

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER The Carrolton of Dunn			STREET ADDRESS, CITY, STATE, ZIP CODE 711 Susan Tart Road , Dunn, North Carolina, 28335	
(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
E0000	<p>Initial Comments</p> <p>The survey team entered the facility on 09/08/25 to conduct an unannounced recertification survey and complaint investigation. The survey team was onsite 09/08/25 through 09/11/25. Additional information was obtained offsite on 09/12/25. Therefore, the exit date was 09/12/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D5DBA-H1.</p> <p>The posting of this Statement of Deficiencies was delayed as a result of the following: a technical problem with iQIES on 9/30/25.</p> <p>In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.</p>	E0000		12/03/2025
F0000	<p>INITIAL COMMENTS</p> <p>The survey team entered the facility on 09/08/25 to conduct a recertification survey and complaint investigation. The survey team was onsite 09/08/25 through 09/11/25. Additional information was obtained offsite on 09/12/25. Therefore, the exit date was 09/12/25. Event ID# 1D5BDA-H1. The following intakes were investigated 2595383, 2576658. 3 of the 3 complaint allegations resulted in deficiency.</p> <p>The posting of this Statement of Deficiencies was delayed as a result of the following: a technical problem with iQIES on 9/30/25.</p> <p>In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.</p>	F0000		12/03/2025
F0561 SS = D	<p>Self-Determination</p> <p>CFR(s): 483.10(f)(1)-(3)(8)</p> <p>§483.10(f) Self-determination.</p> <p>The resident has the right to and the facility must</p>	F0561	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #5, 8, and 25 were interviewed by dietary staff to ensure that the facility had updated preferences on October 30, 2025, and again on November</p>	12/05/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0561 SS = D	<p>Continued from page 1 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, resident interviews and staff interviews, the facility failed to honor residents the choice to warm meals brought from outside the facility for 3 of 3 residents reviewed for choices (Resident #8, Resident #25 and Resident #5).</p> <p>The findings included:</p> <p>1a. Resident #8 was admitted to the facility on 12/23/23. Her diagnoses included type 2 diabetes mellitus, anxiety disorder, and gastroesophageal reflux disease (GERD).</p> <p>The quarterly Minimum Data Set (MDS) assessment for Resident #8 dated 7/21/25 indicated her cognition was intact, she had no upper extremity impairments and was independent with eating.</p> <p>An interview with Resident #8 on 9/9/25 at 9:10am revealed Resident #8 was upset that she could no longer warm meals brought to her by her family. Resident #8</p>	F0561	<p>Continued from page 1 25, 2025.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility Administrator and Director of Nursing met with all alert and oriented residents from November 26, 2025, through December 1, 2025, to discuss the use of microwaves in the facility. The resident representatives for all residents, to include non-alert and oriented residents, were contacted via robocall on December 3, 2025, regarding the facility's policies on microwave use.</p> <p>Two additional residents voiced concerns about using the microwave; therefore, the facility has determined that all residents with family or visitors who bring in food from outside the facility may be affected by the lack of a microwave for reheating outside food.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Carrolton Facility Management representatives, including the Chief Nursing Officer, Chief Operating Officer, and Facility Nurse Consultant, consulted with the facility administrator, Director of Nursing, and Dietary staff in meetings that occurred on November 19, 20, and November 26, 2025, to discuss survey findings, policy changes and audit schedules related to the statement of deficiencies received on November 18, 2025.</p> <p>The following policies were implemented or revised by Carrolton Facility Management, November 26, 2025:</p> <p>15.1 Ready-to-Eat Food Brought in by Family Members and Visitors</p> <p>15.2 Use and Storage of Food Brought in by Family and Visitors</p> <p>15.2a Safe Microwave Use Form</p> <p>The facility Administrator and Director of Nursing met with facility residents from November 26 through December 1, 2025, to educate them on safe food handling</p>	

