STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	11/20/2025

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SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, state involved, and a complaint investigation on November 18, 2025, through November 20, 2025.	D 000	Going forward All residents personal care products will be stored in the lock/area. Staff has been in serviced. Staff will continue. to used the Basket(that is label for each resident(personal care) No personal items will be allowed to be left in any residents room after usage.	1/14/26
X D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 079		
X	This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the Special Care Unit (SCU) was free of hazards in resident rooms related to personal care products that were accessible to residents on the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed as a Special Care Unit (SCU) effective 01/01/25 for a capacity of 85 residents. -The expiration date of the facility's license was			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Grubb | TITLE: ADMIN | (X6) DATE: 1/15/26

Reviewed & Acknowledged SC 1/16/26

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D 079	Continued From page 1 12/31/25. Review of the facility's census on 11/18/25 revealed the facility's census in the SCU was 35 residents. Observation of room 21 on 11/18/25 at 8:58am revealed: -There was a 3.4 ounce (oz) of topical hygiene product used to manage skin health and prevent infections sitting on top of a table in the bedroom. -There was a warning on the back of the topical hygiene product that may cause eye irritation and not intended for oral ingestion. Second observation of room 21 on 11/18/25 at 4:40pm revealed: - There was a 3.4 ounce (oz) of topical hygiene product used to manage skin health and prevent infections sitting on top of a table in the bedroom. -There was a warning on the back of the topical hygiene product that may cause eye irritation and not intended for oral ingestion. Observation of room 2 on 11/18/25 at 9:01am revealed: -There was a prescription bottle of moisturizing lotion 12%, sitting on top of a drawer in the bedroom. -There was a warning on the back of the moisturizing lotion to keep out of reach of children, avoid contact with eyes, lips, and mucus membranes, irritation may occur when used on the face, a mild irritation or rash may occur on sensitive skin. Observation of room 18 on 11/18/25 at 9:06am revealed: -There was a 6 oz bottle of moisturizing lotion sitting on top of a table in the bedroom.	D 079	Sanford Manor is committed to providing, safe, clean and unobstructre SCU from all hazards. The facility will ensure cleaning chemicals are monitored while in use and then locked and secured in a designated storage closet. Ingestible items will be kept in a locked cabinet in a secure location. the Maunteranee Dept will inspect all storage cabinets and closet throughout the SCU to confirm	

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D 079	Continued From page 2 -There was a warning on the back of the moisturizing lotion to avoid contact with eyes and discontinue use if irritation occurs. - There was a 22.5 oz of 3-in-1 body wash, shampoo, and conditioner sitting on top of the sink in the bathroom. -There was a warning on the back of the 3-in-1 body wash, shampoo, and conditioner to keep out of reach of children, do not use on broken skin, and stop use if rash or irritation occurs. Observation of room 10 on 11/18/25 at 9:03am revealed: -There was a 7.4 oz of saline wound wash sitting on top of a dresser drawer in the bedroom. -There was a warning on the back of the saline wound wash to keep out of reach of children, consult a health care professional before use, contents under pressure, avoid excessive heat, do not puncture or incinerate, and do not use after expiration date. -There was a 14.9 oz of shaving cream sitting on top of the sink in the bathroom. -There was a warning on the back of the shaving cream to keep out of reach of children, contents under pressure, do not place in hot water or near radiators, stoves or other sources of heat, contents under pressure, do not puncture or incinerate, store at temperature over 120 Fahrenheit (F), and container may explode if heated. -There was a 22.5 oz of 3-in-1 body wash, shampoo, and conditioner sitting on top of the sink in the bathroom. -There was a warning on the back of the 3-in-1 body wash, shampoo, and conditioner to keep out of reach of children, do not use on broken skin, and stop use if rash or irritation occurs. Second observation of room 10 on 11/18/25 at	D 079	they close and lock properly. HWD, RCC, Maint, and Adm to ensure all areas are clean, safe, and free of hazards also to do random checks.	

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D 079	Continued From page 3 4:36pm revealed: -There was a 7.4 oz of saline wound wash sitting on top of a dresser drawer in the bedroom. -There was a warning on the back of the saline wound wash to keep out of reach of children, consult a health care professional before use, contents under pressure, avoid excessive heat, do not puncture or incinerate, and do not use after expiration date. - There was 14.9 oz of shaving cream sitting on top of the sink in the bathroom. -There was a warning on the back of the shaving cream to keep out of reach of children, contents under pressure, do not place in hot water or near radiators, stoves or other sources of heat, contents under pressure, do not puncture or incinerate, store at temperature over 120 Fahrenheit (F), and container may explode if heated. - There was a 22.5 oz of 3-in-1 body wash, shampoo, and conditioner sitting on top of the sink in the bathroom. -There was a warning on the back of the 3-in-1 body wash, shampoo, and conditioner to keep out of reach of children, do not use on broken skin, and stop use if rash or irritation occurs. Observation of room 12 on 11/18/25 at 9:08am revealed: - There was a 4 oz of moisture cream sitting on top of a table in the bedroom. -There was a warning on the back of the moisture cream for external use only, and if come into contact with eyes, flush eyes with water. Observation of room 1 on 11/18/25 at 10:11am revealed: - There was a 1.4 oz of deodorant inside a drawer in the bedroom. -There was a warning on the back of the	D 079		

