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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on interviews with staff and record reviews, the facility failed to ensure a resident's code status election was accurate throughout the medical record for 1 of 2 residents reviewed for advanced directives (Resident #341). The findings included: Resident #341 admitted to the facility on [DATE]. Resident #341's physician orders dated 9/09/24 through 10/01/24 did not note an order for a code status. In an interview on 10/01/24 02:23 PM, Nurse #2 said thought that Resident #341 had an order for a Full Code code status, meaning to attempt all resuscitative measures in case of cardiac arrest. She said she was told in report by another nurse (name not recalled) that he had a full code order. She said in an emergency, she would have looked in the medical record at the orders to see what his code status was. She looked in the resident's chart but was unable to find a code status order. She continued to review the resident's chart and found a hospital note dated 8/25/24 which indicated his code status was code with limitations. Nurse #2 said she did not know what that meant. She said when a resident was about to be admitted to the facility, the procedure was that the admissions office staff would tell nursing what the code status was. She said because there was no Do Not Resuscitate (DNR) order in the chart, Resident #341 would have been treated as as full code order and would have received all measures in case of an emergency. In an interview on 10/01/24 at 3:47 PM, the Admission Director said when a resident was admitted , she met with the resident and the resident's representative (RR). She explained what advanced directives were to the resident or RR. If the resident or RR requested a DNR, the Admissions Director filled out a form with them formally requesting a DNR code status and then provided it to the charge nurse on duty, who would then request an order and complete the DNR notification form. Resident #341's RR made the decision on code status because the resident was unable to make his own wishes known. The RR requested a DNR order and signed the with the Admissions Director. The Admissions Director notified the charge nurse but was not aware of what happened after that notification. She said she did not remember the name of the nurse because the nurse was new at the time but no longer worked at the facility. (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: 345325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #341's Do Not Resuscitate Request form dated 9/09/24 revealed the RR signed the form indicating Resident #341 was to have a DNR order. In an interview on 10/01/24 at 4:53 PM, the director of nurses (DON) said Resident #341 did not have a DNR order and said one was obtained and a notification form completed on 10/01/24 after the concern was identified by surveyor.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - 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** 49502 Based on observations, record reviews, staff and physician interviews, the facility failed to notify the physician of tube feedings (nutrition administered through a tube directly into the stomach) that were ordered continuously being turned off for 2 of 2 residents (Resident #60 and Resident #74) for an undetermined amount of time and instances. During observations on 10/3/24 Resident #60's and Resident #74's feeding tube pumps (the mechanism that delivers the nutrition) were observed off. Nurse #1 confirmed she turned Resident #60's and Resident #74's tube feedings off without notifying the physician despite her knowledge that the tube feedings were ordered continuously because she believed their stomach needed a rest. Nurse #1 also confirmed this was not an isolated incident for either resident and she had done this before without notifying the physician. Deviating from the physician orders by turning off the tube feedings without notifying the physician deprived Resident #60 and Resident #74 of their assessed nutritional needs. 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 was identified for 2 of 2 residents (Resident #60 and Resident #74) reviewed for physician notification. Immediate jeopardy began on 10/3/24 when Nurse #1 turned off Resident #60's and Resident #74's tube feeding without notifying the physician. Immediate jeopardy was removed on 10/4/24 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 contained 1 employee disciplinary form from 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. During an interview with the Facility Nurse Consultant, Director of Nursing (DON), and Chief Clinical Officer on 10/4/24 at 12:33 pm, the Chief Clinical Officer 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 Facility Nurse Consultant. The Facility Nurse Consultant 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 Chief Clinical Officer explained that new nurses hired had a competency evaluation with a nurse skills checklist that was 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). (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 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 milliliters per hour (ml/hr) with 135 cc water flushes every 6 hours. No recommendations, tube feeding adequate as ordered, and well tolerated with weight stability. 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) An observation on 10/3/24 at 3:08 am revealed 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 on night shift (11:00 pm until 7:30 am). When Nurse #1 was asked 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 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 she did this when she felt [the resident] 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 [the tube feeding pump] off when she thought [the resident's stomach] needed a rest. She revealed she did not notify the physician she turned the tube feeding off on any previous instance. (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 0580 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's) 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. 