STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Williamston	119 Gatling Street Williamston, NC 27892

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to ensure staff communicated to a resident in a respectful and dignified manner for 1 of 2 resident reviewed for dignity (Resident #93). The reasonable person concept was applied to this deficiency as individuals have the expectation to be addressed by staff using language and tone that portrays respect and dignity. Findings included: Resident #93 was admitted to the facility on [DATE], and her diagnoses included intellectual disabilities. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #93 was cognitively intact and exhibited no behaviors in the seven-day look back period. The MDS assessment also indicated Resident #93 was incontinent of urine and stool and required assistance with activities of daily living including toileting and mobility in bed and transfers. A psychiatric physician note dated 1/18/2024 reported Resident #93 had an intellectual disability. The psychiatric physician recorded Resident #93's depression was stable with current medication regimen, and the staff had reported no behaviors recently. A review of the daily nursing assignment sheet dated 1/22/2024 recorded Nurse Aide (NA) #10 worked 11:00 p.m. to 7:00 a.m. shift and was assigned to Resident #93. The daily nursing assignment sheet dated 1/23/2024 recorded NA #5 worked 7:00 a.m. to 3: 00 p.m. and her assignment consisted of residents at the far end of the hall from Resident #93's room. A review of an undated written statement from NA #5 reported as NA #5 was walking by Resident #93's room, she heard NA #10 saying to Resident #93, Didn't I tell you about this damn sh**. You don't want to go back to the hospital. A written statement dated 1/24/2024 10:20 a.m. recorded an interview with Resident #93 by the Social Worker. The written statement reported when Resident #93 was asked to tell the Social Worker if anything happened yesterday (1/23/2024) with anything, the Resident could not think of anything. Resident #93 was asked again if she was sure nothing happened, and Resident #93 replied, Everything was fine. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with NA #5 on 3/12/2024 at 7:02 a.m., she stated when she arrived to work around 6:30 a.m. and while walking pass Resident #93's closed door, she overheard NA #10 fussing and cursing at Resident #93. She stated NA #10 said, Didn't I tell you about that damn shit. You going right back to the hospital to Resident #93. NA #5 reported she did not hear Resident #93 say anything in response and did not enter the room to determine what was occurring behind the closed door. She said she did not speak to NA #10 about the incident or inform the assigned nurse to Resident #93. She stated she informed the Director of Nursing and the Administrator after they reported to work. In a phone interview with NA #10 on 3/12/2024 at 12:10 p.m., she recalled working 1/22/2024 11:00 p.m. to 7:00 a.m. and receiving a call from the Administrator late in the evening on 1/23/2024 questioning her about cursing at Resident #93. NA #10 stated she did not curse or raise her voice at Resident #93 the morning of 1/23/2024, and she was placed on suspension while the facility investigated the incident. She stated she received a call after one to two weeks and was informed she was not allowed to return to work. During the survey, Resident #93 was hospitalized and was unable to conduct an interview with Resident #93 due to her medical condition. In an interview with the Social Worker on 3/13/2024 at 7:50 a.m., she described Resident #93's mental status like that of an elementary child. She recalled obtaining a statement from Resident #93 on 1/23/2024 and stated based on her opinion, she could not say it was true or not because Resident #93 was the type of person who would not want to get anyone in trouble. She reported not observing any change in Resident #93's behaviors after the incident. In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:52 a.m., she stated on 1/23/2024 she overheard NA #5 discussing with other nurse aides how NA #10 was rude, cursing and raising her voice with Resident #93. She explained she went to inform the Administrator, who was out of the facility at the time, because she was new to the role as DON (1/8/2024) and did not know the process for reporting verbal abuse to the state agency. She stated on 1/23/2024 when she saw Resident #93 as she was leaving the facility she questioned Resident #93 if any yelling or cussing occurred the morning of 1/23/2024, and Resident #93 said, Oh Yah. She explained she did not mention any staff members names to Resident #93 because she did not know how to proceed with the investigation. She stated Resident #93 was informed to let the DON know if staff cursed and raised their voices at her and reassured Resident #93 the staff were there to help her with her needs. In an interview with the Administrator on 3/13/2024 at 5:07 p.m., she explained upon learning NA #5 overheard NA #10 cursing at Resident #93 on 1/23/2024, NA #10 was placed on suspension and stated she was not aware of any prior disciplinary issues for NA #10. She stated Resident #93 was easy to redirect and was known to smear feces (stool) everywhere at times, and when NA #10 was questioned, she stated she was in Resident #93's room providing incontinent care. The Administrator said NA #10 reported she did not curse at Resident #93 and refused to write a statement of what happened in Resident #93's room on the morning of 1/23/2024. She explained since there was a witness that heard NA #10 curse and raise her voice at Resident #93, the incident was substantiated, and NA #10 was terminated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observation and staff interviews, the facility failed to ensure bathrooms (room [ROOM NUMBER], #60, #61, #65, #67/69, #70) on the locked unit were free of fecal matter or black/brown matter on various surfaces for 6 of 10 bathrooms reviewed for clean and homelike living environment. The findings included: On 3/10/24, a Sunday, at 1:02 PM, an observation of the bathroom between rooms [ROOM NUMBERS], rooms on the locked unit, revealed the inner and outer parts of the toilet had multiple areas of dried black matter. room [ROOM NUMBER] was occupied by 2 residents, and room [ROOM NUMBER] was occupied by 1 resident. The residents of these rooms were able to use the bathroom on their own or with supervision assistance by staff. On 3/10/24 at 1:03 PM, an observation of the bathroom in room [ROOM NUMBER], a room on the locked unit, revealed brown matter on multiple areas of the toilet. room [ROOM NUMBER] was occupied by 1 resident. The resident of this room was able to use the bathroom on her own. On 3/10/24 at 1:04 PM, an observation of the bathroom in room [ROOM NUMBER] revealed multiple areas of a dried brown matter along the inner rim of the toilet. room [ROOM NUMBER] was occupied by 2 residents. The residents were able to use the bathroom on their own or with supervision assistance by staff. During a continuous observation and interview with the Environmental Services Manager (ESM) on 3/10/24 from 1:05 PM until 1:16 PM, she revealed that every resident room and bathroom were cleaned daily and deep cleaned monthly. Deep cleaning consisted of moving furniture to clean behind and below surfaces, clean the floors and the walls of the bathrooms, and in addition to mopping and sweeping, the floor was also polished. She stated there should have been 4 housekeepers scheduled each day for the whole facility, but on 3/9/24 and 3/10/24 only 2 housekeepers were in the building. An observation of room [ROOM NUMBER], on the locked unit, revealed multiple areas of brown matter on the inside of the toilet bowl and on the outer rim. ESM confirmed the observation and identified the brown matter as feces. Observation of room [ROOM NUMBER]on the locked unit, revealed a dried, light brown matter on the toilet cover that the ESM was able to wipe off. The ESM stated she would have a housekeeper clean the locked unit after lunch meal, and it should take them about 2 hours to clean. On 3/11/24 at 8:07 AM, an observation was made in the bathroom between rooms [ROOM NUMBERS] and brown matter was smeared all over the toilet paper roll sitting on the handlebar next to toilet. On 3/11/24 at 8:10 AM, an observation was made in the bathroom of room [ROOM NUMBER]. [NAME] matter was all over the commode cover, on the toilet seat, and on the floor. On 3/11/24 at 10:09 AM, an observation was made of the bathroom in room [ROOM NUMBER]. The brown matter on the toilet and commode was cleaned slightly, but a brown residue remained on the toilet seat and inside the toilet bowl. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator on 3/13/24 at 8:11 AM. She revealed the locked unit should be cleaned daily and as needed. The Administrator indicated she had not heard of any complaints about resident bathrooms. She further stated Housekeeping was short staffed often and cleaned the locked unit at some point on the same day. She stated that fecal matter on the toilets would need to be cleaned as soon as possible.