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D 079	Continued From page 4 deodorant to keep out of reach of children, do not apply on broken skin, and discontinue use if a rash develops, discontinue use. Interview with a personal care aide (PCA) on 11/18/25 at 10:00am revealed: -She was not aware that personal care items were in resident's rooms. -When she walked through 11/14/25, she did not notice any items in anyone's room. -There were bins with residents' names on them for the residents to keep their personal belongings. Interview with a medication aide (MA) on 11/18/25 at 9:45am revealed: -Some residents did wander on the SCU but not in bedrooms. -Some residents kept their own toiletries although there was a place in the medication room for each resident. -MA were supposed to do rounds and ensure anything in bedrooms was put away and locked. -She had not reported to management about items being in resident's rooms. Interview with the Administrator on 11/19/25 at 5:15pm revealed: -She was not aware that personal care items were in resident's rooms. -She did rounds looking for personal care items but could not say the last time she did rounds. -She created a basket system for residents to place all of their personal care supplies in. -She did not know why personal care items were left in residents' rooms. -She was responsible for ensuring no personal care items were in residents' rooms. Based on observations, record reviews and	D 079		

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D 079	Continued From page 5 interviews, it was determined that the special care residents were not interviewable.	D 079		
X D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		
*	This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#6) who resided in the Special Care Unit (SCU) who eloped from the facility without the staff 's knowledge. The findings are: Review of Resident #6's current FL-2 dated 07/17/25 revealed: -Diagnoses included dementia, essential hypertension, diffuse traumatic brain injury, diabetes mellitus type 2, insomnia, and anxiety disorder. -The resident was intermittently disoriented. -The resident was ambulatory. -The resident's current level of care was domiciliary/other - assisted living (AL).		Going forward 1/14/26 the administrator or designatee will issue a 30-day discharge with valid reason threats to the resident welfare or safety improved health or failure to pay must be	

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D 270	Continued From page 6 Review of the Resident Register for Resident #6 revealed he was admitted to the facility on 03/28/19. Review of Resident #6's mental health provider notes dated 09/17/25 revealed: -There was no abnormal motor activity, gait was not assessed. -His attitude was polite but guarded, with limited eye contact. -His speech was mumbled. -His mood was described as fair with his affect being described as dysthymic (the persistent, low-level depressive symptoms associated with chronic depression) -His thought processes and content were vague with impaired concepts, and no psychotic symptoms. -His cognition was consistent with moderate dementia and memory, and concentration was fair to impaired as well as his insight and judgment. -His diagnoses included unspecified dementia, moderate, with other behavioral disturbance, unspecified dementia, moderate, with mood disturbances, episodic insomnia disorder with non-sleep disorder mental comorbidity and schizophrenia. Review of Resident #6's Incident/Accident report dated 10/13/25 revealed: -The time of the incident was 6:15am. -Describe what happened was noted as "Resident has eloped". -The responsible party for Resident #6 was notified at 8:50am on 10/13/25. -There were no further details as to when Resident #6 was last known to be at the facility.	D 270	documented. Resident incident occurs, incident include falls aggressive, behavior elopment unknown injury and pressure ulcer Med Tech/RCC family, PCP, MCP county monitor All to be notified in a timely manner.	

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D 270	Continued From page 7 Review of local Law Enforcement (LE) report dated 10/13/25 revealed: -The report was for a missing/runaway person. -The incident was called in on 10/13/25 at 7:28am. -Resident #6 was listed as the victim. -The reporting person was documented to be the Supervisor. -Resident #6 was last seen by staff at midnight on 10/13/25. -There were no further details as to what time Resident #6 was located or where he had been located. Review of the local online weather report revealed the outside temperature on 10/13/25 at the time of Resident #6's elopement was 63 degrees Fahrenheit with 67% humidity. Observation of the exit door for the facility in the men's hall on 11/18/25 at 8:00am and 11/19/25 at 9:37am revealed: -The exit door led to a gate that had a horizontal push bar. -Beyond the gate, there was a large rusty brown dumpster and a gray trash bin. -The dumpster was noted to be located to the left front side of the facility. -The main road was 500 feet from the gate nearest the dumpster. -The street was a two-lane street with busy traffic and road construction noted. Interview with a medication aide (MA) on 11/18/25 at 10:20am revealed: -Resident #6 was a resident in the SCU before he had eloped from the facility on 10/13/25. -She was not working when the elopement occurred. -Resident #6 helped the third shift staff with tasks	D 270	Training on incident reports process to be Completed including process for send outs for example elopements Med Aides, RCC HWD+ Administrator plus training at monthly meetings.	1/14/26

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D 270	Continued From page 8 like cleaning and taking out the trash because he had trouble sleeping. -He had the code to the door to be able to take the trash out. -She was not sure who gave Resident #6 the code or how he knew the code to the doors. Telephone interview with the county Department of Social Services supervisor on 11/19/25 at 5:40pm revealed: -The county Department of Social Services was made aware of the elopement of Resident #6 when the facility staff notified them around 8:00am on 10/13/25 as they were Resident #6 's guardian. -He was made aware of Resident #6 's elopement on 10/13/25 around 8:00am when the facility staff called him. -Resident #6 was located at a family members ' home in another county (approximately 50 miles from the facility) when an altercation had occurred (he was not sure who had been involved in the altercation). -The local LE responded to the altercation. -The LE determined that Resident #6 had outstanding warrants in another county, so Resident #6 was placed under arrest and transported to the other county where he was processed and released on his own pretrial release per their protocols. -After his release into the community from the county jail, Resident #6 spent 10 days in and out of the hospitals in that area. -There were 11 different calls made to Emergency Medical Services (EMS) requiring Resident #6 to be transported to the local hospitals. -The guardian did not know who had made the EMS calls. -The hospitals treated him and would discharge	D 270		

