STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/24/25 through 03/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HZUB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/24/25 through 03/27/25. Event ID#HZUB11. The following intakes were investigated: NC00217301, NC00218207, NC00218455, NC00219657, NC00220219, and NC00226338. 3 of the 8 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/17/25

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

Electronically Signed | 04/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents, staff, plumbers, Medical Director, and the Vice President of Property Management the facility failed to maintain repair or replace corroded sewage pipes, that caused sewage to back up onto the hallway floors for 2 of 4 hallways (200, 500) reviewed for maintaining a safe, clean, comfortable, and homelike environment. The findings included: a. On 3/26/25 at 9:40 am on the 200 hall Housekeeper #1 was observed mopping up clear colored, odorless water from the hallway floor, which consisted of square non-porous composite	F 584	1. Immediate action(s) taken for the resident(s) found to have been affected include: The drainage line on 200 hall was clogged during the annual survey on 3/26/25 as a result residents could not use bathrooms, bedside commodes were immediately provided to every resident. The clog was resolved by the plumbing contractor on 3/26/2025 midafternoon. After resolution housekeeping staff ensured all affected surfaces were cleaned and disinfected. 2. Identification of other residents having	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 tiles, outside of room 207. The floor in 207 was noted to be wet with small puddles of water scattered across the floor. Wet floor signs were noted in the center of room 207, the resident was not present in the room at the time, and the wet floor continued down the 200 hall to a covered sewer line access cleanout (also known as a cleanout, a pipe fitting with a threaded plug, found on a sewer line, that provided access to the sewer line for inspection, maintenance, and unclogging of the sewer line) located midway down the hallway. Grayish/clear odorless liquid was noted to seep around and pool on top of a slightly recessed round 4-inch sewer cleanout port located in the floor mid hallway. The observation further revealed a total of 3 covered sewer line cleanout ports on the 200 hall one situated at the beginning of the hallway, one mid-way down the hallway (where the seeping was observed) and one at the opposite end of the hallway. During an interview with Housekeeper #1 on 3/26/25 at 9:42 am Housekeeper #1 stated today (3/26/25) around 9:30 am sewage backed up around the cleanout access midway down the 200 hall near room 209 and she mopped it up. Housekeeper #1 stated the sewer line was beneath the hallway floor and when it became clogged, sewage backed up into the hallways around one or more of the 3 cleanout access on the 200 hall. The interview further revealed that when the sewer lines got clogged and backed up into the hallways, toilets overflowed if they were flushed. Housekeeper #1 stated toilet in the bathroom which rooms 206 and 207 shared and the toilet in the bathroom which rooms 219 and 220 shared overflowed this morning related to the clogged sewer line. The interview further	F 584	the potential to be affected was accomplished by: 100% of all residents on 200 hall were negatively affected. The administrator and maintenance director performed an audit of the entire building to identify any toilets that were not flushing appropriately or sinks that were not draining well. This audit was completed on 3/27/25, with no further drainage concerns identified as of 3/27/25. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Vice President of Property Management, Administrator and Activities provided Education to residents and staff regarding proper disposal of paper towels, wipes and feminine products these items are not to be flushed in toilets due to risk of blockage all education will be completed on 4/15/2025. Signs have been placed in all bathrooms by the maintenance director in the facility asking that no one flush paper towels, wipes or personal feminine items. Placement of the signs and education of residents/staff regarding the signs was completed on 4/8/25. During the residents council meeting held on 4/10/2025, education was provided by activities director on proper disposal of paper towels, wipes and feminine products.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 revealed the sewer backed up through the cleanouts mostly around room 206 (mid-way down the hall) and extended down the hallway to room 211, however at times the sewer cleanout access at the end of the 200 hall backed up as well, but not today. Housekeeper #1 described the sewer water as clear to dark in color, stinking, smelling like sewage, and at times had seen sewage water up to 2 inches deep in the hallway. She stated if the sewer line backed up at night, maintenance was called, and they came to the facility to unclog the sewage line with a "snake thing" that was put down through the sewage cleanout access into the sewer line. She stated she had been employed by the facility for 23 years and the sewer lines had backed up into the hallways at least once a month for as long as she could remember. The Maintenance Director was observed on 3/26/25 at 9:45 am to use an auger (sometimes referred to as a snake, a device used to unclog a plumbing line) in the cleanout access mid-way down the 200 hall. Cloudy gray colored water was observed to overflow out of the clean out access and was level with the top of a slightly recessed area in the floor where the cleanout access was situated. During the observation the Maintenance Director made a statement that the sewage overflowed from the cleanout accesses because someone must have flushed paper towels down a toilet. During an interview with cognitively intact Resident #67, per the quarterly Minimum Data Set (MDS) assessment dated 1/24/25, who resided in room 209, on 3/26/25 at 12:03 pm, he stated he could not remember how many times the sewer backed up into the facility hallway	F 584	The Vice President of Property Mgt asked the plumber the best way to diagnose and confirm the problem. The contracted plumber suggested that provide authorization to him to insert a camera into the 200 and 500 hall sewer lines. The testing was completed on the afternoon of 3/26/25. The Vice President of Property Management asked the plumbing contractor to make recommendations for repair and correction to our system to best prevent a problem recurrence. The contractor identified pipe corrosion and recommended a section of 200 hall between the first and second cleanouts (approximately 60 feet) be replaced; and, that the entire length of 500 hall be replaced (approximately 160 feet). The Vice President of Property Management asked the plumbing contractor to begin plans for doing the replacement on both halls. The plumbing contractor coordinated scheduling with a company that performs concrete sawing and pouring and submitted a quote for the performance of the job. The Vice President of Property Management presented the quote to the governing board on the morning of 4/8/25 and the governing board gave permission to begin the project immediately. The plumbing contractor stated they would begin work on 200 hall on 4/14/25. In preparation for replacing the 200-hall line, facility staff moved all 200 hall residents to 600 hall before the work	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 outside his room because it had happened so many times. He stated his toilet overflowed at least once a month related to a clogged sewer line and the occurrence was not related to any specific time of the day. The interview further revealed when the sewage overflowed into the hallway, he could not flush his toilet and had to go to another bathroom on another hallway. He stated he could not flush his toilet today (6/26/25) because the sewage overflowed into the hallway this morning and the toilet might overflow if he flushed it. Resident #67 stated when the toilets overflowed, and the sewage back flowed into the hallway staff mopped it up, put down wet floor signs, but it was still a slip hazard for anyone that had to walk through it. During an interview with cognitively intact Resident #11, per the admission Minimum Data Set (MDS) assessment dated 11/27/24, who resided in room 207, on 3/26/25 at 3:30 pm, she stated the floors on the 200 hall flooded at least 3 times a month and it smelled like sewage. She further indicated when the hallway flooded her toilet overflowed if it was flushed, the toilet water overflowed into her room, and that's what happened this morning (3/26/25) around 9:00 am. Resident #11 stated she used a bedside commode for her toileting needs but when the floor flooded she could not walk in her room because she did not want to walk in the toilet water because she was afraid she would fall. Resident #11 stated staff cleaned the water up quickly and put wet floor signs down when it happened. An observation was made of the bathroom floors in room 207 and 220 on 3/26/25 during a round which started at 10:00 am. The observation	F 584	commences. After completion of the work and appropriate cleaning, residents will be moved from 600 hall back to 200 hall. The replacement of the 500-hall sewer line is planned to begin on 4/28/25, as that is the next date that the plumber and concrete contractor both have available. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The drainage line on 200 hall was clogged during the annual survey on 3/26/25 as a result residents could not use bathrooms, bedside commodes were immediately provided to every resident. The Vice President of Property Mgt asked the plumber the best way to diagnose and confirm the problem. The contracted plumber suggested that provide authorization to him to insert a camera into the 200 and 500 hall sewer lines. The testing was completed on the afternoon of 3/26/25. The Vice President of Property Management asked the plumbing contractor to make recommendations for repair and correction to our system to best prevent a problem recurrence. The contractor identified pipe corrosion and recommended a section of 200 hall between the first and second cleanouts (approximately 60 feet) be replaced; and, that the entire length of 500 hall be replaced (approximately 160 feet). The maintenance assistant and/or housekeeper will audit 5 bathrooms on each hall to ensure that all draining is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 revealed clear water pooled around the base of the toilet. A wet floor sign was observed in each room outside the bathroom doors and inside each bathroom. During an interview with cognitively intact Resident # 20, per the quarterly Minimum Data Set (MDS) assessment dated 1/14/25, who resided in room 221, on 3/27/25 at 9:58 am, she stated sewage backed up into the hallway often (not sure how often) and at times it flowed into her room. Resident #20 stated when it backed up in the hallway her toilet overflowed and that was what happened yesterday morning (3/26/25). She explained that staff had to mop up the water and put towels down to soak up the water from the floor. She stated sometimes staff had to call Plumber #2 to come service the sewer line. An interview was held with cognitively intact Resident #14, per the quarterly Minimum Data Set (MDS) assessment dated 3/17/25, who resided in room 520, on 3/27/25 at 11:01 am, revealed sewage from the cleanout accesses flooded the 500 hall 2-3 times a month and it smelled like a sewer. Resident #14 stated it randomly happened during the day, evening, and at night. The resident explained maintenance would be called to try to fix it and if they couldn't, a plumber was called. Resident #14 stated when the sewer overflowed into the hallway the toilets overflowed too, and staff had to clean it up. An interview was conducted with NA #5 on 3/27/25 at 8:01 am. NA #5 stated he had worked for the facility for 3 years and the sewage backed up in the hallways every time it rained hard outside. The NA indicated the water got high enough to flow into the 2 rooms by the clean out	F 584	occurring rapidly with no back ups / clogs. He will utilize the Environmental Audit tool to ensure that proper sink and toilet functioning (drainage) is occurring. In the event a problem is identified it will be corrected immediately. Steps to be taken include communication with the Maintenance Director, Administrator, and VP of property management. Audits will be done 5 times a week x 4 weeks, then 3 times a week x 2 weeks, then one time a week x one month. The maintenance director will review the environmental audit tool and address concerns immediately. In addition to the toilet / drainage environmental audit form, the Administrator or designee will interview 2 residents on each hall weekly to ensure that the residents have not experienced problems that we were not aware of. Angel rounds will also be updated to include a specific questions regarding toilets, drainage, and clogging. One time per week the maintenance director will open the drain lines to ensure that water is not backed up. He will provide a weekly report to the Administrator in writing. The maintenance director and senior team members will forward the results of the Environmental Audit tools, Angel Rounds, and weekly drain line evaluations to the Executive Quality Assurance Performance Improvement Committee x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 access port midway down the 200 hall. NA #5 stated the water sometimes was as deep as 2 inches. NA #5 stated when it flooded, he notified the nurses, and they put blankets on the floor to soak up the water. NA #5 stated when the sewage backed up in the hallway you could not flush the toilets or use the sinks, or they would overflow, and continent residents went to another hallway to use the toilet, or they were given bedside commodes. NA #5 stated staff bathed residents by getting water from another hallway until maintenance came and unclogged the sewer lines. NA #5 stated he had been told by maintenance the sewer backed up because paper towels and wipes were flushed down the toilet and clogged the sewage lines. The NA continued and stated he did not believe the paper towels and wipes were the cause and he thought it was because the sewage lines in the building were old and did not work as they should. During an interview with Nurse #6 on 3/26/25 at 9:53 am she stated she had worked for the facility since 2006, and the sewer lines had always backed up in the hallways at least once a month for longer than she could remember. Nurse #6 stated the sewer backed up if residents flushed something other than toilet paper. The interview further revealed the facility had replaced the main sewer line that ran from the entry way of the building back to the kitchen but had not replaced the sewer lines that ran the length of the resident hallways. Nurse #6 could not recall when the other hallways flooded but stated the 200 hall flooded more frequently than the other hallways. Nurse #6 described the flood water as clear in color and smelled like sewage. Nurse #6 stated when the sewer lines backed up into the hallway staff notified the Maintenance Director or his	F 584	Immediate actions will be taken to remedy problems that are identified. Corrective action completion date: April 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7	F 584		

assistant, put down towels and blankets to contain the water, and placed wet floor signs along the hallway because it was a slip hazard. She stated in the meantime, until maintenance unclogged the sewer line, residents had to stay in their bed, so they did not come in contact with the sewer water. Nurse #6 stated when the hallway sewage line got clogged the bathrooms in room 207 and 220 (across the hall from one another) overflowed consistently.

b. An interview with Nurse #8 on 3/27/25 at 7:51 am revealed she worked on the 500 hall on a regular basis on the 11:00 pm to 7:00 am shift and had dealt with sewage backing up from the sewage line through the cleanout accesses located in the down the center of the hallway. She stated the sewer line backed up 3-4 times a month and staff knew when they saw it bubble out of the cleanout accesses, they could not flush toilets or the toilets would overflow and make the problem worse. Nurse #8 stated when sewage backed up into the hallway, she called the Maintenance Director, and he would come to the facility to unclog the sewer line. Nurse #8 stated sewage last backed up into the hallway this past weekend on 3/21/25 at the clean out access port in front of room 512. Nurse #8 stated the sewage had been backing up in the building for the past 10 years and staff were told by administration that it was because residents flushed wipes or paper towels down the toilet.

