STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Nash	**7369 Hunter Hill Road , Rocky Mount, North Carolina, 27804**

(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	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/12/26 through 1/15/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1E01E2-H1. .	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 1/12/26 through 1/15/26. Event ID # 1E01E2-H1. The following intakes were investigated: 239660, 2605773, 2580788, and 2571002. 16 of 16 complaint allegations did not result in deficiency.	F0000		
F0689 SS = D	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 record review, observation, and interviews with resident, Nurse Practitioner (NP), and staff, the facility failed to provide care in a safe manner resulting in the resident sustaining a closed head injury (occurs when a strong force hits the head causing the brain to shake without breaking the skin or	F0689	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #8 sustained a closed head injury and dislocation of the right shoulder with right humerus fracture during the provision of a bed bath by nursing aide #1. When the resident was turned over, the resident continued to roll and fell to the floor. The nurse was called and immediately assessed the patient. The physician was called and sent the patient to the emergency room for assessment and treatment. All nursing staff (nurses and certified nursing assistants) were re-educated by the Director of Nursing on safe handling of residents during care and transfers. The in-service occurred on 11-17-25. Residents with Potential to be Affected: All residents have the potential to be negatively impacted by accidents that result from unsafe handling / transfers. The Director of Nursing and Administrator reviewed all	02/11/2026

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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F0689 SS = D	Continued from page 1 skull) and a dislocation of the right shoulder with a right humerus fracture (a break in the top part of the upper arm bone near the shoulder) during the provision of a bed bath by Nurse Aide #1. The resident was evaluated at the Emergency Department (ED) and nonoperative management with a shoulder sling and orthopedic follow up was determined. The deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents. The findings included: Resident #8 was admitted to the facility on 10/16/20 with diagnoses that included hemiplegia (severe or complete paralysis of one side of the body) and hemiparesis (weakness on side of the body) following cerebral infarction affecting the right dominant side, vascular dementia, age related physical debility, generalized muscle weakness and osteoarthritis. Resident #8's care plan revealed the following: - A focus area last revised on 1/2/24 for the risk of falls related to immobility. The interventions included following the facility fall protocol and reviewing information on past falls and attempt to determine cause of fall and remove potential causes. - A focus area last revised on 6/6/24 for an activities of daily living self-care performance deficit related to osteoarthritis. The interventions included total dependence on staff for bathing and for turning and repositioning in bed as necessary. - A focus area last revised on 6/6/24 for chronic pain related to osteoarthritis. The interventions included give analgesics (pain relievers) as ordered by the physician; monitor and document for side effects and effectiveness; and monitor, document, and report signs and symptoms related to osteoarthritis, acute fractures and compression fractures. The annual Minimum Data Set assessment dated 9/2/25 revealed Resident #8 had moderate cognitive impairment with disorganized thinking and inattention. Resident #8 had impaired functional range of motion affecting one side of her upper extremity and one side of her lower extremity. She was non-ambulatory and dependent on staff for activities of daily living. Resident #8 received antiplatelet medication and scheduled pain medication. Her weight was 241 pounds.	F0689	Continued from page 1 incident reports over the last 60 days (11/1/2025 to 1/30/2026) to identify negative trends related to transfers and safety. One resident was identified and required further assessment and follow-up. Systemic Changes: All nursing staff, including licensed nurses and certified nursing assistants, were re-educated the Director of Nursing (DON) on Safe Handling of residents during care and transfers by 2/5/2026. Incident follow-ups were reviewed again to ensure that appropriate interventions were taken at the time of all incidents. Licensed nurses and certified nursing assistants who were not present for these training sessions were educated prior to beginning work. Newly hired licensed nurses and nursing assistants will receive training during orientation from the Director of Nursing or Unit Managers on Safe Handling of Residents. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee, will monitor the personal care delivery for 5 residents, 3 times per week for 4 weeks. Immediate instruction and education will be provided if concerns with skills present. Following the completion of the 4 weeks, 10 residents will be reviewed monthly for 2 months, to assess resident safety while staff provide care. Audits will be documented on the Resident Care Audit Tool. The completion date of audits will be 4/13/2026. Audit results will be reviewed by Quality Assurance Performance Improvement (QAPI) monthly x3 or until consistent, substantial compliance has been achieved, as determined by the committee. Compliance date: 2/11/2026	

