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	11/18/2025

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews and staff interviews, the facility failed to honor residents the choice to warm meals brought from outside the facility for 3 of 3 residents reviewed for choices (Resident #8, Resident #25 and Resident #5). The findings included: 1a. Resident #8 was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus, anxiety disorder, and gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set (MDS) assessment for Resident #8 dated 7/21/25 indicated her cognition was intact, she had no upper extremity impairments and was independent with eating. An interview with Resident #8 on 9/9/25 at 9:10am revealed Resident #8 was upset that she could no longer warm meals brought to her by her family. Resident #8 stated there was a microwave in the dining room where she was able to warm soups and other things her family brought her. Resident #8 stated about a month ago the microwave was removed. She was told by the kitchen staff that they are not allowed to bring personal food items into the kitchen to heat them. Resident #8 indicated she had complained about having no way to heat meals, but she was told it was a safety hazard. Resident #8 revealed she did not like most of the meals or alternative choices served and would just like to be able to heat up a bowl of soup or chili. b. Resident #25 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus. Resident #25's quarterly MDS assessment dated [DATE] revealed she was cognitively intact, had no upper extremity impairments and was able to eat independently with set up from staff. An interview with Resident #25 was conducted during an impromptu Resident Council meeting on 9/10/25 at 3:22pm. Resident #4 stated the facility had removed the microwave from the dining room about a month ago. She had food that was delivered and was unable to microwave the items to heat them. Resident #4 stated she was upset that she had food at the facility she could not eat. c. Resident #5 was admitted to the facility on [DATE] with diagnoses including depression. Resident #5's quarterly MDS assessment dated [DATE] revealed she was cognitively intact, had one upper extremity impairment and was able to eat independently with set up assistance. During an impromptu Resident Council meeting on 9/10/25 at 3:22pm, Resident #5 revealed the facility had removed the microwave from resident use and staff would not heat food for her if it was not prepared by the kitchen. She stated she was no longer able to heat food brought from outside the facility. If she wanted to save something to eat a later time, she would have to eat it cold. Resident #5 stated she did not think it was fair she had to eat what the facility provided since no outside food could be warmed or reheated. An interview completed with Nurse # 7 on 9/11/25 at 10:32am revealed there was no access to a microwave to warm residents' food. Nurse #7 revealed the microwave was once available for residents and residents' family to use, but it had recently been removed. Nurse #7 stated she tried to let family members know there was no access to warm up food bought from outside, but families could bring resident's food to the facility already warmed. Nurse #7 indicated there were residents and family members upset with change. Interview conducted with the (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietary Manager on 9/11/25 at 4:48pm revealed the microwave the residents used had been removed from the dining room. She indicated she was unsure why the microwave was removed she was told by management that it was a safety concern. The Dietary Manager stated she could provide soup served from the kitchen to Resident #8, but Resident #8 could not bring soup purchased outside the facility into the kitchen to warm it. An Interview conducted with the Director of Nursing (DON) on 9/11/25 at 2:13pm revealed the facility policy stated they could not have a microwave due to safety concerns. The DON indicated the microwave was in the dining room but had been removed about a month and a half ago. No residents at the facility suffered injury while operating or using the microwave at the facility. The DON stated the reason the microwave was removed from the dining room was because the facility was unable to monitor the temperature of the food items residents were heating up in the microwave. Removing the microwave would ensure residents did not burn themselves. The DON indicated the facility would get soup brands and preferences from the residents so the kitchen could purchase something comparable to the brand the resident desired. Resident #8 and other residents were upset about not being able to heat foods they purchased. Resident #8's family brought cans of soup for her to warm. Residents had occasionally used the microwave when the facility meal being served, or alternatives weren't to their liking. Residents were upset about not having access to a microwave or being able to heat food brought in from outside sources. The DON further stated the facility had no way of knowing the temperature of microwaved foods after they had been heated. She further revealed the facility had not considered staff heating food items and temping items food items for safety. An interview was conducted with the Administrator on 9/11/25 at 6:28pm. During the interview the Administrator revealed the microwave was removed from the dining room for safety reasons. There were concerns a resident may burn themselves and his understanding was no outside food could be taken into the kitchen to warm or reheat. The Administrator revealed he expected the residents to have choices, but the microwave was removed for safety.