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F0561 SS = D	<p>Continued from page 2 stated there was a microwave in the dining room where she was able to warm soups and other things her family brought her. Resident #8 stated about a month ago the microwave was removed. She was told by the kitchen staff that they are not allowed to bring personal food items into the kitchen to heat them. Resident #8 indicated she had complained about having no way to heat meals, but she was told it was a safety hazard. Resident #8 revealed she did not like most of the meals or alternative choices served and would just like to be able to heat up a bowl of soup or chili.</p> <p>b. Resident #25 was admitted to the facility on 2/29/24 with diagnosis including diabetes mellitus.</p> <p>Resident #25's quarterly MDS assessment dated 7/18/25 revealed she was cognitively intact, had no upper extremity impairments and was able to eat independently with set up from staff.</p> <p>An interview with Resident #25 was conducted during an impromptu Resident Council meeting on 9/10/25 at 3:22pm. Resident #4 stated the facility had removed the microwave from the dining room about a month ago. She had food that was delivered and was unable to microwave the items to heat them. Resident #4 stated she was upset that she had food at the facility she could not eat.</p> <p>c. Resident #5 was admitted to the facility on 4/26/24 with diagnoses including depression.</p> <p>Resident #5's quarterly MDS assessment dated 7/24/25 revealed she was cognitively intact, had one upper extremity impairment and was able to eat independently with set up assistance.</p> <p>During an impromptu Resident Council meeting on 9/10/25 at 3:22pm, Resident #5 revealed the facility had removed the microwave from resident use and staff would not heat food for her if it was not prepared by the kitchen. She stated she was no longer able to heat food brought from outside the facility. If she wanted to save something to eat a later time, she would have to eat it cold. Resident #5 stated she did not think it was fair she had to eat what the facility provided since no outside food could be warmed or reheated.</p> <p>An interview completed with Nurse # 7 on 9/11/25 at 10:32am revealed there was no access to a microwave to warm residents' food. Nurse #7 revealed the microwave was once available for residents and residents' family</p>	F0561	<p>Continued from page 2 and the facility policy on resident microwave use.</p> <p>The facility Administrator and the Director of Nursing also met with the facility management team (including dietary, admissions, social work, and nursing leaders), as well as clinical staff (including licensed nurses and certified nursing assistants), from November 26 through December 1, 2025, to educate them on the facility's policy on resident microwave use.</p> <p>The microwave was returned to the resident's dining room on December 1, 2025, after all education was completed.</p> <p>On December 2, 2025, facility leaders, including the Administrator, Director of Nursing, Chief Operations Officer, and Chief Nursing Officer, met by phone to discuss the plan of correction after the initial plan was rejected by the state. As a result of this meeting, the following policies were amended:</p> <p>15.1 Ready-to-Eat Food Brought in by Family Members and Visitors</p> <p>15.2 Use and Storage of Food Brought in by Family and Visitors</p> <p>15.2a Safe Microwave Use Form</p> <p>December 3-4, 2025, the facility Administrator and Director of Nursing re-educated residents, administrative staff (including dietary, admissions, social work, and nursing leaders), and clinical staff (including licensed nurses and certified nursing assistants) on the facility policies related to microwave use.</p> <p>This training included:</p> <p>15.1 Ready-to-Eat Food Brought in by Family Members and Visitors</p> <p>Outlines processes to keep ready-to-eat food safe for resident consumption, including in-room storage</p> <p>15.2 Use and Storage of Food Brought in by Family</p>	

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F0561 SS = D	<p>Continued from page 3 to use, but it had recently been removed. Nurse #7 stated she tried to let family members know there was no access to warm up food bought from outside, but families could bring resident's food to the facility already warmed. Nurse #7 indicated there were residents and family members upset with change.</p> <p>Interview conducted with the Dietary Manager on 9/11/25 at 4:48pm revealed the microwave the residents used had been removed from the dining room. She indicated she was unsure why the microwave was removed she was told by management that it was a safety concern. The Dietary Manager stated she could provide soup served from the kitchen to Resident #8, but Resident #8 could not bring soup purchased outside the facility into the kitchen to warm it.</p> <p>An Interview conducted with the Director of Nursing (DON) on 9/11/25 at 2:13pm revealed the facility policy stated they could not have a microwave due to safety concerns. The DON indicated the microwave was in the dining room but had been removed about a month and a half ago. No residents at the facility suffered injury while operating or using the microwave at the facility. The DON stated the reason the microwave was removed from the dining room was because the facility was unable to monitor the temperature of the food items residents were heating up in the microwave. Removing the microwave would ensure residents did not burn themselves. The DON indicated the facility would get soup brands and preferences from the residents so the kitchen could purchase something comparable to the brand the resident desired. Resident #8 and other residents were upset about not being able to heat foods they purchased. Resident #8's family brought cans of soup for her to warm. Residents had occasionally used the microwave when the facility meal being served, or alternatives weren't to their liking. Residents were upset about not having access to a microwave or being able to heat food brought in from outside sources. The DON further stated the facility had no way of knowing the temperature of microwaved foods after they had been heated. She further revealed the facility had not considered staff heating food items and temping items food items for safety.</p> <p>An interview was conducted with the Administrator on 9/11/25 at 6:28pm. During the interview the Administrator revealed the microwave was removed from the dining room for safety reasons. There were concerns a resident may burn themselves and his understanding</p>	F0561	<p>Continued from page 3 Members and Visitors</p> <p>Outlines procedures for safe handling of foods brought from outside the facility that need refrigeration and reheating, including:</p> <p>Labeling, dating, and refrigerating</p> <p>Re-heating- microwave use, including the Safe Microwave Use Form (15.2a)</p> <p>Facility staff assistance in accessing and consuming food brought in from outside the facility</p> <p>Microwave Safety Tips</p> <p>Location of the microwave and procedures to grant access.</p> <p>Staff assistance for residents who may need help with warming food from outside the facility.</p> <p>A robocall was sent to all residents' representatives on December 3, 2025, to educate them about the facility's updated policies on resident microwave use, the microwave's new location (staff break room), and microwave access.</p> <p>Newly hired staff will receive training on Food Brought in by Family Members and Visitors, including facility policies related to microwave use and the Safe Microwave Use Form, during the orientation process from the Administrator, Director of Nursing, or Assistant Director of Nursing.</p> <p>Newly admitted residents will be educated on Food Brought by Family Members and Visitors, including facility policies related to microwave use and the Safe Microwave Use Form, by facility admission or social work staff during the admission process.</p> <p>On December 3, 2025, the microwave was moved to a secure location (staff break room) to better oversee resident safety during microwave use. Residents and family members will be granted access by clinical staff.</p>	