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D 270	Continued From page 9 him, or he would sign himself out against medical advice (AMA). -Resident #6 had lived on the streets for 10 days after being released from jail by local LE until he finally arrived at a hospital where someone knew him. -The hospital contacted LE who was able to contact the guardian. -Resident #6 was currently hospitalized in that county and awaiting to be released on 11/20/25 to another SCU in a different county. -There had been an injury noted on the left side of his face in the mugshots taken when he had been arrested. -He was unsure of how Resident #6 received the injury; he believed it may have been from the altercation at the family members home in the county where he had been arrested. Telephone interview with the hospital case worker on 11/19/25 at 5:53pm revealed: -Resident #6 had been hospitalized since 10/29/25. -He was being discharged on 11/20/25 to another adult care home. -He had been in and out of the hospital ED several times in their county since he eloped from the facility where he had resided until 10/13/25. -She was unsure of how he got as far as their county which was about 50 miles from the facility where he had resided. -Someone (she was not sure exactly) had recognized Resident #6 from his previous time as a patient at the hospital when he lived in that area. -That person knew that Resident #6 was not his own responsible party, so the hospital contacted the local LE who had been in contact with Resident #6's guardian. -The LE contacted his guardian to let him know	D 270		

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D 270	Continued From page 10 that Resident #6 had been hospitalized in their facility. Review of Resident #6's hospital discharge summary dated 11/20/25 revealed: -He had a past medical history of schizophrenia, hypertension, diabetes, alcohol use. -He came to the emergency department (ED) for abdominal pain, hematemesis (vomiting blood), and bloody stools. -He had been to the ED multiple times for similar complaints and ultimately left against medical advice (AMA). -It was later discovered that he had a legal guardian and previously resided at a SCU but eloped from the facility. -He had a history of polysubstance abuse and did not have any further episodes of coffee-ground emesis. -Psychotropic medications were adjusted as per psychiatry recommendations. -He was clinically stable and would be discharged to another facility. -He would need follow-up with a primary care provider (PCP) in 1 to 2 weeks, and urology in couple of weeks for right renal mass, also would need follow-up with psychiatry in 2 weeks. Interview with the Executive Director on 11/19/25 at 2:50pm revealed: -Resident #6's incident report was sent to the county Department of Social Services, and the local law enforcement had been notified when Resident #6 was not located in the facility on 10/13/25 when they made their morning rounds between 5:00am - 5:30am. -The MA and the personal care aide (PCA) who worked the night Resident #6 eloped were terminated immediately. -Resident #6 had left the facility between 5:00am	D 270		

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D 270	Continued From page 11 and 5:30am based on the camera footage. -The staff contacted the ED after looking in the facility. -The ED contacted Resident #6 ' s family member who stated Resident #6 was with another family member in another county (approximately 50 miles away). -The guardian was contacted and had been in contact with the different law enforcement agencies in the different counties that were involved. -She had been contacted regarding Resident #6's return but felt the facility could no longer provide him with the care he required. -The guardian had found another SCU in another county closer to his family and Resident #6 would be transferred to that facility. Telephone interview with Resident #6's primary care provider (PCP) on 11/19/25 at 2:35pm revealed: -She was not aware of any elopement attempts from Resident #6 prior to 10/13/25 when he eloped. -She was concerned for his safety due to his diagnoses of dementia, anxiety, diabetes and hypertension. -He was only oriented to person which could potentially put him at risk for injury and harm. -Resident #6 was prescribed medications to treat his dementia, anxiety, diabetes and hypertension. -She was not sure how long he had been gone from the facility or how long he was without his medications. -He was not competent to make legal decisions and that was why he had a legal guardian. Attempted telephone interview with Resident #6's family member on 11/19/25 at 5:53pm was unsuccessful.	D 270		

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D 270	Continued From page 12 The facility failed to ensure a resident (#6) who had diagnoses of dementia, mild cognitive impairment and resided in a special care unit was supervised resulting in the resident eloping from the facility. The Resident was found 50 miles away from the facility by local law enforcement and was arrested and transferred to another county where he was released and lived on the streets without his medications and was in and out of hospital emergency departments on numerous occasions before his guardian was finally made aware of his location and condition. This failure resulted in serious neglect of the resident and constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on November 19, 2025. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 20, 2025.TYPE A1 VIOLATION	D 270		
D 273 *	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type B Violation Based on interviews and record reviews, the facility failed to ensure referral and follow up to meet the acute health care needs for 3 of 6 sampled residents (#1, #2, #4) to including a	D 273	Going forward the admin + RCC or designee person will ensure appropriate referral and follow up of routine and acute health care	1/14/26

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D 273	Continued From page 13 referral for an orthopedic appointment (#2), a referral for a neurologist appointment (#1), and a referral and follow up after 6 months for a neurologist appointment (#4). The findings are: 1. Review of Resident #2's current FL2 dated 06/02/25 revealed: -Diagnoses included dementia, hypertension, atrial fibrillation, and mood disorder. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #2's Resident Register revealed the resident's admission date was 09/26/23. Review of Resident #2's incident and accident report dated 10/18/25 revealed: -Resident #2 had a fall on 10/18/25 at 3:56pm in the hallway. -She had injuries related to the fall and was bleeding from her head and nose. Review of Resident #2's electronicly signed hospital discharge summary dated 11/03/25 revealed: -The discharge diagnosis was falls and hand fracture. -Follow-up instructions included see primary care provider within 1 week, orthopedic surgery within 1 week. Interview with a family member of Resident #2 on 11/18/25 at 4:35pm revealed: -Resident #2 had a fall on 10/18/25, she fractured her fingers on her left hand and was sent to the emergency room. -Resident #2 was returned to the facility on	D 273	needs Of this to prevent this from happening in the future. RCC, + Health Wellness Director will moniton weekly that all referrals follow up, and appointments are completed in a timely manner to meet the needs of the resident. Continous monitoring and monthly in service sessions will be Conducted by the Administraton	

