Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: ______ B. WING ______	R 02/27/2025

NAME OF PROVIDER OR SUPPLIER: WILLIAMSTON HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 160 SANTREE DRIVE, WILLIAMSTON, NC 27892

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted an annual survey and follow-up survey on Feburary 25, 2025 to Feburary 27, 2025.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure plumbing equipment was maintained in a safe and operating condition for one toilet observed leaking. The findings are: Observation of the bathroom in room 404 on 02/25/25 at 8:35am revealed: -There was standing water around the toilet. -There was a leak from the water supply valve. -There was a bucket under the water supply valve that had water in it. Interview with a resident on 02/25/25 at 8:40am revealed: -The toilet in room 404 was leaking. -He was not sure how long the toilet had been leaking. -There was often water on the floor in the bathroom. Interview with a second resident on 02/25/25 at	D 105	Williamston house will ensure plumbing equipment is maintained in safe and operating condition as stated in rule section 13F .0311 (a) Maintenance technician will monitor each room weekly to ensure all plumbing is in safe and operating order. Housekeeping will report any issues found while doing daily duties.	2/28/25

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stefanie Norman | TITLE: Executive Director | (X6) DATE: 03/26/25

STATE FORM 6899 9LJG11

Jamaal Willis Reviewed and Acknowledged 03/31/25

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D 105	Continued From page 1 8:45am revealed: -The toilet in room 404 had a leak. -He was not sure how long the toilet had been leaking. -Staff cleaned up the water on the floor. -He did not know how long the toilet had been leaking. Interview with the Maintenance Director on 02/25/25 at 9:00am revealed: -The toilet in room 404 had been leaking for two days. -The floor was cleaned everyday by housekeeping staff. -There was a loose pipe in the back of the toilet. -They placed a bucket on the floor next to the toilet to catch the water. -Management placed an order for a new toilet. Interview with the Resident Care Coordinator (RCC) on 02/25/25 at 2:40pm revealed: -She was aware that the toilet in room 404 had been leaking. -She went into the bathroom on 02/24/25 to assist the resident in room 404 and there was water on the bathroom floor. -The Maintenance Director cleaned up the water and placed a bucket by the toilet to catch the water. -She did not know how long the toilet had been leaking. -It was the responsibility of the Maintenance Director to fix any plumbing issues in the facility. Interview with the Administrator on 02/25/25 at 3:00pm revealed: -She was aware that the toilet in room 404 had been leaking. -She learned the toilet was leaking on 02/21/25. -She went into the bathroom in room 404 to assist	D 105		

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D 105	Continued From page 2 a resident and there was water on the floor. -She was concerned that a resident could slip and fall due to water being on the bathroom floor.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimal of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 6 of 9 sinks in resident bathrooms. The findings are: Observation of water temperatures on 2/25/25 from 8:30am to 9:30am in resident bathrooms revealed: -In room 405 the hot water temperature of the sink was 122.5° Fahrenheit (F). -In room 404 the hot water temperature of the sink was 121.7°F. -In room 401 the hot water temperature of the sink was 120.6°F. -In room 207 the hot water temperature of the sink was 122.2°F.	D 113	Williamston House shall maintain water temperatures between 100 degrees Fahrenheit and 116 degrees Fahrenheit as stated in state regulation 13F .0311 (d) Maintenance Tech inserviced by executive director on state regulations and will check water temps weekly and log. ED will check log weekly and do random water checks to ensure they are maintained between 110-116 degrees Fahrenheit.	3/11/25

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D 113	Continued From page 3 -In room 206 the hot water temperature of the sink was 120.6°F. -In room 204 the hot water temperature of the sink was 119.4°F. Interview with a in room 404 resident on 02/25/25 at 9:15am revealed the water in the bathroom sink often got too hot. Interview with the Maintenance Director on 02/25/25 at 10:50am revealed: -The hot water temperatures in the facility should not be above 116°F. -He checked the water temperatures in the facility weekly. -He was responsible for regulating the water temperatures in the facility. Recheck of the hot water temperature after the water heater was adjusted on 02/27/25 at 9:00am revealed: -In room 405 the hot water temperature of the sink was 117°F. -In room 404 the hot water temperature of the sink was 117.5°F. -In room 401 the hot water temperature of the sink was 117.1°F. -In room 207 the hot water temperature of the sink was 115.2°F. -In room 206 the hot water temperature of the sink was 114.8°F. -In room 204 the hot water temperature of the sink was 115°F. Review of the facility's monthly water temperature logs dated 03/15/24 to 02/17/25 revealed water temperatures in multiple bathrooms were always 114°F. Interview with a housekeeper on 02/25/25 at	D 113		