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F0561 SS = D	Continued from page 4 was no outside food could be taken into the kitchen to warm or reheat. The Administrator revealed he expected the residents to have choices, but the microwave was removed for safety.	F0561	Continued from page 4 How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or designee will interview three (3) residents each week for the next four (4) weeks (the week of December 2 through the week of December 22, 2025) to assess issues related to the provision of dietary services, food preferences, and heating outside food. Audit records will be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved, as determined by the committee. Corrective action completion date: December 5, 2025.	
F0582 SS = E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to	F0582	Immediate action(s) taken for the resident(s) found to have been affected include: The facility noted that the Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) forms for residents #8 and #68 were not completed. The Business Office Manager was educated by the facility Administrator on September 11, 2025, about the use of the Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form, 10555. Identification of other residents having the potential to be affected was accomplished by: On December 2, 2025, the Director of Nursing and the Administrator reviewed all service discharges for the past thirty days to determine which residents would be affected by not receiving Advanced Beneficiary Notices. The audit revealed no issues with the submission of SNF-ABN forms. The facility has determined that all residents with qualifying hospital stays and Medicare Part A benefit days available have the potential to be affected. Actions taken/systems put into place to reduce the risk	12/03/2025

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F0582 SS = E	<p>Continued from page 5 residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Form 10055- Skilled Nursing Facility (SNF) Advanced Beneficiary Notification (ABN) when the facility-initiated discharge from Medicare Part A Services when benefit days were not exhausted. This was for 2 of 3 residents reviewed for beneficiary notice protection (Resident #8 and Resident #68).</p> <p>Findings included:</p> <p>1. Resident #8 was admitted to the facility on 5/19/25 under Medicare Part A covered skilled services.</p> <p>Resident #8's Medicare Part A covered skilled services ended on 5/30/25. She remained in the facility.</p> <p>A review of Resident #8's medical record revealed no evidence Resident #8 was provided with a CMS SNF-ABN.</p> <p>On 9/11/25 at 5:23 PM an interview with the Business Office Manager (BOM) indicated Resident #8's Medicare Part A covered skilled services began on 5/19/25. She stated when these covered services ended on 5/30/25, Resident #8 had days remaining and had not used all 100</p>	F0582	<p>Continued from page 5 of future occurrence include:</p> <p>On October 2, 2025, the Carrolton Facility Nurse Consultant educated the Social Worker and Business Office Manager on issuing liability notices, including:</p> <p>Carrolton Policy #2.20 Advance Beneficiary Notices</p> <p>The proper form to be used when issuing a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form, 10555</p> <p>The facility's plan of correction to address Advance Beneficiary Notices (F582)</p> <p>Newly hired social workers and business office staff will be educated by the Administrator or Facility Nurse Consultant on Carrolton Policy #2.20, Advanced Beneficiary Notices, as part of the orientation process.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not reoccur:</p> <p>The Administrator or designee will conduct a random audit of three (3) residents weekly for four (4) consecutive weeks to verify that the correct notices were issued in a timely and appropriate manner. Auditing will begin the week of September 29, 2025, through the week of November 30, 2025.</p> <p>Audit records will be reviewed biweekly by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved.</p> <p>Corrective action completion date: December 3, 2025.</p>	