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D 273	Continued From page 14 11/03/25 with a splint on her left hand. -Resident #2 kept removing the splint off of her hand. -The facility was supposed to schedule and take Resident #2 to an orthopedic appointment to get a cast on her left hand. -She had to take Resident #2 to the orthopedic appointment herself on 11/18/25 because the facility failed to do so. Interview with second family member of Resident #2 on 11/19/25 at 8:15am revealed: -Resident #2 had a fall on 10/18/25 and fractured the middle, ring, and pinky fingers on her left hand. -The facility was supposed to schedule and take her in for an orthopedic appointment immediately. -Resident #2 kept removing the splint on her hand and had to be sent out to the emergency room to get it put back on. -The facility did not schedule an orthopedic appointment for Resident #2. -The family had to schedule and take Resident #2 to her orthopedic appointment on 11/18/25. -A metacarpal finger splint hand brace with velcro straps was placed on Resident #2's left hand during her appointment on 11/18/25. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 10:00am revealed: -Resident #2 went out to the hospital after a fall on 10/18/25. -She returned 13 days later with stitches on her forehead and a splint on her left hand. -The Health and Wellness Director (HWD) was responsible for ensuring the referrals were done. -Resident #2 should have had an orthopedic appointment within seven days of returning to the facility from the hospital. -Resident #2's family member came and took her	D 273	A new Administration was hired 12/19/25 who has 10 years of assisted living and memory care experienced.	

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D 273	Continued From page 15 to her orthopedic appointment on 11/18/25. -She was concerned that Resident #2 could have suffered further injury due to not getting her orthopedic appointment in a timely manner. Interview with the HWD on 11/19/25 at 10:45am revealed: -Resident #2 had a fall on 10/18/25 and was sent to the emergency room with injuries to her face and hand. -She called to get an orthopedic appointment 48 hours after Resident #2 returned to the facility from the hospital. -She was not able to schedule an appointment within a week of the resident returning. -She looked up other orthopedic offices nearby to attempt to get her an appointment. -The RCC reached out to Resident #2's family and asked if they could take her to an orthopedic office nearby. -The family did not want to take her and asked if she could continue to wear the sling that the hospital provided. -She sent an order for a mobile x-ray of Resident #2's hand to see if it was healed. -Resident #2 removed the splint, she was sent to the hospital to get re-splinted before she could get an x-ray done. -An orthopedic referral for Resident #2 should have been scheduled within 24 hours of the order. -Healthcare referrals were made for a reason and needed to be followed up on in a timely manner. Interview with the Executive Director (ED) on 11/19/25 at 11:05am revealed: -Resident #2's primary care provider (PCP) was given her discharge paperwork to issue the orthopedic referral. -She reached out to the PCP several times about	D 273		

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D 273	Continued From page 16 Resident #2's orthopedic referral. -She expected fast turn around when it came to referrals for follow-ups. -The PCP was responsible for the orthopedics appointment for Resident #2 not being done in a timely manner. -The RCC and HWD were responsible for reviewing discharge paperwork and placing them in a folder for the PCP to review. Interview with Resident #2's PCP on 11/19/25 at 2:10pm revealed: -The facility was responsible for calling and getting appointments for referrals as soon as possible. -Resident #2 needed to go to an orthopedic appointment to get her left hand into a cast because she kept taking off the splint that the hospital put on her. -She made a second referral for orthopedics for Resident #2 on 11/11/25, which the facility should have followed-up on immediately. -She was concerned that Resident #2 could cause more damage to her hand and was in pain because she kept taking her splint off. 2. Review of Resident #1's current FL2 dated 07/01/25 revealed: -Diagnoses include dementia, hypertension, prediabetes, hyperlipidemia, hypomagnesemia, epilepsy and recurrent seizures. -The resident was semi-ambulatory. -The resident was constantly disoriented. Review of Resident #1's Resident Register revealed the resident's admission date was 10/06/17. Review of Resident #1's primary care provider (PCP) progress note dated 08/18/25 revealed: -Resident #1's diagnoses included dementia,	D 273		

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D 273	Continued From page 17 hypertension, epilepsy, and hypertension. -The treatment plan was to follow up with Neurology. Telephone interview with Resident's #1's PCP on 11/19/25 at 2:40pm revealed: -She was not aware that Resident #1 was not seen by the Neurologist. -Resident #1 had a history of seizures and took the medication Phenobarbital for seizures. -The purpose to refer to a neurologist was because they specialized in seizure activity and to ensure that Resident #1 was being properly treated through appropriate medications. Interview with the Health and Wellness Director (HWD) on 11/19/25 at 5:40pm revealed: -She was not aware that Resident #1 had a neurologist referral order that had not been followed up. -She recently became the HWD and had not performed an audit. -She and the Special Care Coordinator (SCC) were responsible for performing the audits. Interview with Administrator on 11/19/25 at 5:15pm revealed: -She was not aware that Resident #1 had a neurologist referral order. -The orders were made before she became the Administrator. -She had not performed an audit since she had become the Administrator three months ago. -The clinical team included the HWD and the SCC who were responsible for performing the audits. -She was responsible for reviewing any issues the clinical team found. Based on observations, interviews, and record	D 273		

