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	06/10/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, therapy staff, and the Physician the facility failed to notify the physician when Resident # 3 experienced a change in status resulting in a decline observed by multiple staff members. Resident # 3 entered the facility for rehabilitation. Therapists and Nurse Aides revealed Resident # 3 was initially making progress in therapy to the degree that she could feed herself, ambulate short distances with therapy in parallel bars or with a quad cane, toilet to the commode, and communicate her needs by gestures. Multiple days prior to a transfer to the hospital, Resident # 3 had declined in functional status and was noted to have symptoms which included dizziness, lightheadedness, nausea, periods of altered responsiveness, change in communication ability, dry mouth, poor oral intake, less urine output, dark stools, and a positive COVID (Coronavirus Disease) test. The physician was not notified of the resident's significant change in status for multiple days although it was documented that therapy had talked with nursing staff about a decline and there was a plan to communicate with the physician or DON to determine why the resident was declining. The physician reported he had not been made aware of the change in condition and decline. If he had been made aware, the physician reported he would have seen the resident, probably ordered stat (right away) blood work, and probably sent her back to the hospital. Resident #3 was transferred to the emergency room on [DATE]. At time of hospitalization Resident # 3 was found to be septic (when an individual's body has an extreme reaction to an infection and which can lead to organ failure) due to her COVID infection. The resident was additionally found to have gastrointestinal bleeding, which resulted in a critical hemoglobin of 4.0 and required three units of blood. The resident was hospitalized in the Intensive Care Unit. The resident's 4/8/25 hospital discharge summary noted the resident had sustained heart injury due to the sepsis. This was for 1 of 3 sampled residents reviewed for acute medical conditions (Resident # 3). Immediate jeopardy began on 3/21/25 when a licensed Physical Therapist identified Resident # 3 had an overall change in status and the physician was not notified. Immediate Jeopardy was removed on 6/6/25 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: (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed Resident # 3 was admitted to the facility on [DATE] after being hospitalized on [DATE]. Review of Resident # 3's 3/3/25 hospital history and physical and the resident's 3/8/25 hospital discharge summary revealed the following information. Prior to hospitalization the resident resided independently at home and presented to the hospital on 3/3/25 with slurred speech. While hospitalized the resident underwent an MRI (Magnetic Resonance Imaging) which revealed multiple acute small infarcts (areas of brain damage from a lack of oxygen). The resident was diagnosed with a stroke with right-sided weakness and slurred speech. The discharging physician further noted Resident # 3 needed to be evaluated as an outpatient for chronic blood loss and further gastrointestinal workup would be deferred to the primary care physician. She was also discharged on anticoagulant medications due to her stroke. The resident's 3/8/25 discharge summary also noted the resident had benign hypertension. Review of the facility record revealed an admission nursing note on 3/8/25 at 3:08 PM which noted the resident had a right sided deficit, was awake, alert, oriented to self, and denied any discomfort. Facility physician orders, dated 3/25/25, revealed Resident # 3 was a full code. Occupational Therapy, Speech Therapy, and Physical Therapy were ordered on 3/10/25. Physical Therapist (PT) # 1's notes revealed on 3/10/25 Resident # 3 actively participated with physical therapy. PT # 1 documented the following information regarding the treatment session on 3/10/25. She (PT # 1) directed Resident # 3 to go from a supine (lying) position to a sitting position. The resident transferred with good balance and with bilateral upper extremities and bilateral lower extremities supported. The resident was able to transfer to the toilet with both PT # 1 and an Occupational Therapist present. PT # 1 helped Resident # 3 with trials of transfers with a quad cane and the future plan was to do a trial with the quad cane or hemiwalker (a mobility device for individuals who have limited use of one of their hands) during transfers and ambulation during the next therapy session. According to the record there was one documented visit from the facility physician while the resident resided at the facility on 3/11/25. Within the 3/11/25 physician's progress note, the physician included further diagnoses of thrombocytosis (elevated platelets), cardiomyopathy (disease of the heart muscle), dyslipidemia (elevated cholesterol or fats), and aphasia (loss of ability to express speech clearly or understand). There was no further documentation that the physician saw the resident while she resided at the facility. On 3/11/25 ST (Speech Therapist) # 1 documented the following in a speech therapy progress note, Pt assessed with her lunch meal. Pt [patient] alert and sitting up in her wheelchair. Pt able to feed herself with her left hand for the most part. ST # 1 further noted Resident # 1 consumed 40 percent of her meal before indicating she did not want any more and that she was able to brush her teeth with intermittent minimal assistance. The ST also noted Resident # 3 was receptive to education. On 3/12/25 Physical Therapy Assistant (PTA) # 1 documented multiple treatment modalities in a physical therapy progress note. One included that gait training was begun in the parallel bars, and the resident was able to complete the length of the parallel bars with minimal assistance two times while resting in between. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/25 PTA # 1 documented in a therapy progress note for the session of 3/13/25 the following information. She (PTA # 1) instructed Resident # 3 in the use of the hemiwalker and quad cane and the resident required minimal to moderate assist due to impulsivity, the need to support her right upper extremity, and balance deficits. The resident was documented as walking 12 feet with both the hemi walker and the quad cane on 3/13/25. The resident was documented as needing minimal assistance for transfers on the session date of 3/13/25. The resident had declined wheelchair mobility because she (the resident) wanted to focus on transfers and gait. Resident # 3's admission MDS (Minimum Data Set) assessment, dated 3/14/25 coded the resident as having unclear speech and was moderately cognitively impaired. She was assessed to need substantial to maximum assistance with bathing, dressing, and hygiene. PTA # 1 documented in a therapy progress note for the session of 3/14/25 the following information. She (PTA #1) had instructed the resident on the proper use of the quad cane because she was not using it properly. The resident had also participated in bean bag tossing, transfers from sitting to standing, and ball kicking. PTA # 1 documented in a therapy progress note for the session of 3/17/25 Resident # 3 needed minimal assistance to transfer to the left and that training was done with a Nurse Aide (NA) to allow for the resident to be toileted by the Nurse Aide. ST #1 documented in a speech therapy progress note for the session of 3/17/25 the following information. Pt [patient] participated with expressive language tasks for simple phrase completion and simple responsive naming tasks with improvement noted. Pt completed tasks with 80% accuracy given min to mod [minimal to moderate] verbal cueing. Pt read simple functional phrases out loud with improved fluency. Pt approximately 