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F0689 SS = D	Continued from page 2 Resident #8's active physician's orders for November 2025 included an order initiated on 9/11/21 for aspirin 81 milligrams (mg) daily. Resident #8 had no other physician orders for blood thinning medication. The physician's orders also included an order initiated on 7/29/24 for acetaminophen 650 mg four times a day for pain. Resident #8's pain monitoring on the Medication Administration Record (MAR) from 11/1/25 to 11/16/25 revealed her pain level ranged from 0 to 7 (on a scale of 0 to 10 with 10 being the worst pain possible). A health status note dated 11/17/25 at 12:59 PM written by Nurse #1 revealed Resident #8 was found face down on the floor next to the bed. Resident #8 was assessed to have a large bump on the left side of her forehead with pain and was sent to the emergency department. The post fall incident report completed by Nurse #1 revealed Resident #8 had a fall on 11/17/25 at 8:15 AM while Nurse Aide (NA) #1 was providing care. A statement dated 11/17/25 completed by NA #1 revealed the following information. She was performing personal care on Resident #8 and while trying to roll the resident on her left side the bed continued moving with her. Resident #8 continued to roll and NA #1 caught her by the breast and stomach area. NA #1 indicated the geriatric wheelchair (a padded chair with a wheeled base) and nightstand held the resident up keeping her from hitting the floor. NA #1 reported she screamed and yelled for help. NA #3 and NA #2 came to assist NA #1. NA #1 reported they could not push or lift Resident #8 back onto the bed. NA #1 indicated they guided the resident to the floor very slowly face down because she was rolling to the left side towards the floor. NA #1 stated Nurse #2 assisted them with using the mechanical lift to place Resident #8 back on the bed. An interview was conducted with NA #1 on 1/14/26 at 1:48 PM. NA #1 reported she worked on the 7:00 AM to 3:00 PM shift on 11/17/25 and was assigned to care for Resident #8. NA #1 stated she entered Resident #8's room to give her a bath. The resident was in a private room. When entering the resident's room, her bed was located on the left side of the room with the left side of the bed against the left wall and the head of the	F0689		

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F0689 SS = D	Continued from page 3 bed against the wall where the window was located. A nightstand was located on the wall with the window between the right side of the bed and the window. The nightstand was not in direct contact with the bed when the bed was positioned against the left wall. The resident's geriatric wheelchair (ger-chair) was also positioned on the right side of the bed, not in direct contact with the bed. NA #1 stated she raised the bed up to her waist height, locked the bed, and explained to Resident #8 that she was there to give her a bath. NA #1 reported that as she was attempting to remove Resident #8's shirt, the resident complained of right shoulder pain. NA #1 stated this complaint of shoulder pain was not new. NA #1 stated she proceeded to give Resident #8 a bed bath. NA #1 indicated she unlocked the bed so she could move it away from the left wall in order to be able to fully access the resident from both sides to provide care. When the bed was moved away from the left wall it resulted in the nightstand being in closer proximity to the head of the bed on the right side. She stated she thought she had re-locked the bed after moving it away from the wall. NA #1 indicated she positioned herself on the left side of the bed (between the bed and the left wall), she went to roll the resident away from her (toward the right side of the bed), and both the resident and the bed began rolling away from her. NA #1 revealed she didn't realize the bed wheels weren't locked until the resident and bed began to move at the same time. She indicated to her knowledge; there was nothing wrong with the locking mechanism on the bed. NA #1 stated she grabbed Resident #8 across the middle of her torso and held her with all her strength. The resident was positioned with her head, shoulders and legs hanging off the bed with most of her weight being unsupported by the bed. NA #1 stated she yelled out for help while holding on to Resident #8. NA #1 stated NA #2 and NA #3 came into the room to assist her with trying to lift Resident #8 back onto the bed. NA #1 reported they were unable to assist Resident #8 back onto the bed and the three staff lowered Resident #8 down to the floor. NA #1 stated Resident #8 was positioned face down when they lowered her to the floor. She indicated that everything happened so fast, but she recalled Resident #8 stated that her head hurt. NA #1 stated she was not aware of whether Resident #8 had hit her head on the nightstand that was directly beside the bed but explained that there was nothing else the resident could have hit her head on. A statement dated 11/17/25 written by NA #3 revealed she was doing morning care rounds when she overheard NA #1 yelling for help. NA #3 indicated she stepped into	F0689		