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **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) Form 10055- Skilled Nursing Facility (SNF) Advanced Beneficiary Notification (ABN) when the facility-initiated discharge from Medicare Part A Services when benefit days were not exhausted. This was for 2 of 3 residents reviewed for beneficiary notice protection (Resident #8 and Resident #68).Findings included:1. Resident #8 was admitted to the facility on [DATE] under Medicare Part A covered skilled services.Resident #8's Medicare Part A covered skilled services ended on 5/30/25. She remained in the facility.A review of Resident #8's medical record revealed no evidence Resident #8 was provided with a CMS SNF-ABN.On 9/11/25 at 5:23 PM an interview with the Business Office Manager (BOM) indicated Resident #8's Medicare Part A covered skilled services began on 5/19/25. She stated when these covered services ended on 5/30/25, Resident #8 had days remaining and had not used all 100 covered days. She stated the resident's discharge was initiated by her insurance company, which sent a CMS NOMNC form via email for the facility to present to the resident. The BOM stated she was not aware a SNF-ABN also needed to be provided. She also stated she was aware of the SNF-ABN form which provided the resident's out-of-pocket cost, but that form was not used at the facility. She reported Resident #8 had remained in the facility.On 9/11/25 at 5:35 PM an interview with the Social Worker (SW) revealed she had not been employed by the facility when Resident #8 was issued the CMS NOMNC form; but the SW employed at that time would have been responsible for providing the CMS NOMNC form to Resident #8 when she was discharged from her Medicare Part A covered services on 5/30/25. The SW reported she had only provided the CMS NOMNC form to a resident and had never provided the CMS SNF-ABN form. She stated for an insurance-initiated discharge, the insurance provider would send a blank CMS NOMNC form via email to be completed by the facility and be provided to a resident. The SW discussed not being aware she was required to provide both a NOMNC and SNF-ABN. She stated she was unaware of the SNF-ABN form which provided a resident with an estimated out-of-pocket cost, but the Business Office would be responsible for providing the out-of-pocket cost to a resident.An interview on 09/11/25 at 6:15 PM with the Administrator revealed he had knowledge of the CMS SNF-ABN and CMS NOMNC forms. He stated his expectation would have been for the appropriate notices to be given to Resident #8. The Administrator stated he was aware of a form which provided a resident with an estimated out-of-pocket cost, but he had not seen the form at this facility.2. Resident #68 was admitted to the facility on [DATE] under Medicare Part A covered skilled services.Resident #68's Medicare Part A covered skilled services ended on 9/5/25. She remained in the facility.A review of Resident #68's medical record revealed no evidence Resident #68 was provided with a CMS SNF-ABN.On 9/11/25 at 5:23 PM an interview with the Business Office Manager (BOM) indicated Resident #68's Medicare Part A covered skilled services began on 8/19/25. She stated when these covered services ended on 9/5/25, Resident #68 had days remaining and had not used all 100 covered days. She stated Resident #68's discharge was initiated by her insurance company, which sent a CMS NOMNC form via email for the facility to present to the resident. The BOM stated she was not aware a SNF-ABN also needed to be provided. She also stated she was aware of the SNF-ABN form which provided the resident's out-of-pocket cost, but that form was not used at the facility. She reported Resident #68 had remained in the facility. On 9/11/25 at 5:35 PM an interview with the Social Worker (SW) revealed she issued the CMS NOMNC form to Resident #68 when she was discharged from her Medicare Part A covered services on 9/5/25. She reported Resident #68's insurance provider initiated her discharge and sent a blank CMS NOMNC form via email to be completed and issued by the facility to Resident #68. The SW discussed not being aware she was (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required to provide both a NOMNC and SNF-ABN. She stated she was unaware of the SNF-ABN which provided a resident with an estimated out-of-pocket cost, but the Business Office would be responsible for providing the cost estimate to a resident.An interview on 09/11/25 at 6:15 PM with the Administrator revealed he had knowledge of the CMS SNF-ABN and CMS NOMNC forms. He stated his expectation would have