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 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) An observation on 10/3/24 at 3:10 am revealed 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 on night shift (11:00 pm until 7:30 am). 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. 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. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 she did this when she felt [the resident] 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 [the tube feeding pump] off when she thought [the resident's stomach] needed a rest. She revealed she did not notify the physician she turned the tube feeding off on any previous instance. 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 and to notify the physician for any significant change that required deviation from the orders. During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware that Resident #60's and Resident #74's feeding tube pumps were being turned off by Nurse #1. 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 with turning off the tube feedings was that Resident #60 and Resident #74 were 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: (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 harm based on the actions of Nurse # 1. Nurse # 1 failed to follow the physician orders for Resident # 60 for continuous tube feeding, 24 hours per day. Nurse #1 failed to follow the physician orders for Resident #74 for continuous tube feeding, 22 hours per day. Nurse #1 failed to notify the MD of her deviant practice for both residents #60 and #74. All residents in the facility are deemed to be at risk for serious adverse outcome based on the actions of Nurse #1. On the morning of 10/3/24, upon notification of the problem, 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 feeding pumps that were on and both residents were found to have currently dated and timed feedings infusing per MD orders. The Director of Nursing reviewed the patient medical records for physician notification on the morning of 10/3/24. There was no evidence of MD notification by Nurse #1. The physician was notified of the order deviance and behavior of the nurse on 10/3/24. He was notified by the Administrator. Specify the action the entity will take to alter the system failure to prevent serious adverse outcomes from occurring or recurring. The facility confirmed that all residents with enteral feedings, including residents # 60 and #74, were resumed and infusing at the rate ordered by the physician. This confirmation was made on the morning of 10/3/24 at approximately 9:00 am by the Director of Nursing. On 10/3/24 the Director of Nursing and the Chief Clinical Officer called Nurse #1 to the facility for interview. Nurse # 1 was notified of her failure to follow MD orders and she was interviewed about her conversations during the night with the surveyors. Nurse #1 acknowledged that she did not have a physician order to stop the tube feedings and did not notify the physician of the deviant practice. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Board of Nursing Complaint Evaluation Tool was completed and reviewed with Nurse #1 on the evening of 10/3/24. The employee meeting was conducted by the Administrator, DON, Chief Clinical Officer, and Nurse Clinical Consultant. Prior to suspension, the DON and Chief Clinical Officer counseled and re-educated Nurse # 1 about her deviant practices. After consultation with the Chief Clinical Officer and the Chief Operating Officer, she was suspended at approximately 7:30 pm. Education sessions were begun on 10/3/24 with all licensed nurses and included the following subjects: Consult and notify the MD of resident changes and need to alter treatments Provision of care to ensure that MD orders are followed at all times, including orders for enteral feedings. The DON and Corporate Clinical Nurse and Chief Clinical Officer conducted the education sessions. Education sessions will continue with all staff members until 100% of the licensed nurses have received education. The Director of Nursing, ADON, and nurse managers will review education session sign ins daily to ensure that all staff have received the material effectively and to ensure that no staff members worked prior to receiving it. No licensed nurses will be allowed to work until they have received the education. The Chief Clinical Officer notified the Facility Nurse Consultant on 10/3/24 that new licensed nursing staff will be trained in orientation and education will continue within the facility to ensure understanding of the importance to notify the MD of significant changes in resident's physical, mental, and psychological status, the need to alter resident treatments significantly, and our ZERO tolerance position for [NAME] employees. On 10/3/24 the Chief Clinical Officer notified the Director of Nursing for the need and requirement to complete education prior to employees returning to work. The DON notified the hall nurses at the beginning of shifts that an inservice would be held prior to the shift beginning. These education sessions will continue until 100% of the licensed nurses have been trained. Date of immediate jeopardy removal: 10/4/24 Validation of the immediate jeopardy removal plan was completed on 10/8/24: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews confirmed the physician was notified of the tube feedings being turned off on 10/3/24 by the Administrator and that Nurse #1 verified she did not notify the physician when she turned the tube feedings off. A 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 which was completed on 10/3/24. The signed in-service roster and staff interviews of licensed nurses verified education was providing on consulting and notifying the physician of resident changes and need to alter treatments and ensuring that physician orders are followed at all times to include orders for tube feeding. No licensed nurse worked after 10/3/24 without receiving the education. 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. The immediate jeopardy removal date of 10/4/24 was validated.