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F0689 SS = D	Continued from page 4 the hall to follow the voice which led her to Resident #8's room. NA #1 was holding Resident #8 from the side of the bed in the resident's trunk area. NA #3 stated she helped NA #1 by holding Resident #8's leg and thigh area that was stuck between the geri-chair and the bed. NA #3 stated NA #2 overheard them yelling. NA #3 indicated that NA #2 came in and held Resident #8's head and arm that was hanging off the bed. NA #3 noted that she, NA #2 and NA #1 tried to push Resident #8 back onto the bed but there was no room to maneuver. NA #3 stated the bed continued moving so they lowered the resident slowly to the floor face down because there was no room to turn Resident #8. NA #3 indicated Resident #8 may have hit her head on the nightstand. NA #3 stated nursing was called for assistance after Resident #8 was lowered to the floor. NA #3 stated Nurse #2 entered the room once Resident #8 was on the floor and helped staff get the resident back on the bed with the mechanical lift. An interview was conducted with NA #3 on 1/14/26 at 1:58 PM. NA #3 reported she worked the 7:00 AM to 3:00PM shift on 11/17/25 and was not assigned to Resident #8. NA #3 stated she was in another resident's room when she heard someone yelling "help, help". NA #3 stated she hurried down the hall following the voice. NA #3 reported when she entered Resident #8's room, NA #1 was holding Resident #8 on the bed by her torso. NA #3 indicated she (NA #3) began holding Resident #8's legs. She indicated NA #2 also heard yelling and provided assistance. NA #3 stated Resident #8's bed continued to move even though the three of them were trying to hold the resident steady. NA #3 reported that Resident #8's head was situated by the nightstand and the resident's geri-chair was on the same side as the nightstand. NA #3 explained that there was not a lot of space to maneuver the resident as they tried to assist her back on the bed. NA #3 stated she, along with NA #1 and NA #2, assisted Resident #8 to the floor. NA #3 reported Resident #8 was positioned faced down with her right arm beneath her once she was lowered to the floor. NA #3 stated she did not recall Resident #8 complaining of any pain. She indicated if the resident hit her head, she must have hit it on the nightstand that was directly next to the bed. NA #3 stated Nurse #2 came in and assessed Resident #8 and then Nurse #2 assisted NA #1 and NA #2 to transfer Resident #8 to the bed using the mechanical lift. A statement dated 11/17/25 written by NA #2 revealed she walked into Resident #8's room where 2 NAs (NA #1 and NA #3) were yelling for help. The resident was halfway on the bed, on her side and the NAs were	F0689		

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F0689 SS = D	Continued from page 5 holding onto her. NA #2 indicated she ran in and grabbed the resident's leg and the other 2 NAs were trying to keep the resident from rolling any further but saw that they could no longer hold her so they had to lower the resident to the floor. An interview was conducted with NA #2 on 1/14/26 at 1:37 PM. NA #2 stated she heard NA #1 yelling out for help and she hurried down the hall to Resident #8's room. NA #2 stated when she entered the room NA #1 was on the left side of the bed near the center of the bed and NA #3 was on the right side near the center of the bed. NA #2 stated NA #1 and NA #3 yelled at her to "hurry up, hurry up and grab her leg". NA #2 reported that the three of them were unable to lift Resident #8 back onto the bed due to the resident's body weight not being supported by the bed. NA #2 stated they assisted Resident #8 to the floor and the resident complained of right shoulder pain because she was laying on her right shoulder. NA #2 indicated that Nurse #1 and Nurse #2 entered the room and assisted with assessing and positioning Resident #8. NA #2 stated she did not see Resident #8 hit her head. An interview was conducted with Nurse #1 on 1/14/26 at 3:02 PM. Nurse #1 reported she worked the 7:00 AM to 3:00 PM shift on 11/17/25. Nurse #1 stated she was the nurse that was assigned to Resident #8 on 11/17/25. Nurse #1 indicated she heard the staff yelling for help and when she entered the resident's room, Resident #8 was already on the floor facing down with her right arm underneath her. Nurse #1 stated Resident #8 was assessed by Nurse #2 and was able to move all four extremities. Nurse #1 reported that Nurse #2 informed her that Resident #8 denied any pain when completing range of motion. Nurse #1 stated Resident #8 was assisted by Nurse #2 to turn over. Nurse #1 revealed she was able to see that Resident #8 was visibly injured as the resident had a large knot on her forehead. Nurse #1 stated Resident #8 was not her usual talkative self, and she appeared to be in pain. Nurse #1 reported the resident complained of right arm pain when she was transferred from the floor to the bed using the mechanical lift. Nurse #1 stated Resident #8 had chronic generalized pain and took scheduled acetaminophen. Nurse #1 stated she completed a neurological check and there were no abnormalities. Nurse #1 indicated she called Emergency Medical Services to send Resident #8 out due to the large knot on her head and right arm pain.	F0689		