In an interview with Resident #232, admitted 3/21/25, who was cognitively intact according to his progress notes, who resided in room 512, on 3/24/25 at 12:39 pm, revealed on 3/21/25 around 3:00 am or 4:00 am he dropped his cell phone on the floor in his room and when he picked it up it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8	F 584		

was wet. He stated he looked into the hallway and could see light reflecting off water that had come from the hallway into his room. The interview further revealed maintenance came to his room and told him someone had flushed wipes down the toiled and clogged the pipe. Resident #232 stated nursing came into his room, cleaned the water up with blankets and towels, and housekeeping came in later and mopped the floor.

An interview with Housekeeper #2 on 3/27/25 at 11:06 am revealed she worked on the 500-hallway for the past year. She stated the sewage backed up into the 500 hall from the cleanout accesses 2-3 times a month in the past year and it smelled bad, like raw sewage. Housekeeper #2 stated when sewage backed up into the hallway the toilets overflowed if they were flushed.

In an interview with the Maintenance Director on 3/26/25 at 10:04 am he stated he received a report today (3/26/25 at 9:00 am) that the 200 hall sewer line had backed up into the hallway at the cleanout access midway down the hall, and the toilet in the shared bathroom for rooms 206 and 207 and the toilet in the shared bathroom for rooms 219 and 220 had overflowed. He stated he unsuccessfully attempted to unclog the sewer line and called the plumber and awaited Plumber #2's arrival. The Maintenance Director further indicated until the plumber arrived and corrected the problem the toilets on the 200 hall could not be flushed or they would overflow. The Maintenance Director went on to explain the sewage drain lines went straight down the center of each hallway towards the nurses station and tied into the main sewage line and from that point sewage exited the building to a lift station (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584		

housed location where pumps move wastewater or sewage from lower to higher elevation, particularly where gravity flow is not possible or efficient). He stated the facility had an issue with paper towels or wipes getting flushed down toilets that clogged the sewer lines and that caused raw sewage to back up into the facility through the sewer line cleanout access openings on the hallways. The Maintenance Director stated this had been an ongoing problem throughout the facility for the past 7 years since he had been employed by the facility. The Maintenance Director stated sewage backed up on the 200 hall more frequently than the other hallways. He stated when the sewage lines became clogged the toilets on the affected hallway overflowed. The Maintenance Director stated on average staff notified him by phone or page 2 to 3 times a month with concern of a clogged sewer line and on average he received additional calls 2 times a month on nights, weekends, or holidays and he came into the facility to try to clear the clogged line and if he couldn't he called the plumber. The interview further revealed the Maintenance Director, or his assistant, used an electric auger to clear the clog but at times it just made the problem worse, so he called a plumber, he stated he called a plumber about 2-3 times a month. The interview further indicated sewage backed up through the cleanout accesses more often on the 200 and 500 halls in the past year and the 300, and 400 halls had not had sewage back up in the hallway in more than a year. The Maintenance Director stated he did not recall how often he was called to unclog the sewer lines and did not keep a record of the frequency of when sewage backed up onto the hallways, but he reported every occurrence of backed up sewer lines to the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10	F 584		

A phone interview was conducted with Plumber #1 on 3/26/25 at 1:25 pm. Plumber #1 stated he was the area manager for the contracted plumbing company that serviced the facility, oversaw the plumbing issues in the facility, and Plumber #2 serviced the building. Plumber #1 stated the facility had a problem that the sewage lines in the building were old cast iron pipes that had corroded and needed to be replaced to permanently correct the problem of the sewage backing up into the building. He stated cameras had been run into the sewer lines on the 500 hall with findings of extensive corrosion and erosion with holes in the bottom of the pipe with recommendations to replace the sewer lines. He stated the recommendations were made to the facility's corporate Vice President of Property Management. Plumber #1 stated corrosion builds up and falls off into the sewer line and toilet paper or other flushed debris snagged onto it and that caused the pipes to clog. He stated the main sewer lines for the main hallway through the nurses' station and the upper portion of the 500 hall to the first cleanout access had been replaced in the past, but the remaining sewer lines on the resident hallways remained in a deteriorated condition, and the facility would continue to have problems until they were replaced.

In a phone interview with Plumber #2 on 3/27/25 at 10:48 am he stated he was the service technician for the facility's plumbing issues. Plumber #2 stated while the facility had replaced some of the plumbing in the past, the 200, 300, 400, and 500 halls still had very old plumbing. He stated he received repair calls for the 200 hall and the 500 hall more frequently than any other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11	F 584		

halls. Plumber #2 stated he received a call yesterday (3/26/25) because the 200 hall sewer had backed up into the hallway through a cleanout access. He stated he had been called multiple times (could not recall how many times) to service the 200 hall and 500 hall sewer lines in the past 6 months because the sewer had backed up into the halls. Plumber #2 stated he reported plumbing issues to Plumber #1 and Plumber #1 made recommendations to the Vice President of Property Management. Plumber #2 stated the sewer pipe had outlived its life expectancy and needed to be replaced if the facility wanted to correct the problem of sewage backing up into the facility. He stated he had run cameras down the 500 hall sewer line (not sure when), and it had corrosion with holes that had eaten through the pipe and the sewage drained under the sewer line into the ground under the 500 hall floor. He stated he had not put a camera in 200 hall yet, but the sewer lines were the same age as the lines on 500 hall and all are most likely corroding at the same pace.

A phone interview was held with the corporate Vice President (VP) of Property Management on 3/26/25 at 6:11 pm. The VP oversaw the building and maintenance for the facility. The interview revealed the main sewer line that ran through the center of the nurse's station to the outside of the building and the first portion of the 500 hall sewer lines, up to the first few resident rooms had been replaced in prior years. The VP stated the sewer lines down each resident hallway had not been replaced (with the exception of the first portion of the 500 hall), were constructed of old cast iron sewer lines that had corroded He explained the corrosion had "eaten" holes through the bottom of the lines, sewage was washing into the dirt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12	F 584		

beneath the sewage line, dirt was being washed back into the sewer line and the dirt, along with corrosion that had flaked off and fallen into the sewer line, partially occluded the line. The VP then stated if wipes or paper towels were flushed, they caught onto the debris in the pipe and the pipes clogged. He stated ideally if the lines were fully functional the sewage would be removed from each hall via the sewage pipes that ran down the center of each hallway, connect to the main sewer pipe that exited toward the entrance of the building to a lift station. The VP further indicated the facility contracted with a plumbing company that had made recommendations to replace the corroded pipes multiple times (he did not remember dates) and the problem with sewage backing up into the resident hallways had been ongoing since at least 2020, that he was aware of. The VP stated he had been made aware the 200 hall had sewage back up again today (3/26/25) and he planned to talk to Plumber #2 and have him run a camera into that sewer pipe to diagnose the problem. He stated he was not sure if the sewer line was corroded or not until they looked with the camera but statistically speaking, related to history and age of the building's sewer lines, it was most likely corroded. The VP further stated it was a terrible situation for residents that had to live at the facility and staff who worked at the facility. The VP added when the sewer pipes got clogged the toilets on the affected hallway overflowed if they were flushed. The VP stated that while the 300 hall and 400 hall sewer pipes had the same corrosion problems, sewage did not back up on those hallways as often as the 200 and 500 halls. The VP stated he had made multiple recommendations to the facility for the damaged sewer pipes to be replaced, but it was a very costly project, so they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13	F 584		

had only replaced portions of the most severely damaged sewer pipes. He stated since November of 2020 the facility had replaced 3 sections of the damaged sewer pipe but more needed to be replaced to solve the problem of sewage backing up into the building. The interview further revealed that the Maintenance Director notified the VP if he could not resolve a clogged sewer pipe himself, he had called a plumber.

An interview with the Medical Director on 3/27/25 at 8:53 revealed he was aware the facility had a problem with sewage seeping into the hallways from the sewage cleanout accesses and it was an ongoing problem. The Medical Director stated he was not concerned about the sewage on the hallways unless the resident came into direct contact with the sewage, then infection control would become an issue. He stated it was not an inhalation concern. The Medical Director stated if it took the facility more than an hour to resolve the issue on any given occurrence the facility should relocate the residents to another hall until the issue was resolved to ensure residents did not come in contact with raw sewage.

The Administrator was interviewed on 3/26/25 at 10:51 am and stated she had been employed by the facility for 6 months and she was aware of the concerns with the sewage backing up into the hallways on the 200 hall and the 500 hall through the sewer cleanout accesses. The Administrator stated the sewage lines ran down the length of all resident hallways and if residents flushed paper towels or wipes the sewage pipes got clogged and the sewage would back up into the hallways. The Administrator stated she thought it had happened 4 or 5 times in the past 6 months and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 14 mostly on the 200 hall. In a second interview with the Administrator on 3/27/25 at 11:37 am she stated the plumber was called by the Maintenance Director yesterday morning around 9:30 am (3/26/25) because the sewer lines had backed up through the sewer cleanout access on the 200 hall. The interview further revealed Plumber #2 arrived around 3:30 pm and unclogged the sewer line. She stated when the sewer backed up into the hallways the toilets overflowed in the surrounding rooms, and she instructed staff to give bedside commodes to the residents who used a toilet independently.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the Medical Director, resident, and staff, the facility failed to protect a severely cognitively impaired resident's (Resident #5) right	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

to be free of verbal and physical abuse when a nurse (Nurse #1) entered Resident #5's room, found him lying on the floor near the bathroom and yelled at him to get up and when Resident #5 reached up to grab on to Nurse #1 she slapped him on his upper left arm and told him to get his pissy hands off of her. The deficient practice occurred for 1 of 2 residents reviewed for abuse (Resident #5).

The findings included:

Resident #5 was admitted to the facility on 7/14/23 with diagnoses that included dementia, blindness, and epilepsy.

Resident #5's quarterly Minimum Data Set (MDS) assessment dated 7/2/24 revealed Resident #5 was severely cognitively impaired. He was not assessed to have behavioral problems during the assessment period. Resident #5 required set up and clean up assistance for toilet transfers. Resident #5 was coded as using a wheelchair for mobility but could ambulate independently for 10 feet.

An initial report dated 7/21/24 at 6:26 am revealed that on 7/21/24 Nurse #1 yelled, cursed, and slapped Resident #5's left upper arm and threw a shoe at Resident #5. Resident #5 was observed with redness to the upper left arm that resolved. No other injuries were noted. The report indicated Resident #5 did not recall the event. Nurse #1 was sent home immediately, and an investigation followed. The report was submitted by the Assistant Director of Nursing (ADON) on 7/21/24.

In an interview with Resident #5 on 3/24/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

12:43 pm it was revealed Resident #5 could not recall that Nurse #1 yelled at him or slapped his left arm on 7/21/24. Resident #5 stated he felt safe living at the facility.

Review of Nurse #1's witness statement of the reported abuse that involved Resident #5 on 7/21/24 was difficult to follow and was written verbatim with incomplete and nonsensical sentences as follows:
"I was going on my med pass. I went into residents' room to give him his medicine. He was not in bed. I saw him under the chair by the window. I asked him what happened he would not say anything. [NA #1] came in to help me get him off the floor. He just kept not moving or anything. There were several places on his back where he was under the chair. We attempt multiple for him to keep him to get up. Several other employees came to help. I don't think these I did was tired and would not do anything to help get up. Me [NA #1] finally got him up. [Nurse #2] and CNA in to room to help. I did not lay a hand on him. The areas on his back was d/t him being under the chair trying to get out for under the chair. I am sorry at the time I tried and tried for him to help us. More and more frustrated I became. I'm sorry and this is my 1st. but I guess I need to move on."