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D 273	Continued From page 18 reviews, it was determined that Resident #1 was not interviewable. 3. Review of Resident #4's current FL2 dated 12/31/24 revealed: -Diagnoses included dementia, hypertension, blindness in both eyes, epilepsy, and cerebrovascular disease. -The resident was semi-ambulatory. -The resident was intermittently disoriented. Review of Resident #4's Resident Register revealed the resident's admission date was 11/01/13. Review of Resident #4's primary care provider (PCP) progress note dated 01/28/25 revealed: -Resident #1's diagnoses included dementia, cerebral infarction, and epilepsy. -The treatment plan was to ensure Resident #4 had a follow up with neurologist per records which indicated that he was last seen in June 2024 with instructions to follow up around 6 months. Telephone interview with Resident's #4's PCP on 11/19/25 at 2:30pm revealed: -She was not aware that Resident #4 was not seen by the neurologist. -Resident #4 had a history of seizures. -The purpose of seeing the neurologist was to ensure that Resident #4 was being properly treated and to ensure he was on the most current medication for seizures. Interview with the Health and Wellness Director (HWD) on 11/19/25 at 5:40pm revealed: -She was not aware that Resident #4 had a neurologist referral order that had not been followed up. -She recently became the HWD and had not	D 273		

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D 273	Continued From page 19 performed an audit. -She and the Special Care Coordinator (SCC) were responsible for performing the audits. Interview with Administrator on 11/19/25 at 5:15pm revealed: -She was not aware that Resident #4 had a neurologist referral order. -The orders were made before she became the Administrator. -She had not performed an audit since she had become the Administrator three months ago. -The clinical team included the HWD and the SCC who were responsible for performing the audits. -She was responsible for reviewing any issues the clinical team found. Based on observations, record reviews and interviews, it was determined that Resident #4 was not interviewable. * The facility failed to make and coordinate an appointment with an orthopedic surgeon as ordered by an emergency department physician on 11/03/25 after the resident sustained a fall and fractured three fingers on her left hand. The ED applied a split and the orthopedic appointment was re-ordered by the PCP on 11/11/25 in efforts for the resident to have a cast applied as the resident repeatedly removed her splint which increased the risk of further injury and pain. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/19/25 for this violation. THE CORRECTION DATE FOR THE TYPE B	D 273		

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D 273	Continued From page 20 VIOLATION SHALL NOT EXCEED January 04, 2026.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sampled residents (#4) were treated with dignity and respect related to resident laying on the bathroom floor at the nursing station and staff did not assist him off the floor immediately. The findings are: Review of Resident #4's current FL2 dated 12/31/24 revealed: -Diagnoses included dementia, hypertension, blindness in both eyes, epilepsy, and cerebrovascular disease. -The resident was semi-ambulatory. -The resident was intermittently disoriented. Review of Resident #4's Resident Register revealed the resident's admission date was 11/01/13. Interview with the personal care aide (PCA) on 11/20/25 at 3:30pm revealed: -There were four staff members in the building on 11/02/25, one medication aide (MA) and three PCAs.	D 338	Inservice Resident Rights. All staff member will treat all resident with respect at all times, consideration dignity, and full recognition of his or her individuality and right to privacy. Continue training during monthly staff meetings	1/12/26

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D 338	Continued From page 21 -Resident #4 tried to get out of his wheelchair often to walk. -She saw Resident #4 lay on the floor in the bathroom during her shift on 11/02/25. -She asked the MA to help get Resident #4 off the floor and the MA said, "I'm not helping to pick him up". -She walked to the other hall for help, which took 10 minutes to find someone to get Resident #4 off the floor. -She reported to the MA that Resident #4 tried to get out of his wheelchair to walk but did not know if it was reported to the primary care provider (PCP). Interview with the Health and Wellness Director (HWD) on 11/19/25 at 5:40pm revealed: -On 11/02/25, she did not know that Resident #4 got out of his wheelchair and sat on the floor until she and her Administrator reviewed camera footage with video but no audio. -She and the Administrator were looking for another incident when they came upon footage of Resident #4 on the floor. -She saw the PCA sitting at the nurse station, but they did not acknowledge that Resident #4 was sitting on the floor. -The MA walked to the bathroom door standing over Resident #4 but unable to say what was said due to no audio then the MA turned around and walked away. -Resident #4 was on the floor for over twenty minutes. Interview with Administrator on 11/19/25 at 5:15pm revealed: -No one came to her with concerns that Resident #4 was on the floor and staff did not assist him immediately. -If she knew the date the incident happened she	D 338		

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D 338	Continued From page 22 could review the camera footage. -She did not tolerate staff being disrespectful. Second interview with Administrator on 11/20/25 at 4:10pm revealed: -She had forgotten about the video regarding Resident #4 sitting on the floor. -The moment she saw Resident #4 on the floor, the staff should have assisted him off of the floor. -Resident #4 was in the MA's care and she should have followed proper protocol, which was if she did not know what happened, she was to notify the PCP to get further instructions and complete an incident and accident report. -If the MA knew what happened and no fall was involved, she should have assisted Resident #4 off the floor immediately. Telephone interview with Resident #4's primary care provider (PCP) on 11/20/25 at 3:25pm revealed: -She was not aware that Resident #4 was on the floor on 11/02/25 and did not receive assistance. -He had a diagnosis of having seizures. -Due to his diagnoses, he was unable to get himself off the floor, he could have injured himself, and he could have had a seizure. -The staff should have assisted Resident #4 from the floor immediately. -It was neglectful to leave Resident #4 on the floor with no assistance. Based on observations, record reviews and interviews, it was determined that Resident #4 was not interviewable.	D 338		
X D 358	10A NCAC 13F .1004 (a) Medication Administration	D 358	Going forward an cart audit WAS	