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F0689 SS = D	Continued from page 6 An interview was conducted with Nurse #2 on 1/14/26 at 3:32 PM. Nurse #2 reported he worked the 7:00 AM to 3:00 PM shift on 11/17/25. Nurse #2 stated he was not the nurse that was assigned to Resident #8. Nurse # 2 stated he was responding to the overhead page for “Code Green” (critical situation requiring immediate intervention). Nurse #2 stated when he entered Resident #8’s room he observed the resident lying face down on her stomach with her right arm underneath her. Nurse #2 stated there were 4 or 5 staff already in the room when he arrived. He reported he assessed Resident #8 for pain, and she was able to move all four extremities. He indicated Resident #8 denied any pain during his assessment. Nurse #2 stated he assisted the three NAs in getting Resident #8 on the mechanical lift pad. Nurse #2 stated he did not recall seeing a bump on Resident #8’s head but he did ask her about her right leg because she was positioned with the right leg underneath her. Nurse #2 stated Resident #8 denied any pain in her leg. The ED after summary visit dated 11/17/25 revealed Resident #8 was seen for a head injury and was diagnosed with a fall, closed head injury, and dislocation of her right shoulder. Resident #8 received Fentanyl (powerful opioid pain medication) intravenously (directly into the vein) for right shoulder pain. X-rays were conducted of the right shoulder and right humerus which revealed a right shoulder dislocation and a fracture of the right humerus. A CT (computed tomography) was conducted of the cervical spine and the head and there were no abnormalities. A sling was applied to the right arm for comfort. Orders were given to immobilize right arm, call the orthopedic surgeon to schedule your follow up appointment and Acetaminophen every 6 hours as needed for pain. A health status note dated 11/17/25 at 2:30 PM written by Nurse #1 revealed Resident #8 returned to her room via stretcher with her right eyelid darkened and right eye swollen closed. Resident #8 was alert and denied pain at that time. Resident #8 had her right arm in a sling. The November MAR revealed Resident #8 received her scheduled dose of acetaminophen 650 mg at 4:30 PM on 11/17/25 after return from ED. Resident #8 rated her pain at 0 on a scale of 0 to 10. The MAR further revealed that Resident #8’s pain monitoring from 11/17/25 through 11/30/25 revealed her pain level	F0689		

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F0689 SS = D	Continued from page 7 ranged from 0 to 8. Resident #8's pain was managed with the scheduled Acetaminophen. A physician progress note dated 11/20/25 revealed Resident #8 was seen by the NP for follow up after the 11/17/25 fall. Resident #8 was sent to the ED due to a hematoma (a collection of blood that forms outside of the blood vessels) on her forehead and right shoulder dislocation. Resident #8 reported she was still having pain in her right arm and shoulder. Resident #8 indicated the lump on her head was tender but did not bother her otherwise. The resident denied any headaches or changes to her vision. She had an appointment on 11/20/25 with orthopedics and her arm was in a sling. An interview with the NP on 1/14/26 at 2:47 PM who monitored Resident #8 revealed she was made aware that Resident #8 had fallen and sustained a hematoma to the head by the on-call provider. She indicated she followed up with Resident #8 on 11/20/25 per staff request. She explained it was normal protocol for the in-house provider to see a resident after a fall. The NP stated Resident #8 was alert when she assessed her and complained of pain to her right shoulder and arm. She indicated this was pain from the injury to her right shoulder and arm. She explained that Resident #8 did have generalized pain and was on scheduled pain medication (acetaminophen) 4 times a day. She further explained that the resident had a history of chronic pain due to osteoarthritis and the acetaminophen was effectively managing the resident's pain to her shoulder and arm. The NP stated Resident #8 had a sling to her right arm and was scheduled to see orthopedics later that afternoon (11/20/25). Review of the orthopedic report of consultation dated 11/20/25 revealed Resident #8 was seen for right proximal humerus fracture dislocation and wore a shoulder sling/ brace for comfort. The consultation further revealed that surgery for the humerus fracture would be high risk for minimal benefit. The orthopedist ordered physical therapy for range of motion exercises. Resident #8 was to return for a follow-up appointment in 6 weeks with the orthopedist. Orthopedic documentation dated 1/6/26 indicated Resident #8 was seen by the orthopedist for follow up and the shoulder sling was removed.	F0689		