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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 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. 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). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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) - 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and staff interviews, the facility failed to complete the admission Minimum Data Set (MDS) assessment within the required timeframe for 1 of 1 newly admitted resident reviewed for MDS assessments (Resident #341). Findings included: Resident #341 was admitted on [DATE]. Resident #341's admission Minimum Data Set (MDS) dated [DATE] had not been completed when reviewed on 10/01/24. During an interview on 10/03/24 at 3:17 pm, MDS Nurse #1 stated she was aware there were MDS assessments that had not been completed because there had been no full-time MDS staff for approximately 3 months until 9/30/24. The MDS staff were back-tracking to complete all assessments that were not completed. During an interview on 10/04/24 at 1:15 pm, the Administrator stated he was made aware that there were MDS assessments that had not been completed timely. He stated the facility had hired 2 full-time MDS nurses, and remote MDS nurses were helping the facility to get caught up.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required 14-day timeframe after the Assessment Reference Date (ARD, the last day of the assessment look-back period) for 8 of 21 residents' MDS assessments reviewed (Resident #s 5, 10, 13, 49, 62, 63, 69, and 71). Findings included: a. Resident #49 was admitted on [DATE]. Resident #49's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 7/19/24 was incomplete when reviewed on 10/3/24. b. Resident #5 was admitted on [DATE]. Resident #5's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/17/24 was in progress and was incomplete when reviewed on 10/3/24. c. Resident #71 was admitted on [DATE]. Resident #71's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/13/24 was listed as in progress and was incomplete when reviewed on 10/3/24. 41387 d. Resident #13 was admitted on [DATE]. Resident #13's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 9/16/24 was noted as in progress and was incomplete as of 10/2/24. e. Resident #62 was admitted on [DATE]. Resident #62's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/29/24 was signed as completed on 10/2/24. f. Resident #63 was admitted on [DATE]. Resident #63's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/15/24 was signed as completed on 9/24/24. g. Resident #69 was admitted on [DATE]. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #69's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/17/24 was signed as completed on 9/24/24. h. Resident #10 was admitted to the facility on [DATE]. Resident #10's quarterly MDS assessment with an Assessment Reference Date (ARD, the last day of the assessment look-back period) of 8/13/24 was signed as completed on 9/24/24. During an interview with the Resource Nurse on 10/3/24 at 5:06 pm, she explained that quarterly MDS assessments were not completed within the 14 day time frame prior to 9/30/24 because there were no consistent MDS staff at the facility to complete the assessments except a part-time MDS nurse who worked twice a week. She further explained that the Administrator was aware the completion of quarterly MDS assessments were backed up and on 9/3/24 the administration asked her to help the MDS department to get caught up. During an interview with MDS Nurse #1 on 10/3/24 at 4:57 pm, she stated she started to work at the facility on 9/30/24. She explained there were several quarterly MDS assessments discovered on 9/30/24 which were incomplete, and they were working to complete these assessments. She further explained that quarterly MDS assessments were to be completed within fourteen days of the ARD. During an interview with the Clinical Nurse Consultant on 10/3/24 at 4:46 pm, she stated the quarterly MDS assessments should have been completed within the fourteen day regulation time frame. During an interview with the Administrator on 10/3/24 at 4:50 pm, he stated the quarterly MDS assessments needed to be completed within the regulatory fourteen day time frame. In a follow up interview on 10/4/24 at 1:15 pm, he explained when he started at the facility on 8/30/2024 he was aware the facility was behind in completing quarterly MDS assessments. He stated the facility had hired two MDS nurses and remote MDS nurses to help the facility catch up in completing the quarterly MDS assessments