During an interview with Nurse #1 on 3/26/25 at 11:43 am she stated on 7/21/24 around 5:00 am she went in to give Resident #5 his medications and he was under a chair (not sure what kind of chair) that had rungs. She stated she was not sure how he got under the chair but his whole body was under the chair with his feet and legs sticking out. Nurse #1 stated she asked Resident #5 how he got under the chair, and she stated he said he did not know. Nurse #1 stated she tried to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

get Resident #5 out from under the chair and had to get help from Nursing Assistant (NA) #1, Nurse #2, and NA #2 to get him out. The interview further revealed that Resident #5 was placed back in his bed, and she did not remember if she raised her voice or slapped Resident #5's arm but did not think she did (she became very emotional and cried at this point). She stated she had a post traumatic brain injury prior to the incident (date not provided), and she had already been questioned about the incident, she stated she thought this case had been closed and did not know why she was being questioned at this time. She asked if she could hang up, sobbed heavily and hung up. The interview ended related to the emotional status of Nurse #1.

A review of NA #1's written witness statement revealed NA #1 was asked to go to Resident #5's room because he was on the floor. The review revealed he stated, "I'm not alright" to the nurse and Nurse #1 yelled "get up, you didn't fall". NA #1 further wrote it was a lot of verbal and physical things going on [directed] from Nurse #1 toward Resident #5. NA #1 put in her statement that she asked Nurse #1 to leave the room so things could calm down before they assisted Resident #5 back to bed and that Nurse #1 called for Nurse #2 to come help.

During a phone interview with NA #1 on 3/26/25 at 6:52 pm it was revealed that on 7/21/24 around 5:00 am she was in the hallway near Resident #5's room when she heard Nurse #1 yell for her to come help with Resident #5. NA #1 stated when she entered Resident #5's room she noted Nurse #1 standing beside Resident #5 who was lying on the floor. She stated she observed that Resident #5 had reached up to grab onto Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

#1's hand and Nurse #1 yelled "don't put you f ...ing hands on me" and Resident #5 repeatedly said "I'm not ok, I'm not ok" and continued to reach out for Nurse #1 and Nurse #1 slapped his hand away from her multiple times. NA#1 stated things happened so quickly that she did not recall everything that was said but knew Nurse #1 was upset, yelling and screaming obscenities to Resident #5. The interview further revealed after 2-3 minutes Nurse #1 went to the door of Resident #5's room and called for Nurse #2 to come assist. NA #1 stated Nurse #2 arrived at Resident #5's room in less than a minute followed by NA #2. NA#1 stated Nurse #2 immediately stated she thought Resident #5 had a seizure. NA #1 stated at this time Resident #5 kept trying to sit up and lay down repeatedly in a rocking motion and Nurse #1 yelled at Resident #5 to "get up, you did not fall". NA #1 stated Nurse #2 and NA #2 simultaneously yelled at Nurse #1 to "get out, leave the room now." NA #1 stated when Nurse #1 turned to leave the room she stopped and picked up one of Resident #5's shoes and hurled the shoe toward Resident #5 and the shoe missed Resident #5 hit the wall and bounced back and landed near Resident #5. NA #1 stated Nurse #2 instructed NA #1 and NA #2 to assist Resident #5 back to bed and they did so, and Nurse #2 assessed Resident #5. NA #1 stated Resident #5 had reddened areas on his left arm where Nurse #1 had slapped his arm. NA #1 stated she had not witnessed Nurse #1 react like that toward a resident in the past.

Review of Nurse #2's witness statement revealed on 7/21/24 at 5:07 am she heard Nurse #1 talking loudly down the hallway. She wrote at 5:30 am Nurse #1 yelled for her to come now. When Nurse #2 entered resident #5's room Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

lay on his right side with feet toward the bathroom and head toward the chair in the corner of his room. Nurse #1 yelled at Resident #5 and told him to get up he did not really fall. Nurse #2 wrote she and NA # 1 attempted to assist Resident #5 to get up, but he said he did not feel right. Nurse #1 continued to yell and use curse words and Nurse #2, NA #1, and NA #2 all asked Nurse #1 to leave the room but she would not leave and at one point she reached down with an open palm and slapped Resident #5 as the other staff tried to assist him to get up. Nurse #2 wrote she then stood up and told Nurse #1 to "get away from him [Resident #5]. Nurse #2 wrote that Nurse #1 continued to yell and then picked up Resident #5's shoe and threw it at him before she left the room. Nurse #2 then documented that she, with the assistance of both NAs [NA #1 and NA #2] got Resident #5 back in bed, removed his clothing and completed a full body assessment and noted redness to his right scapula, right trochanter, right lower leg, right wrist and to his left arm where Nurse #1 struck him.

An interview conducted with Nurse #2 on 3/25/25 at 3:17 pm revealed she worked the 11:00 pm to 7:00 am shift on 7/21/24 on the hall opposite to Nurse #1's assigned hallway. Nurse #2 stated she was sitting at the nurse's station around 5:30 am and could hear Nurse #1 yelling loudly from Resident #5's room. Nurse #2 stated she could not hear what Nurse #1 yelled but it sounded like an angry yell, so she went to Resident #5's room to see what was wrong. Nurse #2 stated when she arrived at the doorway of Resident #5, she could see Resident #5 was laying on the floor in his room near the bathroom with his wheelchair toward his back. She stated his feet were situated toward the bathroom and head was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

toward the window. Nurse #2 stated NA #1 was beside Resident #5, and Nurse #1 screamed at Resident #5 that he was faking it, and he needed to get up. Nurse #2 stated she told Nurse #1 to "go, leave the room, I got this". Nurse #2 stated NA #1 told Nurse #1 to leave the room too, but Nurse #1 would not leave and kept saying "he's faking, he didn't really fall". Nurse #2 further stated she went and stood by Resident #5's head to put herself between Resident #5 and Nurse #1 because Nurse #1 was very angry. Nurse #2 stated as she and NA #1 attempted to get Resident #5 up and in his wheelchair Nurse #1 came up beside Nurse #2 and reached toward Resident #5's upper left arm like she was going to assist and before Nurse #2 could intervene Nurse #1 suddenly slapped Resident #5's left upper arm and told him to get his pissy hands off her. Nurse #2 stated Nurse #1 slapped Resident #5's left upper arm hard enough that it left a visible red mark in the shape of a handprint with the fingers. Nurse #2 stated she stood up, eyes wide and with a stern face told Nurse #1 to "get out now!" and pointed toward the door. Nurse #2 stated as Nurse #1 went toward the door to leave the room Nurse #1 picked up Resident #5's shoe and threw it toward Nurse #2, NA #1 and Resident #5 and the shoe passed about 3 feet from Resident #5, hit the wall, bounced off, and landed a few inches in front of Resident #5's groin area as he lay on the floor. The interview further revealed Resident #5 had a history of seizures and Nurse #2 thought he appeared to be in the in the post ictal phase (a period of time immediately following a seizure, during which individuals experience a range of temporary symptoms, including confusion and fatigue, before returning to their baseline state) of a seizure based on his known response to seizures. Nurse #2 stated Resident #5 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

non-verbal during the time she was in the room, and he would normally have yelled out. She stated after she and NA #1 transferred Resident #5 back to bed Nurse #2 did a head-to-toe assessment and he did not report pain and could not remember the event had occurred. She stated once she knew he was alright she left him with NA #1 and NA #2, and she then called the Director of Nursing (DON) to inform her that Nurse #1 was observed to use profanity toward and slapped Resident #5's left arm. She stated the DON instructed her to have Nurse #1 write a written statement, take her keys and escort her out of the building and she did so.

Review of NA #2's witness statement dated 7/21/24 revealed NA #2 heard Nurse #1 yell for Nurse #2 to come help so she went to Resident #5's room to assist as well. NA #2 wrote that when she entered Resident #5's room she witnessed Nurse #1 slap Resident #5 (area not indicated) and told him to get the f ... up and don't put your pissy hands on me. The statement review further revealed NA #2 asked Nurse #1 to leave the room but Nurse #1 did not leave and continued to yell at resident #5 to get his ass up and stop lying, that he did not fall.

In a phone interview with NA #2 on 3/25/25 at 12:41 pm she stated on 7/21/24 around 5:50 am she could hear someone call for help from Resident #5's room so she so she went in the room and entered right after Nurse #2 entered. NA #2 stated she observed Nurse #1 talking harshly, something about pissy, to Resident #5 and Nurse #2 told Nurse #1 to back away and leave the room. NA #2 stated she observed Nurse #1 swing her hand toward Resident #5's arm and say you didn't fall, get up. NA #2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

she immediately told Nurse #1 to leave the room. NA #2 stated things happened so fast, and everyone was talking and trying to help Resident #5 while trying to get Nurse #1 to leave the room that it was hard to remember the order things happened. NA #2 stated she did recall Resident #5's shirt was wet with what looked like urine, yellowish in color and he was on the floor. NA #2 stated Nurse #1 left the room and started crying loudly in the hallway and Nurse #2 went out behind her after she was sure Resident #5 was ok.

In an interview with the ADON on 3/27/25 at 12:01 pm she stated on 7/21/24 around 6:00 am she was notified by Nurse #2 that Nurse #1 yelled at and slapped Resident #5's arm on 7/21/24 around 5:30 am. She stated she arrived at the building at 6:30 am and the ADON accompanied by Nurse #2 assessed Resident #5 for potential injuries. The ADON stated when she arrived at Resident #5's room he was laying in his bed and just stared off, like he did after he had a seizure. The ADON stated when Resident #5 had a seizure he would flail and grab onto things or people within his reach. The interview further revealed Resident #5 was alert and oriented to person and place and could have told her what happened, unless he had a seizure, in which case he would not have remembered the event. She stated upon interview of Resident #5 he had no recall of the event taking place. The ADON stated she did a skin assessment on Resident #5 and he had scattered red marks all the way down his left arm. The ADON stated she then went to the office where Nurse #1 had been asked to wait and told Nurse #1 to clock out and go home and she did.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

During an interview with the DON on 3/27/25 at 12:10 pm she stated that on 7/21/24 early in the morning (did not recall the time) she received a call from Nurse #2 that while Resident #5 was on the floor having a seizure Nurse #1 yelled and hit Resident #5 on the arm. The DON stated the ADON had come in earlier that morning and sent Nurse #1 home, submitted the initial report to the state agency, notified local law enforcement and Adult Protective Services and started an investigation. The interview further revealed the ADON obtained written statements from witnesses, and began abuse and neglect education for staff. The DON stated Nurse #1 had never yelled at or hit a resident before. The DON stated she led the investigation, and abuse was substantiated based on witness statements and Nurse #1 had been discharged on 7/23/24.

In an interview with the Medical Director and Physician for Resident #5 on 3/26/25 at 12:14 pm he stated he was made aware that Resident #5 had been found on the floor on 7/21/24 around 5:00 am by Nurse #1 and she yelled at him and slapped his arm. The Medical Director stated that despite Resident #5 being prescribed large doses of anti-convulsive medication for seizures, he still had break-through seizures and if he had been in the postictal stage of a seizure that could account for him not remembering he had been spoken to harshly and slapped. The interview further revealed if Resident #5 could not remember the event that there would not have been any psychological harm. The Medical Director stated he evaluated Resident #5 two days after the reported abuse and Resident #5 did not know that anything had happened.

An interview conducted with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

3/27/25 at 11:46 am revealed she received a phone call prior to 7:30 am on 7/21/24 from the ADON that Nurse #1 had slapped Resident #5's left upper arm, used profanity and threw a shoe at him on 7/21/24 at around 5:30 am. The Administrator stated she instructed the ADON to ensure Resident #5 and other residents were safe and to suspend Nurse #1 pending investigation and to remove Nurse #1 from the building. The Administrator stated she further instructed the ADON to report the allegation to the Division of Health Service Regulation, local law enforcement, and Adult Protective Services and to begin staff educations on abuse. The Administrator stated Nurse #1 was escorted from the building by the ADON on 7/21/24 around 6:30 am. Nurse #1 was terminated on 7/23/24 when the facility investigation was substantiated. The interview further revealed a local law enforcement arrived on 7/21/24 at 7:40 am and met with Resident #5 but no charges were filed because Resident #5 could not remember that anything happened. The investigation further revealed the facility reported to the North Carolina Board of Nursing on 7/23/24 but had not heard back from them on their findings. The Administrator stated she had not had prior concerns with Nurse #1, and it was out of character for Nurse #1 to cause harm to a resident. The Administrator stated Nurse #1 should not have slapped or spoken harshly to Resident #5.