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F0689 SS = D	Continued from page 8 During an observation and interview of Resident #8 on 1/12/26 at 3:47 PM, the resident was sitting up in her geri-chair at the bedside. During the interview Resident #8 was confused and unable to give any details about the fall that occurred on 11/17/2025. Resident #8 denied any pain as a result of the fracture and dislocation. An interview with the Director of Nursing on 1/15/26 at 12:20 PM revealed she was notified by Nurse #1 of Resident #8's fall with hematoma to her forehead and complaint of right arm and shoulder pain on 11/17/25. The Director of Nursing obtained statements from staff and confirmed Resident #1 had a fall while being cared for by NA #1. The Director of Nursing stated NA #1, NA #2 and NA #3 verbally told her what happened and she had them write statements. The Director of Nursing stated it was likely this incident resulted in the right shoulder dislocation and fracture. She indicated that the resident did have chronic osteoarthritis. The Director of Nursing stated NA #1 should have made sure the resident's bed was locked and Resident #8 should have been a 2 person assist due to her size and physical limitations. She indicated the resident had been assessed for the number of staff needed to assist with providing care back in September 2025. She explained that Resident #8 had been able to assist the staff some with rolling her over on her side at that time.	F0689		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from	F0812	Immediate action(s) taken for the resident(s) found to have been affected include: During the recent survey, it was noted that the kitchen walls were not clean. The deep fryer and air condition unit were also noted to be unclean. The walls, deep fryer, and air condition unit were cleaned immediately, and the air conditioning unit was removed from the kitchen. Additionally wet meal trays and dishes were found in the kitchen that had apparently not been allowed to fully dry prior to stacking. All trays and dishes were immediately washed again, and dryness was ensured by the dietary manager prior to stacking. Residents with Potential to be Affected: All residents have the potential to be negatively impacted by wet meals trays and dishes. All residents have the potential to be negatively impacted by unclean walls, equipment, and utensils. Systemic Changes:	02/11/2026

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F0812 SS = E	Continued from page 9 consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to clean 1 of 1 fryer, 2 of 4 kitchen walls, and 1 of 1 air conditioner wall unit. The facility also failed to allow cook pans, meal trays, and dishes to completely dry prior to assemblage and stacking. These practices had the potential to affect food served to residents. The findings included: Based on observation and staff interviews, the facility failed to clean 1 of 1 fryer, 2 of 4 kitchen walls, and 1 of 1 air conditioner wall unit. The facility also failed to allow cook pans, meal trays, and dishes to completely dry prior to assemblage and stacking. These practices had the potential to affect food served to residents. The findings included: An observation of the kitchen and interview with the Dietary Manager was conducted on 1/12/26 at 10:12 AM. The bottom of the fryer was covered with a dark brown liquid and food crumbs. The food crumbs were also seen along all inside walls. The Dietary Manager stated that the fryer was last cleaned 2 weeks ago. Review of the “Weekly After Each Use Cleaning Schedule” for the months of November 2025 through January 2026 revealed that the fryer was last cleaned on 12/25/25. During a follow-up interview with the Dietary Manager conducted on 1/14/26 at 11:59 AM. She revealed that there was not any new grease to replace the grease in the fryer with until 1/13/26. It was used twice the week before (once was for chicken and the other was for fish). The fryer was also used on 1/12/26 in the evening for fried fish. The Dietary Manager stated that fryer grease should be changed at least weekly. A continuous observation of the kitchen and interview with the Dietary Manager was conducted on 1/14/26 from	F0812	Continued from page 9 The fryer will be cleaned weekly, and as needed, to ensure the cleanliness every day. Cleanings will be documented on the cooking schedule. Walls will be assessed daily and will be cleaned as needed to cleanliness. Dietary staff were re-educated on the importance of completely drying cook pans, meal trays, and dishes before stacking by the dietary manager on 1/12/2026. Education also included cleanliness of kitchen walls and equipment. All new dietary staff will be educated on the importance of drying cook pans, meal trays, and dishes before stacking. The air conditioner units were removed from the dietary department on January 13, 2026. Dietary staff were re-educated by the Dietary manager on the expectations of cleanliness of the walls January 12, 2026. How the corrective action(s) will be monitored to ensure the practice will not recur: The administrator, or designee, will monitor the fryer, cook pans, meal trays, dishes, and walls for cleanliness 2x/week for 4 weeks, and monthly x2, and will document the results in the Dietary Audit Tool. The completion date of the audits will be 4/13/2026. Audit records will be reviewed by Quality Assurance Performance Improvement (QAPI) Monthly x 3 or until consistent, substantial compliance has been achieved, as determined by the committee. Compliance Date: 2/11/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Nash	**7369 Hunter Hill Road , Rocky Mount, North Carolina, 27804**

