

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on November 7, 2025. The complaint was substantiated (intake #NC00234356). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 6 current clients.</p>	V 000		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by</p>	V 290		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 1</p> <p>the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to have a minimum of one staff member present on the premises once the clients' unsupervised time expired affecting 2 of 5 clients (#3 and #4) and failed to review the plan at least annually to ensure clients were capable of remaining in the home or community without supervision affecting 5 of 5 clients (#1, #2, #3, #4 and #5). The findings are:</p> <p>Review on 11/3/25 of client #1's record revealed: -Admission date of 2/11/10. -Diagnosis of Schizo affective disorder. Bipolar type. -Unsupervised time assessment dated 2/27/24.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 2</p> <p>Team agreed to unsupervised time, but time allowed was not listed.</p> <p>-Unsupervised time assessment was not updated annually.</p> <p>Review on 11/3/25 of Client #2's record revealed: -Admission date of 3/11/13. -Diagnoses of Schizoaffective Disorder- Bipolar Disorder, Post Traumatic Stress Disorder, Tobacco Use and High Cholesterol. -Unsupervised time assessment dated 10/17/23. Seven hours at home and seven hours in the community granted. -Unsupervised time assessment was not updated annually.</p> <p>Review on 11/3/25 of Client #3's record revealed: -Admission date of 10/16/18. -Diagnosis of Schizoaffective Disorder- Bipolar Type. -Unsupervised time assessment dated 10/17/23. Six hours at home and six hours in the community granted. -Unsupervised time assessment was not updated annually.</p> <p>Review on 11/3/25 of Client #4's record revealed: -Admission date of 10/7/94. -Diagnoses of Schizoaffective Disorder, Depressive Type; Anxiety Disorder, Unspecified. -Unsupervised time assessment dated 11/2/23. Seven hours at home and seven hours in the community granted. -Unsupervised time assessment was not updated annually.</p> <p>Review on 11/3/25 of Client #5's record revealed: -Admission date of 1/25/10. -Diagnoses of Schizophrenia Disorder; Hypertension; Avoidant Personality Disorder;</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 3</p> <p>Hyperlipidemia; Bipolar Disorder, Uncomplicated. -Unsupervised time assessment dated 9/23/23. Eight hours at home and eight hours in the community granted. -Unsupervised time assessment was not updated annually.</p> <p>Review on 11/7/25 of Staff #8's personnel record revealed: -Hire date of 6/17/24. -She was hired as a Behavioral Specialist-Sleepover. -Termination date of 11/4/25.</p> <p>Review on 11/7/25 of the facility's internal investigation report dated 11/3/25 revealed: -Allegation of Neglect. -Allegation: "During an incident investigation, it was reported that two individuals chose not to go on an outing to the NC (North Carolina) State Fair and were left at the group home for approximately 16 hours without staff." -Conclusion: "In review of unsupervised time for each individual, there were noted discrepancies. Person Centered Plans did not include unsupervised time information for any individual and assessments were not completed on an annual basis." -Recommendations: "Person centered plan and person specific training must be updated to include the amount of time [Clients #1, #2, #3, #4 and #5] can be left unsupervised in the home and community. -It is recommended that the Residential Manager and Team Leader develop a process to review proposed activities/trips and ensure proper planning and staffing is provided for the location. -On call information should be posted in an accessible place in the home to ensure individuals have access to contact</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 4</p> <p>staff/management in the event of an emergency. -It is recommended that on call procedures be evaluated for any potential changes. -The Team Leader should receive an oral counseling due to failing to ensure that unsupervised time policy was followed and required documents were present in the electronic health record. -The Residential Manager should receive an oral warning for unsatisfactory job performance due to failing to ensure the safety of the two individuals in the home."</p> <p>Review on 11/7/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Incident submitted on 10/27/25 for Client #3: "The individual was left at the home for longer than her approved unsupervised time. The individual also missed 8:00 pm medication." -Incident submitted on 10/27/25 for Client #4: "The individual was left at the home for longer than her approved unsupervised time. The individual also missed 8:00 pm medication." -Staff #8's name was listed on the Health Care Personnel Registry on each of the reports.