

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER The Carrolton of Williamston		STREET ADDRESS, CITY, STATE, ZIP CODE 119 Gatling Street Williamston, NC 27892	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident interview and staff interviews, the facility failed to place a resident's call light device within reach to allow for the resident to request assistance as needed for 1 of 2 residents reviewed for accommodation of needs (Resident #90).</p> <p>Findings included:</p> <p>Resident #90 was admitted to the facility on [DATE] with diagnoses including stroke and aphasia (difficulty speaking).</p> <p>The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #90 was severely cognitively impaired with no range of motion impairments to upper and lower extremities and was dependent on staff to provide assistance with all activities of daily living and mobility. The pain assessment in the MDS assessment indicated Resident #92 was not receiving a pain medication regimen or as needed pain medications and was not experiencing pain.</p> <p>On 6/30/2025 at 3:30pm, the beige colored string exiting from the call light wall device on the left side of the bed was observed lying on top of the light fixture in Resident #90's room above Resident #90's head of the bed. Resident #90 was observed repeatedly moving her left hand off the side of the bed and lying her hand on her chest and pointing to her right cheek area, where a tear was observed running down the right side of her face from the outer right eye.</p> <p>During the interview with Resident #90 on 6/30/2025 at 3:30 pm, Resident #90 was asked if she could use the call light device to call for help if the call light device was in her reach. Resident #90 moved her head up and down to answer yes and moved her mouth to answer in a low soft voice yes. Resident #90 also moved her head up and down to answer yes and moved her mouth to answer in a low soft voice yes when asked if she was experiencing pain.</p> <p>In an interview with Nurse #4 on 6/30/2025 at 3:40 pm, she stated Resident #90 couldn't pull the string connected to the call light wall device or push a button-control call light device to call for help. Nurse #4 was informed Resident #90 was pointing to the tear running down her face and indicating she was in pain when asked and pointing to her cheek area. Nurse #4 was observed walking toward Resident #90's room.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/30/2025 at 4:25 pm, Resident #90 was observed lying in the bed. There was a dark brown string observed attached to the beige colored string exiting from the call light wall device on the left side of the bed and the brown string was observed lying across Resident #90's waist. Resident #90 was observed gripping the brown string and picking up the brown string that was lying across the waist without difficulty.</p> <p>In a follow up interview with Nurse #4 on 7/2/2025 at 2:58 pm, she stated on 6/30/2025 Resident #90 complained she was uncomfortable in the position she was lying in and was repositioned up in the bed and the head of the bed was elevated. She stated upon entering the resident's room, the string to the call light wall device was positioned up on the light fixture out of Resident #90's reach. Nurse #4 stated she did not know why the string to the call light device was up on the light fixture out of Resident #90's reach on 6/30/2025 and had recommended Resident #90's call light device be changed to a flat call light device that she could better operate with her hands.</p> <p>In an interview with the Interim Director of Nursing on 7/1/2025 at 5:47pm , she stated Resident #90 could pull the string to activate the call light device. She stated Resident #90's call light device was to be within her reach at all times.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form 10555 prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #38 and Resident #54).</p> <p>The findings included:</p> <p>1. Resident #38 was admitted to the facility on [DATE]. He was readmitted to Medicare Part A skilled services on 3/11/25.</p> <p>Resident #38's Medicare Part A skilled services ended on 3/28/25. He remained in the facility.</p> <p>Record review revealed there was no documentation Resident #38 or his responsible party were issued a SNF-ABN.</p> <p>During an interview with the facility social worker on 7/2/25 at 3:40 PM she stated it was her job to issue the SNF-ABN. She further stated there was an error in processing and Resident #38 did not receive the correct notification.</p> <p>An interview was conducted with the Administrator on 7/2/25 at 6:01 PM who indicated Resident #38 should have received the SNF-ABN as required by Federal guidelines.</p> <p>2. Resident #54 was admitted to the facility on [DATE]. She was admitted to Medicare Part A skilled services on 4/17/25.</p> <p>Resident #54's Medicare Part A skilled services ended on 6/13/25. She remained in the facility.</p> <p>Record review revealed there was no documentation Resident #54 or her responsible party were issued a SNF-ABN.</p> <p>During an interview with the facility social worker on 7/2/25 at 3:40 PM she stated she was responsible for issuing the SNF-ABN. She further stated there was an error in processing and Resident #54 did not receive the correct notification.</p> <p>An interview was conducted with the Administrator on 7/2/25 at 6:01 PM who indicated Resident #54 should have received the SNF-ABN as required by Federal guidelines.