The facility provided the following corrective action plan with a compliance date of 7/24/24.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25 On 7/21/24 at 5:39 am Nurse #1 was immediately removed from the resident care areas and not permitted to access Resident #5. On 7/21/24 at 6:26 am the Assistant Director of Nursing submitted the initial report to the State Agency. On 7/21/24 at 630 am the Assistant Director of Nursing (ADON) and Nurse #2 assessed Resident #5 for any noted change in condition or injuries with redness noted to the upper left arm. On 7/21/24 at 6:30 am, Nurse #1 was removed from the premises and not permitted to return. On 7/21/24 2024 at 7:22 am, the Assistant Director of Nursing notified the local police department and Adult Protective Services (APS). On 2/27/25, Assistant Director of Nursing notified the Physician and responsible parties of Resident #5. On 7/23/24, The Interdisciplinary Team (IDT) which consists of Assistant Director of Nursing, Director of Nursing, Administrator, Social Worker and MDS Coordinator completed a root cause analysis of Resident # 5's incident and determined upon investigative process that Nurse #1 had a history of a traumatic brain injury. On 7/21/24, an investigation was started at 7:30 am by the ADON and the facility Administrator. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26 On 7/21/2024, the facility determined that all residents had the potential to be affected. On 7/21/24, the Assistant Director of Nursing attempted to interview Resident #5, but he was unable to be interviewed because he was nonverbal due to seizure activity during early morning hours. On 7/21/24, the Assistant Director of Nursing attempted to interview Resident #5, he looked toward the wall and would not speak to Assistant Director of Nursing. On 7/22/2024, the Assistant Director of Nursing interviewed Resident #5, and he stated he did not remember the event and that no one hurt him. On 7/21/24 the Social Worker (SW) interviewed alert and oriented residents concerning abuse with no noted concerns identified. On 7/21 /24 the Assistant Director of Nursing performed skin checks on cognitively impaired residents with no areas of concern identified. On 7/21/24 the Administrator reviewed grievances and Resident Council minutes for the previous 30 days with no concerns of physical or mental abuse. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Mandatory in-services were initiated by the Director of Nursing and Assistant Director of Nursing on 7/21/24, and concluded on 7/24/2024,	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27	F 600		

which included direct care staff (nurses/nursing assistants), administrative staff, maintenance, housekeeping, dietary and therapy. The facility did not utilize agency staffing.

Education included the abuse policy and procedure to ensure compliance with resident rights and applicable state and federal law with focus on:

1. Carrolton Facility Policy for Abuse, Neglect and Exploitation.
2. Resident Rights to be free of abuse, neglect misappropriation of resident property and exploitation.
3. Identification of abuse, neglect, misappropriation of resident property and exploitation.
4. Resident protection (including immediate suspension of the alleged employee pending the outcome of the investigation).
5. Immediate reporting of abuse (noting state and federal guidelines).
6. Abuse investigation.
7. Zero abuse tolerance (including employee termination).

All staff (direct care staff - nurses and nursing assistants, administrative staff, housekeeping, maintenance, dietary, and therapy) were required to complete this training prior to working. New hires were educated by the Director of Nursing or Assistant Director of Nursing prior to working. The facility did not utilize agency staffing.

On 7/22/24 a systemic change of daily monitoring of all residents was put in place by the Administrator to monitor interactions between staff and residents to ensure residents had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

been abused verbally or physically.

The systemic changes were as follows:
- On 7/22/24 Implemented (Ambassador) Guardian Angel Rounds. Senior employees and management team round the facility daily and bring results to morning meeting. Angel rounds include resident and staff interviews, observations of care delivery, and identification of problems.

- On 7/22/24 Began weekend charge position with the same nurse employee in facility every weekend to observe care, interact with staff, monitor behaviors, and ensure staff members are treating residents with dignity and respect. Additionally, the charge nurses (and all staff) ensure that residents are not abused in any manner.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 7/22/24 a systemic change of monitoring all residents and staff daily during daily rounds by senior employees and the management team to ensure the wellbeing of all residents, that included Resident #5.

A Quality Assurance and Performance Improvement (QAPI) meeting was held on 7/23/2024 at 9:00 am by the QAPI committee that included the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, and Unit Manager. The team reviewed and discussed the reportable incident and the investigative findings of the incident and decided to monitor for abuse. Beginning the week of 7/28/24, the Assistant Director of Nursing or Social Worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

conducted random interviews on eight cognitively intact residents. The interviews included questions related to physical and mental abuse. Residents were encouraged to report any issues related to abuse to the Social Worker or Assistant Director of Nursing during the interviews conducted per the plan of correction. The Assistant Director of Nursing conducted random skin audits on eight non-cognitively intact residents to make sure there are no signs of suspicious skin injuries or signs of abuse. These interviews and skin audits were conducted weekly for four weeks, then monthly for two months. If concerns were identified, an investigation would have begun immediately and been addressed. No concerns were identified. The Director of Nursing reviewed the resident interviews and skin audit summaries provided by the Social Worker and Assistant Director of Nursing and no concerns were identified. The Administrator presented the findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months and continued until consistent substantial compliance had been achieved. Audits were reviewed by the QAPI Committee until consistent substantial compliance was achieved as determined by the committee.

Alleged Date of compliance: July 24, 2024.