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F0582 SS = E	<p>Continued from page 6 covered days. She stated the resident's discharge was initiated by her insurance company, which sent a CMS NOMNC form via email for the facility to present to the resident. The BOM stated she was not aware a SNF-ABN also needed to be provided. She also stated she was aware of the SNF-ABN form which provided the resident's out-of-pocket cost, but that form was not used at the facility. She reported Resident #8 had remained in the facility.</p> <p>On 9/11/25 at 5:35 PM an interview with the Social Worker (SW) revealed she had not been employed by the facility when Resident #8 was issued the CMS NOMNC form; but the SW employed at that time would have been responsible for providing the CMS NOMNC form to Resident #8 when she was discharged from her Medicare Part A covered services on 5/30/25. The SW reported she had only provided the CMS NOMNC form to a resident and had never provided the CMS SNF-ABN form. She stated for an insurance-initiated discharge, the insurance provider would send a blank CMS NOMNC form via email to be completed by the facility and be provided to a resident. The SW discussed not being aware she was required to provide both a NOMNC and SNF-ABN. She stated she was unaware of the SNF-ABN form which provided a resident with an estimated out-of-pocket cost, but the Business Office would be responsible for providing the out-of-pocket cost to a resident.</p> <p>An interview on 09/11/25 at 6:15 PM with the Administrator revealed he had knowledge of the CMS SNF-ABN and CMS NOMNC forms. He stated his expectation would have been for the appropriate notices to be given to Resident #8. The Administrator stated he was aware of a form which provided a resident with an estimated out-of-pocket cost, but he had not seen the form at this facility.</p> <p>2. Resident #68 was admitted to the facility on 8/19/25 under Medicare Part A covered skilled services.</p> <p>Resident #68's Medicare Part A covered skilled services ended on 9/5/25. She remained in the facility.</p> <p>A review of Resident #68's medical record revealed no evidence Resident #68 was provided with a CMS SNF-ABN.</p> <p>On 9/11/25 at 5:23 PM an interview with the Business Office Manager (BOM) indicated Resident #68's Medicare Part A covered skilled services began on 8/19/25. She stated when these covered services ended on 9/5/25, Resident #68 had days remaining and had not used all 100 covered days. She stated Resident #68's discharge was initiated by her insurance company, which sent a</p>	F0582		

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F0582 SS = E	<p>Continued from page 7 CMS NOMNC form via email for the facility to present to the resident. The BOM stated she was not aware a SNF-ABN also needed to be provided. She also stated she was aware of the SNF-ABN form which provided the resident's out-of-pocket cost, but that form was not used at the facility. She reported Resident #68 had remained in the facility.</p> <p>On 9/11/25 at 5:35 PM an interview with the Social Worker (SW) revealed she issued the CMS NOMNC form to Resident #68 when she was discharged from her Medicare Part A covered services on 9/5/25. She reported Resident #68's insurance provider initiated her discharge and sent a blank CMS NOMNC form via email to be completed and issued by the facility to Resident #68. The SW discussed not being aware she was required to provide both a NOMNC and SNF-ABN. She stated she was unaware of the SNF-ABN which provided a resident with an estimated out-of-pocket cost, but the Business Office would be responsible for providing the cost estimate to a resident.</p> <p>An interview on 09/11/25 at 6:15 PM with the Administrator revealed he had knowledge of the CMS SNF-ABN and CMS NOMNC forms. He stated his expectation would have been for the appropriate notices to be given to Resident #68. The Administrator stated he was aware of a form which provided a resident with an estimated out-of-pocket cost, but he had not seen the form at this facility.</p>	F0582		
F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through</p>	F0609	<p>Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>There was a delay in reporting the abuse allegation by the Director of Admissions to the Administrator for resident #37. The facility administrator re-educated the Director of Admissions at the time of the occurrence and again during the survey on September 11, 2025, regarding the required timeframe for reporting alleged violations, including abuse allegations.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The Facility Nurse Consultant reviewed all facility reportable incidents on November 24, 2025. There was one abuse allegation that had been reported in a timely manner with no issues identified.</p>	12/03/2025

