STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. Building B. Wing	07/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, record review, and staff and resident interviews, the facility failed to treat residents in a dignified manner by failing to knock on doors or ask permission to enter resident rooms for 3 of 8 residents (Resident #2, Resident #10 and Resident #13) reviewed for dignity. The reasonable person concept was applied to this deficiency as individuals have the expectation of a person knocking and identifying themself before entering their room. Findings included: 1. Resident #2 was admitted to the facility on [DATE]. Resident #2's most recent Minimum Data Set (MDS) assessment dated [DATE], a significant change assessment, revealed he was severely cognitively impaired. He was assessed as usually able to understand others and having some distinct words. During an observation on 7/7/25 at 12:01 PM Nurse Aide (NA) #1 entered Resident #2's room without knocking to deliver his lunch tray. During an interview on 7/7/25 at 12:05 PM NA #1 indicated she did not knock or ask permission to enter Resident #2's room. The NA stated she was aware she should do so and could not articulate why she did not. On 7/8/25 at 12:05 PM NA #1 was observed to enter Resident #2's room without knocking to deliver his lunch tray. Attempts to interview Resident #2 were unsuccessful. An interview was conducted with the facility's Wound Nurse on 7/8/25 at 12:10 PM and she stated staff should always knock and introduce themselves when entering a resident's room. During an interview with the Administrator on 7/7/25 at 5:38 PM he stated staff had been trained in resident rights and dignity and stated NA #1 should have knocked and announced herself prior to entering a resident's room. (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	An additional interview was conducted with the Administrator on 7/8/25 at 12:45 PM who stated he personally in-serviced staff on treating residents with dignity and respect since 7/7/25 and was aware NA #1 attended in-services on 7/7/24 and 7/8/25. The Administrator stated the NA should have knocked prior to entering Resident #2's room. 2. Resident #10 was admitted to the facility on [DATE]. Resident #10's most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment, revealed she was assessed as cognitively intact. During an observation on 7/7/25 at 12:02 PM Nurse Aide (NA) #1 entered Resident #10's room without knocking to deliver her lunch tray. During an interview on 7/7/25 at 12:05 PM NA #1 indicated she did not knock or ask permission to enter Resident #10's room. The NA stated she was aware she should do so and could not articulate why she did not. During an observation on 7/8/25 at 12:06 PM NA #1 entered Resident #10's room without knocking to deliver her lunch tray. On 7/8/25 at 12:09 PM Resident #10 was interviewed and could not state how she felt about staff not knocking on her door prior to entrance and instead wanted to talk about her doll. An interview was conducted with the facility's Wound Nurse on 7/8/25 at 12:10 PM and she stated staff should always knock and introduce themselves when entering a resident's room. During an interview with the Administrator on 7/7/25 at 5:38 PM he stated staff had been trained in resident rights and dignity and stated NA #1 should have knocked and announced herself prior to entering a resident's room. An additional interview was conducted with the Administrator on 7/8/25 at 12:45 PM who stated he personally in-serviced staff on treating residents with dignity and respect since 7/7/25 and was aware NA #1 attended in-services on 7/7/24 and 7/8/25. The Administrator stated NA #1 should have knocked prior to entering Resident #10's room. 3. Resident #13 was admitted to the facility on [DATE]. Resident #13's most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment, revealed she was assessed as having moderate cognitive impairment. She was assessed as being understood and being able to understand others. During an observation on 7/8/25 at 12:05 PM Nurse Aide (NA) #1 entered Resident #13's room without knocking to deliver her lunch tray. An attempted interview was conducted with Resident #13 on 7/8/25 at 12:15 PM, The resident did not respond to any questions asked. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a previous interview on 7/7/25 at 12:05 PM NA #1 indicated she did not knock or ask permission to enter resident rooms. The NA stated she was aware she should do so and could not articulate why she did not. An interview was conducted with the facility's Wound Nurse on 7/8/25 at 12:10 PM and she stated staff should always knock and introduce themselves when entering a resident's room. An interview was conducted with the Administrator on 7/8/25 at 12:45 PM who stated he personally in-serviced staff on treating residents with dignity and respect since 7/7/25 and was aware NA #1 attended in-services on 7/7/24 and 7/8/25. The Administrator stated the NA should have knocked prior to entering Resident #13's room.