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D 358	Continued From page 23 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 8 residents (#5 and #7) observed during the medication pass evidenced by errors which included a medication used for the management of moderate to moderately severe pain (#5) and a medication used to treat constipation (#7). The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 9:00am medication pass on 11/18/25. 1. Review of Resident #5's current FL-2 dated 10/14/25 revealed: -Diagnoses included dementia, essential hypertension, benign prostatic hypertrophy (BPH), dyskinesia of the esophagus, malignant neoplasm of the skin upper limb, insomnia, atherosclerotic heart disease, and personal history of traumatic brain injury (TBI). -There was an order for tramadol 50mg one tablet every day used for the management of moderate to moderately severe pain. Observation of] medication pass on 11/18/25	D 358	done on 1/14/26 to ensure that all order match the mars and being followed as the provider order. The Admin retrained on 1/14/26 all med aides and RCC on the importances of administration and the Administrator implementa. 6 rights for medication reconciliation to verify that the prescribe orders by ensure that	

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D 358	Continued From page 24 from 8:49am - 10:00am revealed: -The medication aide (MA) prepared 5 tablets/capsules and placed them into a paper souffle medication cup and administered them to Resident #5. -Tramadol 50mg was not administered to Resident #5. Review of Resident #5's Resident Register revealed he was admitted on 12/19/17. Review of Resident #5's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for tramadol 50mg take one tablet every day scheduled to be administered at 9:00am. -Tramadol 50mg was documented as administered 11/01/25 - 11/16/25 at 9:00am. -Tramadol 50mg was documented as not available on 11/17/25 and 11/18/25 at 9:00am. Interview with the MA on 11/18/25 at 10:05am revealed: -She was nervous being watched administering medications. -She had only been working at the facility for about a month now. -Resident #5 was supposed to receive tramadol 50mg every morning but he did not have any available on the cart to be administered this morning. -Resident #5 needed the tramadol for pain. -Medications were to be reordered when there were 7-10 days of medications remaining. -The MAs and the Special Care Coordinator (SCC) were responsible for reordering medications for the residents. -She was not sure who had reordered Resident #5's tramadol.	D 358	medication administration policies are clearly outline the procedures for preparing and administering medications. The RCC will conduct weekly audits of medication order to ensure compliance with the new processes. The Administrator will review the audits results weekly and provide feedback.	

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D 358	Continued From page 25 -Since tramadol was a controlled medication, he might need a "hard script" from the primary care provider to be sent to the pharmacy. Telephone interview with Resident #5's primary care provider (PCP) on 11/18/25 at 2:35pm revealed: -She expected Resident #5's medications to be administered as ordered. -She was concerned about tramadol not being administered for 2 days because he would have breakthrough pain and it would be harder to control his pain. -She had not been contacted prior to this to get a refill for Resident #5's tramadol. Interview with the Executive Director on 11/19/25 at 2:50pm revealed: -She was concerned that Resident #5 had not received his tramadol in two days because he would be in pain. -The MAs and the SCC were responsible for making sure residents' medications were ordered and refilled to prevent them from running out of medications. -She was not sure what had happened but knew that tramadol would need a prescription sent to the pharmacy since it was a controlled substance. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. 2. Review of Resident #7's current FL-2 dated 06/02/25 revealed: -Diagnoses included dementia, essential hypertension, atherosclerotic heart disease, pure hyperglyceridemia, presence aortocoronary bypass graft, abdominal aortic aneurysm, and adjustment disorder with mixed anxiety.	D 358		

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D 358	Continued From page 26 -There was an order for docusate sodium 100mg one tablet twice a day. Observation of the medication pass on 11/18/25 from 8:49am - 10:00am revealed: -The medication aide (MA) prepared 5 tablets/capsules and placed them into a paper souffle medication cup and administered them to Resident #7. -Docusate was not administered to Resident #7. -Resident #7 informed the MA he needed his stool softner (docusate) when she administered his other medications and informed him that his docusate was not available for administration that morning. Review of Resident #7's Resident Register revealed he was admitted on 10/11/25. Review of Resident #7's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium 100mg take one tablet twice a day scheduled to be administered at 9:00am and 9:00pm. -Docusate sodium 100mg was documented as administered 11/01/25 - 11/17/25 at 9:00am and 9:00pm. - Docusate sodium 100mg was documented as not available on 11/18/25 at 9:00am. Interview with the MA on 11/18/25 at 10:05am revealed: -She was nervous being watched administering medications. -She had only been working at the facility for about a month now. -Resident #7 was supposed to receive docusate sodium every morning and every evening but he did not have any available on the cart to be	D 358		

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D 358	Continued From page 27 administered this morning. -Resident #7's family provided the docusate and he needed it to keep him from becoming constipated. -Medications were to be reordered when there were 7-10 days of medications remaining. -The MAs and the Special Care Coordinator (SCC) were responsible for reordering medications for the residents. -She was not sure if anyone had contacted Resident #7's family to let them know he needed them to bring it into the facility for him. Telephone interview with Resident #7's primary care provider (PCP) on 11/18/25 at 2:35pm revealed: -She expected Resident #7's medications to be administered as ordered. -She was concerned about docusate not being administered because he could become constipated which could lead to impactions. Interview with the Executive Director on 11/19/25 at 2:50pm revealed: -She was concerned that Resident #7 had not received his docusate which could lead to constipation. -The MAs and the SCC were responsible to make sure residents medications were ordered and refilled to prevent them from running out of medications. -Resident #7's family brought the docusate to the facility, so she would contact them and let them know he needed it.	D 358		
X D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367	On 1/14/26 a chart audit, chart, and Physician order was	1/14/26