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident interview and staff interviews, the facility failed to provide maintenance services to a resident room that was observed with damaged sheetrock on the wall to the left side of the bed, a dresser with visible damage and a broken track for the bottom drawer and a bathroom cabinet with doors that did not latch and the pressboard in the bottom of the cabinet was observed sunken inward and covered with a dirty white thin board with dry white paper towel lying flat to the surface observed in the right back corner with dry black material covering over half of the paper towel for 1 of 1 resident reviewed for homelike environment on 1 of 6 halls in the facility (Resident #92).</p> <p>The findings included:</p> <p>A review of the census revealed Resident #92 was moved into room [ROOM NUMBER] on 1/1/2025.</p> <p>Resident #92's quarterly Minimum Data Set assessment dated [DATE] indicated Resident #92 was cognitively intact.</p> <p>A review of undated maintenance logs recorded a work order #2554 that stated the walls needed repair and paint in Resident #92's room.</p> <p>Work order #2557 dated 1/6/2025 recorded that the baseboard behind the bed needed repair and work order #2558 dated 1/6/2025 recorded that the bathroom floor fixtures and the toilet needed repaired in Resident #92's room.</p> <p>On 6/30/2025 at 11:17 am, the right side of Resident #92's bed was observed pushed up against the wall. There was torn sheetrock on the wall approximately 8 inches above the right side rail and the torn sheetrock on the wall continued below the right side rail. There was also torn sheetrock observed in the corner of the wall behind the head of the bed. The left side of Resident #92's dresser was observed with dry cracked and buckled wood four inches from the floor.</p> <p>On 6/30/2025 at 11:17 am in an interview with Resident #92, she stated when she moved into the room the walls were torn and staff at the facility were aware of the torn sheetrock on the walls. Resident #92 stated the male staff member who brought the resident's bed into the room the day she moved into the room stated at that time they would need to fix the wall.</p> <p>On 7/1/2025 at 8:41 am, two wooden cabinet doors were observed open approximately 2 inches in the bathroom of Resident 92's room. The two wooden cabinet doors would not close or latch and there were dry white specks observed on the two wooden cabinet doors in the bathroom. There was a sunken inward dry pressboard observed inside the wooden cabinet in the bathroom that had been covered with a dirty white thin board. There was a dry white paper towel lying flat to the surface in the right back corner of the cabinet with dry black material covering half of the dry paper towel.</p> <p>On 7/1/2025 at 8:45 am, the bottom drawer of Resident #92's wooden dresser was observed unsteady and off track. The wooden drawer (measuring approximately 24 inches in length and 6 inches in height) continued to move forward when opening the dresser drawer and human physical strength was used to prevent the heavy wooden drawer from falling to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/1/2025 at 8:45 am in an interview with Resident #92, she stated she was unable to remember who she voiced her concerns about the wooden dresser and bathroom cabinet. Resident #92 stated the staff was aware because she had dropped the dresser drawer on her foot (x-ray revealed no fracture) and the staff could see the walls and bathroom cabinet when in Resident #92's room.</p> <p>On 7/2/2025 at 6:30 pm in an interview with Resident #92, she stated she washed herself daily in the attached bathroom.</p> <p>On 7/2/2025 at 3:07 pm in an interview with Nurse #4, she stated the bottom drawer of the wooden dresser did not work correctly and the bathroom cabinet was damaged with swelling of the wood. Nurse #4 stated the damaged walls occurred prior to Resident #92 moving into the room and the maintenance department had been informed of the needed repairs. Nurse #4 was unable to recall when the maintenance department was informed of the needed repairs in Resident #92's room but stated it was after Resident #92 moved into the room.</p> <p>On 7/3/2025 at 9:12 am in an interview with the Maintenance Assistant, he stated resident rooms were checked weekly for repairs and he was not aware of the repairs needed in Resident #92's room [ROOM NUMBER]/2/2025. He stated he did not recall the wall in Resident #92's room being scratched up when Resident #92 was moved into the room.</p> <p>On 7/3/2025 at 8:57am, the Maintenance Director was observed pulling the bottom drawer from the wooden dresser that continued to move forward and nearly came out of the wooden dresser on to the floor.</p> <p>On 7/3/2025 at 8:57 am in an interview with Maintenance Director, he explained the torn sheetrock in Resident #92's room came from a previous resident rising the bed up and down with the bed positioned close to the wall. He explained when Resident #92 was moved into the room, it was a quick move and didn't have time to make the repairs to the wall. He stated the bottom of the wooden dresser was caved in and the dresser drawer was not on track to stop the dresser drawer from continuing to be pulled forward and out of the wooden dresser. He explained that water damage to the wooden dresser occurred due to toileting running at some point in time. He explained that the staff reported damage or needed repairs resident rooms through a communication system. The Maintenance Director explained he was not aware of the damaged dresser and bathroom cabinet in Resident #92's room until he was informed by staff on 7/2/25. He explained that the maintenance department had been completing resident room remodeling that started in another part of the facility, and they had not gotten to Resident #92's room to make needed repairs. He stated while remodeling, the maintenance department would attend to needed repairs when there were resident complaints. The Maintenance Director further stated the bathroom cabinet in Resident #92's room was not useable.