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to ensure that a resident with diagnoses of mental disorders had received a Level 2 Preadmission Screening and Resident Review (PASRR) after admission to the facility for 1 of 2 residents reviewed for PASRR (Resident #26). Findings included: A PASRR Level 1 dated 6/22/2015 indicated Resident #26 did not meet the federal definition for mental illness and mental retardation. Resident #26 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel and behave) and bipolar disorder (a serious mental illness characterized by extreme mood swings). A physician order dated 8/2/24 recorded Resident #26 was ordered Haloperidol (an antipsychotic medication) 2 milligrams twice a day for paranoid schizophrenia. The admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #26 was not currently considered by the state level II PASRR process to have a serious mental illness. Resident #26's care plan dated 8/18/24 included the use of antipsychotic medications related to schizophrenia. Interventions included administering antipsychotic medications as physician ordered and monitoring for effectiveness. A psychiatric physician note dated 8/26/24 recorded Resident #26 had a history of paranoid schizophrenia and a bipolar disorder and reported Resident #26's history of behaviors included hallucinations, the refusal of foods, agitation and verbal aggression. The psychiatric physician plan for treatment consisted of no change in Resident #26's medication regimen. A quarterly MDS assessment dated [DATE] indicated Resident #26 was cognitively intact and received antipsychotic medications on a routine basis. A review of the September 2024 and October 2024 Medication Administration Record documented Resident #26's refusal of medications as a behavior. Haloperidol 2 milligrams was recorded as given daily as ordered. During a phone interview with the Social Worker on 10/3/24 at 4:25 pm, she explained Resident #26 was admitted prior to her employment at the facility at the end of September 2024. She stated she had not reviewed Resident #26's diagnoses since starting at the facility and this should have been reviewed on admission. She explained Resident #26's PASRR Level 1 determination was only valid for thirty days from the time of hospitalization . She further explained she had started the process for a PASRR Level 2 screening on 10/2/24 after there had been an inquiry regarding Resident #26's PASRR status. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Clinical Nurse Consultant with the Administrator present on 10/3/24 at 4:31 pm, she stated the Social Worker should have submitted a PASRR Level 2 for Resident #26 due to Resident #26's admitting diagnoses of schizophrenia and bipolar disorder. The Clinical Nurse Consultant and the Administrator were unable to explain why a PASRR Level 2 had not been submitted for Resident #26.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and staff interviews, the facility failed to create a baseline care plan within 48 hours of a resident's admission for 1 of 2 residents (Resident #341) reviewed for baseline care plans. The findings included: Resident #341 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage (brain bleed) and dysphagia (trouble swallowing). Resident #341's Minimum Data Set (MDS) assessment dated [DATE] noted he had no speech, could rarely or was unable to understand others, was unable to participate in the assessment, and had an unhealed Stage IV wound (a wound down to the bone). There was no documentation in the electronic medical record of a baseline care plan for Resident #341. In an interview on 10/03/24 at 4:54 PM, the Director of Nursing (DON) confirmed there was no baseline care plan completed for Resident #341. She said the baseline care plan should have been completed by the charge nurse within 48 hours of admission.