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D 367	Continued From page 28 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 5 sampled residents related to a discontinued medication used to treat high blood pressure being documented as administered (#3) and compression hose documented as applied and removed with no current order for compression hose (#1). The findings are: 1. Review of Resident #3's current FL2 dated 06/30/25 revealed:	D 367	done to assure that order matched and are being follow as the physician order. Inservice with RCC and Med Tech on administration of medication with the importance of following the orders matched the prescribed of preparing and administering medication while ensuring that we continue to folow the physician orders.	1/14/26

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D 367	Continued From page 29 -Diagnoses include dementia, hypertension, muscle weakness, and intellectual disability. -The resident was semi-ambulatory. -There was no information on orientation. Review of Resident #3's Resident Register revealed the resident's admission date was 04/19/18. Review of Resident #3's physician order for amlodipine besylate 10mg take one tablet by mouth once a day dated 10/18/22 (used to treat hypertension). Review of Resident #3's physician order for amlodipine besylate 10mg take one tablet by mouth once a day to be discontinued as of 06/23/25. Review of Resident #3's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine besylate 10mg take one tablet once a day. -There were 3 out of 30 days that amlodipine besylate 10mg was documented as administered. -There were 27 out of 30 days that amlodipine besylate 10mg was documented as not available. Review of Resident #3's October 2025 eMAR revealed: -There was an entry for amlodipine besylate 10mg take one tablet once a day. -There were 10 out of 31 days that amlodipine besylate 10mg was documented as administered. -There were 21 out of 31 days that amlodipine besylate 10mg was documented as not available.	D 367	To prevent this from happening again the RCC will conduct an audit of reviewing Cart and MAR Audit includes comparing with medication orders and making sure are on hand and available for administration. MAR audits also include checking prn medications MAR to be carried out as Ordered.	

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D 367	Continued From page 30 Review of Resident #3's November 2025 eMAR revealed: -There was an entry for amlodipine besylate 10mg take one tablet once a day. -There were 9 out of 18 days that amlodipine besylate 10mg was documented as administered. -There were 9 out of 18 days that amlodipine besylate 10mg was documented as not available. Interview with a medication aide (MA) on 11/19/25 at 00:00am revealed: -She signed off that she administered Resident #3 amlodipine besylate 10mg on 11/19/25. -She accidently signed that the medication was administered that morning. -The amlodipine besylate 10mg was not available on the medication cart. -She did not know how to order medications that had run out. -The MAs were responsible for ordering medications when they ran out. Interview with the PCP on 11/19/25 at 2:10pm revealed: -Amlodipine besylate 10mg was prescribed for hypertension. -She was concerned that Resident #3's blood pressure was not being controlled if he was not being administered his amlodipine besylate 10mg. -She expected the facility to contact her if residents needed refills on medications. -She expected the facility staff to administer medications as ordered. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 4:45pm revealed: -Resident #3's amlodipine besylate 10mg was discontinued 06/23/25.	D 367	Going forward: ~~on cart~~ all medication aides + RCC on the retrained on the importance of the administration of the medication and the Administrator implement a system of the 6 rights for medication reconciliation to verify that the medication being administered match the prescribed orders.	1/14/26

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D 367	Continued From page 31 -Staff did not follow-up with the discontinue order to have it removed from the eMAR. -When an order was discontinued it was removed from the cart and sent to pharmacy. -She did not know who was responsible for removing the medication from the eMAR. -She expected the MAs to document on the eMAR accurately and check medication not available if it is not on the medication cart. Interview with the HWD on 11/19/25 at 4:55pm revealed: -Resident #3's amlodipine besylate 10mg was discontinued 06/23/25. -The RCC and MAs were responsible for pulling discontinued medication off of the medication cart and sending it back to the pharmacy. -The RCC and HWD were able to go into the system and remove a discontinued medication from the eMAR. -She expected the MAs to ask the RCC or pharmacy to check orders for medications that are not available on the medication cart. -She expected MAs to document on the eMAR accurately. -She was concerned because medication orders should be followed as ordered, it could lead to a health issue with the resident. Interview with the Executive Director (ED) on 11/19/25 at 00:00am revealed: -When a medication was discontinued it was pulled from the medication cart and sent back to the pharmacy. -The RCC was responsible for contacting the pharmacy to remove the discontinued order from the eMAR. -She expected MAs to document on the eMAR accurately. -Spot checks should be done by the ED to ensure	D 367		

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D 367	Continued From page 32 eMAR accuracy. 2. Review of Resident #1's current FL2 dated 07/01/25 revealed: -Diagnoses include dementia, hypertension, prediabetes, hyperlipidemia, hypomagnesemia, epilepsy and recurrent seizures. -The resident was semi-ambulatory. -The resident was constantly disoriented. Review of Resident #1's Resident Register revealed the resident's admission date was 10/06/17. Review of Resident #1's chart record on 11/18/25 revealed there was no physician order for compression hose. Review of Resident #1's September, October and November 2025 electronic medication administration records (eMARs) revealed: -There was an entry for compression hose apply every morning and remove at bedtime scheduled at 9:00am and 9:00pm. -There was documentation that the compression hose was applied every morning and removed daily at bedtime 09/11//25 through 11/18/25. -There was no documentation Resident #1 declined to wear the compression hose. Interview with the personal care aide (PCA) on 11/19/25 at 3:18pm revealed: - Resident #1 did not wear compression hose that she knew because Resident 1 always wore socks. -The medication aide (MA) told her when a resident wore compression hose, and no one told her that Resident #1 wore compression hose. Interview with the medication aide (MA) on 11/19/25 at 3:20pm revealed:	D 367	Inservice completed Resident Rights	1/13/26.

