

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER The Carrolton of Dunn		STREET ADDRESS, CITY, STATE, ZIP CODE 711 Susan Tart Road Dunn, NC 28335	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50234</p> <p>Based on record review and staff interviews, the facility failed to report allegations of abuse and neglect to Adult Protective Services (APS). This deficient practice was for 3 of 4 residents reviewed for abuse. (Resident #1, Resident #4, and Resident #6).</p> <p>The findings were:</p> <p>a. Review of the Initial Allegation Report for an allegation of abuse submitted on 3/20/2024 revealed the facility became aware of an incident on 3/20/2024 at 11:20 a.m. for Resident #1. The allegation details revealed Resident #1 alleged that a staff member was verbally abusive and intimidating towards the resident. The initial report indicated local law enforcement was notified on 3/20/24 at 11:47 a.m. The initial report did not indicate whether APS was notified.</p> <p>Review of the facility Investigation Report completed on 3/27/24 for the 3/20/24 incident concerning Resident #1 did not indicate that APS was notified. The notification area was blank.</p> <p>b. Review of the Initial Allegation Report for an allegation of neglect submitted on 5/24/2024 revealed the facility became aware of an allegation on 5/24/2024 at 6:18 p.m. for Resident #6. The allegation details revealed Resident #6 alleged the facility was neglecting the resident causing her to have skin breakdown. The initial report indicated local law enforcement was notified on 5/24/24 at 7:03 p.m. The initial report did not indicate whether APS was notified.</p> <p>Review of the facility Investigation Report completed on 6/2/24 for the 5/24/24 incident concerning Resident #6 did not indicate that APS was notified. The notification area was blank.</p> <p>c. Review of the Initial Allegation Report for an of abuse submitted on 5/24/2024 revealed the facility became aware of an incident on 5/24/2024 at 6:14 p.m. for Resident #4. The allegation details revealed Resident #4 alleged she had been neglected by staff by not receiving hygiene and incontinent care for longer than 6 hours. The initial report indicated local law enforcement was notified on 5/24/24 at 7:03 p.m. The initial report did not indicate whether APS was notified.</p> <p>Review of the facility Investigation Report completed on 6/2/24 for the 5/24/24 incident concerning Resident #4 did not indicate that APS was notified. The notification area was blank.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/31/24 at 5:42 p.m., the Administrator said APS was not notified of the allegations. She said she was not aware that she needed to notify APS and thought she only needed to notify the local police.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234</p> <p>Based on observations, staff and resident interviews, and record reviews, the facility failed to maintain an effective pest control program to prevent mice from entering the facility for 2 of 4 halls (200 and 300 halls).</p> <p>The findings were:</p> <p>Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact, she was undersood and understood others, and did not have a diagnosis of dementia.</p> <p>In an interview on 5/29/24 at 9:43 AM, Resident #2 reported she had seen mice on the 300 hall recently as one week prior.</p> <p>Review of Resident #6's MDS dated [DATE] revealed she was cognitively intact, she was undersood and understood others, and did not have a diagnosis of dementia.</p> <p>In an interview and observation on 5/31/24 at 3:13 PM, Resident #6, whose room was on the 200 hall, gave permission to look in her dresser. In the bottom drawer of her dresser, near an open package of clean briefs, were small black pellets.</p> <p>Review of Resident #3's MDS dated [DATE] revealed she was cognitively intact, she was undersood and understood others, and did not have a diagnosis of dementia.</p> <p>In an interview and observation on 5/31/24 at 4:43 PM, Resident #3 reported the facility had a problem with mice and has had problems for the past year. She said she saw them in her room on the 200 hall around a plastic container she used to store food. The facility had put down glue traps on the floor (date unknown) and three mice had already been caught. Resident #3 said an exterminator had put a metal live mouse trap in the bathroom but she was not sure if any had been caught. Resident #3 said she would open her dresser drawers and find mice droppings in the drawer. Resident #3 pointed to a glue trap next to her air conditioning unit. There was a metal trap next to the toilet in the bathroom. Resident #3 gave permission to look behind the bottom drawer of her dresser where a glue trap was observed. Resident #3 said she was still having problems hearing mice and had been reporting it to the Maintenance Supervisor and her family for the past 6 months.</p> <p>In an interview on 5/31/24 at 5:20 PM, Nurse #3 said residents have complained to her about seeing mice. Nurse #3 said she would tell the Maintenance Supervisor when he came into the facility in the morning.</p> <p>Review of facility Pest Control Treatment Logs for 2023-2024 revealed the facility was treated on 7/1/23 for rats and mice in the interior of the facility where 24 soft baits were placed. On 9/7/23, the facility was treated for rats and mice in the interior with an additional 10 soft baits were placed. 10/2/23 with 20 bait stations placed. There was no other documentation of the facility being treated for rats or mice since 10/2/23.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 5/31/24 at 5:27 PM, the Maintenance Supervisor said the pest control company would put baits outside and glue traps throughout the facility. He said the exterminators had come to the facility since October but had not always documented on visit reports because the exterminator would come as needed. The exterminator had brought the glue traps seen in Resident #3's room as well as more live traps for the exterior grounds. He said the mice have been worse this year than any previous years. The Maintenance Supervisor confirmed the interventions placed in Resident #3's room but said he had not seen any of the mice she had reported. He said staff would verbally report to him when there were complaints of mice but there was not always an official work request put in.</p> <p>In an observation on 5/31/24 at 5:30 PM, Resident #6 gave the Maintenance Supervisor permission to look in her dresser. The Maintenance Supervisor said the small black pellets appeared to him to be mouse droppings and that it appeared there had been a mouse in the dresser drawer.</p> <p>In an interview on 5/31/24 at 5:42 PM, the administrator confirmed there were reports of mice in the facility and said that 2 NAs said they had caught a mouse the other day. The facility was treating for mice but there were still reports from staff and residents that there were mice.</p>		