</p> <p>Interview on 11/6/25 with Client #3 revealed: -Regarding the night of 10/25/25: "We (Clients #3 and #4) didn't go to the fair. We stayed home alone." -"We (clients #3 and #4) have unsupervised time and we can be here without staff." -"We (Clients #3 and #4) were scared and concerned that something may had happened to them. Maybe they had gotten in a car wreck or something!" -"No staff ever called the home. Neither [Staff #8] or any other staff called." -"I called my sister at 1:00 am to let her know about us (client #3 and #4) being alone at the</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 5</p> <p>home." -"I stayed up until 1:30 am that night." -"They got home about 4:30 am the next day." -"I was afraid that someone may try to break inside the home. I did not feel comfortable that night."</p> <p>Interview on 11/5/25 with Client #4 revealed: -Regarding he night of 10/25/25: "We (Clients #3 and #4) stayed at the house (facility) alone. I did not want to go to the fair." -"I have unsupervised time and I'm able to stay home (facility) without a staff for about 7 hours." -"Staff never called to let us know about them running late or what was happening." -"[Client #3] had called her sister to let her know we (clients #3 and #4) were by ourselves with no staff." -"I did not call anyone to inform that we (clients #3 and #4) were by ourselves." -"We got scared that something happened at the fair and we were by ourselves." -"[Staff #8] did not leave a phone number for us to call and reach her." -"Normally, there is always a staff at the facility at night." -"During the night, we never got a call from any staff to let us know that someone would be coming to the home (facility)and covering."</p> <p>Interview on 11/3/25 with Staff #7 revealed: -She was off the night of 10/25/25 when Staff #8 had taken 4 clients to the State Fair and clients #3 and #4 were left alone in the facility unsupervised. -She received a call from Client #3's guardians that night informing her that her sister (Client #3) had not taken her medication and there was no staff at the facility. -"[Clients #3 and #4] did not go to the fair and</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 6</p> <p>stayed home. They both have 7 hours of unsupervised time." -"When the guardian called, I contacted [Staff #8], she told me that she had everything under control. At that moment, I did not know what was happening at the fair." -She came to work the next day at 8:00 am. -"I told her (Staff #8) that she should have called me and let me know what was going on. I would have helped no matter what. I live 30 minutes away and would have informed her of where the information was that she needed."</p> <p>Interview on 11/4/25 with Staff #8 revealed: -She had gotten permission to go to the fair. "All but two of the clients wanted to go. [Client #3] and [Client #4] stayed back." -"All clients but Client #6 have unsupervised time. They all have 7 hours of unsupervised time." -"[Client #6] stayed with me the whole time." -"I called the home at about 8:00 pm to let the ladies know that I was running late and medication would be missed." -"I'm not sure if any plans were made for a staff to meet with the clients that stayed back at the facility when I was at the fair."</p> <p>Interviews on 11/3/25 and 11/6/25 with the Residential Manager revealed: 11/3/25: -"On 10/25/25, I received a call about 8:20 pm from [Staff #8] saying that [Client #1] was lost." -She had been out of town and had weak cell signal that night. -She called Staff #8 back at about 9:50 pm, later at 10:15 pm and at 11:0 5pm. -"[Staff #8] would call me to give me updates." -The fair closed and she told staff #8 to go home and to let the police search for Client #1. -She later called her "Higher up."</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 7</p> <p>- "No staff were contacted to come to the home to take care of the clients that remained at the facility to be with them and to give them their medications."</p> <p>- "[Staff #8] completed incident reports for the clients missed medication."</p> <p>- "All clients but [Client #6] have unsupervised time. They can be by themselves for about 7 hours."</p> <p>- "The unsupervised time assessments are completed by the Qualified Professional."</p> <p>- 11/6/25: - On 10/26/25, she arranged for an additional staff to come in at 9:00 am.</p> <p>- "No other staff was contacted to come to the facility from when I first got the call from [Staff #8] to when the additional staff was contacted the next morning."</p> <p>- Clients #3 and #4 remained at the facility past their unsupervised time.</p> <p>- From the time that Client #1 got lost, there was communication back and forth between her and Staff #8.</p> <p>- She understood that the clients at the facility's unsupervised time had expired.