</p> <p>On 7/1/2025 at 5:31 pm in an interview with the Interim Director of Nursing (DON), she stated when Resident #92 pulled the dresser drawer completely out on 1/5/2025 and it fell on her foot. The dresser drawer was not broken and she was able to be put back into the wooden dresser and replaced on the track. The interim DON explained that the physician was notified, and an x-ray was performed that showed there was no fracture. She stated Resident #92 had bruising to the foot. In a follow up interview on 7/3/2025 at 1:04pm, the Interim DON stated it was the top drawer that Resident #92 pulled out and dropped on her foot on 1/5/2025.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/3/2025 at 1:10 pm in an interview with the Administrator, she stated the facility had been conducting some remodeling and six months was too long to wait for repairs to the walls, dresser and bathroom cabinet in Resident #92's room. She stated the facility's goal was to maintain a homelike environment in the residents' rooms.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of behaviors for 1 of 26 residents whose MDS assessments were reviewed (Resident #167).</p> <p>Findings included:</p> <p>Resident #167 was admitted to the facility on [DATE] with diagnoses that included dementia.</p> <p>A progress note dated 9/13/24 revealed Resident #167 had behaviors including spitting and urinating on the floor. These behaviors were not directed towards others.</p> <p>A progress note dated 9/15/24 revealed Resident #167 refused to have a nursing assessment completed including blood pressure taken. He placed his sheet over his head and refused to answer any questions.</p> <p>A progress note dated 9/17/24 indicated Resident #167 adjusted his brief and voided on the floor.</p> <p>Resident #167's admission Minimum Data Set (MDS) assessment dated [DATE] was coded for having verbal behaviors directed toward others for 1-3 days during the 7-day lookback period. There were no other behavioral symptoms or rejection of care coded.</p> <p>On 7/2/25 at 3:44 PM during an interview with MDS Coordinator #1, she stated the 9/17/24 MDS for Resident #167 should have been coded for having rejection of care and other behaviors. She stated it was a coding error.</p> <p>An interview was conducted with the Administrator on 7/2/25 at 6:01 PM. She stated Resident #167's MDS assessment dated [DATE] should have accurately reflected behaviors present during the 7-day lookback period.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on manufacturer directions, observations and staff interviews, the facility failed to remove 3 multi-dose insulin injector pens that were expired in 2 of 5 medication carts ([NAME] medication cart and Split medication cart), remove expired medication in 1 of 5 medication carts (Split medication cart), and remove 1 opened and expired vial of Pneumococcal vaccine in 1 of 1 medication storage room refrigerator reviewed for medication storage and labeling.</p> <p>The findings included:</p> <p>a. The manufacturer's directions for lispro insulin injector pen stated it should be discarded 28 days after opening.</p> <p>An observation of the [NAME] medication cart on 7/3/25 at 9:23 am revealed one Lispro insulin injector pen that was open and dated 5/20/25.</p> <p>Interview with Nurse # 5 during the medication cart observation on 7/3/25 at 9:23 am and stated the insulin pen should have been removed after 28 days.</p> <p>b. An observation of the Split medication cart on 7/3/25 at 9:30 am revealed two Lispro insulin injector pens that were opened and dated 6/2/25 and a opened bottle of docusate sodium liquid (a medication primarily used as a stool softener) with the expiration date of 1/31/25.</p> <p>Interview with Nurse #5 during the medication cart observation on 7/3/25 at 9:30 am stated the insulins pen should have been removed after 28 days and the docusate sodium liquid should have been removed in January 2025.</p> <p>c. An observation of the medication storage room on 7/3/25 at 9:35 am revealed an opened vial of Pneumococcal vaccine in a plastic bag with an expiration date of 8/12/24 and no open date on the vial or plastic bag.</p> <p>Interview with the interim Director of Nursing (DON) during the medication storage room observation on 7/3/25 at 9:35 am, stated the vial should have been dated when opened and removed when the vial expired. The interim DON did not know when the vial had been opened. The interim DON further stated herself and the nursing staff were responsible for regularly checking the medication carts for expired medications and the medication storage room refrigerators for expired medications and/or vaccines.</p> <p>During an interview with the Administrator on 7/3/25 at 1:50 pm, she stated the nursing staff were responsible for dating the insulin pen injectors when opened and discarding them after 28 days. The Administrator further stated the nursing staff were responsible for checking and removing expired medications from the medication carts. The Administrator indicated all nursing staff were responsible for checking the medication storage room regularly and removing expired medications and vaccines from the refrigerators. The Administrator added that no residents had received the pneumococcal vaccine in the last 6 months.</p>		