of Nursing (BON) for Nurse #1 on 10/7/24 at 10 am. There was a signed roster of staff in all departments who participated in in-service for abuse and neglect dated 10/3/24 and 10/4/24. There was a signed roster of nursing staff who participated in in-service for tube feeding and following the physician order dated 10/3/24 and 10/4/24. The in-services were completed by 10/4/24. The following residents' tube feeding were observed, and orders checked for accuracy: Resident #s 4, 28, 38, 41, 60, 64, 74, 80, and 341. All tube feedings were running or on hold as ordered. On 10/8/24 at 11:30 am 2 nurses, 4 nursing assistants, the newly hired Assistant Director of Nursing (second day) and 1 housekeeping staff were interviewed. All staff had participated in abuse/neglect in-service and nursing staff participated in tube feed/following physician orders in-service in addition to the abuse in-service. The Director of Nursing provided documentation of the daily on-going audits of all residents that have an order for tube feeding to evaluate the status of the pump status/infusion rate and type of feed per physician order. The immediate jeopardy removal date of 10/5/24 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation, resident representative interview, and staff interviews, the facility failed to provide incontinence care to a resident that was dependent on staff for activities of daily living (ADL) for 1 of 1 resident reviewed (Resident #20). Findings included: Resident #20 was admitted to the facility on [DATE] with diagnoses included non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was moderately cognitively impaired and was frequently incontinent of urine and stool. The quarterly MDS indicated Resident #20 required partial assistance with toileting. Resident #20's care plan that was last reviewed on 8/3/24 stated Resident #20 was at risk for a not performing ADL due to impaired mobility and impaired cognition. Interventions included staff providing extensive assistance with toileting needs. Resident #20's care plan also included a focus for bowel and bladder incontinence. Interventions included staff monitoring Resident #20 for incontinence of urine and stool and cleaning the perineum (space between the anus and genitals) with each incontinent episode. On 10/2/24 at 11:20 am in an interview with Resident #20's Resident Representative, Resident #23 (who was also Resident #20's roommate), Resident #23 stated Resident #20's adult brief had not been changed since 9:00 pm on 10/1/24. Resident #23 stated no one had been into their room (Resident #20's and Resident #23's room) except to assist Resident #20 to eat breakfast. Resident #23's quarterly MDS assessment dated [DATE] indicated he was cognitively intact and he was observed during interviews alert and oriented to person, place, time and situation. On 10/2/24 at 11:25 am an interview was conducted with Resident #20. When Resident #20 was asked if her adult brief needed changing, she stated she did not think she was wet. Resident #20 agreed for nursing staff to check the adult brief for incontinence. On 10/2/24 at 11:26 am upon request of the surveyor, Nurse Aide (NA) #2 was observed checking Resident #20's adult brief for incontinence. Resident #20's adult brief was observed saturated with dark amber colored urine at the top of the adult brief. NA #2 stated Resident #20's adult brief was soaked and the pad underneath the resident was wet with urine also. There was no redness observed to Resident #20's skin. NA #2 was observed providing incontinent care to Resident #20, applying a clean adult brief and a new pad under Resident #20. On 10/02/24 at 11:30 am in an interview with NA #2, she explained NA #3 was the assigned nurse aide for Resident #20. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 11:33 am in an interview with NA #3, she stated at that time she had not checked Resident #20 for incontinence of urine or stool since she began her shift at 7:15 am. She stated she had only assisted Resident #20 with her breakfast meal and had informed Resident #20 she would come back. NA #3 stated she was to check residents every two hours and had been providing ADL care to other residents and was planning to address Resident #20's bath and incontinent needs next. In a follow up interview with NA #3 on 10/2/24 at 2:27 pm, she stated 10/2/24 was the first time caring for Resident #20 since she was readmitted to the facility. She explained before hospitalization , Resident #20 would inform the nursing staff when her adult brief needed to be changed. She explained Resident #20 informed her (NA #3) her adult brief did not need changed after assisting Resident #20 with feeding her breakfast. NA #3 stated she did not check Resident #20 at that time. NA #3 admitted Resident #20's ADL needs had changed since returning to the facility included assisting Resident #20 with feeding and the need to provide incontinent care because the resident wasn't able to walk to the bathroom and wasn't using her call light to communicate incontinent needs. On 10/2/24 at 3:45 pm in a phone interview with NA #1, she stated she had worked the 7:00 pm to 7:00 am shift on 10/1/24 and was assigned to Resident #20. She admitted she provided incontinent care to Resident #20 on 10/1/24 at approximately 10:00 pm and did not recheck Resident #20 for incontinent care needs the remaining time of her shift because Resident #23 (Resident #20's representative and roommate) had told her (NA #1) not to worry about checking on Resident #20 until day