Validation of the corrective action was completed on 3/27/25. This included staff interviews regarding staff-to-resident abuse. Education was verified for staff on resident abuse, resident protection, reporting, investigating, and zero tolerance for abuse. The audits completed by the Social Worker, and the Assistant Director of Nursing were verified and there were no concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30 identified. Skin assessment for Resident #5 documentation, and documents that indicated notification were made to the State Agency, local police, APS, Physician and responsible parties for Resident #5 were all verified. Ambassador rounding audit tools were verified and is ongoing. The facility's alleged compliance date of 7/24/24 was validated.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 31 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 3 residents reviewed for tube feeding (Resident #58). The findings included: Resident #58 was admitted to the facility on 2/26/25 with diagnoses that included osteomyelitis (bone infection) of vertebra (spine), sacral and sacrococcygeal region (low back). A review of Resident #58's 5-day Minimum Data Set (MDS) assessment dated 3/4/25 indicated she had a gastrostomy tube (g-tube: a surgically placed tube that provided direct access to the stomach for nutrition, hydration and medication). A review of Resident #58's care plan dated	F 656	1. Immediate action(s) taken for the resident(s) found to have been affected include: The resident # 58 care plan was updated on 3/25/2025 to include G-Tube and orders for care. 2. Identification of other residents having the potential to be affected was accomplished by: It was determined that all residents with gastrostomy tubes have the potential to be affected. 100% Audit of all G Tube fed residents was completed on 3/27/2025 using G Tube audit tool to ensure all G tubes were care planned appropriately, any additional concerns were addressed immediately. 100% Audit of all new admission care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 32 3/19/25 revealed no care plan that addressed the Resident's g-tube. In an interview with the Minimum Data Set (MDS) Nurse on 3/25/25 at 12:47 PM she revealed she should have included a care plan that addressed Resident #58's g-tube when she completed the comprehensive care plan. The MDS Nurse indicated she did not have a reason why the g-tube was not included in Resident #58's comprehensive care plan. An interview with the Director of Nursing (DON) on 3/25/25 at 12:39 PM revealed the MDS Nurse was ultimately responsible for developing care plans. She was unaware Resident #58 did not have a care plan for her g-tube. An interview with the Administrator was conducted on 3/25/25 at 2:18 PM. She stated Resident #58 should have had a care plan for her g-tube and was not aware one had not been completed.	F 656	plans was completed by Director of Nursing and Assistant Director of Nursing by 4/14/2025 to ensure comprehensive care plan development, including G tubes, using Care Plan Audit Tool, any identified concerns were addressed immediately. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Education was provided to care plan team by Administrator and Director of Nursing regarding comprehensive care plan development, including G Tube, this was completed 4/9/2025. Education was provided to all nurses regarding comprehensive care plans, items to be care planned, including G Tube, this is to be completed by 4/14/2025. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: 10% of all new admissions care plans will be reviewed by the Director of Nursing and/or Assistant Director of Nursing using the care plan audit tool to ensure comprehensive care plan development, including G Tube as appropriate weekly x 4 weeks, then every 2 weeks x 1, then monthly x 1. All negative findings will be addressed immediately. 10% of all G Tube fed residents will be reviewed by the Director of Nursing and/or Assistant Director of Nursing using the G Tube Audit tool to ensure all G tubes are care planned, weekly x 4 weeks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 33	F 656	every 2 weeks x 1, then monthly x 1. All negative findings will be addressed immediately. The Director of Nursing will forward the results of the Comprehensive Care Plan Tool and G Tube Audit tool the Executive Quality Assurance Performance Improvement Committee monthly x 3. Corrective action completion date: ___4/17/2025	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to ensure there was an order for gastrostomy tube (g-tube) site dressing changes for 1 of 3 residents reviewed for tube feeding (Resident #58). Findings included: Resident #58 was admitted to the facility on 2/26/25. A 5-day Minimum Data Set (MDS) dated 2/26/25 revealed Resident #58 was severely cognitively impaired and was admitted with a g-tube. A review of Resident #58's care plan dated 3/2/25	F 658	1. Immediate action(s) taken for the resident(s) found to have been affected include: Physician made aware of “no orders for G-Tube site care” for resident #58 on 3/25/2025, new orders received and updated to include G -Tube site care. Education was provided by Director of Nursing to nurse #4 and Wound Care Nurse regarding requirement for orders for G Tube site care. 2. Identification of other residents having the potential to be affected was accomplished by: It was determined that all residents with gastrostomy tubes has the potential to be	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 34 revealed no care plan that addressed the resident's g-tube. Resident #58's Physician's orders revealed no order for skin care and dressing changes to the g-tube insertion site on her abdomen. The Physician's order further revealed an order for 250 milliliters of a nutritional supplement to be given via g-tube if the resident did not eat at least 50% of each meal. Resident #58's Medication Administration Record (MAR) for the month of March 2025 revealed the nutritional supplement was given via g-tube at least once daily for 21 of the 24 days reviewed. During an interview conducted in conjunction with an observation of Resident #58 with Nurse #4 on 3/25/25 at 12:11 PM she revealed she had sometimes cleaned the g-tube insertion site with soap and water and applied a split sponge dressing between the flange of the tube and Resident #58's skin when she felt the site needed care. Nurse #4 further revealed there was no order for the care of the g-tube insertion site, and she cared for it based on what she had done in the past for g-tube sites on other residents. An observation of the g-tube site revealed the site had a split sponge dressing, with no initials or date, between the flange of the g-tube and the skin of Resident #58. Nurse #4 indicated she had not placed the observed dressing. An interview was conducted on 3/25/25 at 12:57 PM with the Wound Care Nurse. She stated she was responsible for caring for g-tube insertion sites. She further stated she had been caring for Resident #58's g-tube site since she was admitted. The Wound Care Nurse indicated she	F 658	affected. On 3/27/2025, the Director of Nursing Completed Audit of all G – Tube residents to ensure orders were in place for G-tube site care, any additional concerns were addressed immediately. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel Registered Nurses and Licensed Practical Nurses were in-serviced on 4/14/2025, by the Director of Nursing and Assistant Director of Nursing: The in-services included the following information: o G – Tube site care - ensuring orders are in place for site care Any nursing staff who do not complete education will not be allowed to work until education has been completed. Newly hired licensed nurses will receive training on G-Tube site care – ensuring orders are in place for site care by the DON/ADON during the orientation process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing and/or Assistant Director of Nursing will complete weekly audits of all residents with gastrostomy tubes to ensure site care orders are in place using the G-Tube audit tool weekly for 4 weeks, then every 2 weeks x 2, then monthly x 1. The Director of Nursing will forward the results of the G-Tube Audit tool to the Executive Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 35 had been cleaning the site with soap and water or normal saline and applying a split sponge dressing between the flange of the g-tube and Resident #58's skin 5 days a week. The Wound Care Nurse did not write an order for care of the site as she thought an order wasn't needed for g-tube site care. In an interview with the Director of Nursing (DON) on 3/25/25 at 12:39 PM she stated Nurse #4, and the Wound Care Nurse should not have been caring for the g-tube insertion site without an order. The DON revealed that the Wound Care Nurse should have written an order for wound care to the g-tube insertion site or asked the physician to write an order. In an interview with the Administrator on 3/25/25 at 2:18 PM she indicated care of the g-tube site should have a physician's order.	F 658	Improvement Committee monthly x 3. Corrective action completion date: 4/17/2025	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide nail care to a dependent resident for 1 of 5 residents reviewed for activities of daily living care (Resident #3). Findings included: Resident #3 was admitted to the facility on 5/4/16.	F 677	1. Immediate action(s) taken for the resident(s) found to have been affected include: Nail Care was provided to resident #3 by Unit Manager on 3/26/2025 to include trimming of fingernails. Education was provided to nurse # 5 on 3/26/2025 by Director of Nursing, regarding providing nail care.	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 36 His active diagnoses included diabetes mellitus and hemiplegia and hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body) following other cerebrovascular disease affecting right dominant side. Resident #3's Minimum Data Set assessment dated 2/12/25 revealed Resident #3 was assessed as cognitively intact and was coded to have no rejection of care. He was dependent on staff for personal hygiene. Resident #3's care plan dated 3/10/25 revealed he was care planned to need assistance with activities of daily living and personal care. The interventions included to provide physical assistance with personal hygiene and grooming. During an observation on 3/24/25 at 10:27 AM Resident #3's fingernails were observed to extend approximately 1/3rd of an inch past his fingertips. During an interview on 3/24/25 at 10:27 AM Resident #3 stated yesterday he asked a staff member to clip his fingernails, but he supposed the staff member forgot and he could not remember who it was. Resident #3 stated he could not use his right hand well and was unable to clip his own fingernails. During observation on 3/25/25 at 12:08 PM Resident #3's fingernails were observed to be the same length as on 3/24/25. During observation on 03/26/25 at 8:35 AM Resident #3's fingernails were observed to be the same length as on 3/24/25.	F 677	2. Identification of other residents having the potential to be affected was accomplished by: It was determined all residents have the potential to be affected. Hall Nurses completed 100% Audit of all residents nails to determine need for nail care including trimming of nails, any additional concerns were addressed immediately, nail care provided as resident allowed, any resident who had specific preferences care plan was updated to reflect. Audit was completed on 4-4-2025. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Assistant Director of Nursing provided education to all nursing staff regarding nail care to include trimming of nails. Education was completed on 4/14/2025. Any nursing staff who have not completed education will not be allowed to work until education has been completed. All new hires will receive training from the Assistant Director of Nursing upon hire on nail care. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing and/or Assistant Director of Nursing will audit 10 residents on each hall using Nail Care Audit tool to ensure nails clean, appropriate length, trimmed as per resident preference weekly x 4 weeks, then every 2 weeks x 2, then monthly x 1. All negative findings will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 37 During an interview on 3/26/25 at 8:37 AM the Director of Nursing, upon observing Resident #3's fingernails, stated his fingernails were long and should have been clipped prior to now since Resident #3 did not want his fingernails long. She stated fingernail care should be offered to residents and alert and oriented residents should not have to ask for fingernail care for it to be offered. She stated Resident #3 was diabetic so nurses would have to clip his fingernails, and Nurse #5 was his nurse and responsible for his fingernail care on this date (3/26/25). During an interview on 3/26/25 at 8:52 AM Nurse #5 stated nursing was responsible for fingernail care on diabetic residents and Resident #3 was a diabetic resident. She further stated she would be made aware when diabetic residents needed their fingernails trimmed when she observed any diabetic resident's fingernails were long, when staff notified her a diabetic resident needed fingernail care, or when a resident requested it. She stated no one had notified her of the length of his fingernails and she had unfortunately not observed how long his fingernails were yesterday or today when she was his nurse on the hall. He had not requested fingernail care to her knowledge. Upon observing Resident #3's fingernails, the nurse concluded Resident #3 should have been offered to have his fingernails trimmed prior to now. During an interview on 3/26/25 at 10:15 AM Nurse Aide #4 stated she was Resident #3's nurse aide yesterday (3/25/25) and today (3/26/25). She provided care to Resident #3 both days. She concluded she had not noted his fingernails were long and Resident #3 had not mentioned this concern to her.	F 677	The Director of Nursing will review audit tools and forward the results of the Nail Care Audit tool to the Executive Quality Assurance Performance Improvement Committee monthly x 3. Corrective action completion date: 4/17/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain repair or replace corroded sewage pipes, that caused sewage to back up on the hallways and create an accident hazard for 2 of 4 hallways (200 hall and 500 hall) reviewed accident hazards. The findings included: On 3/26/25 at 9:40 am on 200 hallway Housekeeper #1 was observed mopping water up in the hallway outside of room 207. The floor was observed to have non-porous square composite tiles. The floor in 207 was noted to be wet with small puddles of water scattered across the floor. Wet floor signs were noted in the center of room 207, and down 200 hall to a sewer line access cleanout (also known as a cleanout, is a pipe fitting with a threaded plug, found on a sewer line, that provided access to the sewer line for inspection, maintenance, and unclogging of the sewer line) located midway down the hallway. Grayish/clear liquid was noted to seep around and pool on top of a slightly recessed round 4-inch sewer cleanout port located in the floor. No residents were noted in the hallway.	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: The drainage line on 200 hall was clogged during annual survey on 3/26/25 as a result residents could not use bathrooms, bedside commodes were immediately provided to every resident. Signage placed immediately upon notification of risk regarding slip/trip/fall risk due to wet floor, equipment obtained to dry wet floor floor dried. 200 hall drain line unstopped on 3/26/2025 by plumbing contractor at approximately 330pm. Plumbing contractor on site 3/29/2025 to assess piping for plan for needed repairs. All resident relocated to 600 hall on 3/31/2025 pending replacement of drainage line on 200 hall -scheduled to be completed 4/14/2025. 2. Identification of other residents having the potential to be affected was accomplished by: 100% Audit of rooms was completed by the Administrator and Maintenance Director to identify additional risk related	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 During an interview with Housekeeper #1 on 3/26/25 at 9:42 am Housekeeper #1 stated today (3/26/25) around 9:30 am sewage backed up around the cleanout access midway down the 200 hall near room 209 and she mopped it up. Housekeeper #1 stated the sewer line was beneath the hallway floor and when it got clogged up, sewage backed up into the hallways around one or more of the 3 cleanout access on the 200 hall. The interview further revealed that when the sewer lines got clogged and backed up into the hallways, toilets overflowed if they were flushed. Housekeeper #1 stated toilet in the shared bathroom for rooms 206 and 207 and the toilet in the shared bathroom for rooms 219 and 220 had overflowed this morning related to the clogged sewer line and the water flowed into the residents' rooms. The interview further revealed the sewer backed up through the cleanouts mostly around room 206 and extended down the hallway to room 211 but at times the sewer cleanout access at the end of the 200 hall backed up as well, but not today. Housekeeper #1 stated at times she had seen sewage water up to 2 inches deep in the hallway and that created an accident hazard until they could get the water mopped up and wet floor signs in place. During an interview with alert and oriented Resident #11, per the admission Minimum Data Set dated 11/27/24, who resided in room 207, on 3/26/25 at 3:30 pm, she stated the floors on the 200-hallway flooded at least 3 times a month and it smelled like sewage. She further indicated when the hallway flooded, her toilet overflowed if it was flushed, and the toilet water overflowed into her room and that was what happened this morning (3/26/25) around 9:00 am. Resident #11 stated she used a bedside commode for her	F 689	to hazards from water overflow. No further identified concerns at this time, all lines draining properly at this time. It was determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Administrator/Activities Director provided Education to all residents/staff on 4-14-2025 regarding disposal of paper towels, wipes and personal feminine products these are not to be flushed in toilets due to risk of blockage. Administrator and Activities Director provided Education to all residents/staff on 4-14-2025 regarding decreasing risk of slips/trips/falls and proper procedure to handle i.e. wet floor signs, calling for help, promptly cleaning spills and reporting drain issues immediately. The resident council meeting was held on 4/11/2025, education was provided by the activities director regarding proper disposal of paper towels, wipes and feminine products. Reporting spills immediately. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance assistant and/or housekeeper will audit 5 rooms on each hall using the Environmental Audit tool this will include proper sink/toilet drainage/monitoring rooms for spills to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 toileting needs, when the floor flooded she could not walk in her room because she did not want to walk in the toilet water, and she was afraid she would fall. An observation was made of the 200 hall floor and rooms 207 and 220 on 3/26/25 at 9:45 am after mopping was completed. Pooled water was not observed, and the freshly mopped wet floors were left to dry in the open air. Wet floor signs were in place in the hallway and in resident rooms 207 and 220. Staff were observed walking slowly and cautiously up and down the hallway around the freshly mopped floors. The floors were no longer pooled with water but still wet underfoot and required caution to prevent slipping and falling. An observation was made of the bathroom floor in room 207 and 220 on 3/26/25 at 10:00 am and revealed clear water pooled around the base of the toilet. A wet floor sign was observed in each room outside the bathroom doors and inside each bathroom. An interview was conducted with Nurse Aide (NA) #5 on 3/27/25 at 8:01 am. NA #5 stated he had worked for the facility for 3 years and the sewage backed up in the hallways every time it rained hard outside. He explained the water got high enough to flow into the 2 rooms by the clean out access port midway down the 200 hall. NA #5 stated the water sometimes was as deep as 2 inches. NA #5 stated when it flooded, he notified the nurses, and they put blankets on the floor to soak up the water. NA #1 stated when the floor was wet it became a safety issue because someone could fall if they walked on the wet floor and slipped.	F 689	ensure appropriate actions are taken to correct risks. This will occur 5 times a week until repairs are completed, then weekly x 4 weeks after repair, then monthly x 3 months. Any identified concerns will be addressed immediately. The maintenance director will review and forward the results of the Environmental Audit tool to the Executive Quality Assurance Performance Improvement Committee for analysis and trending x 3 months. Corrective action completion date: ___4/17/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

During an interview with Nurse #6 on 3/26/25 at 9:53 am she stated she had worked for the facility since 2006, and the sewer lines had always backed up in the hallways at least once a month for longer than she could remember. Nurse #6 stated when the sewer lines backed up into the hallway staff put down towels and blankets to contain the water and placed wet floor signs along the hallway because it was a slip hazard. She stated in the meantime, until maintenance unclogged the sewer line, that residents had to stay in their bed, so they did not get up and slip and fall.

An interview with Housekeeper #2 on 3/27/25 at 11:06 am revealed Housekeeper #2 worked on the 500 hall for the past year. She stated the sewage backed up into the 500 hall from the cleanout accesses 2-3 times a month in the past year. She stated that when sewage backed up into the hallway the toilets overflowed if they were flushed. Housekeeper #2 stated when the floors were wet, they became a fall risk because they were slippery, so she put out wet floor signs until the area was cleaned up and dried.