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F0812 SS = E	Continued from page 10 11:48 AM to 11:55 AM. A yellow, sticky substance was observed on the wall behind the bread rack and around the bulletin board. The substance was also seen below the air conditioner. The Dietary Manager stated that the walls were probably not cleaned in over a month. She further stated that cleaning the walls was not included in the current cleaning schedule; however, they should be included. The air conditioner wall unit above a preparation table directly to the right of the kitchen entrance had a black/brown substance inside the unit as well as covering the spaces over the filter. The Dietary Manager stated the last time the air conditioner unit was cleaned was during the months of Summer 2025 and it was not included in the cleaning schedule but should be. The Administrator was interviewed on 1/15/26 at 10:14 AM and stated the cleaning of the fryer, as well as the walls and air conditioner unit should be completed in a timely, consistent manner. A continuous observation of the kitchen and interview with the Dietary Manager was conducted on 1/12/26 from 9:57 AM to 10:09 AM. Over seventy meal trays stacked ready for use on the tray line were observed with wet nesting. The Dietary Manager stated that all meal trays should be air dried. Normally, they were left on a rack on top of the meal carts to fully dry. The Dietary Manager then instructed kitchen staff to re-wash and air dry all the meal trays. Fifty-five plastic juice cups were observed with wet nesting stacked by two on top of each other under the tea machine ready for service. The Dietary Manager stated that she had a newly hired staff member (Cook #2) who required further training. Four full-service pans on the cook's clean cart were observed with wet nesting. Ninety-one (91) plate bottoms behind the tray line were observed with wet nesting. The Dietary Manager stated that Cook #2 was responsible for air drying all dishes/trays that were observed with wet nesting, but he had only been working at the facility for a few days. The Dietary Manager indicated that kitchen orientation usually included three days of training. The Dietary Manager noted Cook #2 was still in training and had completed three days as a cook and this was the first day of three for training as a dietary aide, which included the dish room. During a follow-up interview with the Dietary Manager on 1/14/26 at 12:00 PM, she revealed that the kitchen staff on 1/12/26 were moving too fast during dish washing and did not allow enough time for all items to air dry. She stated that there was a process in place	F0812		

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F0812 SS = E	Continued from page 11 for air drying all dishes washed; however, the staff were just rushing. She should not have put all the responsibility on Cook #2 being a new staff member. An observation of the kitchen was conducted on 1/13/26 at 10:04 AM. Nine full pans and 73 meal trays were observed with wet nesting. An interview was conducted with Dietary Aide #1 on 1/13/26 at 10:06 AM. She stated that she was responsible for air drying the meal trays on 1/13/26 after breakfast meal. Dietary Aide #1 further stated all dishes and silverware needed to be air dried before service. Dietary Aide #1 indicated there might have been some wetness around the edges of the meal trays because her hands had gloves on that were wet. She indicated that the meal trays were air dried prior to the observation at 10:04 AM. An interview was conducted with Cook #1 on 1/13/26 at 10:07 AM. He stated he was responsible for cleaning the pots/pans this morning (1/13/26) after breakfast meal. Cook #1 stated the Dietary Manager went over the importance of air drying during his orientation when he was first hired 5 months ago. However, he claimed that he already knew about letting all pots/pans air dry before storage because he was in food service for over 30 years. This morning, he indicated that he had too many pots/pans to clean, and there was not enough room to air dry them all. The Administrator was interviewed on 1/15/26 at 10:14 AM. She revealed that all dishes and pans should be air dried prior to use/storage.	F0812		