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F 0638 Level of Harm - Potential for minimal 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** 43332 Based on record review and staff interview the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the 14-day required timeframe for 3 of 41 residents reviewed for quarterly Minimum Data Set (MDS) assessments (Resident #29, Resident #16, and Resident #75). Findings included: 1. Resident #29 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed the assessment was signed as completed on 9/11/23. An interview was conducted with the MDS Nurse on 3/13/24 at 8:25 A.M. The MDS nurse indicated she was aware of the timeline requirements for completion of the MDS assessments and unsure why Resident #29's quarterly assessment was completed late. An interview was conducted with the Administrator on 3/13/24 at 1:01 P.M. The Administrator stated she had identified late MDS assessments during a spot check and worked to get them caught up. She stated she was aware of the required completion date had been missed and stated the deadline shouldn't have been missed. 2. Resident #16 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed the assessment was signed as completed on 1/8/24. An interview was conducted with the MDS Nurse on 3/13/24 at 8:25 A.M. The MDS nurse indicated she was aware of the timeline requirements for completion of the MDS assessments and unsure why Resident #16's quarterly assessment was completed late. An interview was conducted with the Administrator on 3/13/24 at 1:01 P.M. The Administrator stated she had identified late MDS assessments during a spot check and worked to get them caught up. She stated she was aware of the required completion date had been missed and stated the deadline shouldn't have been missed. 43222 3. Resident #75 was admitted into the facility on [DATE] with diagnoses of dementia, diabetes, and hypertension. A review of Resident #75's medical record revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of 8/14/23 was completed on 8/29/23. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	The MDS Nurse was interviewed on 3/13/24 at 8:25 AM. She stated that she had 14 days from the ARD to complete quarterly assessments. The MDS Nurse explained she should have completed the quarterly assessment for Resident #75 sooner and could not provide a reason for why it was late. An interview was conducted with the Administrator on 3/13/24 at 9:38 AM. She revealed that MDS assessments should be completed within 14 days of the ARD date.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations, staff interviews and interviews with Wound Care Physician Assistant (PA), the facility failed to (1) perform wound care to a pressure ulcer per physician's order (Resident #19), (2) set the alternating pressure air mattress at the correct setting based on the resident's weight (Resident #104), and (3) change the treatment for a pressure ulcer when ordered by the Wound Care PA (Resident #77) for 3 of 4 residents reviewed for pressure ulcers. The findings included: 1. Resident #19 was admitted to the facility on [DATE], and diagnoses included dementia and right hip fracture. Resident #19's care plan dated 1/14/2024 included a focus for a right heel suspected deep tissue injury (SDTI). Interventions included administration of treatments as ordered by the physician and monitor effectiveness of treatments. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #19 was moderately cognitively impaired and was receiving treatments for a pressure ulcer. Wound Care PA notes reported an odorless slough adherence to the right heel pressure ulcer, tenderness and mild redness to the skin around the wound on 2/21/2024. Visible necrotic tissue was debrided, and Resident #19 was stated on Doxycycline, an antibiotic, for seven days. On 3/6/2024, the Wound Care PA documented improvement of Resident #19's right heel pressure ulcer measuring 1.05 x 1.5 x 0.7 x 0.3 centimeters with 90% pink granulated tissue and 10% yellow tissue and moderate amounts of serosanguineous drainage. Physician orders dated 2/29/2024 included an order to cleanse the right heel with wound cleaner, to apply collagen particles before applying calcium silver alginate and a foam heel dressing and to secure the dressing with kerlix (a wrap to hold primary and secondary dressings in place) every other day for wound healing. A review of the March 2024 Treatment Administration Record (TAR) for Resident #19 indicated Nurse #3 recorded providing treatment of the right heel pressure ulcer on 3/11/2024. During observation of wound care to Resident #19's right heel pressure ulcer on 3/12/2024 at 10:05 a.m., the old foam dressing to the right heel was observed dated 3/9/2024 with NA #6 initials. On 3/12/2024 at 10:12 a.m. in an interview with the Director of Nursing (the nurse who provided Resident #19's wound care on 3/12/202), she stated Nurse #3 had documented on 3/11/2024 changing the pressure ulcer dressing to the right heel on Resident #19's TAR and stated obviously based on the date and NA #6 initials (who was a NA II that had been trained to help with stage I and Stage II pressure ulcer dressings) on the right heel dressing it was not changed. The Director of Nursing explained due to the absence of the Wound Nurse, she had informed Nurse #3 on 3/11/2024 she was responsible for Resident #19's wound care, and Nurse #3 assured her she had performed Resident #19's wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempts to interview Nurse #3 were unsuccessful. On 3/13/2024 at 8:30 a.m. in an interview with the Wound Care Nurse and the Wound Care PA, they stated Resident #19's right heel pressure ulcer was treated with antibiotics in February due to increased pain and inflammation to the area. They stated Resident #19's right heel pressure ulcer had improved and was slowing decreasing in size. They stated in the absence of the wound nurse, the nursing staff were responsible for changing Resident #19's right heel pressure ulcer dressing every other day as ordered. 43222 2. Resident #104 was admitted to the facility on [DATE] with diagnoses that included a stage 3 pressure ulcer of other site, diabetes, and hypertension. Review of the admission Minimum Data Set (MDS) dated [DATE] assessed Resident #104 as moderately cognitively impaired and required supervision or touching assistance with rolling left to right in bed. The MDS indicated a stage 3 pressure ulcer was present on admission and a pressure reducing device was used for the bed. The care plan revised on 1/24/24 identified Resident #104 had a stage 3 pressure ulcer to her sacrum on admission. Interventions included: administer treatments as ordered and monitor for effectiveness, educate the resident/family/caregivers as to causes of skin breakdown, and follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of the documented weights for Resident #104 revealed on 3/4/24 the resident weighed 140.6 pounds (lbs.). Observations on 3/10/24 at 11:56 AM and 3/12/24 at 8:18 AM revealed Resident #104 was in bed with an alternating pressure air mattress in place that was functioning. The air mattress settings were locked, and the weight set at 350 lbs. During both observations, Resident #104 complained that the air mattress was lumpy and caused pain to the sacral pressure ulcer site. The Wound Care Nurse was interviewed on 3/13/24 at 8:38 AM. She revealed that Resident #104's air mattress setting was supposed to be at 120 lbs. During her rounds, the Wound Care Nurse indicated that she would double check the air mattress settings for all residents with wounds. She stated Resident #104 never complained that the air mattress caused her pain in the sacral area. During an interview with the Wound Care Physician Assistant on 3/13/24 at 8:45 AM, she revealed that Resident #104's air mattress should have been set at the appropriate setting. During rounds, she and the Wound Care Nurse would correct the settings if not accurate. An observation and interview were conducted on 3/13/24 at 9:00 AM with Nurse #1. Nurse #1 observed Resident #104 in bed with the alternating pressure air mattress functioning and the settings locked and the weight at 350 lbs. Nurse #1 stated Resident #104 did not weigh 350 lbs. and that maintenance usually set up the air mattresses in resident rooms. Nurse #1 then adjusted the weight setting to 150 lbs., which was closest to Resident #104's weight value. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Maintenance Director on 3/13/24 at 9:10 AM. He stated the air mattresses were calibrated by the resident's weight. He indicated that he did not adjust the settings on the air mattresses, he only installed them when needed. The Maintenance Director revealed the Wound Care Nurse adjusted the correct settings. The Director of Nursing (DON) was interviewed on 3/13/24 at 9:41 AM. She revealed according to the manufacturer, the resident's weight determines the setting. The Wound Care Nurse was responsible for setting the weight on Resident #104's air mattress. The DON indicated that the Wound Care Nurse just came back to the facility after being away for 3-4 days. She stated that she was not aware of Resident #104's complaint related to the firmness of the air mattress. The DON revealed that she did not know why Resident #104's air mattress was set to 350 lbs. She stated she had discussed with the Maintenance Director last week about the air mattress control settings and witnessed him turn the weight all the up in a resident's room. She notified him that was incorrect. The Maintenance Director told her that was what he was told to do. The air mattress was supposed to pressure reducing. The DON stated that if it was on the wrong setting, the pressure ulcer could worsen or a new pressure ulcer could develop on the bony prominence. During an interview with the Administrator on 3/13/24 at 9:58 AM, she revealed that maintenance puts the air mattresses in the rooms. The Wound Care Nurse researched the resident's weight and adjusted the settings for the air mattress. The Administrator stated she was not sure why Resident #104's air mattress was set to 350 lbs. The Wound Care Nurse checked the air mattress settings when providing wound care. She indicated that she was not aware Resident #104 complained the air mattress was too lumpy and caused her pain. 50234 3. Resident #77 was admitted to the facility on [DATE] with diagnoses including history of prostate cancer, Chronic Obstructive Pulmonary Disorder (COPD), and a sacral pressure sore. Resident #77 Minimum Data Set, dated dated dated [DATE] revealed Resident #77 had short- and long-term memory and severely impaired decision making. Resident #77 was totally dependent on staff for all Activities of Daily Living. Resident #77 was at risk of pressure ulcers and had 1 unstageable pressure ulcer which was present on admission. Resident #77's care plan updated 3/3/24 revealed he had a Stage 4 pressure ulcer on his sacrum with osteomyelitis. The treatment listed on the care plan was Silver Alginate and a foam dressing. Interventions included to administer treatments as ordered and monitor for effectiveness. Record review of Resident #77's physician's orders revealed a wound treatment order dated 1/21/24 to clean the unstageable pressure ulcer with normal saline/wound cleanser. Apply calcium silver alginate and cover with a foam dressing every day shift for wound healing. Record review of Resident #77's wound consultant Progress Notes Report dated 3/6/24 revealed the treatment order was Change to Dakin's 0.5% wet to moist gauze covered with super absorbent dressing - change daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/13/24 at 8:33 AM with the Wound Care Nurse and the Wound Care Physician Assistant. The Wound Care Nurse stated when the Wound Care Physician Assistant changed the treatment orders, the Wound Care Nurse usually wrote the wound care order change. If the Wound Care Nurse was not available, the nurse on the hall had the responsibility to change any wound care order from a provider in her absence. Observation on 3/13/24 at 9:20 AM of Resident #77's wound dressing change by the Wound Care Nurse. Resident #77's wound bed was beefy red with a small amount of slough in the center. Resident #77's wound had copious amounts of drainage. There was no odor. The Wound Care Physician Assistant measured the wound in centimeters 6.6 x3.8 tunneling was 15cm at 3 o'clock, 7cm at 12 o'clock and 0.9 cm at 9 o'clock. During the interview the wound was scraped by the Wound Care Physician Assistant, who described removing the slough to encourage tissue growth. The wound was dressed in Calcium Alginate and a foam silicone dressing. In an interview with the Wound Care Physician Assistant on 3/13/24 at 9:30 AM, she changed the treatment order on 3/6/24 to Dakin's 0.5% wet to moist gauze covered with a super absorbent dressing the be changed daily. However, because the wound was draining and had not progressed, she would change the order back to calcium silver alginate and with a foam dressing. The Wound Care Nurse indicated that the staff had not changed the order from the wound visit on 3/6/24 while the Wound Care Nurse was on leave. Review of the Treatment Administration Record for March 2024 revealed Resident #77 received the calcium silver alginate and foam dressing treatment every day shift from 3/6/24 through 3/11/24. Record review revealed that on 3/6/24 that Nurse #5 was the assigned nurse and responsible for the dressing change. In an interview 3/13/24 at 11:08 AM with Nurse #5 indicated that she changed the dressing order on 3/6/24 but did not recall who worked with the Wound Care Physician Assistant that day. She did not know how the wound care orders were communicated to the facility from the Wound Care Physician Assistant. She stated that if she made rounds with the Wound Care Physician Assistant, she would have known there was a change. She stated that she did not know who was responsible for putting the wound care orders into the medical record system, that the Wound Care Nurse always changed those. In an interview on 3/13/24 at 11:15 AM, the Wound Care Physician Assistant indicated on 3/6/24, NA #6 made rounds with her. She said that the wound care notes were sent to the facility. In an interview with Nurse #6 on 3/13/24 at 11:47 am, she stated she was also the unit manager. She said she was responsible for confirming the physician orders and the Wound Care Nurse updated the wound care orders. The Wound Care Physician Assistant sent the order change by email to the Director of Nurses (DON). The DON would update the orders or would delegate the order updates to Nurse #6 or the floor nurse. Nurse #6 indicated that on 3/6/24, the Wound Care Nurse was not on duty, and she was not aware of any change to any wound treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/13/14 at 1:48PM with the DON revealed that the wound care nurse was responsible for changing wound orders made by the Wound Care Physician Assistant. She indicated she did not know how the wound care nurse obtained the order changes. She stated she was provided the wound care consultant treatment notes via email for all residents treated. Review of the reports with the DON revealed that the documents included the order changes in bold print. When asked if the bold printed text was considered an order, the DON said Yes. She stated she should have had someone change the orders.