75% intelligible when reading simple phrases given moderate cueing [pt wearing glasses for reading task]. Pt alert and up in her wheelchair for po [oral] trials. ST # 1 further noted she educated the resident on swallowing recommendations and the resident was able to participate in solid food trials with minimal improvement in pocketing. Review of weight records revealed on 3/18/25 Resident # 3's weight was documented as 150.3 pounds, which indicated she had gained weight from her documented 3/8/25 admission weight of 147.1. ST # 1 documented in a speech therapy progress note for the session of 3/18/25 the following information. Resident # 3 was dysarthric (difficulty speaking) but she participated with naming common pictured items with 75 % accuracy when given minimal to moderate cueing. Her speech was approximately 75 % intelligible. During the session the resident's right side of her face suddenly started to twitch and Resident # 3 grabbed her face. The physician was notified via nursing. The resident was able to brush her teeth with minimal assistance. The resident was able to drink through a straw without signs of aspiration. ST # 1 was interviewed on 6/3/25 at 3:35 PM and reported the following information. During the first part of Resident # 3's speech therapy she was feeding herself. It was not perfect but all things considered she was doing good. She also had the will to do good. She started to use a divided plate to help with meals. There was a day when the resident had some facial twitching. The resident seemed aware of it and then it went away. The nurse was told about the facial twitching. During the end of therapy, the resident had some general malaise. The date of 3/18/25 was the last date that the resident received speech therapy. ST # 1 reported she was out of work following 3/18/25. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/18/25 at 11:20 AM Nurse # 1 completed a SBAR narrative (situation, background, assessment, and recommendation) which noted the following information. Speech therapy had been in with the resident and the resident experiencing twitching to the right side of her face with slower speech than baseline per therapy. Her vitals were within normal limits. The physician was notified and ordered baclofen 10 mg (a muscle relaxer medication) twice per day as needed for spasms. This was the last documented notification to the physician in the narrative nursing notes about a change in the resident's condition prior to 3/25/25. Interview with Nurse # 1 on 6/4/25 at 3:50 PM revealed the only thing she was aware of on 3/18/25 was that the resident had some twitching. She had talked to the physician and the physician thought the twitching was related possibly to residual effects of her stroke. Nurse # 1 reported she did not see any further change in the resident on 3/18/25. On 6/4/25 at 2:00 PM Nurse # 2 entered a late entry into the nursing notes for the date of 3/20/25 at 3:52 PM which read, Therapist brought resident back to room saying resident unable to participate. No [mechanical lift pad] under resident. Assist X 3 to bed. Assist X 2 to get situated in bed. VS WNL [vital signs within normal limit] for resident bed low. Call light in reach. PTA # 1 documented in a therapy progress note for the session of 3/20/25 the following information. Resident # 3 was brought to the gym for therapy and while working on transfers, PTA # 1 documented, With each attempt (2 attempts made) patient required increased assist. When asking patient about what was wrong patient noted to not be attempting to verbalize as per her usual. When asked if she felt bad patient nodded yes. When asked if she was hurting anywhere patient again nodded yes. When asked where she was hurting patient put left had [as written] to her head. Immediately returned patient to her room and informed nursing. Patient became less responsive and was assisted to bed with dependent assist. Patient placed in supine and hall nurse and DON (Director of Nursing) assessed patient. Later in day patient noted to not be in bed and this therapist was informed she was in WC [wheelchair] with activities for bingo. Still later found patient in her room slumped with head back and eyes open, partially responsive. Returned patient to bed with max/dep [maximum dependent] assist and notified nursing. Spoke with activities who stated patient was sitting with head back during activities and said she wanted to go back to bed so she was pushed to her room and call bell activated. PTA # 1 was interviewed on 6/3/25 at 4:22 PM and reported the following information. The first few days when Resident # 3 resided at the facility, she was making progress. She could walk with help and had some really, really good days. She also could get her point across with gestures and she communicated with staff in that manner. Then one day she had a big change. She stopped trying to gesture and stopped trying to verbalize. She started to need a lot more assistance in therapy with transfers. She (PTA #1) had reported this to the nursing staff. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 2 had cared for Resident # 3 on the day of 3/20/25. Additionally, the file noted Nurse # 2 had cared for Resident # 3 on 3/17/25, 3/19/25, 3/20/25 and 3/24/25. Nurse # 2's signed 3/26/25 statement read in part, In my opinion [Resident # 3] was a candidate for hospice. [Resident # 3] was unable to speak, she moaned and pointed a lot. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse # 2 was interviewed on 6/4/25 at 3:40 PM and reported the following information. She did not routinely work with Resident # 3 and only recalled working with Resident # 3 twice. The resident always seemed to be in bed and not doing well when she cared for her. Nothing had ever been communicated to her (Nurse # 2) that the resident had been making progress in therapy and had been walking in therapy. She recalled a therapist one day saying the resident could not participate in therapy, and she wondered, given what she knew about the resident, why therapy had the resident out of bed. The nurse reported there had been some communication breakdown because if she had known the resident had in recent weeks been able to walk with a quad cane she would have had her sent out to the hospital. She validated she had not called the physician on 3/20/25. On 3/21/25 licensed PT # 1 documented the following, PT [Physical Therapist] completes progress note with patient today. Patient found in supine with appearance that she is ready to get up. PT directs patient in rolling L & R [left and right] to finish putting pants on. Patient requires mod A [moderate assist] to roll to L side and CGA cues [contact guard assist cues] for rolling to R side. PT directs patient in 2X supine < >EOB (Edge of Bed) transfers with max A [maximum assistance] and cues with both attempts patient reporting dizziness, lightheadedness, nausea, and overall not feeling well. PT takes BP [blood pressure], during second attempt noting it to be 118/60 in seated from 132/58 in supine at rest. PT notes this to be a mild decrease in BP, however not enough to be considered orthostatic hypotension. PT discusses this change in BP with nurse and overall change in status from admission. Nurse plans to pass the message along to DON and/or doctor for potential further workup on why patient is declining in functional status & overall feeling. Patient is only able to respond to questions with head nocks/shakes [as written] for yes/no questions. PT # 1 was interviewed on 6/3/25 at 4:10 PM and reported the following information. When Resident # 3 was initially admitted , she and the Occupational Therapist conducted their initial evaluations together. The resident was able to go to the bathroom with moderate assistance. In therapy she began walking with a quad cane. In her progression of therapy, the resident went up and did really well and then went down. In the beginning of therapy, the