In an interview with the Assistant Director of Nursing (ADON) on 3/27/25 at 12:35 pm she stated she was aware sewage flooded the resident hallways, the halls would become wet from the flooding, wet floor signs were put up, and the area was then cleaned up and then mopped. The ADON stated the flooding had occurred about once a month. The ADON explained she attended the fall risk assessment meetings every morning and while wet floors created a fall risk, there had been no falls related to the sewer overflow into the hallways.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42 In an interview with the Administrator on 3/27/25 at 11:37 am she stated she was aware the sewer backed up into the facility, toilets overflowed, which caused the floors to become wet. She stated housekeeping staff mopped the water up, put wet floor signs down, and there had been no falls related to the wet floors.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to: example #1.) a.) label the ready to hang prefilled enteral formula (a	F 693	1. Immediate action(s) taken for the resident(s) found to have been affected include:	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 43 liquid nutritional product that is delivered into the gastrointestinal tract) that was infusing through a gastrostomy tube (g-tube: a surgically placed tube that provided direct access to the stomach for nutrition, hydration and medication) with the date and time it was started, label the bag used for water flushes or the bag holding the 60 cubic centimeter (cc) syringe. The facility also failed to clean and store a tube feeding syringe with the plunger separate from the barrel which created a potential for bacterial growth. b.) administer the enteral feeding formula at the physician ordered rate. This was for 1 of 3 residents reviewed for enteral feeding management (Resident #28). Example #2.) The facility failed to ensure there was a physician's order for g-tube free water flushes. This was for 1 of 3 residents reviewed for enteral feeding management (Resident #58). 1.) a.) Resident #28 was admitted to the facility on 11/11/24 with diagnoses that included hemiplegia (weakness) and hemiparesis (paralysis) of the left side after cerebrovascular accident (stroke). A review of Resident #28's Physician's orders revealed an order that read: - Enteral Feed Order every shift for Nutritional support/supplementation Isosource 1.5 calorie at 60 cubic centimeters (cc) per hour continuous. Start date 1/10/25. A quarterly Minimum Data Set (MDS) dated 2/15/25 revealed Resident #28 was severely cognitively impaired and had a gastrostomy tube A review of Resident #28's care plan dated 2/10/25 revealed a focus that he required a feeding tube due to dysphagia (unable to	F 693	All residents with enteral feedings, including residents #28 and #58, were checked to ensure that tube feedings were infusing at the rate ordered by the physician and flush orders were present. Nurse #4 immediately cleaned and separated syringe on 3/24/2025 for proper storage and feeding/flush bag was labeled. Nurse #4 was educated by Director of Nursing on 3/24/2025 on proper labeling and storage of gastrostomy tube supplies, including feeding/flush bag and syringe labeling. 2. Identification of other residents having the potential to be affected was accomplished by: All residents with Gastrostomy tubes have the potential to be affected. 100% audit of all G tube fed residents was completed by Administrator on 3/26/2025 using G tube audit tool to ensure G tube rate was as per orders, feeding/flush bags and syringes were labeled/stored appropriately, any identified concerns were addressed immediately. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Education for Licensed Nurses: All licensed nurses were in-serviced by the Assistant Director of Nursing on 4/11-4/14/2025, regarding the facilities expectations for providing enteral feedings as ordered, including: • Following MD orders (tube feeding type, rates, flushes and treatment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 44 swallow) following a stroke. An observation of Resident #28's enteral formula bag, water flush bag and 60 cc syringe was conducted on 3/24/25 at 10:52 AM. It was observed that the enteral formula bag, the bag for water flushes and the bag holding the 60 cc syringe was not labeled with the date and time that they were hung. It was further observed that the g-tube syringe was stored in its original plastic bag hanging on the pole that the enteral feed, water for flushing and enteral feeding pump was attached to. The g-tube syringe was stored with the piston inside of the barrel with a small amount of tan substance in the tip of the barrel. In an interview with Nurse #4 on 3/24/25 at 10:56 AM she stated she hung the enteral feeding, the water bag for flushes and used the 60 cc syringe this morning. She further stated Resident #28 returned from the hospital around 8:00 AM and she did not have time to label the enteral feed bag, the bag for water flushes or the bag used to store the 60 cc syringe. Nurse #4 revealed she always stored the syringe with the piston inside the barrel and did not rinse it first. Nurse #4 indicated she had not received training on enteral feeding except when someone showed her how to use the enteral feeding pump. An interview with the Director of Nursing (DON) was conducted on 3/25/25 at 12:45 PM. The DON stated Nurse #4 should have labeled the enteral feed bag, the bag used for water flushes and the 60 cc syringe bag. She further stated syringes should be rinsed well after use and stored with the piston and barrel separately in the bag. The DON revealed that not rinsing and separating the barrel and piston can lead to	F 693	duration) • Notifying the MD of any resident concerns regarding tube feeding or resident change in condition. • Tube feedings are not to be held without a MD order to do so. • Labeling of delivery system (bag/flush bag) and storage of syringe for flushes Any License Nurse who have not completed the education on enteral feedings will not be allowed to work until education has been completed, newly hired licensed nurses will receive training on enteral feeding by the ADON during the orientation process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Assistant Director of Nursing will monitor all residents with Gastrostomy Tube utilizing the G Tube Audit Tool weekly x 4 weeks, then every 2 weeks x 1, then monthly x 1 to ensure following MD orders for proper rate, proper labeling of bag/flush bag, and syringe storage, all negative findings will be addressed immediately. The Director of Nursing will forward the results to the Executive Quality Assurance Performance Improvement Committee monthly x 3. Corrective action completion date: 4/17/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 45	F 693		

bacterial growth in the syringe.

In an interview with the Administrator on 3/25/25 at 2:25 PM she stated that the enteral feeding bag, the bag used for water flushes and the bag used to store the 60 cc syringe should all have been labeled at the time they were hung by Nurse #4. She further stated the 60 cc syringe should be rinsed well after use and the two parts, the piston and the barrel, should be stored in the bag apart from each other to prevent bacterial growth.

b). Resident #28's Medication Administration Record (MAR) for March 2025 was reviewed. The MAR revealed Resident #28's enteral tube feeding was assessed by a nurse once each shift. The MAR indicated the Assistant Director of Nursing (ADON) signed that she had checked the tube feeding on day shift on 3/26/25.

A review of Resident #28's Physician's orders revealed an order that read:
- Enteral Feed Order every shift for Nutritional support/supplementation Isosource 1.5 calorie at 60 cubic centimeters (cc) per hour continuous. Start date 1/10/25.

An observation of Resident #28's tube feeding machine on 3/26/25 at 10:56 AM revealed it was set to administer the enteral feed at 55 cc per hour.

In an interview with the ADON on 3/26/25 at 12:09 PM she stated she had signed the MAR this morning showing she had assessed that Resident #28's tube feeding was running correctly. During an observation of the enteral tube feed pump with the ADON at this time, she stated she thought it was set correctly at 55 cc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 46	F 693		

per hour. The ADON was observed checking Resident #28's enteral tube feeding orders and stated it read that it should have been set at 60 cc per hour. The ADON revealed she set the machine by her memory of the ordered rate without checking the order first.

In an interview with the Director of Nursing (DON) on 3/26/25 at 12:02 PM she revealed that the ADON should have checked Resident #28's orders before setting the tube feeding machine at 55 cc per hour.

2.) Resident #58 was admitted to the facility on 2/26/25 with diagnoses that included osteomyelitis (bone infection) of vertebra, sacral and sacrococcygeal region (low back, base of spine).

A 5-day Minimum Data Set (MDS) dated 2/26/25 revealed Resident #58 was severely cognitively impaired and was admitted with a gastrostomy tube (g-tube: a surgically placed tube that provided direct access to the stomach for nutrition, hydration and medication).

A review of Resident #58's care plan dated 3/2/25 revealed no care plan that addressed the resident's g-tube.

Resident #58's Physician's orders revealed no order for free water flushes of the g-tube. The Physician's orders revealed Resident #58 was given 250 millileters (mls) of a liquid dietary supplement by g-tube if she ate less than 25% of any meal.