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The Carrolton of Williamston	119 Gatling Street Williamston, NC 27892

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review, resident interview, and staff interviews, the facility failed to implement effective interventions to prevent a severely cognitively impaired resident (Resident #46) from hitting another resident (Resident #31) in the face two days after he initially exhibited physically aggressive behaviors directed toward another resident (Resident #55). Resident #31 sustained a scratch to the face as a result of the incident. This was for 1 of 4 residents reviewed for accidents (Resident #46). Findings included: 1. Resident #46 was admitted to the facility on [DATE] with diagnoses which included dementia and schizoaffective disorder. The Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #46 was severely cognitively impaired and required supervision of 1 person for locomotion on the unit. Resident #46 was coded with no physical behaviors directed towards others. As of 7/24/23 Resident #46's comprehensive care plan revealed no evidence the resident had any physical behaviors directed toward other residents. a. Resident #55's Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #55 was severely cognitively impaired. Nursing Progress note dated 7/25/23 and written by Nurse #2 revealed at approximately 7:30 PM, Nurse #2 was called onto the locked unit because Resident #46 had hit Resident #55 in the face. Resident #46 was sitting on his buttocks on the floor. Resident #55 was hit in face, in return hit Resident #46 back knocking him to the floor. Both residents were separated. The Administrator was notified, who then notified the Director of Nursing (DON). The Medical Director (MD) was also called and notified. A new order was received for Resident #46 of Ativan 1 milligram (mg) now. Ativan was given. Both residents continued to be separated and Resident #46 was currently in bed with his eyes closed. Review of Resident #46's physician orders revealed on 7/25/23 Ativan 1 milligram (mg) was given one time only. Review of the Initial Allegation Report dated 7/25/23 and completed by the Administrator revealed the incident occurred on 7/25/23. The facility was notified the same day at 7:30 PM. Resident #46 hit Resident #55. Law Enforcement was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Investigation Report dated 7/31/23 and completed by the Administrator revealed the incident on 7/25/23 occurred in the day room of the locked unit. The witness to the event was Nursing Assistant (NA) #3. Resident #46 hit Resident #55 unprovoked. Resident #55 got up from her chair and hit Resident #46 back. Both residents were separated, and safety was assured for both with redirection as indicated. The facility had to substantiate the abuse because the residents did make contact with each other. There were not any injuries, and the facility quickly responded to ensure safety for both parties involved in the altercation. The facility could not have anticipated the interaction of the residents. Staff increased monitoring of both residents. A Psychiatry service referral was made for Resident #46 due to the unprovoked response. The Department of Social Services (DSS) was notified but did not conduct an investigation. An interview was conducted with NA #3 on 3/12/24 at 10:32 AM. She revealed she was assigned to the locked unit in the evening of 7/25/23. NA #3 indicated that she was sitting next to Resident #46 and Resident #55 was sitting with other residents nearby. Resident #46 was standing and began to say [Resident #55] has my money. NA #3 told him that Resident #55 did not have any money, and the bank was closed. He (Resident #46) then hit her (Resident #55) in the mouth, and NA #3 jumped up to separate them. She called for help and another staff member (name unknown) brought Resident #55 to her room, and Resident #46 remained in the dining room of the locked unit. She notified Nurse #2. Nurse #2 was interviewed by phone on 3/13/24 at 9:17 AM, and she revealed that she no longer worked at the facility. Nurse #2 stated she did not witness the incident on 7/25/23. NA #3 notified her and took her to the locked unit. After she was notified, the residents were already separated by 2 staff members (names unknown). During an interview with the Administrator on 3/13/24 at 8:27 AM, she revealed that the incident between Residents #46 and #55 was an isolated incident. He hit her, and she hit him back. They were separated immediately, and both were redirected. No injuries were noted, and staff made more frequent rounds of both residents. Psychiatric services were referred for Resident #46 due to an unprovoked response. The Administrator stated that the allegation was substantiated because it did occur. b. Resident #31's Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #31 was moderately cognitively impaired. Review of a Health Status note dated 7/27/23 and written by Nurse #2 revealed that at approximately 9:00 AM, it was reported to her that Resident #46 was cussing and walked by Resident #31 in the hallway. Resident #31 told him to be quiet. Staff attempted to re-direct her (Resident #31), but Resident #46 hit her. Both parties were separated. An open area noted to Resident #31's left cheek, and she complained of left sided jaw pain. An x-ray was ordered to her left jaw. The Administrator and MD were notified. Review of a Health Status note dated 7/27/23 and written by Nurse #2 revealed an x-ray was performed on Resident #31's left jaw. Results were pending. Review of x-ray results to the left mandible (jawbone) of Resident #31 dated 7/27/23 revealed no abnormalities of the mandible were identified in the available views, and there was not any evidence of acute bony injury. Review of a Skin Referral dated 7/27/23 revealed Resident #31 had a scratch to the left cheek. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Psychiatry Progress Note dated 7/27/23 and written by the Psychiatry Physician Assistant (PA) revealed Resident #46 was in physical altercations twice this week. Resident #46 walked up to another resident on 7/25/23 and punched Resident #55 in the face, which was witnessed by staff. Today, Resident #31 stated Resident #46 hit her in the face, leaving a red mark. This incident was unwitnessed. As a result, changes to Resident #46's medication regimen included: Increase scheduled Ativan to 0.75 mg twice daily. Start Ativan 0.5 mg tab by mouth every 12 hours as needed for agitation. Hold for sedation. Review of Resident #46's physician orders revealed Ativan was increased to 0.75 mg twice daily for anxiety on 7/27/23. Also on 7/27, Ativan 0.5 mg was added every 12 hours as needed for agitation. Review of the Initial Allegation Report dated 7/27/23 and completed by the Administrator revealed the facility became aware on 7/27/23 at 9:00 AM. Resident #46 hit Resident #31 on the left side of her face while in the locked unit. A skin assessment was completed on Resident #31, and a scratch to the left side of her face resulted. Law enforcement was notified. Review of the Investigation Report dated 8/2/23 and completed by the Administrator revealed Resident #31 was antagonizing Resident #46, per staff, prior to him hitting her. A scratch to the side of Resident #31's face was noted. Staff applied ice to the area to decrease the chance of swelling. No mental anguish was identified. DSS was notified and did not complete an investigation. Resident #31 was interviewed on 3/13/24 at 5:33 PM, and she revealed that on the date of the incident, Resident #46 was in the hallway cussing. She went out to tell him not to cuss around women. He then struck her in the face. Staff responded and cleaned her wound. Review of the Activities Director's witness statement dated 7/27/23 read: At 9:05 AM, the [former] Activity Aide came to her office to report that [Resident #31] had a 'scar' that [Resident #46] had hit her . The former Activity Aide was interviewed by phone on 3/12/24 at 9:29 AM. She revealed that she witnessed the incident on 7/27/23 between Residents #46 and #31. Resident #46 was cursing in the hallway and appeared mad. He approached Resident #31, but he did not hit her. She stated she needed to call this surveyor back but never did. Review of the witness statement by Medication Aide [MA] #1 (date not specified) revealed that it read: I, [MA #1], witnessed [Residents #46 and #31] exchanging harsh words. (Resident #46) began swinging in the air in the direction of [Resident #31], and [she] was swinging her walker in the direction of him. I intervened and separated them. It was then that I noticed a scratch on the left side of Resident #31's face. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MA #1 was interviewed on 3/12/24 at 10:51 AM, and she revealed that she was performing medication pass on 7/27/23, and Resident #46 was already having behavioral issues or in a mood (agitated). At first, he was just walking and fussing at the residents. Resident #46 said something to Resident #31 and she said something back. MA #1 could not recall what was said or if he (Resident #46) hit her (Resident #31). Resident #31 had a scratch on her face. MA #1 stated she could not recall all the exact details. She approached both residents after she locked her medication cart, and the NA (unknown name) helped separate the residents. Nurse #2 was working that day, and she (MA #1) notified her of the incident. Nurse #2 notified the Administrator, who visited the locked unit and assigned another NA (name unknown) to provide 1:1 supervision for Resident #46. An interview was conducted with Nurse #2 on 3/13/24 at 9:17 AM. She indicated on 7/27/23 the residents were already separated when she came to the locked unit and were monitored by separate staff members. Skin assessments were performed on both residents. During an interview with the Psychiatry Nurse Practitioner (NP) on 3/12/24 at 2:45 PM, she revealed that the Psychiatry PA who worked at the facility in July 2023 was no longer employed at the facility. She began in October 2023. The Psychiatry NP stated when a resident had behaviors, facility staff would contact her. She made recommendations, and the MD wrote the orders. She often recommended that residents be separated and put on 1:1 supervision for a specified period. They may need medication adjustment, if agitated. NA #2, who worked during the day shift on the locked unit on 7/27/23, was interviewed. She indicated she did not witness the incident between Resident #46 and Resident #31 on 7/27/23. NA #2 stated she could not recall if she was aware that Resident #46 was aggressive with another resident 2 days prior. She indicated if she knew about Resident #46's incident on 7/25/23, she would have closely monitored him and checked on him frequently. NA #1, who worked on the locked unit during the day on 7/27/23, was interviewed. She revealed that she did not recall the incident that took place on 7/27/23 between Residents #46 and #31. NA #1 stated she was not aware that Resident #46 was aggressive 2 days prior to 7/27/23. She stated redirection and close monitoring would have helped prevent Resident #46 hit Resident #31. During an interview with the Administrator on 3/13/24 at 8:27 AM, she revealed that when the sun went down, Resident #31 turned into someone else. On 7/27/23, Resident #31 tried to get Resident #46 to quiet down, and she was the instigator. The Administrator stated Resident #31 told her that he (Resident #46) hit her. They were separated immediately, and Psychiatry services were referred. A skin check was completed for Resident #31, and she changed rooms. She indicated that the allegation of abuse was substantiated because it happened. The Administrator stated that monitoring was increased on 7/25 for Resident #46 but maybe not enough. Ideally, he would not have hit Resident #31 on 7/27/23. Resident #46 should have been on 1:1 supervision beginning 7/25/23 to prevent the 7/27 incident from occurring. During that time, there were enough staff to assign 1:1 supervision. If 2 residents were arguing, then they should have been separated immediately to prevent further escalation.