resident could shake her head yes and no to communicate. She was doing better with communication near the beginning. Near the end of her stay she was minimally communicating. She went from transferring and walking with the quad cane to being totally dependent for transfers near the end of her stay. It had been Nurse # 1 who had been in the room on the day that the resident's blood pressure was taken and dropped. Nurse # 1 (who was assigned to care for Resident # 3 on 3/21/25) was interviewed on 6/4/25 at 3:50 PM and reported the following information. She knew Resident # 3 had a major stroke when she was admitted to the facility and had always had right sided neglect (where a person's awareness of one side of their body is impaired after a stroke). She seemed to be the same the times she took care of her, and it had never been communicated to her that the resident could stand, pivot, and was progressing with therapy soon after admission. She did not ever witness that herself. She did not recall therapy talking to her about changes or problems. She had not called the physician. If she had known the resident had previously in therapy been doing more for herself to the degree that she could stand and pivot, then she would have for sure called the physician. At times therapy also communicated with the Unit Manager about things. The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported she was not aware of a change in condition for Resident # 3 and had not notified the physician. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON (Director of Nursing) was interviewed on 6/5/25 at 4:00 PM. The DON reported the following. She only recalled one time when a change in condition had been mentioned to her about Resident # 3 and that was regarding the twitching the resident had on 3/18/25. She (the DON) knew physician orders were obtained for that and she was not aware of the resident's decline. Therefore, she had not communicated with the physician since it had not been made clear to her. On 3/22/25 a Point of Care Testing Result for COVID showed Resident # 3 tested positive for a COVID infection. On the form, the resident was checked as having no symptoms. On 3/22/25 at 11:20 AM Nurse # 1 documented she had called and talked to Resident # 3's responsible party and that the resident's vitals were stable. The resident had left sided neglect, had difficulty swallowing, was pocketing food, and she was receiving therapy services. On 3/22/25 at 6:02 PM the Unit Manager documented, Writer called first Emergency contact and informed her of resident testing positive for COVID received verbal consent to start antiviral medication. Record review revealed no notation in the progress notes or on the COVID test result that the physician was notified of the resident testing positive for COVID on 3/22/25. On 6/4/25 at 2:15 PM the Administrator, DON, Nurse Consultant, and Chief Clinical Officer were interviewed and reported the following information. The Administrator reported they had an outbreak of COVID on 3/18/25 and Resident # 3 did not test positive until 3/22/25. When residents tested positive, there was a procedure that the Unit Manager was supposed to contact the physician and determine if he wanted them to receive antiviral treatment. They could not find in the record that was done. The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported the following information. There was a lot that happened during the outbreak, and she could not recall for sure whether she had contacted the physician and what he said about Resident # 3 having COVID. On 3/23/25 OTA# 1 (Occupational Therapist Assistant) documented Resident # 3 was unable to follow commands, utilize utensils, or engage in self-feeding in any manner without total assistance. OTA # 1 further noted, Pt appeared dehydrated. Pt (patient) able to utilize straw for sucking for brief period and did not react to bringing drink or food to mouth. Collaborated with nursing regarding PO [oral] intake to improve therapeutic potential, however Pt (patient) unable to engage in meal task at this time. OTA # 1 was interviewed on 6/5/25 at 9:30 AM and reported the following. She could not recall specific details of who she had talked to in nursing or working with Resident # 3 on 3/23/25. She would not have written the resident appeared dehydrated unless the resident's mouth was dry or the resident did not pass the skin pinch test. (A test to assess hydration and skin elasticity by seeing how quickly the skin returns to its normal position when pinched and released) On 3/23/25 at 3:24 PM Nurse # 1 documented the following in a nursing note. Resident # 3 continued with right-sided neglect and her right side was flaccid. The resident was moving her left side, but without purposeful movements. The resident would look when spoken to and her eyes would drift towards the left side. Her vitals were stable and she was not in apparent distress. On 3/23/25 at 8:23 PM Nurse # 1 noted, correction R sided neglect. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/24/25 COTA # 2 (Certified Occupational Therapist Assistant) wrote, Pt very lethargic. Required max cues to maintain alertness and participate. Pt was dependent for all tasks. Licensed Occupational Therapist # 1 was interviewed on 6/3/25 at 3:53 PM and reported the following. The resident could stand and pivot at the start of her therapy treatment. She would make eye contact and try to tell the staff things when she first started therapy. The therapy staff noticed a distinct change a few days before she was discharged from the facility. She was not functioning per her normal and was not as alert. This had been communicated to the nurses, but the licensed OT could not recall which nurses had been told. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse Aide (NA) #1 had cared for Resident # 3 on the dates of 3/10/25, 3/11/25, 3/15/25, 3/16/25, 3/18/25, 3/19/25, 3/24/25, and 3/25/25. Review of NA # 1's signed 3/26/25 statement in the investigative file revealed in part the following information. When [Resident # 3] first arrived at the facility [Resident # 3] was unable to verbalize her needs; she used her hands and head to communicate. [Resident # 3] needed assistance with feeding. As a few days went by she was getting up in her wheelchair and was able to feed herself. I noticed a change in condition on approximately 3/18/25, [Resident # 3] was acting differently having facial twitching. I noticed [Resident # 3] eating less and [Resident # 3] was unable to sit up in a wheelchair like she had been doing previously. I notified the hall in the change of condition (as written), not sure which nurse was working that day. The nurse went into the room and assessed [Resident # 3]. NA # 1's statement specifically included information about the date of 3/24/25 which read, On 3/24/25 I noticed [Resident # 3] was placing her hands in her brief, pulling off her clothes and at lunch, [Resident # 3] had pulled her lunch tray off of the over the bed table into the bed. [Resident # 3] was also staring off into space and moaning, but unable to verbalize if anything was wrong when she was asked. I reported the changes to the hall nurse [Nurse # 2]. [Nurse #2] went into the room and assessed [Resident # 3]. NA # 1 was interviewed on 6/3/25 at 2:40 PM and reported the following information. When Resident # 1 was admitted the resident worked with therapy and could sit up all day in her wheelchair. She could eat and drink with her good hand. She could pivot to the toilet and have a bowel movement. She could communicate by motioning for her needs. Prior to Resident # 3 testing positive for COVID there was a day when she (NA # 1) had observed Resident # 3 slumped over in her wheelchair. The resident's head was bent over near her knees, and she was almost ready to hit the floor. She (NA # 1) recalled she obtained the assistance of NA # 2 and they lifted the resident back to bed. The resident was limp and seemed out of it. At some point after that episode, she (NA #1) recalled Resident # 3 started to twitch. It was not just in her face but at times her shoulder would move up and down with the twitching. The twitching continued but was better some days than other days. The resident would stare off in space and not eat. She seemed to have less urine in her brief. She (NA #1) changed her about two times per shift. The resident would put her hand in her brief. Prior to the change that she (NA #1) noticed, the resident seemed to be cold in nature. After the change, Resident # 3 would snatch off her clothes. NA # 2 was interviewed on 6/3/25 at 2:52 PM and reported the following information. She was the Lead NA and helped everywhere. She did recall there was a day when she had helped NA # 1 get Resident # 3 back to bed because the resident was slouching and it seemed like she could not sit up. That was new for Resident # 3 and she did not seem herself. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 3 had cared for Resident # 3 on the dates of 3/13/25, 3/14/25, 3/17/25, 3/20/25, 3/22/25, and 3/23/25. Review of NA # 3's 3/26/25 signed statement in the investigative file revealed in part the following information. When [Resident # 3] first arrived at the facility [Resident # 3] would attempt to communicate utilizing paper, [Resident # 3] was unable to communicate verbally. After [Resident # 3] was diagnosed with COVID her condition changed. [Resident # 3] started placing hand in her brief, staring off in to space, taking off her clothes and twisting and turning in the bed. NA # 3 further added in her statement that she had worked the weekend of 3/22/25 and 3/23/25 with Resident # 3. She had not noted a difference in the resident's urination or bowels, but the resident did not eat or drink much either day which NA # 3 noted was a change when compared to before the time the resident had COVID. NA # 3 was interviewed on 6/3/25 at 9:22 AM and reported the following information. When Resident # 3 was admitted the resident had worked with therapy and she (NA # #3) had watched the therapist use the gait belt and take Resident # 3 to the bathroom. She (NA # 3) learned to do this from the therapist, and Resident # 3 could stand and pivot to the wheelchair and then stand and pivot to the toilet. The resident made attempts to communicate with paper with her family. The resident would get up for meals and progressed to the point where she could feed herself. After the resident got COVID she did a complete 360 and changed. She would look off into space. When she (NA #3) helped turn the resident in bed, the resident would swing her arms as if falling. She would rip her brief off her body and dig in her brief. She had to be fed and did not eat or drink much. Her mouth looked dry as if she had a film over it. She (NA # 3) would tell the nurses she worked with that this person is not right. She recalled Nurse # 1 saying that Resident # 3 was declining. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 4 had cared for Resident # 3 on the dates of 3/20/25, 3/21/25, and 3/24/25 during the 3:00 PM to 11:00 PM shift. Review of NA # 4's signed 3/25/25 statement in the investigative file revealed in part the following information. I'm not real familiar with [Resident # 3] due to the fact I only worked with [Resident # 3] on a few occasions. I attempted to feed [Resident # 3] and get [Resident # 3] to drink something the days I was assigned to [Resident # 3] but [Resident # 3] would refuse. I was in the room when a therapist stated they had attempted to get [Resident # 3] to eat and drink but were unable to get [Resident # 3] to do either. When I provided incontinent care [Resident # 3] had urinated a small amount. I do recall that [Resident # 3] had a small bowel movement that was noted to be black in color. I do not recall foul odors; I do remember her placing her hands in her brief and picking at the brief. I do recall [Resident # 3] would throw her pillows on the floor consistently. [Resident # 3] would constantly stare at the ceiling. Family member came in on 3/24/25 asking about how much [Resident # 3] was eating. I informed family member that she didn't' eat dinner for you [as written]. Family went to [Nurse # 2] asked [Nurse # 2] about how much [Resident # 3] had eaten on 3/24/25. The family member seemed concerned and confused. NA # 4 was interviewed on 6/3/25 at 3:06 PM and reported the following information. She did not know how Resident # 3 had been when she first arrived at the facility. When she cared for her, the resident would stare off distantly and seemed fixated on the ceiling. She (NA # 4) could not get her to focus. It was very noticeable that she would pick at her brief. There was one day when the therapist was in the room and the resident would not swallow. When the resident had a dark stool, she (NA #4) thought that the resident was possibly on iron and she did not notice blood or a foul odor with the stool. (continued on next page)

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	345325	A. Building B. Wing	06/10/2025

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documentation in the record of the physician being notified the resident was not eating, staring off distantly, would not focus, was having dark bowel movements while also exhibiting these symptoms. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 5 had cared for Resident # 3 on the 11:00 PM shift to 7:00 AM shift on 3/15/25, 3/16/25, 3/17/25, 3/19/25, 3/20/25, 3/21/25, 3/24/25. Review of NA # 5's signed statement in the investigative file revealed the following information. I worked 3rd shift I never observed [Resident # 3] eating or drinking but food/snacks were in her room. [Resident # 3] never communicated with me or used her call light while I was working. [Resident # 3] was incontinent and did not urinate or have a lot of bowel movements. [Resident # 3] moved around a lot in bed, moved her legs, removed her bed covers, removed her brief and would throw her pillow on the floor. On 3/24/25, I noticed around [Resident # 3's] mouth that it was dry. During incontinent care [Resident # 3] had a dark, almost black bowel movement on the morning of 3/25/25. At approximately 5:15 AM while providing incontinent care I noticed a rattling sound in her throat, that I had not heard before, I notified [Nurse # 5] and [Nurse #6] . I witnessed [Nurse # 5] go into [Resident # 3's] room for approximately 2-3 minutes. I did not go back into the room again before the end of my shift. NA # 5 was interviewed on 6/3/25 at 11:20 PM and reported the following information. When she cared for Resident # 3 the resident would be awake at night. She would move her legs back and forth and she always appeared that way when she had cared for her. On the last night she had cared for Resident # 3, she (NA # 5) had been in the room at 5:15 AM and could hear a rattle in the resident's throat while standing at her bedside. The resident had her eyes open but she would not respond. She saw Nurse # 5 go into the resident's room after she reported the rattle. She (NA # 5) did not go back in the room after the nurse went to check on the resident. Nurse # 5 was interviewed on 6/3/25 at 11:12 PM and reported she had not been assigned to Resident # 3, was not aware of a change in the resident, and did not call the physician. Nurse # 6 had cared for Resident # 3 on the shift which began at 7:00 PM on 3/24/25 and ended at 7:00 AM on 3/25/25. Nurse # 6 reported the following. She had not called the physician when Resident # 3 was observed rattling on the night shift. She did not recall this being reported to her or any other change that warranted a phone call to the physician prior to the dayshift staff coming on duty on 3/25/25. That was when the dayshift Nurse Aide (NA # 1) reported the resident was not right and she had been telling the nurses on daysh[TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on