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 _____	R 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Lee County Department of Social Services conducted Follow-Up survey, state involved, and a complaint investigation on February 24 -25, 2026.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents related to a resident whose blood pressure (BP) was not checked as ordered once daily for seven days, then once weekly (#3). The findings are: Review of Resident #3's current FL-2 dated 01/16/26 revealed: -Diagnoses included dementia, essential hypertension, hyperlipidemia, and stage 3 chronic kidney disease -The resident was intermittently disoriented. -The resident was semi-ambulatory with a wheelchair and walker.	D 276		

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D 276	Continued From page 1 Review of the Resident Register for Resident #3 revealed she was admitted to the facility on 01/18/26. Review of physician orders dated 01/26/26 revealed orders for blood pressure checks once daily for seven days then once weekly, report systolic blood pressure less than 90 or greater than 160. Review of Resident #3's January 2026 electronic Medication Administration Record (eMAR) revealed there was no blood pressure checks documented. Review of Resident #3's record revealed there were no blood pressure checks documented. Interview with the Health and Wellness Director (HWD) on 02/28/26 at 2:00pm revealed: -Resident #3 should have gotten blood pressure checks as ordered by the primary care provider (PCP). -The medication aides (MAs) were responsible for ensuring the Resident Care Coordinator (RCC) was given all follow-up paperwork. -It was the responsibility of the RCC and HWD to make sure all orders were completed. -It was important for the health of the residents that all the orders were followed up on by the RCC and HWD. Interview with the RCC on 02/28/26 at 12:10pm revealed: -She was responsible for ensuring all orders were followed up on for all residents. -She had concerns about orders not being implemented because they were put in place for the benefit of the resident's health. -Not following-up on PCP orders could be	D 276		

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D 276	Continued From page 2 detrimental to the health of residents. Interview with the Administrator on 02/28/26 at 1:15pm revealed: -PCP orders were put in place for the healthcare needs of the residents. -She expected all PCP orders to be followed up on by facility staff. -The RCC was responsible for ensuring all PCP orders were followed-up on. -The RCC needed to look at all orders and discuss them with the HWD to make sure the orders were sent to the pharmacy to be added to the eMAR. -She was concerned that the PCP orders for blood pressure checks were not followed up on because Resident #3 could have had outcomes including a stroke. Interview with Resident #3's PCP on 02/28/26 at 2:30pm revealed: -She placed the order for Resident #3 to have blood pressure checks because her blood pressure was low. -She wanted to know what her blood pressure was so she could make adjustments to her medications if she needed to do so. -She was concerned that the facility was not checking her blood pressure because she would not know if the medications she was administered were effective. -She expected the facility to carry out her orders for the healthcare needs of the residents. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable.	D 276		

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D 358	Continued From page 3	D 358		
D 358	10A NCAC 13F .1004 (a) Medication Administration 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 physicians' orders which were not implemented for 1 of 5 sampled residents related to an order for 2 medications to treat behaviors (#2). The findings are: Review of Resident #2's current FL2 dated 02/16/26 revealed a diagnosis of dementia, vitamin D deficiency, benign prostatic hypertrophy, profound intellectual disability, edema, schizoaffective disorder, and epilepsy. Review of Resident #2's signed mental health provider (MPH) orders dated 01/21/26 revealed: -There was an order for Depakote DR Sprinkles 125mg one capsule three times a day. -There was an order to decrease his haloperidol from 20mg to 15mg every morning. Review of Resident #2's January 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for haloperidol 20mg every	D 358		

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D 358	Continued From page 4	D 358		

morning at 9:00am.
-There was no entry for Depakote DR Sprinkles 125mg one capsule three times a day.

Review of Resident #2's February 2026 eMAR revealed:
-There was an entry for haloperidol 20mg every morning at 9:00am.
-There was no entry for Depakote DR Sprinkles 125mg one capsule three times a day.

Observation of medications on hand for Resident #2 on 02/25/26 at 11:30am revealed:
-There was a bubble pack containing 20mg haloperidol tablets with 6 tablets remaining.
-The label indicated haloperidol 20mg - 30 capsules were dispensed for Resident #2 on 02/05/26.
-There was no Depakote DR Sprinkles 125mg on hand for administration.

Interview with a medication aide (MA) on 02/24/26 at 3:15pm revealed:
-She administered residents' medications according to the orders in the eMAR system.
-Resident #2's orders in the eMAR system included haloperidol 20mg every morning at 9:00am.
-She administered haloperidol 20mg one tablet to Resident #2 that morning (02/24/26).
-There was no order in the eMAR system for Depakote DR Sprinkles 125mg one capsule three times a day so she could not administer it.
-She thought the Resident Care Coordinator (RCC) and Health and Wellness Director (HWD) were responsible for carrying out the orders from the providers and getting them to the pharmacy and into the eMAR system.

Interview with the RCC on 02/25/26 at 1:00pm

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D 358	Continued From page 5	D 358		

revealed:
-She had only worked at the facility for about 2 weeks now and was not sure how residents' medication orders were processed before she started.
-She had known there were some changes in staffing as well as providers prior to her starting work at the facility.
-She had been working on resident record audits since she started but had not audited Resident #2's record.
-The facility had a new procedure in place for the HWD or her (RCC) to be the ones to process all care providers' orders.

Interview with the HWD on 02/25/26 at 1:10pm revealed:
-He had worked at the facility since the first part of February.
-He was not aware of the procedure for processing orders for the residents.
-He knew there had been a turnover in staffing prior to his start.
-He and the RCC were working on auditing all the residents records and knew there was much to be done.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/25/26 at 11:40am revealed:
-The pharmacy had not received an order from Resident #2's mental health provider (MHP) to decrease his haloperidol from 20mg down to 15mg every morning.
-There was no order for Depakote DR Sprinkles 125mg one capsule three times a day for Resident #2 in the system.
-The dispense records of the pharmacy showed the last haloperidol was dispensed on 02/05/26 and there were 30 tablets of 20mg haloperidol

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D 358	Continued From page 6 dispensed. Interview with Resident #2's MHP on 02/25/26 at 9:35am revealed: -She had ordered the haloperidol 20mg to be decreased to 15mg every morning and Depakote DR Sprinkles 125mg one capsule three times a day to help with Resident #2's behaviors not for seizures. -Resident #2 already had medications he was prescribed and taking to control his seizures. -She had concerns about the orders not being processed as ordered but knew there had been a lot of staff turnover. -She had not been made aware Resident #2 had any behaviors since she last saw him. -The RCC had contacted her agency's triage yesterday (02/24/26) regarding Resident #2's orders for haloperidol 20mg to be decreased to 15mg every morning and Depakote DR Sprinkles 125mg one capsule three times a day. -The on-call triage nurse advised the facility that Resident #2 would be seen by the MHP the next day on 02/25/26 and the MHP would evaluate the need for the orders at that time. -She saw Resident #2 and since he had not had any behaviors there was no need for the haloperidol to be decreased to 15mg and no need to order Depakote DR Sprinkles 125mg. -She wrote an order to discontinue the previous order for haloperidol to be decreased to 15mg and Depakote DR Sprinkles 125mg written on 01/21/26. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable.	D 358		