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43332 Based on observations, record review and staff and physician interviews, the facility failed to obtain post dialysis vital signs, record post dialysis weights, and maintain ongoing communication with the dialysis facility for 1 of 1 resident reviewed for dialysis (Resident #58). Findings included: Resident #58 was admitted to the facility on [DATE] with diagnoses which included renal insufficiency and dependence on renal dialysis. The quarterly Minimum Data Set, dated dated dated [DATE] revealed that Resident #58 was cognitive intact. He was also coded for dialysis. Review of Resident #58's care plan last reviewed 2/6/24 indicated a focus for dialysis related to renal failure with an intervention check and change dressing daily at access site and monitor for signs/symptoms of bleeding, hemorrhage, and septic shock. Review of Resident #58's Physician's orders revealed an order dated 2/29/24 record post dialysis weight and vitals upon return every Tuesday, Thursday, and Saturday. Review of Resident #58's February Medication Administration Record (MAR) revealed that he was ordered to have post dialysis vital signs at 2:00 P.M. every Tuesday, Thursday, and Saturday. Of the 10 days he went to dialysis, there were 7 days documented. The MAR showed vital signs were not documented on the following days: - 2/2/24: documented as daily checks by Medication Aide #2 - 2/10/24: documented as resident absent from facility by Nurse #1 - 2/13/24: documented as resident absent from facility by Nurse #1 Review of Resident #58's medical record for February 2024 showed he had a weight entered on 2/2/24 of 119.9 pounds and on 2/29/24 of 130.9 pounds. There was no weight entered on 2/1/24, 2/3/24, 2/10/24, 2/13/24, 2/17/24, 2/20/24, or 2/22/24. Resident #58 was in the hospital on 2/24/24 and 2/27/24. Revie of Resident #58's March MAR revealed he was ordered to have post dialysis vital signs at 2:00 P.M. every Tuesday, Thursday, and Saturday. Of the 4 days he went to dialysis, there was 1 day of vital signs documented. The MAR showed vital signs were not documented on the following days: - 3/5/24: documented as resident absent from facility by Nurse #1 - 3/7/24: documented as resident absent from facility by Nurse #1 - 3/10/24: documented as resident refused by Medication Aide #3 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/12/24: documented as resident absent from facility by Nurse #1 Review of Resident #58's medical record for March 2024 showed he had a weight entered on 3/2/24 he of 127.3 pounds and on 3/5/24 of 127.3 pounds. There was no weight entered on 3/7/24 or 3/12/24. Review of Resident #58's dialysis communication forms located at the nursing station showed there were no communication sheets dated 2/2/24, 2/10/24, and 2/13/24. There was an uncompleted dialysis communication form for 3/5/24, 3/10/24, and 3/12/24. The dialysis communication form dated 3/1/24 and 3/7/24 were completed. An interview was conducted on 3/13/24 at 2:02 P.M. with Resident #58. Resident #58 indicated he usually left for dialysis treatment a little before 7:00 A.M. and returned to the facility after his dialysis treatments between 11:30 A.M. and 12:00 P.M. During the interview, he explained there was a dialysis communication form used between the facility and the dialysis facility that included his vital signs and pre and post dialysis treatment weight. Resident #58 indicated he brought the form back with him from each dialysis appointment. He explained when he arrived at the facility, his assigned nurse did not always take his vital signs or ask about his weight. During the interview Resident #58 stated on 3/12/24, he returned from dialysis about 12:00 P.M. and his assigned nurse did not take his vital signs when he returned. An interview was conducted on 3/13/24 at 11:17 P.M. with Nurse #1 who was assigned Resident #58 on 3/12/24. Nurse #1 stated he did not take Resident #58's vital signs on 3/12/24 when he returned from dialysis because he was not aware the resident had returned to the facility. Nurse #1 stated when Resident #58 returned from dialysis his vital signs should be assessed and documented in his medication record. During the interview, Nurse #1 stated when Resident #58 returned from dialysis without a completed dialysis communication form, he did not follow up with the dialysis clinic to get the missing information. No reason was given as to why Nurse #1 did not follow up with the dialysis clinic. When Nurse #1 reviewed Resident #58's MAR for February 2023 and March 2023, he stated he documented absent from facility because he does not always see Resident #58 prior to the end of his shift at 3:00 P.M. An interview was attempted with Medication Aide #2 to inquire about the daily checks documented the MAR for 2/2/24, was unsuccessful. An interview was conducted on 3/13/24 at 11:28 A.M. with the Unit Manager. During the interview the Unit Manager stated the assigned nurse was responsible for entering a resident's vital signs and post dialysis weight when the resident returned from dialysis. The Unit Manager explained when a resident returned from dialysis with an uncompleted dialysis communication form, the assigned nurse was responsible for calling the dialysis clinic to follow up. The Unit Manager stated on 3/12/24, Resident #58 returned to the facility from dialysis at about 12:00 P.M. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/13/24 at 3:20 P.M. with the Director of Nursing (DON). The DON indicated when Resident #58 returned from a dialysis appointment, staff should be getting his vital signs and entering his post treatment weight into his medical record as ordered. The DON explained if the information was not provided through the dialysis communication form, the assigned nurse had the responsibility to contact the dialysis facility to get the information. During the interview, the DON stated Resident #58 usually arrived back at the facility around 1:00 P.M. The DON stated she was unaware the staff had not documented vital signs or weights for Resident #58 when he returned from his dialysis appointments, and she was unsure why this hadn't been done. An interview was conducted on 3/13/24 at 1:12 P.M. with the Administrator who stated the nursing staff should be following the physician orders by documenting vital signs and post dialysis weights when Resident #58's returned from dialysis treatments.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41387 Based on observations, record review, resident interview, staff interviews and a Physician interview, the facility failed to provide sufficient nursing staff to ensure a resident was administered morning scheduled medications in the allotted time frame for 1 of 1 resident reviewed for significant medications (Resident #211). Resident #211 not receiving her scheduled morning medications in the allotted time frame caused Resident #211 to remain in bed for fear of falling due to feeling dizzy. Findings included: This tag is cross reference to: F760: Based on record review, observation, resident interview, staff interviews and a Physician interview, the facility failed to administer significant medications of a resident's medication regimen in the scheduled time frame that caused the resident to remain in bed for fear of falling due to feeling dizzy for 1 of 1 resident reviewed for administration of significant medications (Resident #211). In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:15 a.m., she explained on 3/13/2024 due to the call out of a scheduled medication aide, NA (Medication Aide) #7 was assigned both the sparks unit and skills unit medication cart. She explained usually one nurse/medication aide was assigned the sparks unit and skills unit medication carts since the skills unit fluctuated in the number of residents and the level of care on the unit. She stated Nurse #6 was assigned to the cover the sparks unit and skills unit for nursing tasks, and it would have been best if she (DON) had assigned Nurse #6 to one of the medication carts so the administration of medications were administered in the scheduled time frame for Resident #211. The Director of Nursing reported attendance issues among the nursing staff and the issue of not having enough staff for the five medications carts had caused a delay in scheduled medications administered in the allotted time frame. She stated as the DON she had been assigned a medication cart to administered medications due to not having enough staff, and the facility was slowly hiring nurses and nurse aides. In an interview with the Administrator on 3/13/2024 at 4:36 p.m., she stated Resident #211 should have received her medications one hour before or after the scheduled time and explained the reason Resident #211 received her medications late was because a medication aide called out on 3/12/2024. She explained due to the residents on the sparks unit having fewer medications, one nurse/medication aide was assigned the sparks unit and skills unit medications cart when there were limited nurses/medications aides in the facility. She stated retaining enough nurses/medications aides for the five medication carts in the facility was a challenge. She stated nursing staff worked overtime to help cover staff needs and the facility made every effort to ensure residents received their scheduled medications in a timely manner. She also stated she continued to work in recruiting new nursing staff.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 43332 Based on record reviews and staff interviews, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days a week, to designate a director of nursing (DON) who worked on a full-time basis, and to have the DON only serve as a charge nurse when the average daily census was 60 residents or less for 23 of 39 days reviewed for staffing. Findings included: The nursing staff schedule and staff posting was reviewed from 2/1/24 through 3/10/24. The daily staff sheet indicated a Registered Nurse (RN) was not scheduled for at least eight consecutive hours a day on 2/3/24. Review of staff timecard dated 2/3/24 showed there was not an RN on duty at the facility that day. Review of the staffs' timecards dated 2/10/24 showed one RN worked. The RN was scheduled for the day shift 7:00 A.M. to 3:00 P.M. The timecard showed the RN worked from 7:49 A.M. to 3:29 P.M. for a total of 7 hours and 40 minutes. Review of the DON time punches for the week of 2/15/24 through 2/21/24 showed the DON worked 29.36 hours in the DON role. - 2/15/24, Thursday: DON hours logged 9:30 A.M. to 3:00 P.M., RN hours logged 3:01 P.M. to 12:08 A.M./ total DON hours 5.30, total RN hours 9.07 - 2/16/24, Friday: RN hours logged 3:19 P.M. to 11:37 P.M./ total RN hours 8.18 - 2/17/24, Saturday: RN hours logged 2:15 P.M. to 9:57 P.M./ total RN hours 7.42 - 2/19/24, Monday: DON hours logged 9:01 A.M. to 3:05 P.M./ total DON hours 6.04 - 2/20/24, Tuesday: DON hours logged 7:06 A.M. to 4:50 P.M./ total DON hours 9.44 - 2/21/24, Wednesday: DON hours logged 8:32 A.M. to 5:30 P.M./ total DON hours 8.58 Review of the DON time punches showed the week of 2/22/24 through 2/28/24 the DON worked 30.47 hours in the DON role. - 2/22/24, Thursday: DON hours logged 8:29 A.M. to 3:00 P.M.; RN hours logged 3:01 P.M. to 11:25 P.M./ total DON hours 6.32, total RN hours 8.24 - 2/23/24, Friday: DON hours logged 12:11 P.M. to 3:00 P.M./ total DON hours 2.49 - 2/24/24, Saturday: RN hours logged 3:01 A.M. to 10:42 A.M. and 3:23 P.M. to 11:20 P.M./ total RN hours 7.41 and 7.57 (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 2/26/24, Monday: DON hours logged 8:48 A.M. to 5:10 P.M./ total DON hours 8.22 - 2/27/24, Tuesday: DON hours logged 9:30 A.M. to 4:52 P.M./ total DON hours 7.22 - 2/28/24, Wednesday: DON hours logged 8:37 A.M. to 3:00 P.M., RN hours logged 3:01 P.M. to 11:25 P.M. / total DON hours 6.23, total RN hours 8.24 Review of the DON time punches for the week of 2/29/24 through 3/6/24 showed the DON worked 37.02 hours in the DON role. - 2/29/24, Thursday: DON hours logged 9:44 A.M. to 5:27 P.M./ total DON hours 7.43 - 3/2/24, Saturday: DON hours logged 3:14 P.M. to 8:57 P.M. / total DON hours 5.43 - 3/3/24, Sunday: DON hours logged 3:08 P.M. to 12:07 A.M./ total DON hours 8.59 - 3/6/24, Wednesday: DON hours logged 4:55 P.M. to 8:52 P.M./ total DON hours 15.57 During the week of 2/29/24 through 3/6/24 the DON was on the schedule with a resident assigned on 3/2/24 during the shift from 3:00 P.M. -11:00 P.M. and 3/3/24 during the shift from 3:00 P.M. - 11:00 P.M. The facility had a census greater than 60 residents. An interview was conducted on 3/13/24 at 12:30 P.M. with Scheduler #2 who stated she was aware an RN was to be scheduled for 8 consecutive hours each day. She indicated the facility no longer had agency staff working at the building and she was not always able to find a RN available to work. The Scheduler explained when she was unable to find the RN coverage, she filled the schedule with other licensed nurses to meet resident needs. During the interview, Scheduler #2 explained the Administrator and the Director of Nursing were aware of the lack of RN coverage because they reviewed the schedule weekly when it was created. An interview was conducted on 3/13/24 at 4:54 P.M. with the Director of Nursing (DON) who stated when the schedule was completed, she reviewed it to ensure the schedule had enough staff to meet resident needs. The DON indicated she was unaware of the requirement that the facility needed a RN for eight consecutive hours a day. The DON explained the facility only had one RN other than herself, and they had been unsuccessful at hiring additional RNs. The DON explained the facility does not work with agency staff at this time. During the interview, the DON indicated when staff called out, she tried to find coverage and when she was unable to find any coverage, she worked on the medication cart to meet resident needs. She further explained she had also been assigned the medication cart, typically on the evening 3:00 P.M. to 11:00 P.M. shift, when no one else was available. The DON stated she tried to complete her responsibilities as DON any time she had a free minute, no matter if she was working in the DON role or as a nurse on the medication cart. The DON indicated when she was assigned to a medication cart with a resident assignment, she had gotten pulled away by staff to handle DON responsibilities. During the interview, the DON indicated the facility census had been approximately 102 since she started in January 2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Williamston	119 Gatling Street Williamston, NC 27892