record review and interviews with staff, responsible party (RP), therapy staff, and the Physician, the facility failed to obtain labs as directed by the physician and ensure staff effectively communicated amongst themselves in order that a change in condition be recognized by the licensed nursing staff and a resident receive evaluation and necessary medical treatment. Resident # 3 entered the facility for rehabilitation. Therapists and Nurse Aides revealed Resident # 3 was initially making progress in therapy to the degree that she could feed herself, ambulate short distances with therapy in parallel bars or with a quad cane, toilet to the commode, and communicate her needs by gestures. Days prior to a hospital discharge, Resident # 3 had a decline in functional status that included symptoms of dizziness, lightheadedness, nausea, and periods of altered responsiveness. Following this decline, Resident # 3 tested positive for COVID (Coronavirus Disease) on 3/22/25 with no indication of evaluation or treatment for her decline and COVID infection. Following 3/22/25, the resident had a poor appetite, her mouth appeared dry, she would stare off in space, and not focus on staff. The resident did not receive evaluation and medical treatment to treat her change in condition until she was transferred to the hospital on 3/25/25 where she was found to be septic (when an individual's body has an extreme reaction to an infection, and which can lead to organ failure) due to her COVID infection. The resident was additionally found to have gastrointestinal bleeding, which resulted in a critical hemoglobin of 4.0 (normal 12-16) and required three units of blood. The resident was hospitalized in the Intensive Care Unit. The resident's 4/8/25 hospital discharge summary noted the resident had sustained heart injury due to the sepsis. This was for 1 of 3 sampled residents reviewed for professional standards of practice to address a change in medical condition (Resident # 3). Immediate jeopardy began on 3/21/25 when a significant decline in Resident #3's condition was identified and a comprehensive evaluation was not conducted and treatment was not implemented. Immediate Jeopardy was removed on 6/6/25 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: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 3's 3/3/25 hospital history and physical and the resident's 3/8/25 hospital discharge summary revealed the following information. Prior to hospitalization the resident resided independently at home and presented to the hospital on 3/3/25 with slurred speech. While hospitalized the resident underwent an MRI (Magnetic Resonance Imaging) which revealed multiple acute small infarcts (areas of brain damage from a lack of oxygen). The resident was diagnosed with a stroke with right-sided weakness and slurred speech. At the time of the 3/8/25 hospital discharge the resident's physical exam showed left sided facial deviation (drooping), right upper extremity strength of 2 out of 5, right lower extremity strength of 5 out of 5 and left upper and left lower extremity strength of 5 out of 5 (five indicating normal strength against gravity and resistance whereas 2 representing a degree of impairment in muscle strength). Discharge medications included Plavix 75 milligrams (mg) every day for 41 doses (an anticoagulant), Lovenox 40 mg injection for 13 days (an anticoagulant), and Aspirin 81 mg every day for 17 doses. Resident # 3 was also identified to have microcytic, hypochromic anemia (a general term for anemia when the red blood cells are pale) with no evidence of acute blood loss. The resident's Hgb and Hct (hemoglobin and hematocrit) were documented to be stable at time of her 3/8/25 discharge. The discharging physician further noted Resident # 3 needed to be evaluated as an outpatient for chronic blood loss and further gastrointestinal workup would be deferred to the primary care physician. The resident's 3/8/25 discharge summary also noted the resident had benign hypertension. Resident # 3 was admitted to the facility on [DATE] with diagnoses of stroke, anemia, and hypertension. An admission nursing note on 3/8/25 at 3:08 PM noted the resident had a right sided deficit, was awake, alert, oriented to self, and denied any discomfort. Physician orders revealed Resident # 3 was a full code. Occupational Therapy, Physical Therapy, and Speech Therapy were ordered on 3/10/25. Resident # 3's care plan initiated on 3/10/25 indicated the resident had a self-care deficit related to weakness, deconditioning, and mobility limitations related to her stroke. The care plan noted Resident # 3 would receive therapy. There were also directions on the care plan to monitor/document as needed any changes and any potential for improvement, reasons for self-care deficit, expected course and declines in function. Physical Therapist (PT) # 1's notes revealed on 3/10/25 Resident # 3 actively participated with physical therapy. PT # 1 documented the following information regarding the treatment session on 3/10/25. She (PT # 1) directed Resident # 3 to go from a supine (lying) position to a sitting position. The resident transferred with good balance and with bilateral upper extremities and bilateral lower extremities supported. The resident was able to transfer to the toilet with both PT # 1 and an Occupational Therapist present. PT # 1 helped Resident # 3 with trials of transfers with a quad cane and the future plan was to do a trial with the quad cane or hemi-walker (a mobility device for individuals who have limited use of one of their hands) during transfers and ambulation during the next therapy session. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the record there was one documented visit from the facility physician while the resident resided at the facility on 3/11/25. Within the 3/11/25 physician's progress note, the physician included further diagnoses of thrombocytosis (elevated platelets), cardiomyopathy (disease of the heart muscle), dyslipidemia (elevated cholesterol or fats), and aphasia (loss of ability to express speech clearly or understand). The physician noted the plan was to complete labs which included a complete blood count, a thyroid stimulating hormone, Vitamin B 12 level, Vitamin D level, folate, liver panel, basic metabolic panel, and c-reactive protein. The physician's plan also included therapy and the resident's prognosis was documented as fair. Review of the facility record revealed no orders for the lab work the physician had documented in the plan in the 3/11/25 progress note were entered into the computer and they were never completed while the resident resided at the facility. Interview with Resident # 3's Physician on 6/4/25 at 5:50 PM revealed he made rounds with the nurses, instructed nurses to read his notes, and follow the directions in his notes. According to the Physician, the labs noted in the 3/11/25 physician note should have been done. On 3/11/25 PTA (Physical Therapy Assistant) # 1 documented a care plan was held with the resident, family, social worker, and that the family's plan was that Resident # 3 go home with family after therapy and discharge. On 3/11/25 ST (Speech Therapist) # 1 documented the following in a speech therapy progress note, Pt [Patient] assessed with her lunch meal. Pt alert and sitting up in her wheelchair. Pt able to feed herself with her left hand for the most part. ST # 1 further noted Resident # 1 consumed 40 percent of her meal before indicating she did not want any more and that she was able to brush her teeth with intermittent minimal assistance. The ST also noted Resident # 3 was receptive to education. On 3/12/25 PTA # 1 documented multiple treatment modalities in a physical therapy progress note. One included that gait training was begun in the parallel bars and the resident was able to complete the length of the parallel bars with minimal assistance two times while resting