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F0609 SS = D	<p>Continued from page 8 established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure for immediately reporting an allegation of staff to resident physical abuse to the Administrator resulting in the allegation not being reported to the State Agency, local law enforcement, and to Adult Protective Services within the required time frame. Additionally, the initial report did not accurately reflect the date and time the facility became aware of the abuse allegation. This was for 1 of 3 residents reviewed for abuse (Resident #37).</p> <p>The findings included:</p> <p>A review of the facility policy titled Abuse, Neglect and Exploitation, revised 3/20/23 indicated violations needed to be reported to the Administrator, State Agency, Adult Protective Services, and to all required agencies (law enforcement if applicable) immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>Resident #37 was admitted to the facility on 12/22/23.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 7/24/25 revealed Resident #37 was cognitively intact.</p> <p>A review of the facility grievances revealed on 8/19/25 the Admissions Director had completed a grievance form after she spoke with Resident #37 who stated, "the girl who gave me a bath-she beat me up." Resident #37 stated, "she was a black girl, but I don't know her name". She slapped me all in my face and "I don't remember her, but she has pearls in her hair."</p>	F0609	<p>Continued from page 8</p> <p>The facility has determined that all residents have the potential to be affected by delays in reporting abuse allegations in a timely manner.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service was conducted by the Administrator, Director of Nursing, and Facility Nurse Consultant on October 2, 2025, with all staff responsible for reporting alleged violations (including all facility department heads).</p> <p>The Administrator, Director of Nursing, and Facility Nurse Consultant in-serviced all staff regarding Abuse Reporting Requirements, October 2 – October 5, 2025.</p> <p>These in-services addressed the following:</p> <p>Resident rights to be free from abuse and neglect</p> <p>Carrolton Policy #3.2 Compliance with Reporting Allegations of Abuse, Neglect, Exploitation</p> <p>Timeframes for reporting reportable events</p> <p>The facility's plan of correction for Reporting Allegations of Abuse, Neglect, and Exploitation Timely (F609)</p> <p>Newly hired staff will receive training on Abuse, including the processes for Reporting Allegations by the Administrator, Director of Nursing, or Facility Nurse Consultant during the orientation process.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Administrator or designee will audit all facility-reported incidents daily for four (4) consecutive weeks to ensure that reporting has been completed in a timely manner.</p> <p>The facility Nurse Consultant will audit all facility-reported incidents weekly for four (4) consecutive weeks to ensure that reporting has been completed in a timely manner.</p>	

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F0609 SS = D	<p>Continued from page 9 The Admissions Director was interviewed on 9/10/25 at 10:22 am. She stated she had worked late (did not specify a time) on 8/19/25 and when she walked by Resident #37's room the resident called her into her room and told her that on 8/18/25 while taking her shower the Nurse Aide (NA) hit her in the face for no reason. Resident #37 was unable to recall the name of the NA. Admissions Director shared that she did not recall the exact details of what Resident #37 shared with her on 8/19/25. The Admissions Director stated she filled out a grievance form on 8/19/25 and did not report the allegation to nursing staff, Director of Nursing (DON), or Administrator until the morning of 8/20/25 during the morning meeting around 9:30 am when she reported the allegation of abuse to the Administrator. The Admissions Director stated she knew she should have reported the allegation right away but stated it was late and had been a long day. She stated that evening (8/19/25) she had not observed any markings on Resident #37 and didn't think about telling the Administrator at that time. She stated there were no signs of abuse, no bruises, scratches or red marks on 8/19/25.</p> <p>An initial allegation report dated 8/20/25 at 9:35 am, was completed by the Administrator. The initial report documented the facility initially became aware of the allegation of abuse on 8/20/25. The Administrator interviewed Resident #37 on 8/20/25 and the resident reported she was hit in the face by a black lady with pearls in her hair while receiving a bed bath the afternoon of 8/16/25. Resident #37 stated she was hit in the face multiple times, the lady hit her using her fist. The initial report did not indicate Adult Protective services or law enforcement was notified. The initial report was faxed to the State Agency on 8/20/25 at 3:30 pm.</p> <p>The investigation report dated 8/22/25 completed by the Administrator revealed the allegation of staff to resident abuse was unsubstantiated. The investigation report was faxed to the State Agency on 8/22/25 at 7:13 pm. Adult Protective Services (APS) was notified by Administrator on 8/20/25.</p> <p>A review of Resident #37's skin assessment completed on 8/20/25 by Nurse #1 revealed no trauma to her face or issues with her skin other than a dime size pressure spot to Resident #37's right pinky toe.</p>	F0609	<p>Continued from page 9 Audits will begin the week of September 29, 2025, through the week of November 30, 2025.</p> <p>Audit records will be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved, as determined by the committee.</p> <p>Corrective action completion date: December 3, 2025.</p>	

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F0609 SS = D	Continued from page 10 An interview with Nurse #1 was conducted on 09/09/25 at 4:25pm. She stated she completed a skin assessment on the day the Facility Nurse Consultant asked her to do it (she was unable to recall the date). Nurse #1 discussed during the skin assessment she did not observe any concerns on Resident #37's face, no signs of trauma, no redness, bruising, scratches or discoloration. Resident #37's skin was intact. The DON was interviewed on 9/10/25 at 10:45 am. She stated if a resident shared with staff that they had been abused, the staff member should have notified her or the Administrator right away so the facility could report the allegation of abuse to the State Agency in 2 hours. An interview with the Administrator occurred on 9/10/25 at 10:55 am. He stated the Admissions Director notified him of Resident #37's allegation of abuse on 8/20/25 during the morning meeting around 9:00 am. He indicated that the Admissions Director was notified of the allegation of abuse on 8/19/25 and failed to report to him until the next day (8/20/25), which was why the Administrator stated he dated the initial allegation for 8/20/25. He stated he wanted staff to notify him immediately when they became aware of any abuse allegations. The Administrator discussed contacting Adult Protective Services on 8/20/25 but not law enforcement due to no injury to Resident #37.	F0609		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(C) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3]	F0727	Immediate action(s) taken for the resident(s) found to have been affected include: The facility was noted to have not had eight hours of coverage by a Registered Nurse (RN) on two of the days reviewed during the DHHR annual survey. The facility administrator provided re-education regarding RN Coverage to the Director of Nursing and the scheduler on September 11, 2025. Identification of other residents having the potential to be affected was accomplished by: On November 24, 2025, the Facility Nurse Consultant completed an audit of staffing sheets to review RN coverage for the past thirty days. The facility has met the requirements for RN coverage since November 2,	12/03/2025