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D 367	Continued From page 33 - Resident #1 did not have compression hose and could not say how long she had been without compression hose. -Check marks on the MARs meant the treatment was being done, the compression hose was being checked in the morning that they were on and being checked at night that they were off. -She could not say why she and the MAs were checking off that they were applying compression hose on and off daily. -She did not follow up with the primary care provider (PCP) or the Health and Wellness Director (HWD) to clarify the order. Interview with the Health and Wellness Director (HWD) on 11/19/25 at 5:40pm revealed: -She was not aware that compression hose was on the MAR for Resident #1. -She was responsible for cart audits to monitor what is on the MAR and what is on the cart and to see if everything matched up. -She had been with the facility for three weeks and had not implemented a cart audit schedule. Interview with Administrator on 11/19/25 at 4:35pm revealed: -She was not aware that Resident #1 did not have an order for compression hose. -Resident #1's last order was on 12/19/23 and the start date was 01/3/24. -The compression hose was received on 01/03/24 and did not know what happened when Resident #1 was to receive a new order in January 2025. -The HWD was responsible for monitoring and catching the inactive physician order. -She was ultimately responsible for catching the inactive physician order. -She had not performed an audit since she had become the Administrator three months ago.	D 367		

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D 367	Continued From page 34 Telephone interview with Resident's #1's PCP on 11/19/25 at 2:25pm revealed: -She was not aware Resident #1 was not wearing compression hose. -The last order she saw was on 01/03/24. -She became the facility PCP a month earlier and her last PCP visit with Resident #1 was on 10/27/25 by telehealth for a sick visit. Based on observations, record reviews and interviews, it was determined that Resident #1 was not interviewable.	D 367		
★ D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. ★ This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete incident/accident reports and notify the county Department of Social Services (DSS) for 1 of 6 residents sampled (#2) who required emergency medical and hospital evaluations. The findings are:	D 451	Going forward Training on incident reports process to be completed, and discussed per staff meeting, Med Tech, Aides RCC + Administrator must be filed in a timely matter. All parties must be notified.	1/14/26

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D 451	Continued From page 35 Review of Resident #2's current FL2 dated 06/02/25 revealed: -Diagnoses include dementia, hypertension, atrial fibrillation, and mood disorder. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #2's Resident Register revealed the resident's admission date was 09/26/23. Review of incident and accident report dated 11/05/25 revealed: -Resident #2 removed her splint on from her left hand applied for three fractured fingers. -The document was labeled as reportable. Review of 72 hour follow-up on resident fall dated 11/13/25-11/16/25 revealed the facility staff took steps to put fall intervention in place after Resident #2 had a fall on 11/13/25. Interview with the Adult Home Specialist (AHS) for the county Department of Social Services (DSS) on 11/19/25 at 8:55pm revealed: -She did not received an incident report regarding Resident #2's hospital emergency room visit that occurred on 11/05/25. -She did not received an incident report regarding Resident #2's fall and hospital emergency room visit that occurred on 11/13/25. -The facility should complete and send her all incident and accident reports when a resident is sent to the emergency room. -The facility should send DSS the reports within a week of the incident. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 10:00am revealed:	D 451	Med Aide, RCC Admin, PCP, MCH, dss offices family members	

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D 451	Continued From page 36 -Resident #2 was observed with a knot on her forehead, date unknown. -The resident was sent to the hospital emergency room to be evaluated for the injury. -The facility did not complete an incident and accident report for this incident. -The facility did not contact DSS about this incident. -Incident and accident reports were supposed to be completed any time a resident is injured. -The Health and Wellness Director (HWD) was responsible for sending all incident and accident reports to DSS. Interview with the HWD on 11/19/25 at 10:45am revealed: -Resident #2 was observed by staff to have a new bruise on her face and head, date was unknown. -After investigating she found out that third shift staff observed Resident #2 sitting on the floor in her room and assisted her back in to the bed. -She sent Resident #2 to the emergency room to be evaluated because the injury on her face appeared to be getting worse. -Resident #2 returned from the emergency room the same evening. -She was not sure if an incident or accident report was completed for this incident. -She did not know if a report was sent to DSS for this incident. -Resident #2 was sent to the emergency room on 11/05/25 because she removed the splint on her left hand. -Any incident when a resident is sent to the hospital there needed to be an incident report completed. -She was responsible for reviewing all incident and accident reports for accuracy and making sure all parties are notified. -After she reviewed the incident and accident	D 451		

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D 451	Continued From page 37 reports she gave them to the Executive Director (ED) to be sent to DSS. Interview with the Executive Director (ED) on 11/19/25 at 10:40am revealed: -When a resident has an incident, she expected staff to complete a incident and accident report. -The HWD reviewed all incident and accident reports and gave them to her to be sent to DSS. -She was not sure if an incident and accident report was completed for Resident #2's fall on 11/13/25. -She should have sent the incident and accident report for the incident on 11/05/25 to DSS within 24 hours.	D 451		