in between. On 3/14/25 PTA # 1 documented in a therapy progress note for the session of 3/13/25 the following information. She (PTA # 1) instructed Resident # 3 in the use of the hemi-walker and quad cane and the resident required minimal to moderate assist due to impulsivity, the need to support her right upper extremity, and balance deficits. The resident was documented as walking 12 feet with both the hemi-walker and the quad cane on 3/13/25. The resident was documented as needing minimal assistance for transfers on the session date of 3/13/25. The resident had declined wheelchair mobility because she (the resident) wanted to focus on transfers and gait. Resident # 3's admission MDS (Minimum Data Set) assessment, dated 3/14/25 coded the resident as having unclear speech and was moderately cognitively impaired. She was assessed to need substantial to maximum assistance with bathing, dressing, and hygiene. PTA # 1 documented in a therapy progress note for the session of 3/14/25 the following information. She (PTA #1) had instructed the resident on the proper use of the quad cane because she was not using it properly. The resident had also participated in bean bag tossing, transfers from sitting to standing, and ball kicking. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PTA # 1 documented in a therapy progress note for the session of 3/17/25 that Resident # 3 needed minimal assistance to transfer to the left and that training was done with a Nurse Aide (NA) to allow for the resident to be toileted by the Nurse Aide. ST #1 documented in a speech therapy progress note for the session of 3/17/25 the following information. Pt participated with expressive language tasks for simple phrase completion and simple responsive naming tasks with improvement noted. Pt completed tasks with 80% accuracy given min to mod [minimal to moderate] verbal cueing. Pt read simple functional phrases out loud with improved fluency. Pt approximately 75% intelligible when reading simple phrases given moderate cueing (pt wearing glasses for reading task). Pt alert and up in her wheelchair for po [oral] trials. ST # 1 further noted she educated the resident on swallowing recommendations and the resident participated with eating solid food with minimal improvement in pocketing food. Review of weight records revealed on 3/18/25 Resident # 3's weight was documented as 150.3 pounds, which indicated she had gained weight from her documented 3/8/25 admission weight of 147.1. ST # 1 documented in a speech therapy progress note for the session of 3/18/25 the following information. Resident # 3 was dysarthric (difficulty speaking) but she participated with naming common pictured items with 75% accuracy when given minimal to moderate cueing. Her speech was approximately 75% intelligible. During the session the resident's right side of her face suddenly started to twitch and Resident # 3 grabbed her face. The physician was notified via nursing. The resident was able to brush her teeth with minimal assistance. The resident was able to drink through a straw without signs of aspiration. ST # 1 was interviewed on 6/3/25 at 3:35 PM and reported the following information. During the first part of Resident # 3's speech therapy she was feeding herself. It was not perfect but all things considered she was doing good. She also had the will to do good. She started to use a divided plate to help with meals. There was a day when the resident had some facial twitching. The resident seemed aware of it and then it went away. The nurse was told about the facial twitching. During the end of therapy, the resident had some general malaise (general feeling of being unwell). The date of 3/18/25 was the last date that the resident received speech therapy. ST # 1 reported she was out of work following 3/18/25. On 3/18/25 at 11:20 AM Nurse # 1 completed a SBAR narrative (situation, background, assessment, and recommendation) which noted the following information. Speech therapy had been in with the resident and the resident experiencing twitching to the right side of her face with slower speech than baseline per therapy. Her vitals were within normal limits. The physician was notified and ordered baclofen 10 mg (a muscle relaxer medication) twice per day as needed for spasms. Interview with Nurse # 1 on 6/4/25 at 3:50 PM revealed the only thing she was aware of on 3/18/25 was that the resident had some twitching. She had talked to the physician and the physician thought the twitching was related possibly to residual effects of her stroke. Nurse # 1 reported she did not see any further change in the resident on 3/18/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PTA # 1 documented in a therapy progress note for the session of 3/20/25 the following information. Resident # 3 was brought to the gym for therapy and while working on transfers, PTA # 1 documented, With each attempt (2 attempts made) patient required increased assist. When asking patient about what was wrong patient noted to not be attempting to verbalize as per her usual. When asked if she felt bad patient nodded yes. When asked if she was hurting anywhere patient again nodded yes. When asked where she was hurting patient put left had [as written] to her head. Immediately returned patient to her room and informed nursing. Patient became less responsive and was assisted to bed with dependent assist. Patient placed in supine and hall nurse and DON [Director of Nursing] assessed patient. Later in day patient noted to not be in bed and this therapist was informed she was in WC [wheelchair] with activities for bingo. Still later found patient in her room slumped with head back and eyes open, partially responsive. Returned patient to bed with max/dep [maximum dependent] assist and notified nursing. Spoke with activities who stated patient was sitting with head back during activities and said she wanted to go back to bed so she was pushed to her room and call bell activated. PTA # 1 was interviewed on 6/3/25 at 4:22 PM and reported the following information. The first few days when Resident # 3 resided at the facility, she was making progress. She could walk with help and had some really, really good days. She also could get her point across with gestures and she communicated with staff in that manner. Then one day she had a big change. She stopped trying to gesture and stopped trying to verbalize. She started to need a lot more assistance in therapy with transfers. She (PTA #1) had reported this to the nursing staff. On 6/4/25 at 2:00 PM Nurse # 2 entered a late entry into the nursing notes for the date of 3/20/25 at 3:52 PM which read, Therapist brought resident back to room saying resident unable to participate. No [mechanical lift pad] under resident. Assist X 3 [assistance of 3 persons] to bed. Assist X 2 to get situated in bed. VS WNL [vital signs within normal limits] for resident Bed low. Call light in reach. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 2 had cared for Resident # 3 on the day of 3/20/25. Additionally the file noted Nurse # 2 had cared for Resident # 3 on 3/17/25, 3/19/25, 3/20/25 and 3/24/25. Nurse # 2's 3/26/25 signed statement included, In my opinion [Resident # 3] was a candidate for hospice. [Resident # 3] was unable to speak, she moaned and pointed a lot. Nurse # 2 was interviewed on 6/4/25 at 3:40 PM and reported the following information. She did not routinely work with Resident # 3 and only recalled working with Resident # 3 twice. The resident always seemed to be in bed and not doing well when she cared for her. Nothing had ever been communicated to her (Nurse # 2) that the resident had been making progress in therapy and had been walking in therapy. She recalled a therapist one day saying the resident could not participate in therapy, and she wondered, given what she knew about the resident, why therapy had the resident out of bed. The nurse reported there had been some communication breakdown because if she had known the resident had in recent weeks been able to walk with a quad cane she would have had her sent out to the hospital. Nurse #2 indicated she never recalled a nurse aide telling her Resident #3 had a change in condition. On 3/21/25 there was no narrative nursing progress notes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/21/25 PT # 1 documented the following, PT completes progress note with patient today. Patient found in supine with appearance that she is ready to get up. PT directs patient in rolling L & R [left and right] to finish putting pants on. Patient requires mod A (moderate assist) to roll to L side and CGA cues [contact guard assist cues] for rolling to R side. PT directs patient in 2 X supine < >EOB (Edge of Bed) transfers with max A [maximum assistance] and cues with both attempts patient reporting dizziness, lightheadedness, nausea, and overall not feeling well. PT takes BP [blood pressure], during second attempt noting it to be 118/60 in seated from 132/58 in supine at rest. PT notes this to be a mild decrease in BP, however, not enough to be considered orthostatic hypotension. PT discusses this change in BP with nurse and overall change in status from admission. Nurse plans to pass the message along to DON and/or doctor for potential further workup on why patient is declining in functional status & overall feeling. Patient is only able to respond to questions with head nocks/shakes [as written] for yes/no questions. PT # 1 was interviewed on 6/3/25 at 4:10 PM and reported the following information. When Resident # 3 was initially admitted , she and the Occupational Therapist conducted their initial evaluations together. The resident was able to go to the bathroom with moderate assistance. In therapy she began walking with a quad cane. In her progression of therapy, the resident went up and did really well and then went down. In the beginning of therapy, the resident could shake her head yes and no to communicate. She was doing better with communication near the beginning. Near the end of her stay she was minimally communicating. She went from transferring and walking with the quad cane to being totally dependent for transfers near the end of her stay. It had been Nurse # 1 who had been in the room on the day that the resident's blood pressure was taken and dropped. Nurse # 1 (who was assigned to care for Resident # 3 on 3/21/25) was interviewed on 6/4/25 at 3:50 PM and reported the following information. She knew Resident # 3 had a major stroke when she was admitted to the facility and had always had right sided neglect (where a person's awareness of one side of their body is impaired after a stroke). She seemed to be the same the times she took care of her, and it had never been communicated to her that the resident could stand, pivot, and was progressing with therapy soon after admission. She did not ever witness that herself. She did not recall therapy talking to her about changes. At times, therapy talked to the Unit Manager. The DON was interviewed on 6/5/25 at 4:00 PM. The DON reported the following. She only recalled one time when a change in condition had been mentioned to her about Resident # 3 and that was regarding the twitching the resident had on 3/18/25. She (the DON) knew physician orders were obtained for that and she was not aware of the resident's decline. On 3/22/25 a Point of Care Testing Result for COVID showed Resident # 3 tested positive for a COVID infection. On the form, the resident was checked as having no symptoms. On 3/22/25 at 11:20 AM Nurse # 1 documented she had called and talked to Resident # 3's responsible party and that the resident's vitals were stable. The resident had left sided neglect, had difficulty swallowing, was pocketing food, and she was receiving therapy services. On 3/22/25 at 6:02 PM the Unit Manager documented, Writer called first Emergency contact and informed her of resident testing positive for COVID received verbal consent to start antiviral medication. Review of the record revealed no medication treatment orders were begun on 3/22/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported the following information. She had tested residents during the COVID outbreak. Typically, the symptoms they were seeing with COVID positive residents were a runny nose and/or cough. Resident # 3 did not have those symptoms when Resident # 3 tested positive on 3/22/25. She (the Unit Manager) had called the family and asked for permission about placing the resident on an antiviral if the physician chose to do so when the resident tested positive. There was a lot that happened during the outbreak, and she could not recall for sure whether she had contacted the physician and what he said about Resident # 3 having COVID. At times in general she knew that he was hesitant about antivirals because of kidney function. She had not realized Resident # 3 was having a decline. If it had been communicated to her clearly and she had realized this, then she would have gone into action to make sure she got treatment. On 6/4/25 at 2:15 PM the Administrator and DON were interviewed with the Nurse Consultant and Chief Clinical Officer also present. The following information was present. The Administrator reported they had an outbreak of COVID on 3/18/25 and Resident # 3 did not test positive until 3/22/25. The DON and Administrator reported the Unit Manager tested the residents. The DON further reported when residents tested positive, there was a procedure that the Unit Manager was supposed to contact the physician and determine if he wanted them to receive antiviral treatment. The family would also be notified. Because some of the antivirals could affect kidney function, the use of any ordered antiviral would also be reviewed by the pharmacy in conjunction with a resident's kidney function before starting the medication. They (these administrative staff) had looked at Resident # 3's medical record the previous evening (6/3/25). Excluding the Unit Manager's actions to obtain family consent for an antiviral, they could find no record this procedure had been done for Resident # 3. On 3/23/25 OTA # 1 (Occupational Therapist Assistant) documented Resident # 3 was unable to follow commands, utilize utensils, or engage in self-feeding in any manner without total assistance. OTA # 1 further noted, Pt appeared dehydrated. Pt able to utilize straw for sucking for brief period and did not react to bringing drink or food to mouth. Collaborated with nursing regarding PO intake to improve therapeutic potential, however Pt unable to engage in meal task at this time. OTA # 1 was interviewed on 6/5/25 at 9:30 AM and reported the following. She could not recall specific details of who she had talked to in nursing or working with Resident # 3 on 3/23/25. She would not have written the resident appeared dehydrated unless the resident's mouth was dry or the resident did not pass the skin pinch test (assesses skin elasticity and potentially indicate dehydration). On 3/23/25 at 3:24 PM Nurse # 1 documented the following in a nursing note. Resident # 3 continued with right-sided neglect and her right side was flaccid. The resident was moving her left side, but without purposeful movements. The resident would look when spoken to and her eyes would drift towards the left side. Her vitals were stable and she was not in apparent distress. On 3/23/25 at 8:23 PM Nurse # 1 noted, correction R sided neglect. Nurse # 7 had cared for Resident # 3 on the shift which began at 7 PM on 3/23/25 and ended on 3/24/25. Nurse # 7 was interviewed on 6/3/25 at 4:56 PM and reported the following information. She did not recall a big change in Resident # 3. Resident # 3 had always been sluggish and to her knowledge had been admitted that way. She filled in as a nurse at the facility and she had never been told in report that the resident had been up walking or trying to eat on her own. If so, she would have been more concerned about any sluggishness she had noted. Review of narrative nursing progress notes revealed no notation for the date of 3/24/25. (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	06/10/2025