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F0727 SS = F	<p>Continued from page 11 §1819(b)(4)(C) REQUIRED NURSING CARE.-</p> <p>§1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.</p> <p>§483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>§483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 2 of 30 days reviewed for staffing (8/30/25 and 8/31/25).</p> <p>The findings included:</p> <p>Review of the facility's daily nurse staffing postings for 8/10/25 through 9/10/25 revealed there was not a RN scheduled for at least 8 hours a day on 8/30/25 and 8/31/25.</p> <p>During an interview with the Director of Nursing (DON) on 9/11/25 at 3:45pm revealed there was no RN coverage in the facility on 8/30/25 and 8/31/25 because the scheduled weekend RN called out. The DON stated she was not notified on either day (8/30/25 and 8/31/25) the RN called out and did not find out the facility had no RN coverage until Monday morning (9/1/25). The DON indicated she knew the facility was required to have 8 hours of RN coverage each day and she expected to be notified when the scheduled RN called out.</p> <p>The Administrator was interviewed on 9/11/25 at 6:28pm and he stated he expected the facility to have a RN coverage 8 hours a day 7 days a week.</p>	F0727	<p>Continued from page 11 2025.</p> <p>The facility has determined that all residents are at risk of being affected by a failure to ensure eight hours of RN coverage in a twenty-four-hour period.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Chief Nursing Officer and Facility Nurse Consultant met with the Administrator and Director of Nursing on October 2, 2025, to discuss RN Coverage. The facility has secured enough RNs to provide the RN coverage needed.</p> <p>The Facility Nurse Consultant in-serviced all staff responsible for scheduling (including the Director of Nursing, scheduler, and Lead Nursing Assistant) on October 2, 2025. This in-service included the following information:</p> <p>Carrolton Policy # 10.2 Nursing Services- Registered Nurse</p> <p>Procedures to ensure that Nurse Staffing Posting Information is kept accurate with all information, including the total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift:</p> <p>Registered Nurses (at least 8 hours in a 24-hour period)</p> <p>Licensed Practical Nurses</p> <p>Certified Nurse Aides</p> <p>The facility's plan of correction to address RN Coverage (F731)</p> <p>Newly hired scheduling staff will be educated by the Director of Nursing or Facility Nurse Consultant on procedures to ensure that RN Coverage is scheduled correctly (at least eight hours in a 24-hour period) and that Nurse Staffing Posting Information is kept accurate, as part of the orientation process.</p>	

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F0727 SS = F		F0727	Continued from page 12 How the corrective action(s) will be monitored to ensure the practice will not recur: The facility Director of Nursing or Administrator will review daily and initial schedules for the next four (4) consecutive weeks beginning the week of September 29, 2025, through the week of November 30, 2025. The facility Director of Nursing or Administrator will review and initial the staff posting for the previous twenty-four (24) to forty-eight (48) hours to ensure that the posting is maintained accurately, including RN coverage. This audit will occur daily (Monday- Friday) for four (4) consecutive weeks beginning the week of September 29, 2025, through the week of November 30, 2025. Corrective action completion date: December 3, 2025.	
F0732 SS = A	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F0732		11/30/2025

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F0732 SS = A	<p>Continued from page 13 §483.35(i)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to ensure the daily nurse staffing posting had the correct census for 20 of 30 days reviewed (8/10/2025 through 8/14/2025, 8/18/2025, 8/22/2025 through 8/26/2025, 8/28/2025 through 9/1/2025, 9/3/2025, 9/5/2025, 9/6/2025 and 9/9/2025).</p> <p>The findings included:</p> <p>A review of the facility's daily nurse staffing postings from 8/10/2025 through 9/9/2025 revealed the following:</p> <p>a. Daily nurse staffing posting dated 8/10/2025 revealed a census of 90. Review of the facility's detailed census report dated 8/10/2025 revealed a census of 91.</p> <p>b. Daily nurse staffing posting dated 8/11/2025 revealed a census of 94. Review of the facility's detailed census report dated 8/11/2025 revealed a census of 92.</p> <p>c. Daily nurse staffing posting dated 8/12/2025 revealed a census of 91. Review of the facility's detailed census report dated 8/12/2025 revealed a census of 93.</p>	F0732		