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 3/13/24 at 1:08 P.M. with the Administrator who stated she was aware of the requirement a RN worked eight consecutive hours in a day and to her knowledge the facility had a RN scheduled to meet these needs. The Administrator stated she was not aware a RN had not worked a scheduled shift until the shift had already passed. The Administrator indicated she had a limited number of RNs employed at her facility and this made it difficult to cover the RN hour requirements. During the interview, the Administrator stated the facility had one RN hired full time, one RN hired part time, and the DON assisted on the floor as needed. The Administrator explained the facility did not have any agency staff working at this time and there were no waivers in place. The Administrator stated she was aware the DON was unable to serve as a charge nurse if the facility census was greater than 60 and she stated the DON was picking up the 3:00 P.M. to 11:00 P.M shift after her DON responsibilities were completed. During the interview, the Administrator further indicated if she had been made aware the DON responsibilities were not being completed, she would pull staff from a sister facility to provide assistance.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on observation, record review and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 5 of 47 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry with an active Nurse Aide I certification (NA #6, NA #9, NA #4, NA #1,and NA #8). Findings included: 1. On [DATE] at 8:12 a.m., NA #6, who was a Medication Aide, was observed passing medications to Resident #59. A review of NA #6's employment record reported a hired date as [DATE], and NA #6's verification report listed the NA I expiration date as [DATE] for the NC Nurse Aide Registry, and the NC Medication Aide Registry listed an expiration date of [DATE]. A review of daily nursing assignment schedules since [DATE] listed NA #6 assigned as a medication aide on the following dates: * [DATE] 7am-3pm; 8pm and 5am on the Skills and Sparks Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 3pm-11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm on the Skills and Sparks Unit. * [DATE] 3pm-11pm on the Skills and Sparks Unit. * [DATE] 3pm-11pm on the [NAME] Unit. * [DATE] 7am-3 pm and 5am on the [NAME] Unit. * [DATE] 3pm-11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm on the [NAME] Unit. (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* [DATE] 7am-3 pm and 3 pm- 11pm on the [NAME] Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the Skills and Sparks Unit. * [DATE] 3pm-11pm on the [NAME] Unit. * [DATE] 3pm-11pm on the [NAME] Unit. * [DATE] 3pm-11pm on the [NAME] Unit. * [DATE] 7am-3 pm and 3 pm- 11pm on the [NAME] Unit. * [DATE] 3pm-11pm on the Skills and Sparks Unit. * [DATE] 7am-3 pm on the Skills and Sparks Unit and 3 pm- 11pm on the [NAME] Unit. * [DATE] 7am-3 pm on the [NAME] Unit and 3 pm- 11p NA #6 was removed from schedule. On [DATE] at 1:30 p.m., a review of the electronic NC Nurse Aide I Registry listed NA #6's NA I certification expired as of [DATE], and the NC Medication Aide Registry listed NA #6's expiration date as [DATE]. A review of NA #6's employee timesheet since [DATE] listed NA #6 working the following dates: * On [DATE] at 5:06 pm to 11:22pm as Cerified Nurse Aide (CNA) I Medication Aide. * On [DATE] at 3:19pm to 8:04am on [DATE] as CNA I Medication Aide. * On [DATE] at 3:45pm to 10:07 pm as CNA I Medication Aide. * On [DATE] at 7:50 am to 10:03 pm as CNA I Medication Aide. * On [DATE] at 9:39 am to 3:21 pm as CNA I Medication Aide. * On [DATE] at 7:19am to 10:02 pm as CNA I Medication Aide. * On [DATE] at 8:53 am to 10:08 pm as CNA I Medication Aide. * On [DATE] at 8:33 am to 7:11pm as CNA I Medication Aide. * On [DATE] at 7:01am to 4:55 pm as CNA I Medication Aide. (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with NA #6 on [DATE] at 4:20 pm, he stated he had been a NA I since 2014 and a Medication Aide since 2020, and his assignments mainly consisted of being a medication aide due to the shortage of nurses in the facility. He said the Administrator informed him at 2:45 pm that day his NA I certification was expired, and he was removed from his assignment to go home. He explained he knew he had to have a NA I certification to work as a medication aide and thought the past DON had sent the information into the NC Nurse Aide Registry for renewal of his NA I certification. He stated no one at the facility had mentioned his NA I certification had expired before that day. In an interview with the Administrator on [DATE] at 4:34 pm, she stated medication aides had to have a current NA I certification to practice as a medication aide, and the Director of Nursing (DON) was responsible for monitoring nursing certification/licensure for expirations and renewals. She explained there had been six different DONs in the facility over the last year, and NA #6's NA I certification expiration had fell through the cracks. She further stated the facility was conducting an immediate audit to ensure all Nurse Aide certifications had not expired from the NC Nurse Aide Registry. In an interview with the Director of Nursing (DON) on [DATE] at 11:04 am, she stated she had been slowly learning the role of DON since starting in the role as DON on [DATE]. She explained no one had informed her to track/monitor nurse aide certifications for expirations, and she did not know who was responsible for the task prior to this week. She further stated she was not aware NA #6's NA I certification had expired and a NA I certification was required with a medication aide certification. 2. a. On [DATE] at 5pm, a review of the audit conducted by the facility on [DATE] to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #9's NA I certification expired on [DATE]. A review of NA #9's employment timesheet since [DATE] reported she worked as a nurse aide of the following dates: * On [DATE] from 8:29 am to 3:04 pm. * On [DATE] from 7:05 am to 3:10 pm. * On [DATE] from 7:12 am to 7:00 pm. * On [DATE] from 7:38 am to 3:01 pm. * On [DATE] from 7:26 am to 3:11 pm. * On [DATE] from 7:12 am to 3:05 pm. * On [DATE] from 9:19 am to 3:01 pm. b. On [DATE] at 5pm, a review of the audit conducted by the facility on [DATE] to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #4's NA I certification expired on [DATE]. (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of NA #4's employment timesheet since [DATE] reported she worked as a Nurse Aide II of the following dates: * On [DATE] from 3:05 pm to 7:17 am on [DATE]. * On [DATE] from 3:48 pm to 7:08 am on [DATE]. * On [DATE] from 3:41 pm to 7:16 am on [DATE]. * On [DATE] from 3:09 pm to 7:15 am on [DATE]. * On [DATE] from 3:21 pm to 7:25 am on [DATE]. * On [DATE] from 3:22 pm to 7:13 am on [DATE]. * On [DATE] from 3:04 pm to 7:10 am on [DATE]. * On [DATE] from 3:26 pm to 5:00 pm c. On [DATE] at 5pm, a review of the audit conducted by the facility on [DATE] to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA) #1's NA I certification expired on [DATE]. A review of NA #1's employment timesheet sine [DATE] reported she worked as a Nurse Aide/Medication Aide of the following dates: * On [DATE] from 7:39 am to 10:21 pm. * On [DATE] from 7:33 am to 2:48 pm. * On [DATE] from 7:31am to 2:35 pm. * On [DATE] from 7:29 am to 2:42 pm. * On [DATE] from 7:29 am to 11:08 pm. * On [DATE] frp, 7:38 am to 3:04 pm. * On [DATE] from 7:44 am to 8:15am. d. On [DATE] at 5pm, a review of the audit conducted by the facility on [DATE] to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry reported Nurse Aide (NA)#8's NA I certification expired on [DATE]. A review of NA #8's employment timesheet reported he working as a nurse aide of the following dates: * On [DATE] from 2:59 pm to 11:07 pm. (continued on next page)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* On [DATE] from 2:52 pm to 11:08 pm. * On [DATE] from 2:55 pm to 11:13 pm. In an interview with the Director of Nursing (DON) on [DATE] at 11:04 am, she explained she started in the role of DON on [DATE], and she was slowly learning the role and duties of the DON. She explained she was not aware NA #9's, NA #4's, NA #1's and NA #8's NA I certifications had expired from the NC Nurse Aide Registry until the Administrator conducted an audit conducted on all nurse aides on [DATE] to ensure Nurse Aide certifications had not expired from the NC Nurse Aide Registry. She explained Accounts Payable Personnel was responsible for verifying NA I certifications when new nurse aides were hired, and she did not know that she was responsible for monitoring NA I certification for expiration on the NC Nurse Aide Registry until this week. In an interview with the Administrator on [DATE] at 4:44 pm, she stated the Director of Nursing was responsible for monitoring NA I certifications for expiration and renewal on the NC Nurse Aide Registry, and it was in the DON job description. The Administrator further stated she wasn't sure the DON was aware of her responsibility to monitor the certifications of the nurse aides due to limited time of orientation. She explained on [DATE], NA #9, NA #4, NA #1 and NA #8 were sent home if working and removed from daily nursing assignments. She explained they would not be allowed to work until their NA I certification was renewed and posted on the NA Nurse Aide Registry as active.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43332 Based on staff interviews and record reviews, the facility failed to complete a performance review every 12 months for 4 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #4, NA #7, NA #6, and NA #5). Findings included: 1. NA (Nurse Aide) #4's personnel file was reviewed and revealed a date of hire of 10/1/20. The personnel file for NA #4 did not include evidence a performance review had been completed since the NA's date of hire. Attempts were made to reach NA #4 for an interview were unsuccessful. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA #4 based on the outcome of her performance evaluation. An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no performance evaluations in NA #4's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error. 2. NA #7's personnel file was reviewed and revealed a date of hire of 10/1/20. The personnel file for NA #7 did not include evidence a performance review had been completed since the NA's date of hire. Attempts were made to reach the NA for an interview were unsuccessful. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA#7 based on the outcome of her performance evaluation. (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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no performance evaluations in NA #7's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error. 3. NA #6's personnel file was reviewed and revealed a date of hire of 9/7/22. The personnel file for NA #6 did not include a performance review for September 2023. . An interview was conducted on 3/12/24 at 1:29 P.M. with NA #6. During an interview with NA #6, he stated the facility had not completed a performance review in the past twelve months and he was unable to recall if the facility had ever evaluated his work during his employment at the facility. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA #6 based on the outcome of his performance evaluation. An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no performance evaluations in NA #6's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON for completion. The Administrator stated the DON was aware her job responsibilities included completing and tracking NA performance evaluations. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error. 4. NA #5's personnel file was reviewed and revealed a date of hire of 10/4/22. The personnel file for NA #5 did not include a performance review for October 2023. An interview was conducted on 3/12/24 at 1:00 P.M. with NA #5. During an interview with NA #5, she stated the facility had not completed a performance review in the past twelve months and she was unable to recall if the facility had ever evaluated her work during her employment at the facility. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated she was unaware she was required to complete NA performance review until this past Monday 3/11/24. She shared the performance reviews had not been completed due to turnover in the position of the DON. The DON explained she had not provided individual training to NA #5 based on the outcome of her performance evaluation. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there was no performance evaluation in NA #5's personnel file. The Administrator indicated the facility currently did not have a Staff Development Coordinator and the responsibilities from this position fell to the DON to complete. The Administrator stated the DON was aware of her job responsibilities of training and performance evaluations for NA to be completed and tracked. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43332 Based on record review and staff interviews, the facility failed to display accurate daily nursing staffing information, the resident census on each shift, and/or maintain the daily nurse staff posting on file for 39 out of 39 days from February 2024 and March 2024 reviewed for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) for February 1, 2024, through March 10, 2024, was conducted. The staffing posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nursing Assistance (NAs) and Medication Assistant, the census (number of residents in the facility), a column for actual hours worked and a column for staffing total. The number of unlicensed and licensed staff and actual hours worked during the evening shift, the night shift, and the facility census were not documented during the evening shift and night shift for the following days: 2/1/24, 2/2/24, 2/5/24, 2/6/24. 2/7/24, 2/12/24, 2/13/24, 2/16/24, 2/19/24, 2/20/24, 2/23/24, 2/24/24, 2/25/24, 2/26/24, 2/27/24, 2/28/24, 3/1/24, 3/4/24, 3/5/24, and 3/7/24. The number of unlicensed and licensed staff and actual hours worked during the night shift and the facility census were not documented for the following days: 2/9/24, and 2/10/24. Review of the Daily Nursing Staff sheet dated 3/10/24 showed the resident census was not completed for the evening shift and night shift. The facility was unable to provide staffing sheets for 2/3/24, 2/4/24, 2/8/24, 2/11/24, 2/14/24, 2/15/24, 2/17/24, 2/18/24, 2/21/24, 2/22/24, 3/2/24, 3/3/24, 3/6/24, 3/8/24, and 3/9/24. An interview was conducted on 3/12/23 at 10:09 A.M. with Front Desk Staff #1 who stated she filled out the daily nursing staff sheet for the shifts she was assigned to work at the front desk. The Front Desk Staff #1 indicated when she arrived in the morning for her shift, either the Scheduler took her the schedule for that day, or she went to the Scheduler to get the schedule. She used the information on the daily schedule to complete the daily nursing staff sheet. During the interview, the Front Desk Staff #1 indicated when her shift ended prior to the start of the 3:00 P.M. shift, her replacement was responsible for completing the daily nurse staffing sheet for the evening shift. The Front Desk Staff #1 was unsure who completed the daily nurse staffing sheet for the night shift. An interview was conducted on 3/12/24 at 5:25 P.M. with the Front Desk Staff #2. During the interview Front Desk Staff #2 stated the individual assigned to work the front desk during the first shift was responsible for completing the daily nursing staff posting sheet and she explained the sheet was completed prior to her arriving for her shift. The Front Desk Staff #2 indicated she had not completed the daily nursing staff sheet and did not review the daily nursing staff sheet when she started her work shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview was conducted on 3/12/24 at 10:05 A.M. with the Administrator. During the interview, the Administrator stated the individual assigned to work the front desk was responsible for filling out the daily nursing staff sheet and posting the completed sheet on the window at the front entrance of the building. The Administrator indicated the daily nursing staff sheet should have been completed for each shift and then posted in the window where it was visible for anyone entering the building.

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The Carrolton of Williamston	119 Gatling Street Williamston, NC 27892

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation, resident interview, staff interviews and a Physician interview, the facility failed to administer significant medications of a resident's medication regimen in the scheduled time frame that caused the resident to remain in bed for fear of falling due to feeling dizzy for 1 of 1 resident reviewed for administration of significant medications (Resident #211). Findings included: Resident #211 was admitted to the facility on [DATE] with diagnoses including hypertension, atrial fibrillation, epilepsy (seizures), anxiety and pain. Resident #211's care plan dated 2/29/2024 included a focus for hypertension and atrial fibrillation, and interventions included giving antihypertensive medications as physician ordered and monitoring for side effects. Resident #211's care plan also included the use of anti-anxiety and seizure medications. Interventions included administering the medications as ordered by the physician, monitoring for side effects and effectiveness of the medications and seizure precautions. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #211 was cognitively intact and received anti-anxiety medications, opioids (pain relief medications) and antiplatelets (medications that prevent the blood to clot). A review of physician's orders indicated Resident #211 was ordered the following significant medications in her medication regimen on 2/29/2024: * Metoprolol Tartrate oral tablet 25 milligrams (mg) two tablets by mouth two times a day for hypertension. * Lorazepam oral tablet 0.5 mg one tablet by mouth two times a day for anxiety. * Lisinopril oral tablet 20 mg one tablet by mouth one time a day for hypertension. * Levetiracetam oral tablet 500 mg one tablet by mouth two times a day for seizure. * Dronedarone HCl oral tablet 400mg one tablet by mouth two times a day for heart failure. * Aspirin Enteric Coated Tablet Delayed Release 81mg one tablet by mouth two times a day for coronary artery disease/atrial fibrillation. A review of Resident #211's March Medication Administration Record (MAR) reported Metoprolol Tartrate, Lorazepam, Lisinopril, Dronedarone HCL and Aspirin were scheduled for administration at 8:30 a.m. daily and given. A review of Resident #211's medication audit report from 3/1/2024 to 3/12/2024 reported Resident #211 received her scheduled 8:30 a.m. medications after the one-hour time frame for administration on the following dates: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	* On 3/2/2024, Nurse #1 recorded medications were administered at 10:55 a.m. * On 3/3/2024, NA (Medications Aide) #7 recorded medications were recorded administered between 10:13am and 10:19 a.m. * On 3/4/2024. Nurse #3 recorded medications were administered at 11:06 a.m. * On 3/8/2024, NA (Medications Aide) #7 recorded medications were administered between 10:56 a.m. and 11:00 a.m. * On 3/12/2024, NA (Medications Aide) #7 recorded medications were administered between 10:57 a.m. and 11:02 a.m. A review of Resident #211's blood pressure readings indicated a slight elevation on 3/3/2024 at 4:46 a.m. with a reading of 140/86, 3/3/2024 at 3:21 a.m. with a reading of 138/85, and on 3/11/2024 at 1:01 a.m. 142/74. On 3/10/2024 at 10:34 a.m. in an interview with Resident #211, she said the nursing staff usually administered her medications between 8:00 am and 9:00 a.m., and there was one day since admission she received her scheduled morning medications at 11:00 a.m. She explained the morning she received her morning medications at 11:00 a.m., she was feeling dizzy by the time her medications were administered. She said she spoke to the nurse about receiving her morning medications earlier in the morning. She was unable to recall the date when her medications were given at 11:00 a.m. and the name of the nurse she had spoken with about receiving her medications earlier in the morning. On 3/12/2024 at 8:21 a.m. in a follow up interview with Resident #211, she explained she didn't take her medications at home late in the morning and would experience dizziness, trembling and jitters when her medications were administered later in the morning around 11:00 a.m. She stated the dizziness, trembling and jitters disappeared after receiving her morning medications. On 3/12/2024 at 9:27 a.m. NA (medications Aide) #7 was observed exiting the sparks unit with a medications cart and moving to the skills unit medication cart to begin the scheduled morning medications. In an interview with NA (medications Aide) #7 on 3/12/2024 at 9:27 a.m., she explained she was assigned both medications carts for the sparks unit and the skills unit, and Nurse #6 and the Director of Nursing (DON) knew she was assigned both medications carts. She said had the keys to both medication carts since reporting to work at 7:00 a.m., and no one had been to get the keys for the skills medication cart to start the scheduled morning medications for the residents. She stated medications were to be administered one hour before or after the scheduled time, and due to starting the skills hall medication administration at this time, she would not be able to administered the residents' their scheduled morning medications on time. On 3/12/2024 at 11:05 a.m., NA (medications Aide) #7 was observed in Resident #211 room and the skills unit medication cart outside the Resident #211 door. NA (medications Aide) #7 stated she had just administered Resident #211 her scheduled morning medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with Resident #211 on 3/12/2024 at 11:08 a.m., she stated she had asked three times for her scheduled morning medications and had just received her medications. She stated that due to feeling dizzy she had stayed in the bed so she wouldn't fall. Resident #211 denied needing to get out of bed while waiting to receive her medications and stated the dizziness would go away now that she had been administered her scheduled morning meds. In an interview with Nurse #4 on 3/13/2024 at 2:44 p.m., he stated he couldn't recall why the medications were given after the scheduled time frame on 3/2/2024 to Resident #211. He explained usually there was one nurse or medication aide assigned to both the sparks unit medication cart and the skills unit medication cart, and it was not unusual for residents' medications to be administered medications after the scheduled time frame. He further stated on 3/2/2024 he did not inform the physician Resident #211's mediations were administered after the scheduled time frame and was not a usual practice. Attempts to interview Nurse #3 were unsuccessful. In an interview with Nurse #6 on 3/13/2024 at 2:35 p.m., she stated as unit manager she notified the physician when medications were administered after the scheduled time frame and called the physician on 3/12/2024. She stated she was not aware on 3/2/2024, 3/3/2024, 3/4/2024 and 3/8/2024 Resident #211 received her medications after the scheduled time frame. She explained on 3/12/2024 NA (Medication Aide) #7 was assigned the medication cart for the sparks and skills unit because there were only four nurses/medication aides scheduled and there were five medication carts in the facility. She stated she did not work the medication cart often, and the Director of Nursing (DON) made the decision when the unit manager worked a medication cart if not enough staff. She said on 3/12/2024, the DON made decision for her to not work a medication cart. In an interview with the Director of Nursing (DON) on 3/13/2024 at 11:15 a.m., she explained scheduled medications were to be administered one hour before or after the scheduled time, and Resident #211 receiving her scheduled morning medications after 11:00 a.m. was not acceptable. The DON explained usually with one medication aide and a nurse covering the hall, residents' medications were administered in the scheduled allotted time frame. She explained on 3/13/2024 due to a scheduled medication aide calling out, NA (Medication Aide) #7 was assigned both the sparks unit and skills unit medication cart. She stated Nurse #6 was assigned to the cover sparks unit and skills unit for nursing tasks and it would had been best if she had been assigned one of the medication carts for administration of medications in the scheduled time frame for Resident #211. In a phone interview with Physician #1 on 3/13/2024 at 1:54 p.m., he stated Resident #211's scheduled morning medications should be administered in the allotted time frame. He explained the nursing staff informed him on 3/12/2024 there was a delay in administering Resident #211's medications and noted the reason was due to staffing. He stated Resident #211 receiving her scheduled morning medications two hours after the allotted scheduled time frame was not acceptable and should not cause any harm. He explained that Resident #211 not receiving the Metoprolol Tartrate (a medication for high blood pressure) medication timely could have caused some slight dizziness. Physician #1 said he was not notified of Resident #211 not receiving her morning scheduled medications in the allotted time frame on 3/2/2024, 3/3/2024, 3/4/2024 and 3/8/2024, and the facility needed to improve in administering scheduled medications in a timely manner. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Administrator on 3/13/2024 at 4:27 p.m., she explained that due to residents' complaints of receiving medications late, the nursing staff received an in-service in administering medications in a timely manner one to two months ago. She stated Resident #211 should have received her medications one hour before or after the scheduled time.