been for the appropriate notices to be given to Resident #68. The Administrator stated he was aware of a form which provided a resident with an estimated out-of-pocket cost, but he had not seen the form at this facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure for immediately reporting an allegation of staff to resident physical abuse to the Administrator resulting in the allegation not being reported to the State Agency, local law enforcement, and to Adult Protective Services within the required time frame. Additionally, the initial report did not accurately reflect the date and time the facility became aware of the abuse allegation. This was for 1 of 3 residents reviewed for abuse (Resident #37). The findings included: A review of the facility policy titled Abuse, Neglect and Exploitation, revised 3/20/23 indicated violations needed to be reported to the Administrator, State Agency, Adult Protective Services, and to all required agencies (law enforcement if applicable) immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #37 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. A review of the facility grievances revealed on 8/19/25 the Admissions Director had completed a grievance form after she spoke with Resident #37 who stated, the girl who gave me a bath-she beat me up. Resident #37 stated, she was a black girl, but I don't know her name. She slapped me all in my face and I don't remember her, but she has pearls in her hair. The Admissions Director was interviewed on 9/10/25 at 10:22 am. She stated she had worked late (did not specify a time) on 8/19/25 and when she walked by Resident #37's room the resident called her into her room and told her that on 8/18/25 while taking her shower the Nurse Aide (NA) hit her in the face for no reason. Resident #37 was unable to recall the name of the NA. Admissions Director shared that she did not recall the exact details of what Resident #37 shared with her on 8/19/25. The Admissions Director stated she filled out a grievance form on 8/19/25 and did not report the allegation to nursing staff, Director of Nursing (DON), or Administrator until the morning of 8/20/25 during the morning meeting around 9:30 am when she reported the allegation of abuse to the Administrator. The Admissions Director stated she knew she should have reported the allegation right away but stated it was late and had been a long day. She stated that evening (8/19/25) she had not observed any markings on Resident #37 and didn't think about telling the Administrator at that time. She stated there were no signs of abuse, no bruises, scratches or red marks on 8/19/25. An initial allegation report dated 8/20/25 at 9:35 am, was completed by the Administrator. The initial report documented the facility initially became aware of the allegation of abuse on 8/20/25. The Administrator interviewed Resident #37 on 8/20/25 and the resident reported she was hit in the face by a black lady with pearls in her hair while receiving a bed bath the afternoon of 8/16/25. Resident #37 stated she was hit in the face multiple times, the lady hit her using her fist. The initial report did not indicate Adult Protective services or law enforcement was notified. The initial report was faxed to the State Agency on 8/20/25 at 3:30 pm. The investigation report dated 8/22/25 completed by the Administrator revealed the allegation of staff to resident abuse was unsubstantiated. The investigation report was faxed to the State Agency on 8/22/25 at 7:13 pm. Adult Protective Services (APS) was notified by Administrator on 8/20/25. A review of Resident #37's skin assessment completed on 8/20/25 by Nurse #1 revealed no trauma to her face or issues with her skin other than a dime size pressure spot to Resident #37's right pinky toe. An interview with Nurse #1 was conducted on 09/09/25 at 4:25pm. She stated she completed a skin assessment on the day the Facility Nurse Consultant asked her to do it (she was unable to recall the date). Nurse #1 discussed during the skin assessment she did not observe any concerns on Resident #37's face, no signs of trauma, no redness, bruising, scratches or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discoloration. Resident #37's skin was intact. The DON was interviewed on 9/10/25 at 10:45 am. She stated if a resident shared with staff that they had been abused, the staff member should have notified her or the Administrator right away so the facility could report the allegation of abuse to the State Agency in 2 hours. An interview with the Administrator occurred on 9/10/25 at 10:55 am. He stated the Admissions Director notified him of Resident #37's allegation of abuse on 8/20/25 during the morning meeting around 9:00 am. He indicated that the Admissions Director was notified of the allegation of abuse on 8/19/25 and failed to report to him until the next day (8/20/25), which was why the Administrator stated he dated the initial allegation for 8/20/25. He stated he wanted staff to notify him immediately when they became aware of any abuse allegations. The Administrator discussed contacting Adult Protective Services on 8/20/25 but not law enforcement due to no injury to Resident #37.