</p> <p>Interviews on 11/3/25 and 11/7/25 with the Team Lead/Qualified Professional (TL/QP) revealed: - 11/3/25: - "On the night of 10/25/25, I received a call at about midnight, but I did not hear the phone and did not find out about the call until 7:00 am the next day on Sunday. That's when I saw that I had a missed call." - She was not aware that Clients #3 and #4 had been left unsupervised at the facility overnight.</p> <p>- "All clients, but [Client #6] have unsupervised time." - "The unsupervised time is completed by the treatment team. The team is composed of the</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 8</p> <p>TL/QP, the Residential Manager, house staff, guardian or family member and the client. The assessment is a series of questions asked. The team determines the amount of time that a person can be unsupervised at home and at the community." -11/7/25: -"Unsupervised time assessments are reviewed every year, but if there is no change, a new assessment is not made. We just continue with the old one."</p> <p>Interview on 11/3/25 with the Residential Director revealed: -The night of 10/25/25, she had received a call after midnight from the Residential Manager informing her of what was happening at the fair with Client #1 being missing. -She informed the Residential Manager for Staff #8 to go back to the facility and to let the police handle the situation. -"The residential manager makes sure the facility is staffed appropriately." -"No arrangements were made for a staff to go to the facility to be with [Client #3] and [Client #4]. [Staff #8] was to return back because there was nothing else for her to do. It was in the hands of the police." -"Moving forward, If the staff that is supposed to be at the home takes longer than expected to return, the manager would come to the home." -Facility did not have an "on-call" phone number. -"All staff are considered on-call."</p> <p>Review on 11/7/25 of the Plan of Protection dated 11/7/25 written by the Team Leader/Qualified Professional revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? -The staff [Staff #8] was terminated.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	<p>Continued From page 9</p> <ul style="list-style-type: none"> -Everyone's plan will be reviewed and the assessments will be updated. All individuals assessments will be updated. -If there are any outings, additional staff will be called in for support. -If any individual does not want to participate, their approved unsupervised time will be used. If it exceeds unsupervised time, manager will come in to support. -Describe your plans to make sure the above happens: <ul style="list-style-type: none"> -There is a monthly calendar to determine when an outing will occur to know ahead of time what the plan is and an assessment will be completed to determine whether we need additional staff. -We will put a clause in the plan. The unsupervised time was reviewed, sign and date it. It will be signed and dated when reviewed. -All staff will be in-serviced on person specifics, that includes unsupervised time and any changes." <p>The facility served six adult clients whose diagnoses included Schizoaffective Disorder-Bipolar Type, Post Traumatic Stress Disorder, Schizoaffective Disorder- Depressive Type; Anxiety Disorder- Unspecified, Schizophrenia Disorder, Hypertension, Avoidant Personality Disorder, Hyperlipidemia and Trichotillomania. The unsupervised time assessments for Clients #1, #2, #3, #4 and #5 had not been reviewed annually and facility staff assumed that Clients #1, #2, #3, #4 and #5 had seven hours of unsupervised time both at home and in the community. On October 25, 2025, Staff #8 along with four of the clients (#1, #2, #5 and #6) attended the State fair. Clients #3 and #4 chose to stay at the facility and were left at the facility without staff supervision. During the outing, Client #1 separated from the group and was unable to</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SEAWELL STREET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 108 EAST SEAWELL STREET SANFORD, NC 27332
--	---

(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
V 290	Continued From page 10 be found. Staff #8 stayed at the fair grounds searching and trying to get assistance from local law enforcement until 4:00 am. While Staff #8 was at the fair, no arrangements were made by management for an additional staff to go to the facility and be with Clients #3 and #4 and to administer them their medications. Clients #3 and #4 were left unattended until Staff #8 returned to the facility on the morning of October 26th at 4:30 am. Clients #3 and #4 were worried for the clients that attended the fair and were also afraid that someone may try to break inside the facility during the time they were left alone. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 290		