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/24/25 COTA # 2 (Certified Occupational Therapist Assistant) wrote, Pt very lethargic. Required max cues to maintain alertness and participate. Pt was dependent for all tasks. Occupational Therapist # 1 was interviewed on 6/3/25 at 3:53 PM and reported the following. The resident could stand and pivot at the start of her therapy treatment. She would make eye contact and try to tell the staff things when she first started therapy. The therapy staff noticed a distinct change a few days before she was discharged from the facility. She was not functioning per her normal and was not as alert. This had been communicated to the nurses, but OT # 1 could not recall which nurses had been told. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse Aide (NA) #1 had cared for Resident # 3 on the dates of 3/10/25, 3/11/25, 3/15/25, 3/16/25, 3/18/25, 3/19/25, 3/24/25, and 3/25/25. Review of NA # 1's 3/26/25 signed statement in the investigative file revealed the following information. When [Resident # 3] first arrived at the facility [Resident # 3] was unable to verbalize her needs; she used her hands and head to communicate. [Resident # 3] needed assistance with feeding. As a few days went by she was getting up in her wheelchair and was able to feed herself. I noticed a change in condition on approximately 3/18/25, [Resident # 3] was acting differently having facial twitching. I noticed [Resident # 3] eating less and [Resident # 3] was unable to sit up in a wheelchair like she had been doing previously. I notified the hall in the change of condition [as written], not sure which nurse was working that day. The nurse went into the room and assessed [Resident # 3]. NA # 1's statement specifically included information about the date of 3/24/25 which read, On 3/24/25 I noticed [Resident # 3] was placing her hands in her brief, pulling off her clothes and at lunch, [Resident # 3] had pulled her lunch tray off of the over the bed table into the bed. [Resident # 3] was also staring off into space and moaning, but unable to verbalize if anything was wrong when she was asked. I reported the changes to the hall nurse [Nurse # 2]. [Nurse #2] went into the room and assessed [Resident # 3]. Nurse Aide (NA) # 1 was interviewed on 6/3/25 at 2:40 PM and reported the following information. When Resident # 3 was admitted the resident worked with therapy and could sit up all day in her wheelchair. She could eat and drink with her good hand. She could pivot to the toilet and have a bowel movement. She could communicate by motioning for her needs. Prior to Resident # 3 testing positive for COVID there was a day when she (NA # 1) had observed Resident # 3 slumped over in her wheelchair. The resident's head was bent over near her knees and she was almost ready to hit the floor. She (NA # 1) recalled she obtained the assistance of NA # 2 and they lifted the resident back to bed. The resident was limp and seemed out of it. At some point after that episode, she (NA #1) recalled Resident # 3 started to twitch. It was not just in her face but at times her shoulder would move up and down with the twitching. The twitching continued but was better some days than other days. The resident would stare off in space and not eat. She seemed to have less urine in her brief. She (NA #1) changed her about two times per shift. The resident would put her hand in her brief. Prior to the change that she (NA #1) noticed, the resident seemed to be cold in nature. After the change, Resident # 3 would snatch off her clothes. NA # 2 was interviewed on 6/3/25 at 2:52 PM and reported the following information. She was the Lead NA and helped everywhere. She did recall there was a day when she had helped NA # 1 get Resident # 3 back to bed because the resident was slouching and it seemed like she could not sit up. That was new for Resident # 3 and she did not seem herself. (continued on next page)

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	345325	A. Building B. Wing	06/10/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 3 had cared for Resident # 3 on the dates of 3/13/25, 3/14/25, 3/17/25, 3/20/25, 3/22/25, and 3/23/25. Review of NA # 3's signed 3/26/25 statement in the investigative file revealed in part the following information. When [Resident # 3] first arrived at the facility [Resident # 3] would attempt to communicate utilizing paper, [Resident # 3] was unable to communicate verbally. After [Resident # 3] was diagnosed with COVID her condition changed. [Resident # 3] started placing hand in her brief, staring off in to space, taking off her clothes and twisting and turning in the bed. NA # 3 further added in her statement that she had worked the weekend of 3/22/25 and 3/23/25 with Resident # 3. She had not noted a difference in the resident's urination or bowels but the resident did not eat or drink much either day which NA # 3 noted was a change when compared to before the time the resident had COVID. NA # 3 was interviewed on 6/3/25 at 9:22 AM and reported the following information. When Resident # 3 was admitted the resident had worked with therapy and she (NA # #3) had watched the therapist use the gait belt and take Resident # 3 to the bathroom. She (NA # 3) learned to do this from the therapist, and Resident # 3 could stand and pivot to the wheelchair and then stand and pivot to the toilet. The resident made attempts to communicate with paper with her family. The resident would get up for meals and progressed to the point where she could feed herself. After the resident got COVID she did a complete 360 and changed. She would look off into space. When she (NA #3) helped turn the resident in bed, the resident would swing her arms as if falling. She would rip her brief off her body and dig in her brief. She had to be fed and did not eat or drink much. Her mouth looked dry as if she had a film over it. She (NA # 3) would tell the nurses she worked with that this person is not right. She recalled Nurse # 1 saying that Resident # 3 was declining. Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 4 had cared for Resident # 3 on the dates of 3/20/25, 3/21/25, and 3/24/25 during the 3:00 PM to 11:00 PM shift. Review of NA # 4's signed 3/25/25 statement in the investigative file revealed the following information. I'm not real familiar with [Resident # 3] due to the fact I only worked with [Resident # 3] on a few occasions. I attempted to feed [Resident # 3] and get [Resident # 3] to drink something the days I was assigned to [Resident # 3] but [Resident # 3] would refuse. I was in the room when a therapist stated they had attempted to get [Resident # 3] to eat and drink but were unable to get [Resident # 3] to do either. When I provided incontinent care [Resident # 3] had urinated a small amount. I do recall that [Resident # 3] had a small bowel movement that was noted to be black in color. I do not recall foul odors; I do remember her placing her hands in her brief and picking at the brief. I do recall [Resident # 3] would throw her pillows on the floor consistently. [Resident # 3] would constantly stare at the ceiling. Family member came in on 3/24/25 asking about how much [Resident # 3] was eating. I informed family member that she didn't' eat dinner for you [as written]. Family went to [Nurse # 2] asked [Nurse # 2] about how much [Resident # 3] had eaten on 3/24/25. The family member seemed concerned and confused. NA # 4 was interviewed on 6/3/25 at 3:06 PM and reported the following information. She did not know how Resident # 3 had been when she first arrived at the facility. When she cared for her, the resident would stare off distantly and seemed fixated on the ceiling. She (NA # 4) could not get [TRUNCATED]