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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 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)

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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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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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.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observations, record reviews, staff and physician interviews, the facility failed to administer tube feedings via a gastrostomy tube as ordered by the physician for 3 of 3 residents reviewed for nutrition maintenance (Resident #60, Resident #74, and Resident #341). The findings included: 1. 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. Review of Resident #60's Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired. Resident #60 and completely dependent upon staff for all activities of daily living (ADL) and was coded for a feeding tube. Resident #60's active physician orders related to her 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. Review of the RD's progress note for Resident #60 dated 8/21/24 revealed completed a readmission evaluation on 8/21/24 and noted no new recommendations, the tube feeding was 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. Review of Resident #60's weights revealed the following weights: - 6/3/24 255.0 pounds - 7/2/24 249.8 pounds - 8/8/24 267.8 pounds - 9/9/24 247.5 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #60. 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 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 which is part of Resident #60's necessary care and services. Review of Resident #60's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1. 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. In a second interview on 10/3/24 at 3:26 pm with Nurse #1 she stated she turned Resident #60's and feeding tube pump off when she thought her stomach needed a rest. Nurse #1 stated she did this now and then but 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. 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. 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. 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 pump off for Resident #60 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed Resident #60 and notified the physician of any changes in her 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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/24 at 12:00 pm with the Physician, he stated he was not aware of Resident #60's feeding tube pump 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 pump being turned off; however, he was not notified at all. The Physician explained one of his concerns was Resident #60 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 pump 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 pump being turned off. He further explained Nurse #1's reason for the feeding tube pump being turned off was not a good enough reason for Nurse #1 to make that decision. 2. 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. Review of Resident #74's Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired. Resident #74 required maximum assistance from staff with activities of daily living (ADL) and was coded for a feeding tube. Resident #74's active physician orders related to her 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) - 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. 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 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/3/24 at 3:43 am with Nurse #1 she indicated she was the nurse assigned for Resident #74. 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 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 which is part of Resident #74's necessary care and services. Review of Resident #74's electronic medical record (EMR) revealed no progress notes which documented turning the feeding tube pump off by Nurse #1. 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 she did this now and then but 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. 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 4:30 am on 10/3/24. 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 (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 indicated Resident #74 had a physician's order for her feeding tube pump to be turned off 2 hours a day (2hrs/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. During an interview with the Facility Nurse Consultant, Director Of Nursing, and Chief Clinical Officer on 10/4/24 at 12:33 pm, revealed 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, and random unannounced facility visits which included evening, night, and weekend shifts. There was no written documentation for the plan of action for monitoring Nurse #1 provided by the facility. The Chief Clinical Officer 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. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 pump off for Resident #74 which disregarded the physician's order. The DON further stated Nurse #1 should have assessed 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 #74's feeding tube pump 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 at all. The Physician explained one of his concerns was 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 pump 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 pump being turned off. He further explained Nurse #1's reason for the feeding tube pump being turned off was not a good enough reason for Nurse #1 to make that decision. 