Resident #58's Medication Administration Record (MAR) for the month of March 2025 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 47 Nurse #4 administered the liquid dietary supplement 29 times in the month of March 2025. In an interview with Nurse #4 on 3/25/25 at 12:11 PM she stated she gave 150 mls of free water flushes through Resident #58's g-tube after she gave the supplement every time. She stated there was not an order for the free water flushes so she went by what she had given other residents with a g-tube in the past. In an interview with the Director of Nursing (DON) on 3/25/25 at 12:39 PM she stated Nurse #4 should not have been giving free water flushes to Resident #58 without an order. The DON revealed that Nurse #4 should have asked the Physician for an order for the free water flushes. In an interview with the Administrator on 3/25/25 at 2:18 PM she indicated that free water flushes through a g-tube needed to have a Physicians order.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Medical Director interview the facility failed to	F 695	Immediate action(s) taken for the resident(s) found to have been affected	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 48 follow professional standards of practice and infection prevention measures when a nurse failed to perform hand hygiene and don (put on) sterile gloves after touching and disposing of a soiled split gauze pad and inner cannula and before placing the new sterile inner cannula and clean split gauze. This was for 1 of 1 resident (Resident #28) reviewed for tracheostomy care. Findings included: Resident #28 was admitted to the facility on 11/11/24 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left dominant side. Resident #28's quarterly Minimum Data Set (MDS) dated 2/15/25 revealed he was significantly cognitively impaired. He was documented to receive tracheostomy care in the facility. Resident #28's care plan dated 11/18/24 revealed him to have a tracheostomy. A continuous observation of tracheostomy care was observed on 3/26/25 at 11:23 AM with Nurse #3. At 11:30 AM she performed hand hygiene and donned sterile gloves. Nurse #3 then opened sterile drape and set it on the table before dumping the contents of the tray onto the sterile drape, opening a new bottle of normal saline and pouring some into the sterile tray. She then cleaned around the cannula with a sterile q-tip dipped in sterile normal saline and threw the q-tip away. Nurse #3 then removed the soiled tracheostomy cap and then the soiled inner tracheostomy cannula. She then threw the soiled cannula away. Without removing the soiled	F 695	include: Education was provided to nurse #3 on proper tracheostomy care by Director of Nursing. Identification of other residents having the potential to be affected was accomplished by: No identified resident with tracheostomy in facility currently other than resident #28. The Director of Nursing will complete skills check-off with all licensed nurses on providing Tracheostomy Care using Carrolton Policy 8.12, by 4/16/2025. All residents with orders for Tracheostomy care have the potential to be affected by this practice. Actions taken/systems put in place to reduce the risk of future occurrence include: All licensed nursing staff including Registered Nurses and Licensed Practical Nurses, will be in-serviced on tracheostomy care and have competency validation by the Director of Nursing by 4/16/2025. Any licensed nursing staff including Registered Nurses and Licensed Practical Nurses not completing education will not be allowed to work until education and competency validation has been completed. Newly hired licensed nursing staff will be educated and competency validated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 49 gloves and performing hand hygiene, Nurse #3 opened a new, sterile inner cannula and inserted it into the tracheostomy tube. Next, Nurse #3 removed the soiled gauze split sponge and disposed of it, opened a clean split sponge and placed it between the tracheostomy flange and Resident #28's skin. Lastly, Nurse #3 changed the tracheostomy ties that hold the tracheostomy tube in place. In an interview with Nurse #3 on 3/25/25 at 11:50 AM she stated she might have had training on tracheostomy care with annual training. She further stated she should have removed the gloves and performed hand hygiene after touching the soiled tracheostomy cap and inner cannula. Nurse #3 indicated she should have removed the cap, soiled inner cannula and soiled split gauze, performed hand hygiene, donned sterile gloves and then handled the sterile inner cannula and clean split gauze. In an interview with the Infection Preventionist (IP) on 3/26/25 at 3:14 PM she stated that Nurse #3 should have handled the contaminated gauze and inner cannula, discarded them, performed hand hygiene by washing her hands with soap and water and then donned sterile gloves before handling the sterile inner cannula and clean split gauze. The IP indicated keeping the procedure as sterile as possible was important to prevent the spread of bacteria to Resident #28's respiratory system. In a telephone interview with the Medical Director on 3/27/25 at 8:51 AM he indicated it was important to follow infection prevention procedures when providing tracheostomy care. He stated Resident #28 is at risk of respiratory	F 695	the ADON and administrative nurses during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Assistant Director of Nursing will randomly observe nurses providing tracheostomy care two (2) times per week for four (4) weeks, then monthly for two (2) months. Using the Carrolton Policy 8.12. Any discrepancies noted will be immediately addressed. The Director of Nursing or Designee will review all audits. The Director of Nursing (DON) will discuss the audit results during the monthly Quality Assurance Performance Improvement (QAPI) meetings for analysis and trending x 3 months. Corrective action completion date: 4/17/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 50 infection due to having a tracheostomy and handling the inner cannula and clean gauze with contaminated gloves could introduce bacteria to his respiratory tract. The Medical Director stated Resident #28 does not currently have a respiratory infection. He further stated Nurse #3 should have washed her hands with soap and water and donned sterile gloves after handing contaminated items and before handling sterile items such as the inner cannula. An interview was conducted with the Administrator on 3/26/25 at 12:10 PM. She indicated Nurse #3 should not have touched the sterile inner cannula and clean gauze without performing hand hygiene and donning sterile gloves first. She stated bacteria could have been transferred from the soiled gloves to the sterile cannula and then to Resident #28's respiratory system potentially causing a respiratory infection.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Registered Dietitian and Medical Director interviews the facility failed to maintain dialysis communication forms and monitor the weight status for 1 of 1 resident reviewed for dialysis (Resident #9). The findings included:	F 698	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #9 dialysis weights were updated under weights/vital signs portal by the Director of Nursing. Resident #9 dialysis communication book which	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 51 Resident #9 was admitted to the facility on 5/3/24 with diagnoses that included End Stage Renal Disease needing hemodialysis. Resident #9's medical record revealed the last documented weight was 197.6 pounds (lbs) on 11/20/24. Resident #9's care plan dated 1/14/25 revealed a focus of potential fluid deficit related to fluid restriction and hemodialysis. The goals included that Resident #9 would be free of symptoms of dehydration. The interventions for Resident #9 included monitoring for weight loss. A quarterly Minimum Data Set (MDS) dated 2/7/25 revealed Resident #9 was cognitively intact and received hemodialysis. Her weight was recorded as 198 lbs. Resident #9's last documented dialysis dry weight (after dialysis was performed) was 157.5 lbs. This weight was taken from the dialysis communication form dated 3/24/25. There were no other dialysis communication forms available as staff were unable to locate Resident #9's dialysis communication book. In an interview with the Unit Manager (UM) on 3/25/25 at 11:01 AM she stated the dialysis communication book was kept at the nurse's station when the resident did not have it with her at dialysis, and she was unable to locate Resident #9's book. The UM was only able to find the dialysis communication form for 3/24/25. She indicated that Resident #9's book was likely left either at dialysis or on the transportation van. The UM revealed weights were recorded in the	F 698	contained communication forms was obtained on 3/26/2025. Assistant Director of Nursing was educated by the Director of Nursing on 3/26/2025 on ensuring dialysis weights are entered into Point Click Care (PCC), under weights/Vitals tab, upon resident return from dialysis using dialysis communication form with identified concerns addressed immediately. 2. Identification of other residents having the potential to be affected was accomplished by: • 100% audit of all resident's receiving dialysis was completed 3/26/2025 by the Director of Nursing to ensure weights monitored/documented weights/vital signs portal, with any identified concerns addressed immediately. • 100% audit of all residents receiving dialysis communication books were audited by Director of Nursing to ensure communication book/forms were in place during survey (3/26-3/27/2025). • All residents receiving dialysis have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • All Licensed Nurses were educated by the Director of Nursing on ensuring communication book/forms return with resident upon return from dialysis 4/14/2025. • All Licensed Nurses were educated by the Director of Nursing on ensuring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 52 residents' chart by the Assistant Director of Nursing (ADON) using the weight recorded by dialysis on the dialysis communication sheet. She was unaware weights were not being recorded for Resident #9. An interview with the ADON was conducted on 3/25/25 at 11 :01 AM. The ADON revealed she was responsible for recording weights in residents' medical records and used that information to track weight loss. She stated she was responsible for recording the weights for Resident #9 and she used the dry weight received from dialysis. The ADON stated she recorded weights on a weekly basis. The ADON was unable to state why Resident #9 had no recorded weights since November 2024. She was unaware of the weight discrepancy recorded in Resident #9's medical record. In a telephone interview with Registered Dietitian (RD) #1 on 3/25/25 at 4:17 PM RD #1 indicated Resident #9 had stopped going to dialysis for a few months and started back in January 2025 after being hospitalized due to fluid overload. RD #1 indicated she should have written an order for weight monitoring. She stated she had not requested a current weight for Resident #9 when she wrote her RD notes in January and February of 2025 but used the November weight of 197.6 lbs. RD #1 did not give a reason she did not request a current weight but indicated she should have done so. An interview with the Director of Nursing (DON) was conducted on 3/25/25 at 12:27 PM. The DON stated she was unaware that Resident #9 had no recorded weights since November 2025. She further stated she was unaware of the	F 698	weights are entered from dialysis communication form upon resident returning from dialysis on 4/14/2025. • All new nurses will be educated on entering dialysis weights upon resident return from dialysis using dialysis communication form by the Assistant Director of Nursing during orientation. • All new nurses will be educated on ensuring residents receiving dialysis the communication book returns with dialysis communication form in place after dialysis appointments by the Assistant Director of Nursing. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • Director of Nursing will monitor dialysis weights and presence of dialysis communication book weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months, using dialysis weight input audit tool, to ensure weights are entered in Point Click Care, Weigt/Vital Sign portal and dialysis communication book available in facility, any identified concerns will be addressed immediately. • The Director of Nursing will forward the results of the Dialysis weight input audit tool to the Executive Quality Assurance Performance Improvement Committee monthly x 3. Corrective action completion date: 4/17/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 53 discrepancy in weights between November 2024 and March 2025. The DON indicated that Resident #9 should have had an order for weight monitoring as she was on dialysis which made her at risk for fluid imbalance. In an interview with the Medical Director on 3/26/25 at 12:11 PM he stated Resident #9 had stopped going to dialysis in June of 2024 and started again in January of 2025 after being hospitalized for fluid overload. He stated he was not surprised at the amount of weight loss between the recorded weights in November of 2024 and March of 2025 due to how much fluid she had retained while not receiving dialysis. The Medical Director stated that although the weight loss was not unexpected, and dialysis monitored weights, it did not absolve the facility from monitoring weights themselves. In an interview with the Administrator on 3/25/25 at 4:15 PM she stated dialysis weights should be recorded in the residents' medical record each time they returned from a dialysis session. She was unaware Resident #9's weights were not being documented.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 54 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing side rails for 3 of 3 residents reviewed for side rails (Resident #1, Resident #9 and Resident #58). Findings included: 1. Resident #1 was admitted to the facility on 4/29/21 with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebrovascular disease affecting right side. A care plan for Resident #1 with the latest review date of 11/18/24 revealed use of one side rail on the left side of the bed to promote independence and assist with bed mobility. A quarterly Minimum Data Set (MDS) dated 1/31/25 revealed Resident #1 was moderately cognitively impaired. The MDS indicated Resident #1 was completely dependent on staff for bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #1 had impairment of	F 700	1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents #1, #9 and #58 were reassessed by the Director of Nursing for need and alternative interventions to side rail use. 2. Identification of other residents having the potential to be affected was accomplished by: • 100% side rail audit was completed by the Director of Nursing on 4/14/2025, negative findings were addressed. • All residents have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • All new admissions and readmissions will have alternative intervention documentation prior to using side rails if appropriate. • All nurses were educated on the use of side rails and alternative interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 55 one side of upper extremities and impairment of both lower extremities. The MDS indicated Resident #1's siderails were not used as a restraint. A review of Resident #1's record revealed an assessment titled "side rail use assessment form" dated 2/7/25 and completed by the Minimum Data Set (MDS) Nurse revealed there was no questions regarding attempting alternatives to side rails before implementing them. An observation on 3/24/25 at 10:45 AM revealed Resident #1 lying in bed with a one-quarter length side rail in the raised position on the left side of the bed. An observation on 3/25/25 at 11:40 AM revealed Resident #1 sitting in bed with the head raised at a 45-degree angle. The one-quarter length side rail on the left side of the bed was in the raised position. The MDS Nurse was interviewed on 3/25/25 at 1:56 PM. The MDS Nurse stated she completed the side rail assessment for Resident #1 on 2/7/25. She revealed that she approved the use of side rails at Resident #1's request and alternatives to side rails were not attempted beforehand. The MDS Nurse indicated that alternatives to side rails are not attempted before the use of side rails unless the therapy department orders an alternative. An interview with the Assistant Director of Nursing (ADON) was conducted on 3/25/25 at 2:05 PM. The ADON stated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement.	F 700	by the Director of Nursing on 4/14/2025. • Any nurses who have not completed education will not be allowed to work until education has been completed. • All newly hired nurses will be educated on the use of side rails during orientation by the Director of Nursing or Assistant Director of Nursing. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • The Assistant Director of Nursing and/or Unit Manager will randomly audit 10 residents using the side rail audit tool monitoring other alternatives were attempted prior to placement of side rails weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months. • The Director of Nursing will forward the results of the Side Rail Audit Tool to the Executive Quality Assurance Improvement Committee monthly x 3. Corrective action completion date: 4/17/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 56	F 700		

In an interview with the Director of Nursing (DON) on 3/25/25 at 2:15 PM she stated they did not try interventions before using side rails as she was not aware this was a requirement.

In an interview with the Administrator on 3/25/25 at 2:27 PM she stated alternative interventions to side rails should be tried before implementation of side rails, the alternatives should be documented as to why they failed, and the resident should be reevaluated for use of side rails. The Administrator was unaware that alternatives to side rails were not being tried or documented on.

2. Resident #9 was admitted to the facility on 5/3/24 with diagnoses that included end stage renal disease.

A care plan for Resident #9 with the latest review date 5/3/24 revealed bilateral one quarter side rails for safety and bed mobility.

A review of Resident #9's record revealed an assessment titled "side rail use assessment form" dated 1/31/25 and completed by the Assistant Director of Nursing (ADON) revealed no questions regarding attempting alternatives to side rails before implementing them.

A quarterly Minimum Data Set (MDS) dated 2/27/25 revealed Resident #9 was cognitively intact and was dependent on staff for bed mobility. The MDS indicated Resident #9's siderails were not used as a restraint.

An observation on 3/24/25 at 11:05 AM revealed Resident #9 lying in bed with bilateral one quarter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 57	F 700		

length side rails in the raised position.

An interview with the Assistant Director of Nursing (ADON) was conducted on 3/25/25 at 2:05 PM. The ADON stated she completed the side rail assessment for Resident #9 on 1/31/25. She indicated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement.

In an interview with the Director of Nursing (DON) on 3/25/25 at 2:15 PM she stated they did not try interventions before using side rails as she was not aware this was a requirement.

In an interview with the Administrator on 3/25/25 at 2:27 PM she stated alternative interventions to side rails should be tried before implementation of side rails, the alternatives should be documented as to why they failed, and the resident should be reevaluated for use of side rails. The Administrator was unaware that alternatives to side rails were not being tried or documented on.

An observation on 3/25/25 at 3:24 PM revealed Resident #9 in bed with the one quarter length side rails in the raised position.

3. Resident #58 was admitted to the facility on 2/26/25 with diagnoses that included osteomyelitis (bone infection) of vertebra, sacral and sacrococcygeal region (low back, base of spine).

A review of Resident #58's record revealed an assessment titled "side rail use assessment form" dated 2/26/25 and completed by the Assistant Director of Nursing (ADON) revealed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 58	F 700		

questions regarding attempting alternatives to side rails before implementing them

An Admission Minimum Data Set (MDS) dated 2/26/25 revealed Resident #58 was severely cognitively impaired and was dependent on staff for bed mobility. The MDS indicated Resident #58's siderails were not used as a restraint.

A care plan for with the latest review date 3/2/25 revealed no reference to side rail usage for Resident #58.

An observation on 3/24/25 at 11:28 AM revealed Resident #58 lying in bed with a left side one quarter length side rail in the raised position.

An observation on 3/25/25 at 9:06 AM revealed Resident #58 in bed with the left side quarter length side rail in the raised position.

An interview with the Assistant Director of Nursing (ADON) was conducted on 3/25/25 at 2:05 PM. The ADON stated she completed the side rail assessment for Resident #58 on 2/26/25. She indicated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement.

In an interview with the Director of Nursing (DON) on 3/25/25 at 2:15 PM she stated they did not try interventions before using side rails as she was not aware this was a requirement.