shift. NA #1 stated NA #4, who was assisting her with Resident #20's incontinent care, overheard Resident #23 requesting not to check Resident #20 during the night. NA #1 explained Resident #20 had not verbalized the need for incontinent care during her night shift. She reported there was a change in Resident #20's ADL abilities as she was no longer able to walk to the bathroom and use the call bell to verbalize incontinent needs since readmission to the facility. NA #1 said she did not notify the nurse or nurse aide reporting for the day shift on 10/2/24 that Resident #20 had not been checked or changed during the night because NA #3, who was assigned to Resident #20 on 10/2/24, had not reported to work before she left the facility. On 10/2/24 at 4:40 pm in an interview with NA #4, he stated he had helped NA #1 changed Resident #20's adult brief on the evening of 10/1/24. NA #4 recalled seeing NA #1 and Resident #23 (Resident #20's representative and roommate) talking and stated he did not recall hearing Resident #23 telling NA #1 not to check Resident #20 for ADL care during the night of 10/1/24. NA #4 stated nurse aides were to check all residents every 2-3 hours and as needed. On 10/2/24 at 4:43 pm in a follow up interview with Resident #23, he stated no one entered the room of Resident #20 and Resident #23 during the night of 10/1/24 and stated he did not tell NA #1 not to come into the room during the night to check on Resident #20 or that the morning nursing staff would change Resident #20. On 10/2/24 at 11:47 am in an interview with the Director of Nursing she stated nurse aides were to check Resident #20 every two hours entering Resident #20's room to check for incontinent needs. The DON stated since readmission to the facility due to a change in her health, Resident #20 required the nurse aides to check her for incontinent needs every two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to conduct and document an admission screening assessment to identify and communicate any changes in the resident's cognitive and functional levels after an hospitalization for 1 of 1 resident reviewed for activities of daily living (Resident #20). Findings included: Resident #20 was admitted to the facility on [DATE], with diagnoses that included non-Alzheimer's dementia. Resident #20 was discharged from the facility on 9/23/24 and readmitted to the facility on [DATE] with a diagnosis that included a fracture to right hip. The significant change Minimum Data Set (MDS) assessment dated [DATE] was reported as in progress and was not complete. The quarterly MDS dated [DATE] indicated resident #20 was moderately cognitively impaired and required assistance setting up her meal for eating, and supervision for mobility and transfers and partial assistance with toileting. The MDS also indicated Resident #20 was frequently incontinent of urine and stool. There was no nursing documentation since Resident #20's re-admission to the facility communicating the cognitive state and level of function of Resident #20 in the electronic medical record There was no admission screening assessment (an assessment that would determine changes in Resident #20's cognitive and functional levels) located in Resident #20's electronic medical record since her readmission on 09/27/24. In an interview with the Director of Nursing (DON) on 10/2/24 at 11:47 am, she stated on readmission to the facility, Resident #20 was not able to recognize her incontinent needs, and staff would need to check on Resident #20 every 2 hours. In an follow up interview with the DON on 10/2/24 at 4:34 pm, she stated Resident #20's admission screening assessment that would identify and communicate changes in Resident #20 when she was readmitted to the facility after hospitalization should have been completed for Resident #20 within 24 to 48 hours after returning to the facility. The DON further stated she was the nurse assigned to Resident #20's on 9/27/24 when Resident #20 returned to the facility, and she did not complete the admission screening assessment. The DON stated she left a packet with Resident #20's admission screening assessment inside at the nurses station and did not verbally inform Nurse #5, who was working 7:00pm to 7:00 am (night shift) on 9/27/24 of the need to complete Resident #20's admission screening assessment. In an interview with Nurse #5 on 10/3/24 at 3:20 am, she stated she worked from 7:00 pm to 7:00 am (night shift) on 9/27/24. She explained if Resident #20 returned to the facility at 6:00pm on 9/27/24, the DON assigned to Resident #20 was responsible for completing the admission screening assessment. Nurse #5 stated no one reported to her on 9/27/24 upon reporting to work that Resident #20 needed the admission screening assessment completed, and she had not seen a packet for Resident #20 with the admission screening assessment at the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Dunn	711 Susan Tart Road Dunn, NC 28335

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Clinical Nurse Consultant on 10/3/24 at 4:35 pm, she stated when Resident #20 was readmitted to the facility on [DATE], the DON assigned to Resident #20 should have started Resident #20's admission screening assessment to determine cognitive and functional changes. She explained if the DON was not able to complete Resident #20's admission screening assessment, the DON should have communicated the need for Resident #20's admission screening assessment to be completed to Nurse #5 who was working the night shift on 9/27/24.