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F0732 SS = A	Continued from page 14 d. Daily nurse staffing posting dated 8/13/2025 revealed a census of 92. Review of the facility's detailed census report dated 8/13/2025 revealed a census of 93. e. Daily nurse staffing posting dated 8/14/2025 revealed a census of 93. Review of the facility's detailed census report dated 8/14/2025 revealed a census of 95. f. Daily nurse staffing posting dated 8/18/2025 revealed a census of 96. Review of the facility's detailed census report dated 8/18/2025 revealed a census of 94. g. Daily nurse staffing posting dated 8/22/2025 revealed a census of 96. Review of the facility's detailed census report dated 8/22/2025 revealed a census of 93. h. Daily nurse staffing posting dated 8/23/2025 revealed a census of 94. Review of the facility's detailed census report dated 8/23/2025 revealed a census of 93. i. Daily nurse staffing posting dated 8/24/2025 revealed a census of 94. Review of the facility's detailed census report dated 8/24/2025 revealed a census of 93. j. Daily nurse staffing posting dated 8/25/2025 revealed a census of 94. Review of the facility's detailed census report dated 8/25/2025 revealed a census of 93. k. Daily nurse staffing posting dated 8/26/2025 revealed a census of 92. Review of the facility's detailed census report dated 8/26/2025 revealed a census of 93. l. Daily nurse staffing posting dated 8/28/2025 revealed a census of 94. Review of the facility's detailed census report dated 8/28/2025 revealed a census of 95. m. Daily nurse staffing posting dated 8/29/2025 revealed a census of 93. Review of the facility's detailed census report dated 8/29/2025 revealed a census of 94. n. Daily nurse staffing posting dated 8/30/2025 revealed a census of 91. Review of the facility's detailed census report dated 8/30/2025 revealed a	F0732		

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F0732 SS = A	<p>Continued from page 15 census of 92.</p> <p>o. Daily nurse staffing posting dated 8/31/2025 revealed a census of 90. Review of the facility's detailed census report dated 8/31/2025 revealed a census of 91.</p> <p>p. Daily nurse staffing posting dated 9/1/2025 revealed a census of 89. Review of the facility's detailed census report dated 9/1/2025 revealed a census of 90.</p> <p>q. Daily nurse staffing posting dated 9/3/2025 revealed a census of 89. Review of the facility's detailed census report dated 9/3/2025 revealed a census of 92.</p> <p>r. Daily nurse staffing posting dated 9/5/2025 revealed a census of 92. Review of the facility's detailed census report dated 9/5/2025 revealed a census of 91.</p> <p>s. Daily nurse staffing posting dated 9/6/2025 revealed a census of 91. Review of the facility's detailed census report dated 9/6/2025 revealed a census of 89.</p> <p>t. Daily nurse staffing posting dated 9/9/2025 revealed a census of 88. Review of the facility's detailed census report dated 9/9/2025 revealed a census of 90.</p> <p>An interview with the Staffing Scheduler was conducted on 9/11/2025 at 12:40pm. She stated she was responsible for completing the daily posting for nurse staffing. The Staffing Scheduler obtained the census number each morning from the Receptionist which included residents in the building as of midnight the prior day. The Staffing Scheduler stated she did not change the daily posting of nurse staffing if the census changed with any admissions or discharges.</p> <p>The Receptionist was interviewed on 9/11/2025 at 2:23pm. The Receptionist revealed she provided the Staffing Scheduler with a copy of the daily census numbers every morning. The Receptionist was unaware if the numbers had been adjusted for admission or discharges.</p> <p>During a interview with the Director of Nursing (DON) on 9/11/25 at 2:29pm revealed she was unsure why the daily nurse staffing posting did not match the facility's detailed census report. She further indicated she did not review the daily nurse staffing posting for accuracy.</p>	F0732		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	Immediate action(s) taken for the resident(s) found to have been affected include:	12/03/2025