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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. Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 2 of 30 days reviewed for staffing (8/30/25 and 8/31/25). The findings included: Review of the facility's daily nurse staffing postings for 8/10/25 through 9/10/25 revealed there was not a RN scheduled for at least 8 hours a day on 8/30/25 and 8/31/25. During an interview with the Director of Nursing (DON) on 9/11/25 at 3:45pm revealed there was no RN coverage in the facility on 8/30/25 and 8/31/25 because the scheduled weekend RN called out. The DON stated she was not notified on either day (8/30/25 and 8/31/25) the RN called out and did not find out the facility had no RN coverage until Monday morning (9/1/25). The DON indicated she knew the facility was required to have 8 hours of RN coverage each day and she expected to be notified when the scheduled RN called out. The Administrator was interviewed on 9/11/25 at 6:28pm and he stated he expected the facility to have a RN coverage 8 hours a day 7 days a week.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to label and date leftover food items and failed to discard food with signs of spoilage in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. The facility also failed to ensure clean dishes were not stacked wet and ensure dishes that were ready for use were clean for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents.The findings included:a. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:00 AM revealed the following in the walk-in cooler: Five (5) of the 5 cantaloupes in the walk-in cooler had soft, brown and black spots with white fuzz. Fourteen (14) of the 14 lettuce heads in the walk-in cooler were brown and slimy with spots of white fuzz.b. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:10 AM revealed the following in the walk-in freezer:One half (1/2) of a two-pound bag of meatballs in the freezer was opened to the air, undated, and had a layer of ice crystals.One half (1/2) of a two-pound bag of French fries in the freezer was opened to the air, undated, and had a layer of ice crystals. One fourth (1/4) of a two-pound bag of peas in the freezer was opened to the air, undated, and had a layer of ice crystals.c. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:30 AM revealed the following on the tray line:Eleven (11) of 12 clean bowls that were on the tray line ready for use were stacked wet.Two (2) of 3 clean quarter pans that were ready for use were stacked wet.Ten (10) of 10 divided plates that were on the tray line ready for use were stacked wet.Thirty-one (31) of 57 plate covers that were on the tray line ready for use were stacked wet.Seven (7) of 10 divided plates that were on the tray line ready for use had black, yellow, and brown spots on them.Two (2) of 57 plate covers that were on the tray line ready for use had black and brown spots on them. An interview with the Dietary Manager on 09/08/2025 at 11:00 AM stated she had been working in the kitchen for about three months. The Dietary Manager stated the person who washed the dishes was new to his position, and she had educated him that the dishes needed to be dry before they were stacked and that he needed to check the dishes for cleanliness before placing them on the tray line. Furthermore, she stated today (09/08/2025) was the day she went through the kitchen and made sure that everything was dated, and that there was no food spoilage. The Dietary Manager explained she performed this task every Monday. She did not identify if any other dietary staff were responsible for the task of ensuring that the food items were accurately labeled and dated. Additionally, food items that were identified as spoiled would be discarded. The Dietary Manager stated the food items identified during the observation should have been discarded.An interview on 09/11/2025 at 4:41 PM with the Administrator revealed he was told about the concerns identified in the kitchen. The Dietary Manger made him aware of the wet dishes and undated food. The Administrator stated he was unaware of food with signs of spoilage. Furthermore, the Administrator stated he expected the dietary staff to label and date open food items in the walk-in, ensure that clean dishes were stacked dry, and ensure that food with signs of spoilage was properly disposed of.