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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 observations and staff interviews, the facility failed secure the keys for a medication cart when Medication Aide #7 left the medication cart keys for the skilled-hall medication cart in Resident #211's room. This deficient practice was for 1 of 5 medication carts in the facility. Findings included: On 3/12/2024 at 11:05 a.m., Medication Aide #7 was observed locking the skilled-hall medication cart and positioning the medication cart against the wall outside Resident #211's door before walking down the hall away from Resident #211's door. On 3/12/2024 at 11:08 a.m., during an interview with Resident #211, she picked up a double ring key chain and stated the Medication Aide #7 had left the keys in her room after administering her medications. Three keys were observed on one ring and four keys were observed on the other ring. On 3/12/2024 at 11:11a.m., when Medication Aide #7 returned to Resident #211's room, Resident #211 was observed holding up the double ring key chain and stating, You forgot these. Medication Aide #7 with a surprise facial gesture stated, Oh and gathered the keys from Resident #211. Medication Aide #7 explained the keys were to the skilled-hall medication cart. On 3/12/2024 at 11:13 a.m. in an interview with Medication Aide #7, she stated the keys were to the skilled-hall medication cart positioned outside Resident #211's room and should always be kept in her possession. In a follow up interview with Medication Aide #7 on 3/13/2024 at 3:05 p.m., she stated she had laid the keys to the medication cart down in Resident #211's room to administer her medications, and Resident #211 had some questions about her discharge medications. She explained when she left Resident #211's room to address her questions, she forgot to get the keys to the skilled-hall medication cart. On 3/13/2024 at 12:10 p.m. in an interview with the Director of Nursing, she stated keys to the skilled hall medication cart were to remain in Medication Aide #7 as all times and leaving the keys in Resident #211's room was not acceptable practice.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43222 Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide a pureed food item with a smooth consistency. This failure had the potential to affect 9 of 105 residents with diet orders for a pureed diet texture. The findings included: A review of the Diet Order Report dated 3/12/24 revealed 9 residents with diet orders for a pureed diet texture. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. A continuous observation of the lunch meal tray line on 3/12/24 from 11:43 AM - 11:56 AM revealed Cook #1 recorded the internal temperature of the food items stored on the tray line intended for the lunch meal service, including pureed egg noodles. The pureed egg noodles were observed with a lumpy consistency smaller than pea-sized when the food was stirred. Cook #1 stated she intended to serve the pureed egg noodles as it was. The District Manager observed the lumpy consistency and told Cook #1: There are chunks in there but all squishy. The District Manager removed the pureed egg noodles from the tray line to further blend. The pureed egg noodles were a smooth pureed consistency. Cook #1 was interviewed on 3/12/24 at 12:44 PM. She stated that puree consistency was supposed to look like baby food, smooth, and no chunks. Cook #1 stated she had learned how to prepare the pureed food on her own from previous work experience. She revealed that she did not pay attention to the pureed egg noodles before placing on the tray line because she was not the one who prepared it. She indicated that the puree foods were prepared the day before, but she did not know by whom. An interview was conducted with the Dietary Manager on 3/12/24 at 12:46 PM. She revealed that Dietary Aide #1 had prepared the pureed egg noodles. The DM indicated that puree consistency was supposed to be like pudding. She stated that Dietary Aides participate in the preparation of pureed food and other parts of the meal. She further stated that Cook #1 should have inspected the pureed food before placed on the tray line. The DM revealed that Dietary Aide #1 was re-hired 2 weeks ago, and training/education was provided upon rehire. An interview was conducted on 3/12/24 at 12:48 PM with the District Manager. She confirmed that there were lumps in the pureed egg noodles. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Speech Therapist (ST) was interviewed on 3/12/24 at 4:06 PM. She revealed she began at the facility in January 2023 as needed. The ST stated she had not seen pureed foods that caused concern or to question the consistency. However, she normally visited the facility twice weekly. If pureed foods were lumpy, they could be a choking hazard and could lead to aspiration pneumonia. The ST indicated that the expected consistency of puree foods should be like baby food. If a food was modified with a machine, it should have a uniform consistency, which can be achieved by liquids or corn starch or bread or milk. The Administrator stated in an interview on 3/13/24 at 8:16 AM that whatever the diet order said in the medical record was the expected consistency. She stated that the kitchen staff should have further blended the pureed egg noodles immediately, and it should have never touched the tray line with a lumpy consistency.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41387 Based on record review, North Carolina Board of Nursing Registry, observations, resident interviews, staff interviews and a Physician interview, the facility failed to provide effective leadership and oversight to ensure the Director of Nursing (DON) implemented her responsiblities in these areas: sufficiently staffing the facility to administer medications in a timely manner, having a registered nurse work eight consecutive hours daily and a DON who worked full time and only serves as a charge nurse when census was less than 60 residents, monitoring and tracking expiration of nursing licenses (Nurse #3) and nurse aide certifications (NA #9, NA # 4, NA #1, and NA #8), completing yearly performance evaluations for nurse aides (NA #4, NA #7, NA #6 and NA #5) and providing and monitoring 12 hours of annual training for nurse aides (NA #4, NA #7, NA #6 and NA #5). This deficient practice had the potential to affect 105 of 105 facility residents. Findings included: This tag is cross reference to: F725: Based on observations, record review, resident interview, staff interviews and a Physician interview, the facility failed to provide sufficient nursing staff to ensure a resident was administered morning scheduled medications in the allotted time frame for 1 of 1 resident reviewed for significant medications (Resident #211). Resident #211 not receiving her scheduled morning medications in the allotted time frame caused Resident #211 to remain in bed for fear of falling due to feeling dizzy. F727: Based on record reviews and staff interviews, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days a week, to designate a director of nursing (DON) who worked on a full-time basis, and to have the DON only serve as a charge nurse when the average daily census was 60 residents or less for 23 of 39 days reviewed for staffing. F729: Based on observation, record review and staff interviews, the facility failed to monitor the North Carolina (NC) Nurse Aide (NA) Registry to ensure 5 of 47 nurse aides employed at the facility remained listed on the NC Nurse Aide Registry with an active Nurse Aide I certification (NA #6, NA #9, NA #4, NA #1, and NA #8). F730: Based on staff interviews and record reviews, the facility failed to complete a performance review every 12 months for 4 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #4, NA #7, NA #6, and NA #5). F839: Based on observations, record review, North Carolina Board of Nursing (NCBON) verification registry and staff interviews, the facility failed to ensure Nurse #3, who was observed providing resident care at the facility, maintained a current and active professional nursing licenses with the NCBON for 1 of 12 nurses reviewed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F947: Based on record review and staff interviews, the facility failed to ensure at least 12 hours of annual training to include dementia and areas of weakness as determined in the nursing aides' performance reviews were completed for 4 Nursing Assistants (NA #4, NA #7, NA #6, and NA #5) of 5 reviewed for staffing. In an interview with the Administrator on 3/13/2024 at 6:00 p.m., she explained in June 2023 the corporate office made the decision not to use agency nursing staff in the facility, and due to the location of the facility in the non-healthcare community, she was finding it hard to recruit nurses to the facility. She explained the Director of Nursing had only had a few days with another sister facility's Director of Nursing (DON) since her employment date 1/8/2023 and the facility could not locate the DON's competency worksheets since her employment. She explained that due to her (the Administrator) nursing background, she helped to ensure resident care was provided and assisted with Minimum Data Set (MDS) assessments as needed. She stated she needed a staff development position in the facility to minimize workload of the DON and herself, and there had been an increase the nursing pay scale in attempt to attract nurses to the facility.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on observations, record review, North Carolina Board of Nursing (NCBON) verification registry and staff interviews, the facility failed to ensure Nurse #3, who was observed providing resident care at the facility, maintained a current and active professional nursing licenses with the NCBON for 1 of 12 nurses reviewed. Finding included: A review of the nursing licensure audit conducted by the facility on [DATE] reported Nurse #3's license expired on [DATE]. The electric NCBON Registry listed Nurse #3's license with an expiration date of [DATE]. A review of the employee time sheet for Nurse #3 indicated she had worked at the facility since [DATE] on the following dates: * [DATE] from 7:22 a.m. to 3:25 p.m. * [DATE] from 7:02 a.m. to 3:00 p.m. * [DATE] from 7:12 a.m. to 7:34 p.m. * [DATE] from 7:19 a.m. to 3:33 p.m. * [DATE] from 7:25 a.m. to 3:08 p.m. * [DATE] from 7:36 a.m. to 3:24 p.m. * [DATE] from 7:15 a.m. to 3:23 p.m. * [DATE] from 7:00 a.m. to 3:25 p.m. On [DATE] at 10:30 a.m., Nurse #3 was observed working on the Skills Unit (the hall that housed residents that were admitted for rehabilitation therapy). On [DATE] at 8:49 a.m., Nurse #3 was observed conducting a medication pass to Resident #211 on the Skills Unit. Attempts to reach Nurse #3 for an interview were unsuccessful. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Accounts Payable Personnel on [DATE] at 4:21 p.m., she stated she was responsible for only verifying nursing licensure before conducting background checks on new employees and was not responsible for keeping a record of when nursing licenses expired. She explained she provided the DON with a list of the licensure dates when new nurses were employed, and the DON was responsible for keeping up when Nurse #3's license expired. She stated the last DON kept a record of when each nurses' license expired and was unsure if the new DON was aware she was responsible to monitor expiration of Nurse #3's license. In an interview with the Director of Nursing (DON) on [DATE] at 11:04 a.m., she explained she was not aware Nurse #3's license had expired on [DATE] until the Administrator informed her on [DATE]. She stated Nurse #3 last worked at the facility on [DATE], and she had not been able to contact Nurse #3 per phone. She further explained there had been no changes in Nurse #3 responsibilities as a nurse at the facility since the expiration date. The DON stated she started at the facility as the DON on [DATE] and had not been tracking nursing licenses for expirations because she had not been informed it was her responsibility. The DON further stated she had not reported to the NCBON that Nurse #3 had worked without an active nursing license. In an interview with the Administrator on [DATE] at 1:01 p.m., she stated when she conducted a licensure audit for all nursing staff on [DATE], she discovered Nurse #3's license expired on [DATE]. She explained initially Accounts Payable did the verification of nursing licensure for new employees before providing the licensure information to the DON, and the DON was responsible for monitoring expiration of Nurse #3's license. The Administrator stated since the new DON's employment, she had reviewed the DON job description with the DON and was unsure if the DON had the information needed to monitor expiration of Nurse #3's license. The Administrator further stated she had not reported Nurse #3 to the NCBON for working without a license but would notify the agency that day.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record related to documentation of the treatment for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #19). Findings included: Resident #19 was admitted to the facility on [DATE]. Physician orders dated 2/29/2024 included an order to cleanse the right heel with wound cleaner, to apply collagen particles before applying calcium silver alginate and a foam heel dressing and to secure the dressing with kerlix (a wrap to hold primary and secondary dressings in place) every other day for wound healing. A review of the March 2024 Treatment Administration Record (TAR) for Resident #19 indicated Nurse #3 recorded providing treatment of the right heel pressure ulcer on 3/11/2024. During observation of wound care to Resident #19's right heel pressure ulcer on 3/12/2024 at 10:05 a.m., the old foam dressing to the right heel was observed dated 3/9/2024 with Nurse Aide #6 initials. On 3/12/2024 at 10:12 a.m. in an interview with the Director of Nursing (the nurse who provided Resident #19's wound care on 3/12/202), she stated Nurse #3 had documented on 3/11/2024 changing the pressure ulcer dressing to the right heel on Resident #19's TAR. She stated obviously based on the date (3/9/2024) and initials (Nurse Aide #6) on the right heel dressing when she changed Resident #19's right heel dressing, Nurse #3 did not change the right heel dressing on 3/11/2024. The Director of Nursing explained Nurse Aide #6 was a Medication Aide and Nurse Aide II who had been trained to help the Wound Care Nurse with Stage I and Stage II dressing changes. The Director of Nursing further explained due to the absence of the Wound Care Nurse, she had informed Nurse #3 on 3/11/2024 she was responsible for Resident #19's wound care, and Nurse #3 assured her she had performed Resident #19's wound care. Attempts to interview Nurse #3 were unsuccessful. In another interview with the Director of Nursing (DON) on 3/13/2024 at 11:35 a.m., she explained Nurse #3 falsified documentation on Resident #19's TAR by documenting wound care to the right heel was performed on 3/11/2024. She stated Nurse #3 had not answered her calls to discuss the documentation of wound care, and documentation should be accurate on Resident #19's TAR. In an interview with the Administrator on 3/13/2024 at 5:04 p.m., she stated documentation on Resident #19's TAR should reflect adequate documentation that treatments were recorded correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Williamston	119 Gatling Street Williamston, NC 27892

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on observation, resident interview, Wound Care Physician Assistant interview, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee following the recertification and complaint investigation surveys of 6/10/21 and 11/18/22 and the complaint investigation surveys of 2/27/23 and 9/7/23. This was for 6 deficiencies that were recited on the current recertification and complaint investigation survey of 3/13/24 in the areas of Resident Rights (F550), Environment (F584), Treatment and Services for Pressure Sores (F686), Supervision to Prevent Accidents (F689), Medication Storage (F761), and Complete/Accurate Medical Records (F842). The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F550: Based on record review and staff interviews, the facility failed to ensure staff communicated to a resident in a respectful and dignified manner for 1 of 2 resident reviewed for dignity (Resident #93). The reasonable person concept was applied to this deficiency as individuals have the expectation to be addressed by staff using language and tone that portrays respect and dignity. During the recertification and complaint investigation survey of 6/10/21, the facility was cited for failing to ensure residents were spoken to in an appropriate manner and for staff to sit while feeding residents. During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to ensure residents were spoken to in a dignified manner when a staff member scolded a resident. F584: Based on observation and staff interviews, the facility failed to ensure bathrooms (room [ROOM NUMBER], #60, #61, #65, #67/69, #70) on the locked unit were free of fecal matter or black/brown matter on various surfaces for 6 of 10 bathrooms reviewed for clean and homelike living environment. During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to ensure the walls and lighting fixtures on 3 of 4 units were maintained in good repair. F686: Based on record review, observations, staff interviews and interviews with Wound Care Physician Assistant (PA), the facility failed to (1) perform wound care to a pressure ulcer per physician's order (Resident #19), (2) set the alternating pressure air mattress at the correct setting based on the resident's weight (Resident #104), and (3) change the treatment for a pressure ulcer when ordered by the Wound Care PA (Resident #77) for 3 of 4 residents reviewed for pressure ulcers. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to update a physician's order for wound treatment and failed to apply to correct treatment to the wound. F689: Based on record review, resident interview, and staff interviews, the facility failed to implement effective interventions to prevent a severely cognitively impaired resident (Resident #46) from hitting another resident (Resident #31) in the face two days after he initially exhibited physically aggressive behaviors directed toward another resident (Resident #55). Resident #31 sustained a scratch to the face as a result of the incident. This was for 1 of 4 residents reviewed for accidents (Resident #46). During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing ensure an outlet with exposed wiring was not accessible to residents. During a complaint investigation survey on 2/27/23, the facility failed to provide care in a safe manner resulting in a hematoma and a left ankle fracture for a resident. F761: Based on observations and staff interviews, the facility failed secure the keys for a medication cart when Medication Aide #7 left the medication cart keys for the skilled-hall medication cart in Resident #211's room. This deficient practice was for 1 of 5 medication carts in the facility. During the recertification and complaint investigation survey of 11/18/22, the facility was cited for failing to keep medications locked in an unattended treatment cart. During a recertification and complaint investigation survey on 6/10/21, the facility failed to discard expired medications, to monitor the temperature for refrigerated medications, and to ensure unattended medications carts were locked. F842: Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record related to documentation of the treatment for pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #19). During a complaint investigation survey on 9/7/23, the facility failed to accurately document wound treatments provided to residents. In an interview on 03/13/24 at 06:25 PM, the Administrator said the QAA Committee monitored issues that were cited on previous surveys but only for a short length of time relative to the issue and were not reviewed again.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43332 Based on record review and staff interviews, the facility failed to ensure at least 12 hours of annual training to include dementia and areas of weakness as determined in the nursing aides' performance reviews were completed for 4 Nursing Assistants (NA #4, NA #7, NA #6, and NA #5) of 5 reviewed for staffing. Findings included: a) NA (Nursing Aide) #4's date of hire was 10/1/20. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. b) NA # 7's date of hire was 10/1/20. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. c) NA #6's date of hire was 9/7/22. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. d) NA #5's date of hire was 10/4/22. Review of NA #4's Education/In-service records did not include evidence of training for areas of weakness as determined in the NA's performance review. Review of a dementia in-service training dated 1/23/24 showed NA #5 had not signed the attendance roster. No other in-service was provided to show NA #5 had completed dementia training. An interview was conducted on 3/13/24 at 3:40 P.M. with the Director of Nursing (DON). During the interview, the DON stated the NA performance reviews had not been completed due to high turnover in the DON position. The DON explained she had conducted training with staff through in-services for dementia and abuse, but she had not provided individual training to the NAs based on the outcome of their performance evaluations. The DON did not provide a reason why NA #5 had not completed the dementia training. An interview was conducted on 3/13/24 at 5:10 P.M. with the Administrator who stated there were no annual training logs kept showing the courses the NAs had completed. The Administrator indicated the in-services completed by staff in January 2024 did not provide the length of hours for each in-service and she was unable to determine how many hours the training lasted. The Administrator indicated the facility currently did not have a Staff Development Coordinator and therefore, responsibilities from this position fell to the DON. The Administrator stated the DON was aware her job responsibilities included completing annual training on all staff. During the interview, the Administrator stated there had been a high turnover in the DON position and she felt these responsibilities were overlooked in error.