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F0812 SS = E	<p>Continued from page 16</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to label and date leftover food items and failed to discard food with signs of spoilage in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. The facility also failed to ensure clean dishes were not stacked wet and ensure dishes that were ready for use were clean for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>a. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:00 AM revealed the following in the walk-in cooler:</p> <p>Five (5) of the 5 cantaloupes in the walk-in cooler had soft, brown and black spots with white fuzz.</p> <p>Fourteen (14) of the 14 lettuce heads in the walk-in cooler were brown and slimy with spots of white fuzz.</p> <p>b. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:10 AM revealed the following in the walk-in freezer:</p>	F0812	<p>Continued from page 16</p> <p>During a recent survey, dishes were noted to be stored prior to being fully dried on the drying rack, undated and spoiled food items were noted in the walk-in refrigerator.</p> <p>The dishes were immediately sent back to the dishwasher; they were rewashed and dried fully on the drying rack prior to storage.</p> <p>The outdated food was thrown away immediately.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>The Administrator completed a walk-through audit of the kitchen on November 24, 2025, to determine if the facility was in compliance with the deficiencies noted during the recent state survey. There were no deficient practices noted in the kitchen during this audit.</p> <p>The facility has determined that all residents have the potential to be affected by deficient practices such as dishes not being dried correctly, food items being spoiled or opened food items being left undated.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>The Dietary Area Manager in-service all dietary staff on November 20, 2025, regarding the facility policies and procedures for dish washing, proper use of drying rack, and disposing of outdated and spoiled food items. This training included:</p> <p>A review of the regulation and policy to allow dishes to air dry on the drying rack prior to moving to the storage rack.</p> <p>A review of opening and closing procedures and use of the daily opening and closing checklists to include checking outdated food items and discarding them timely.</p> <p>Newly hired dietary staff will be trained by the Dietary Manager or Area Dietary Manager regarding policies related to dishwashing and drying as well as</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345325	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
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F0812 SS = E	<p>Continued from page 17</p> <p>One half (1/2) of a two-pound bag of meatballs in the freezer was opened to the air, undated, and had a layer of ice crystals.</p> <p>One half (1/2) of a two-pound bag of French fries in the freezer was opened to the air, undated, and had a layer of ice crystals.</p> <p>One fourth (1/4) of a two-pound bag of peas in the freezer was opened to the air, undated, and had a layer of ice crystals.</p> <p>c. An initial observation with the Dietary Manager of the kitchen on 09/08/2025 at 11:30 AM revealed the following on the tray line:</p> <p>Eleven (11) of 12 clean bowls that were on the tray line ready for use were stacked wet.</p> <p>Two (2) of 3 clean quarter pans that were ready for use were stacked wet.</p> <p>Ten (10) of 10 divided plates that were on the tray line ready for use were stacked wet.</p> <p>Thirty-one (31) of 57 plate covers that were on the tray line ready for use were stacked wet.</p> <p>Seven (7) of 10 divided plates that were on the tray line ready for use had black, yellow, and brown spots on them.</p> <p>Two (2) of 57 plate covers that were on the tray line ready for use had black and brown spots on them.</p> <p>An interview with the Dietary Manager on 09/08/2025 at 11:00 AM stated she had been working in the kitchen for about three months. The Dietary Manager stated the person who washed the dishes was new to his position, and she had educated him that the dishes needed to be dry before they were stacked and that he needed to check the dishes for cleanliness before placing them on the tray line. Furthermore, she stated today (09/08/2025) was the day she went through the kitchen and made sure that everything was dated, and that there was no food spoilage. The Dietary Manager explained she performed this task every Monday. She did not identify if any other dietary staff were responsible for the task of ensuring that the food items were accurately labeled and dated. Additionally, food items that were identified as spoiled would be discarded. The Dietary Manager stated the food items identified during the observation should have been discarded.</p>	F0812	<p>Continued from page 17</p> <p>opening and closing procedures, including the discarding of outdated and spoiled food items as part of the orientation process.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The (Administrator/Dietary Manager or designee, etc.) will complete random daily audits for two weeks to check the appropriate usage of drying racks and storage racks and the presence of outdated or spoiled foods.</p> <p>After two weeks of daily checks, random audits will be done for two additional weeks, a minimum of 3 times per week. Audits will be conducted the week of November 24 through the week of December 15, 2025.</p> <p>The random audits will include:</p> <p>Checking stored dishes for condensation/moisture, and process management to validate that no staff members are drying dishes with dish cloths.</p> <p>Checking for outdated and spoiled food items.</p> <p>Identification of problems or systemic errors will result in immediate correction, including dish rewashing, discarding spoiled or outdated food items, and employee counseling.</p> <p>Audit records will be reviewed biweekly by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved.</p> <p>Compliance Date: December 3, 2025</p>	

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F0812 SS = E	Continued from page 18 An interview on 09/11/2025 at 4:41 PM with the Administrator revealed he was told about the concerns identified in the kitchen. The Dietary Manger made him aware of the wet dishes and undated food. The Administrator stated he was unaware of food with signs of spoilage. Furthermore, the Administrator stated he expected the dietary staff to label and date open food items in the walk-in, ensure that clean dishes were stacked dry, and ensure that food with signs of spoilage was properly disposed of.	F0812		