50234 3. Resident #341 admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage (brain bleed), dysphagia (trouble swallowing), and had a gastrostomy tube (a g-tube, feeding tube into the stomach) and tracheostomy (breathing tube into the trachea). Resident #341's Minimum Data Set (MDS) dated [DATE] noted he was unable to participate in the assessment, had an altered level of consciousness, had a tracheostomy, and he had a g-tube and consumed more than 51% of his calories and more than 501 cubic centimeters (cc) of fluids through the g-tube. The MDS indicated he had an unhealed Stage IV wound (a wound down to the bone). Resident #341's physician orders dated 9/12/24 noted he was to receive tube feeding 1.5 calorie formula at 50 cc an hour and a water flush at a rate of 200 ml every 6 hours. Observation on 9/30/24 at 11:24 AM revealed Resident #341 was laying in bed with his eyes closed. He did not respond to any questions. The resident had a g-tube pump with a bottle of tube feeding 1.5 calorie formula and a bag of fluids hanging with formula infusing into the resident's g-tube. The pump settings were set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. There was approximately 250 cc remaining in the bottle. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach. Observation on 09/30/24 at 3:47 PM revealed Resident #341 was laying in bed with his eyes closed. He did not respond to any questions. The resident had a g-tube pump with an almost full bottle of tube feeding 1.5 calorie formula and a bag of fluids hanging with formula infusing into the resident's g-tube. The pump settings were set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. The formula bottle was labeled as being started on 9/30 at 1:55 PM. There were no nurse's name or initials to indicate who had started the formula. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/01/24 at 2:17 PM revealed Resident #341's g-tube pump settings were still set to infuse 40 cc of formula every hour and 100 milliliters (ml) of fluid every 6 hours. The tubing was the color of the resident's formula, indicating the formula was infusing into the resident's stomach. The formula bottle was labeled as being started on 9/30 at 1:55 PM and there was less than 200 cc left in the bottle. The bag of fluids were dated 9/30/24 and was approximately half full. In an interview on 10/01/24 02:23 PM, Nurse #2 said she had started Resident #341's g-tube formula on 9/20/24. She said she wrote down the formula and fluid rate based on what was already programmed into the pump but had not confirmed the rate with the orders. She said she had not seen any coughing, residual, reflux, or distress when she had worked with him that week that would cause her to reduce the rate of the feeding. She said one of the night shift nurses (name not recalled) told her the resident had been coughing a few days ago and thought the rate may have been reduced by the night nurse. She was not sure if the doctor was notified about the coughing. She looks for the most current order and confirmed the pump should have been set to infuse the formula at 50 cc an hour and for the fluids to be set to 200 ml every 6 hours. She was unable to find any other orders in the resident's chart. Attempts to interview the nurse who worked on 9/28-9/30/24 were not successful. In an interview on 10/03/24 at 10:43 AM, the Registered Dietitian (RD) said Resident #341's formula rate had been increased to provide extra nutrients for the resident's Stage IV wound. He said the resident would still be getting enough calories for the wound, but it was important for the resident to receive the ordered nutrients. In an interview on 10/03/24 at 12:06 PM, Resident #341's Physician said the resident needed to receive the ordered rate of formula for wound healing. The Physician said the resident was getting approximately 300 fewer calories, which was not enough to help heal his wound. The Physician was not notified by any staff that Resident #341 had been coughing or that he had any symptoms that would indicate a need to reduce the feeding rate. He said nurses should not be changing the resident's feeding rate without consulting him first. In an interview on 10/03/24 at 2:14 PM, the Director of Nursing (DON) said Resident #341 should have received the ordered feeding rate and she had not been notified of him being in distress which would indicate a need to turn the rate lower.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38129 Based on record review and staff interviews, the facility failed to have a registered nurse daily for 8 consecutive hours, 7 days a week for 3 of 60 days reviewed (8/3/24, 8/18/24 and 9/15/24). Findings included: A review of the facility's daily nurse staffing totals and nursing clock-in sheets for August and September of 2024 documented there was no registered nurse present for dates 8/3/24, 8/18/24, and 9/15/24. A telephone interview with the prior Director of Nursing was unsuccessful. On 10/3/24 at 5:30 pm an interview was conducted with the Chief Clinical Officer. The Chief Clinical Officer stated there was not a registered nurse present as required on 8/3/24, 8/18/24, and 9/15/24. The schedule only had licensed practical nurses and medication aides scheduled due to a lack of registered nurses available at the time. The facility had offered overtime and bonuses to the existing staff to cover. On 10/3/24 at 5:40 pm an interview was conducted with the Administrator. He stated he was not aware of the lack of registered nurses for the 3 dates.