In an interview with the Administrator on 3/25/25 at 2:27 PM she stated alternative interventions to side rails should be tried before implementation of side rails, the alternatives should be documented as to why they failed, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 59 resident should be reevaluated for use of side rails. The Administrator was unaware that alternatives to side rails were not being tried or documented on.	F 700		
F 837 SS=E	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, Vice President of Property Management, and plumber interviews, the governing body failed to ensure the replacement of aged, malfunctioning, and corroded sewer lines. Due to the state of disrepair of the sewer lines, sewage backed up on multiple occasions each month through sewer cleanout access ports to the point where the replacement of the sewer lines was required to stop the sewer lines from overflowing. When the	F 837	1. Immediate action(s) taken for the resident(s) found to have been affected include: The drainage line on 200 hall was clogged during the annual survey on 3/26/25. As a result, residents could not use bathrooms, bedside commodes were immediately provided to every resident.	4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 60 sewer lines would overflow, several facility toilets on the same hall could not be flushed because they would start to overflow. Furthermore, the corrosion of the drainage lines had deteriorated the integrity of the pipe to the point where there were holes in the pipe and wastewater from the sewer lines was draining into the soil under the facility. The failure to replace the sewer lines on 2 of 4 hallways (200 hall and 500 hall) affected all residents residing on those hallways. Findings included: The Maintenance Director was observed on 03/26/25 at 9:45 am using an auger (sometimes referred to as a snake, a device used to unclog a plumbing line) in the cleanout access mid-way down the 200 hall to attempt to unclog the sewer line. Cloudy, gray colored, and odorless water, without particulate matter, was observed to overflow out of the clean out access and was level with the top of a slightly recessed area in the floor where the cleanout access was situated. During the observation the Maintenance Director made a statement that the sewage overflowed from the cleanout accesses because someone must have flushed paper towels down a toilet. In an interview with the Maintenance Director on 3/26/25 at 10:04 am he. He stated the facility had an issue with paper towels or wipes getting flushed and clogged the sewer line and that caused raw sewage to back up into the facility through the sewer line clean out access openings on the hallways. The Maintenance Director stated this had been an ongoing problem throughout the facility for the 7 years he had been employed by the facility and it occurred on the 200 hall more	F 837	The drainage line on 200 hall was unclogged by the plumbing contractor on 3/26/2025. After the clog was resolved, housekeeping staff ensured that all affected surfaces were cleaned and disinfected. 2. Identification of other residents having the potential to be affected was accomplished by: 100% of all residents on 200 hall were negatively impacted. The administrator and maintenance director performed an audit of the entire building to identify any toilets that were not flushing appropriately or sinks that were not draining well. This audit was completed on 3/27/25, with no further drainage concerns identified as of 3/27/25. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Vice President of Property Management, Administrator and Activities provided Education to residents and staff regarding proper disposal of paper towels, wipes and feminine products these items are not to be flushed in toilets due to risk of blockage all education will be completed on 4/15/2025. Signs have been placed in all bathrooms by the maintenance director in the facility asking that no one flush paper towels, wipes or personal feminine items.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 61 frequently than the other hallways. He stated when the sewage lines became clogged the toilets on the affected hallway overflowed. The Maintenance Director stated, on average, staff notified him by phone or page 2 to 3 times a month with concern of a clogged sewer line. He explained on average he received calls 2 times a month on nights, weekends, or holidays and he would have to come in to try to clear the clog, and if he couldn't clear the clog in the line he would call the plumber. The interview further revealed the Maintenance Director or his assistant used an electric auger to clear the clog but at times it just made the problem worse and he had to call a plumber, and this occurred about 2-3 times a month. The Maintenance Director stated he reported every occurrence of backed up sewer lines to the Administrator and the problem occurred more on the 200 and 500 hall in the past year, and the 300 and 400 halls had not had sewage back up in the hallway in more than a year. He stated he received a report today (3/26/25 at 9:00 am) the 200 hall sewer line had backed up into the hallway at the clean out access midway down the hall, and the toilets in 206/207 and 219/220 had overflowed. He stated he unsuccessfully attempted to unclog the sewer line and called the plumber and awaited Plumber #2's arrival. The Maintenance Director further indicated until the plumber arrived and corrected the problem the toilets on the 200 hall could not be flushed or they would overflow. The Maintenance Director stated he had reported sewer lines becoming clogged to the Vice President of Property Management. A phone interview was conducted with Plumber #1 on 3/26/25 at 1:25 pm. Plumber #1 stated he was the area manager and oversaw the plumbing	F 837	Placement of the signs and education of residents/staff regarding the signs was completed on 4/8/25. During the residents council meeting held on 4/10/2025, education was provided by activities director on proper disposal of paper towels, wipes and feminine products. The Vice President of Property Mgt asked the plumber the best way to diagnose and confirm the problem. The contracted plumber suggested that provide authorization to him to insert a camera into the 200 and 500 hall sewer lines. The testing was completed on the afternoon of 3/26/25. The Vice President of Property Management asked the plumbing contractor to make recommendations for repair and correction to our system to best prevent a problem recurrence. The contractor identified pipe corrosion and recommended a section of 200 hall between the first and second cleanouts (approximately 60 feet) be replaced; and, that the entire length of 500 hall be replaced (approximately 160 feet). The Vice President of Property Management asked the plumbing contractor to begin plans for doing the replacement on both halls. The plumbing contractor coordinated scheduling with a company that performs concrete sawing and pouring and submitted a quote for the performance of the job. The Vice President of Property Management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 62 issues in the facility. He stated Plumber #2 serviced the building. Plumber #1 stated the facility had a problem that the sewage lines in the building were old cast iron pipes that had corroded and needed to be replaced to permanently correct the problem of the sewage backing up into the building. He stated cameras had been run into the sewer lines on the 500 hall with findings of extensive corrosion and erosion with holes in the bottom of the pipe with recommendations to replace the sewer lines. He stated the recommendations were made to the facility's corporate Vice President of Property Management. Plumber #1 stated the corrosion builds up and falls off into the sewer line and toilet paper snags onto it and that caused the pipes to clog. He stated the main sewer lines in the main hallway by the nurses' station and the upper portion of the 500 hall to the first clean out access had been replaced in the past, but the remaining sewer lines on the resident hallways remained in a deteriorated condition and would continue to have problems until that were replaced. In a phone interview with Plumber #2 on 3/27/25 at 10:48 am he stated he was the service technician for the facility's plumbing issues. Plumber #2 stated while the facility had replaced some of the plumbing in the past, the 200, 300, 400, and 500 halls still had very old plumbing. He stated he received repair calls for the 200 hall and the 500 hall more frequently than any other hall. Plumber #2 stated he received a call yesterday (3/26/25) because the 200 hall sewer had backed up into the hallway. He stated he had been called at least 2 times in the past 6 months for 200 hall plumbing issues, and he could not recall how many times he had been called because of the sewer backing up on 500 hall, he	F 837	presented the quote to the governing board on the morning of 4/8/25 and the governing board gave permission to begin the project immediately. The plumbing contractor stated they would begin work on 200 hall on 4/14/25. In preparation for replacing the 200-hall line, facility staff moved all 200 hall residents to 600 hall before the work commences. After completion of the work and appropriate cleaning, residents will be moved from 600 hall back to 200 hall. The replacement of the 500-hall sewer line is planned to begin on 4/28/25, as that is the next date that the plumber and concrete contractor both have available Education was provided to residents and staff regarding proper disposal of paper towels, wipes and feminine products. These items are not to be flushed in toilets due to risk of blockage. All education will be completed by 4/14/2025. Signs have been placed in all bathrooms in the facility asking that no one flush paper towels, wipes or personal feminine items. Placement of the signs and education of residents/staff regarding the signs was completed on 4/8/25. During the residents council meeting held on 4/10/2025, the Vice President of Property Management provided education on the current sewer problems, plans for correction, and for proper disposal of paper towels, wipes and feminine products.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 63 thought it had been once a week sometimes more in the past 2 years. Plumber #2 stated he reported plumbing issues to Plumber #1 and Plumber #1 made his recommendations to the Vice President of Property Management. Plumber #2 stated the sewer pipe had outlived its life expectancy and needed to be replaced if the facility wanted to correct the problem of sewage backing up into the facility. Plumber #2 stated he made a recommendation to replace the sewer lines to the Maintenance Director. He stated he had run cameras down 500 hall's sewer line and it had corrosion with holes that had eaten through the pipe and sewage drained into the ground under the sewer line. He stated he had not put a camera in 200 hall yet, but the sewer lines were the same age as the lines on 500 hall and all are most likely corroding at the same pace. A phone interview was held with the corporate Vice President (VP) of Property Management on 3/26/25 at 6:11 pm. The VP stated he oversaw the building and maintenance for the facility. The interview revealed the main sewer line that ran through the center of the nurses' station to the outside of the building and the first portion of the 500 hall sewer lines, up to the first few resident rooms) had been replaced in prior years. The VP stated the sewer lines down each resident hallway had not been replaced (with the exception of a portion down the front of the 500 hall). He explained the sewer lines in the remaining halls were constructed of old decaying cast iron sewer lines that had corroded, and the corrosion had "eaten" holes through the bottom of the lines. As a result of there being holes in the sewer line, the sewage was washing into the dirt beneath the facility, dirt was being washed into the sewer line, and the dirt, along with corrosion	F 837	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The drainage line on 200 hall was clogged during the annual survey on 3/26/25 as a result residents could not use bathrooms, bedside commodes were immediately provided to every resident. The Vice President of Property Mgt asked the plumber the best way to diagnose and confirm the problem. The contracted plumber suggested that provide authorization to him to insert a camera into the 200 and 500 hall sewer lines. The testing was completed on the afternoon of 3/26/25. The Vice President of Property Management asked the plumbing contractor to make recommendations for repair and correction to our system to best prevent a problem recurrence. The contractor identified pipe corrosion and recommended a section of 200 hall between the first and second cleanouts (approximately 60 feet) be replaced; and, that the entire length of 500 hall be replaced (approximately 160 feet). The maintenance assistant and/or housekeeper will audit 5 bathrooms on each hall to ensure that all draining is occurring rapidly with no back ups / clogs. He will utilize the Environmental Audit tool to ensure that proper sink and toilet functioning (drainage) is occurring. In the event a problem is identified it will be corrected immediately. Steps to be taken include communication with the Maintenance Director, Administrator, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 64 that had flaked off and fallen into the pipe, partially occluded the pipe. The VP explained if wipes or paper towels were flushed, they caught onto the debris in the pipe and the pipes clogged. The VP further indicated the facility contracted with a plumbing company that had made recommendations to replace the corroded pipes multiple times (he did not remember dates) and the problem with sewage backing up into the resident hallways had been ongoing since at least 2020, that he was aware of. He stated he was not sure if it was corroded or not until they looked with the camera but statistically speaking, related to past history of the building's sewer pipe issues, it was most likely corroded. He stated he had made multiple recommendations to the Maintenance Director for the damaged sewer pipes to be replaced, but it was a very costly project, so they had only replaced portions of the most severely damaged sewer pipes. He stated since November of 2020 the facility had replaced 3 sections of the damaged sewer pipe but more needed to be replaced to solve the problem of sewage backing up into the building. The Administrator was interviewed on 3/26/25 at 10:51 am and stated she had been employed by the facility for 6 months and she was aware of concerns with the sewage backing up into the hallways on the 200 hall and the 500 hall through the sewer cleanout accesses. The Administrator stated the Maintenance Director reported to her when the sewage backed up into the building and she thought it was because residents had flushed paper towels or wipes down the toilets. The Administrator further stated she thought it had happened 4 or 5 times in the past 6 months and mostly on the 200 hall. The Administrator explained the sewer lines had not been replaced	F 837	VP of property management. Audits will be done 5 times a week x 4 weeks, then 3 times a week x 2 weeks, then one time a week x one month. The maintenance director will review the environmental audit tool and address concerns immediately. In addition to the toilet / drainage environmental audit form, the Administrator or designee will interview 2 residents on each hall weekly to ensure that the residents have not experienced problems that we were not aware of. Angel rounds will also be updated to include a specific questions regarding toilets, drainage, and clogging. One time per week the maintenance director will open the drain lines to ensure that water is not backed up. He will provide a weekly report to the Administrator in writing. If problems occur, the Vice President of Property Management, Chief Operating Officer, and Chief Clinical Officer will immediately be notified via text, call, or email. Immediate resolution will be implemented. The maintenance director and senior team members will forward the results of the Environmental Audit tools, Angel Rounds, and weekly drain line evaluations to the Executive Quality Assurance Performance Improvement Committee x 3 months. Immediate actions will be taken to remedy problems that are identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 65 on the 200-hallway because a camera needed to be inserted into the line to determine why the sewer line backed up. The facility was unable to provide a current quote for the recommended repairs to the sewer lines on the 200 hall and the 500 hall.	F 837	Corrective action completion date: 4/18/25	