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D 113	Continued From page 4 10:15am revealed she was not aware of any residents having problems or complaining about the hot water. Interview with a personal care aide (PCA) on 02/25/25 at 10:30am revealed: -She was not aware of hot water temperatures being too hot in the facility. -She was not aware of any residents getting burned by hot water in the facility. Interview with the Resident Care Coordinator (RCC) on 02/25/25 at 11:00am revealed: -She was aware hot water temperatures in the facility should be between 100°F and 116°F. -She was not aware of hot water temperatures being too hot in the facility. -The Maintenance Director checked the water temperatures in the facility weekly -The Maintenance Director was responsible for ensuring water temperatures were within the correct range in the facility. -She had concerns that residents could burn themselves if the water in the facility was too hot. Interview with the Administrator on 02/25/25 at 3:00pm revealed: -She knew the hot water temperature should have been 110°F - 116°F. -She was not aware of hot water temperatures exceeding 116°F in the facility. -The Maintenance Director checked water temperatures in the facility weekly. -The Maintenance Director was responsible for ensuring water temperatures were within the correct range in the facility. -She was concerned that residents could burn themselves if the water in the facility was too hot.	D 113		

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D 310	Continued From page 5	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 5 sampled residents (#3) with a texture modified diet order. The findings are: Review of Resident #3's current FL-2 dated 10/17/24 revealed diagnoses included essential hypertension, paroxysmal atrial fibrillation, chronic heart disease, and gout. Review of Resident #3's diet order sheet dated 10/16/24 revealed: -There was an order for an Advanced (Mechanical Soft/Chopped) diet. -Entire meal with meats was to be chopped. Observations during the initial kitchen tour on 02/25/25 at 9:30am revealed: -There was a resident dietary report posted on the wall. -Resident #3 was not listed on the dietary report. Observation of breakfast service for Resident #3 on 02/26/25 at 8:25am revealed: -Hash browns, eggs, sausage and fruit were on the menu. -Resident #3's plate consisted of scrambled eggs,	D 310	Williamston House will ensure that all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician as stated in state regulation 13F .0904 (e) (4) Executive Director will in-service all dietary staff on resident diet orders and where they are located. Facility will print new diet orders weekly to ensure staff is aware of proper and updated diets. Executive director will in-service all clinical staff on resident diet orders and where they are located to ensure staff stays in compliance with physician orders. RCC will observe random meals to ensure staff is in compliance with resident diet orders.	3/11/25 3/19/25

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D 310	Continued From page 6	D 310		

hashbrown (whole), sausage (whole), and two orange slices.
-Resident #3 ate 100% of her meal.

Observation of the therapeutic diet menu for lunch service on 02/26/25 revealed mechanical soft/chopped diet should have been ground cooked sausage to 1/8-inch dice, shredded hash browns, scrambled eggs, and apple sauce.

Interview with Resident #3 on 02/26/25 at 8:35am revealed:
-Her food did not get chopped by kitchen staff.
-She did not know she was on a mechanical soft diet.
-She was served meats daily including pork chops, that were not chopped by kitchen staff.

Interview with a personal care aide (PCA) on 02/26/25 at 8:42am revealed:
-She served Resident #3 her breakfast in her room.
-Resident #3 was not on a therapeutic diet.
-Resident #3 did not get her food chopped by kitchen staff.

Interview with the Dining Services Manager on 02/26/25 at 9:10am revealed:
-She was aware that resident #3 was on a mechanical soft/chopped diet.
-She had not updated her diet order sheet that was posted on the wall in the kitchen to add Resident #3.
-She thought that since the meat and hash brown were soft in texture it was considered mechanical soft.
-She did not know the meat and hashbrowns needed to be chopped.
-She was not following the therapeutic diet recipes.

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D 310	Continued From page 7 Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 9:25pm revealed: -Resident #3 was on a mechanical soft diet. -Resident #3's entire meal should have been chopped. -She expected the kitchen staff to follow modified diet orders. -Kitchen staff were responsible for plating residents' food and ensuring therapeutic diets were prepared correctly. -Interview with the Administrator on 02/26/25 at 9:35am revealed: -Mechanical soft diets consisted of the entire meal being chopped. -The meal that was observed on 02/26/25 was not properly prepared. -There was a diet order sheet posed in the kitchen for staff to follow. -Kitchen staff should follow the therapeutic diet menu in order to serve proper therapeutic diets to the residents. -She expected kitchen staff to follow therapeutic diets as ordered. Interview with Resident #3's primary care provider (PCP) on 02/26/25 at 11:00am revealed: -Mechanical soft diets were ordered for residents who had difficulties swallowing. -Mechanical soft diets should have the entire meal chopped. -She expected the facility to follow the diet order for Resident #3. -She was concerned about aspiration pneumonia for a resident not getting their therapeutic diet as ordered.	D 310		