

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL042005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/30/2025
NAME OF PROVIDER OR SUPPLIER CAROLINA REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up and complaint investigation on January 29, 2025 through January 30, 2025.	{D 000}		
D 272	10A NCAC 13F .0902(a) Health Care 10a NCAC 13F .0902 Health Care (a) An adult care home shall provide care and services in accordance with the resident's care plan. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide care and services in accordance with the physician orders for 1 of 5 sampled residents (#2) including thromboembolic deterrent (TED) hose. The findings are: Review of Resident #2's current FL-2 dated 07/11/24 revealed diagnoses included chronic obstructive pulmonary disease, poly osteoarthritis, cerebral ischemia, and type II diabetes, . Review of Resident #2's physician order dated 12/18/24 revealed there was an order for compression socks wear during awake hours. Observation of Resident #2 on 01/30/25 at 8:45am revealed she was asleep with her thromboembolic deterrent (TED) hose on. Interview with Resident #2 on 01/30/25 at 8:49am	D 272	The facility will ensure all physician orders are followed precisely. LHPS will conduct staff training to reinforce the policy of carrying out all orders as prescribed, including proper application of TED hose. All medication aides will receive additional training on FL2 forms and the importance of reviewing and adhering to the orders documented on them. Evening staff will receive immediate training on the importance of removing TED hose at bedtime per physician orders and will begin assisting residents to ensure this is done. The manager, assistant manager, and resident care coordinator will monitor this daily.	2-05-25

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

4SBM13

If continuation sheet 1 of 7

Jamaal Willis

Reviewed and Acknowledged 02/17/25

Division of Health Service Regulation

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D 272	Continued From page 1 revealed: -She usually slept with her TED hose on. -Staff at night did not assist her with removing her TED hose. -The medication aide (MA) at night told her to take the TED hose off. -She was worried that the morning MA would not assist her with putting her TED hose on. Review of Resident #2s December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose wear beginning in the morning and remove at night. -Compression socks were documented as applied 3 of 12 days and removed 12 of 12 days. Review of Resident #2s January 2025 eMAR revealed: -There was an entry for TED hose wear beginning in the morning and remove at night. -Compression socks were documented as applied 12 of 30 days and removed 30 of 30 days. Interview with a medication aide (MA) on 01/30/25 at 9:00am revealed: -Resident #2 had slept in her TED hose. -Resident #2 was in bed asleep and she did not check to see if she had her TED hose on. -She did not attempt to apply her TED hose that morning because Resident #2 was asleep. -She must have slept in her TED hose. Interview with the Licensed Health Professional Staff (LHPS) Nurse on 01/30/25 at 9:10am revealed: -Resident #2 wore TED hose for circulation issues in her legs. -Resident #2's TED hose should have been	D 272		

Division of Health Service Regulation

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D 272	Continued From page 2 applied in the morning and removed at night. -TED hose should not be worn at night because the legs were elevated in bed. -She was concerned that wearing the TED hose 24 hours could cause circulation problems from the heart to the legs. Second interview with a MA on 01/30/25 at 9:50am revealed: -Resident #2 wore TED hose because she had poor circulation and her legs got swollen. -Resident #2's TED hose were supposed to be applied each morning and removed at night. -The MAs were responsible for applying and removing Resident #2's TED hose. -There had been times when Resident #2 had her TED hose on in the morning when she checked her. -She was concerned that Resident #2's legs would become more swollen if the TED hose were not removed at night. Telephone interview with a second MA on 01/30/25 at 2:03am revealed: -Resident #2 was supposed to apply her TED hose on each morning and remove them at night before bed. -She reminded Resident #2 to take her TED hose off at night. -She did not know if she was supposed to assist Resident #2 with removing her TED hose. Interview with the Executive Director on 01/30/25 at 2:30pm revealed: -TED hose for Resident #2 should have been applied each morning and removed each night. -The MAs were responsible for applying and removing TED hose each morning. -She expected staff to provide care according to physician orders.	D 272			

Division of Health Service Regulation

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D 272	Continued From page 3 Attempted telephone interview with the Resident Care Coordinator (RCC) on 01/30/25 at 9:34am was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/30/25 at 9:30am was unsuccessful.	D 272			
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records(eMAR) were	{D 367}			

Division of Health Service Regulation

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{D 367}	Continued From page 4 accurate for 1 of 5 sampled residents (#2) including inaccurate documentation of thromboembolic deterrent (TED) hose. The findings are: Review of Resident #2's current FL-2 dated 07/11/24 revealed diagnoses included chronic obstructive pulmonary disease, poly osteoarthritis, cerebral ischemia, and type II diabetes, . Review of Resident #2's physician order dated 12/18/24 revealed there was an order for compression socks wear during awake hours. Interview with Resident #2 on 01/30/25 at 8:49am revealed: -She usually slept with her thromboembolic deterrent (TED) hose on. -Staff at night did not assist her with removing her TED hose. -The medication aide (MA) at night told her to take the TED hose off. -She was worried that the morning MA would not assist her with putting her TED hose back on. Review of Resident #2s December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for compression socks wear beginning in the morning and remove at night. -Compression socks were documented at applied 3 of 12 days and removed 12 of 12 days. Review of Resident #2s January 2025 eMAR revealed: -There was an entry for compression socks wear beginning in the morning and remove at night. -Compression socks were documented as	{D 367}	The facility will assure all orders are correctly documented on eMAR as prescribed. A staff training for all medication aides will be held by LHPS to reinforce policy of importance of correct documentation of orders as prescribed including proper application of TED hose as well as documentation of residents refusal of treatments. This will be monitored daily by manager, assistant manager and resident care coordinator.	2-5-25

Division of Health Service Regulation

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{D 367}	Continued From page 5 applied 12 of 30 days and removed 30 of 30 days. Interview with a medication aide (MA) on 01/30/25 at 9:00am revealed: -Resident #2 has slept in her TED hose. -She only signed the eMAR as applied when she physically applied Resident #2's TED hose. -She made notes on the eMAR when Resident #2 refused or was asleep and TED hose were not applied. -MAs were responsible for accuracy of the eMAR. Interview with the Licensed Health Professional Staff Nurse on 01/30/25 at 9:10am revealed: -Resident #2 wore TED hose for circulation issues. -Resident #2's TED hose should have been applied in the morning and removed at night. -MAs should have signed the eMAR accurately for Resident #2s TED hose application and removal. Telephone interview with a second MA on 01/30/25 at 2:03am revealed: -Resident #2 was supposed to apply her TED hose each morning and remove them at night before bed. -She reminded Resident #2 to take her TED hose off at night. -She signed that the TED hose were removed on the eMAR after she told Resident #2 to remove them at night. -She did not wait to see if Resident #2 removed her TED hose before signing the eMAR. -She was not aware that she was supposed to ensure Resident #2 removed the TED hose before documenting that they were removed. Interview with the Executive Director on 10/03/24	{D 367}			

Division of Health Service Regulation

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{D 367}	Continued From page 6 at 10:38am revealed: -She expected the MAs to document Resident #4 was refusing her TED hose if that was the case. -She expected the MAs to document what they were applying and what was being refused accurately. Attempted telephone interview with the Resident Care Coordinator (RCC) on 01/30/25 at 9:34am was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/30/25 at 9:30am was unsuccessful.	{D 367}			
{D9999}	Final Observation	{D9999}			