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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 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41387

Based on record review, staff interviews and Consultant Pharmacist interview, the facility failed to address recommendations made by the Consultant Pharmacist for 1 of 5 residents reviewed for unnecessary medications (Resident #84).

Findings included:

Resident #84 was admitted to the facility on [DATE] with diagnoses including dementia and Alzheimer's disease.

A physician order dated 8/14/24 for Resident #84 to receive the following medications: Quetiapine Fumerate (an antipsychotic/neuroleptic medication) 50 milligrams (mg) twice a day for dementia.

The 5-day admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #84 was severely cognitively impaired and received antipsychotic medications on a routine daily basis.

A review of Resident #84's EMR reported monthly Medication Regimen Reviews (MRR) were conducted on 8/16/24 and 9/26/24. The Consultant Pharmacist wrote a nursing recommendation each month for an AIMS assessment due to Resident #26 receiving an antipsychotic for monitoring the side effects associated with antipsychotic drug therapy.

There was no written response to the pharmacy recommendation for an AIMS assessment on the Nursing Recommendations from Pharmacist forms dated 8/16/24 and 9/26/24.

There was no abnormal Involuntary Movement Scale (AIMS) assessment (an assessment to assess the severity of tardive dyskinesia, abnormal involuntary movements, in patients receiving antipsychotic/neuroleptic medications) in Resident #84 electronic medical record (EMR).

A review of the September 2024 and October 2024 Medication Administration Record (MAR) recorded Resident #84 received the Quetiapine Fumerate 50 mg as ordered.

In a phone interview with the Consultant Pharmacist on 10/4/24 at 2:00 pm, she explained in July 2024 that she identified a concern with AIMS assessments not being completed for residents on antipsychotics/neuroleptic medications and emailed the Administrator, Director of Nursing (DON) and the facility's corporate office about the concern. She stated Resident #84 nursing recommendation for an AIMS assessment was initially written in August 2024 when admitted and was re-requested in the MMR for September 2024 since the AIMS assessment had not been conducted. She stated she was unsure if the new DON had seen the September pharmacy recommendation for Resident #82's AIMS assessment and did not recall reaching out to the Interim DON in August 2024 since Resident #84 was a new admission.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Clinical Nurse Consultant (Interim DON) on 10/3/24 at 4:32 pm, she stated she was the Interim DON in August 2024. She stated she was unable to recall whether she received Resident #84's pharmacy nursing recommendation dated 8/16/24 for an AIMS assessment. She explained AIMS assessments were to be completed on admission and quarterly to assess for side effects of antipsychotics/neuroleptic medications, and the nursing staff would have been verbally informed to conduct Resident #84's AIMS assessment. She further stated she was unable to recall informing the nursing staff to complete the AIMS assessment on Resident #84. In an interview with the DON on 10/3/24 at 3:15 pm, she stated she started as the DON in September 2024. She stated she had received the pharmacy recommendations for September 2024 and had not addressed the pharmacy's nursing recommendation dated 9/26/24 to conduct an AIMS assessment on Resident #84. The DON was unable to provide a reason why the nursing recommendation had not been addressed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41387 Based on record review, observation and staff interviews, the facility failed to discard an expired insulin aspart flex pen from 1 of 4 medication carts observed for medication storage (300-hall medication cart). Findings included: An observation of the 300-hall medication cart on 10/3/24 at 3:42 pm was conducted in the presence of Medication Aide #1. An insulin aspart (fasting acting insulin) flex pen with a label attached to the insulin aspart flex pen dated opened 8/23 was observed on the top drawer of the 300-hall medication cart. The expiration date on the insulin aspart flex pen was 8/31/26. The 300-hall medication cart was observed locked by Medication Aide #1 without the removal of the insulin aspart flex pen discarded Manufacturer information on the insulin aspart flex pen recommended to throw away the insulin aspart flex pen 28 days after opening. In an interview with Medication Aide #1 on 10/3/24 at 3:42 pm, she stated she did not know when the insulin aspart flex pen would have expired based on the label opened 8/23 because insulin medications had different expiration time periods after the medication was opened. A second observation of the 300-hall medication cart on 10/3/24 at 3:51pm was conducted in the presence of the Director of Nursing (DON). The insulin aspart flex pen was observed with 50 units of insulin in the syringe with a label attached to the flex pen dated open 8/23. The DON was observed removing and discarding the insulin aspart flex pen from the 300-hall medication cart. In an interview with the DON on 10/3/24 at 3:52 pm, she stated insulin aspart flex pen expired twenty eight days after the opening date of 8/23 and should have been discarded on 9/19/24. She stated she checked the 300-hall medication cart earlier in the week for expirations and was unable to explain why the expired insulin aspart flex pen was on the 300-hall medication cart. In an interview with the Chief Clinical Officer on 10/7/24 at 4:00 pm, she stated medication carts were checked frequently for medication expirations by the nursing staff prior to administering medications, by the pharmacy staff monthly and by the nursing administration staff at the facility randomly for audits. She said expired medications should be discarded from the 300-hall medication cart when medications were observed expired.