STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

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FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 conducted an Annual Survey and a Complaint investigation on 10/21/25 to 10/22/25.	D 000		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure there was a medical examination completed no more than 90 days prior to admission for 1 of 5 sampled residents (#5).	D 235		

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D 235	Continued From page 1 The findings are: Review of Resident #5's current FL-2 dated 04/03/25 revealed diagnoses included unspecified dementia, hypertension, major depression disorder, anxiety, history of breast cancer and nicotine dependence. Review of Resident #5's resident register revealed an admission date of 08/07/25. Review of Resident #5's record on 10/22/25 revealed there was an FL-2 dated 01/30/25, and an FL-2 dated 04/03/25. Interview with the Resident Care Coordinator (RCC) on 10/22/25 at 11:45am revealed: -She did not know that the FL-2 needed to be dated by the provider within 90 days before the resident moved in. -She thought the FL-2 needed to be dated within 30 days before the resident moved in. -She was not responsible for reviewing the admission paperwork. -The Regional Clinical Supervisor was responsible for reviewing the admission paperwork and approving the admission. Interview with the Administrator on 10/22/25 at 2:10pm revealed: -She did not review the new admission paperwork. -She was not aware that the admission FL-2 for Resident #5 was not correct. -The Regional Clinical Supervisor was responsible for reviewing the admission paperwork.	D 235		

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D 271	Continued From page 2	D 271		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff for 1 of 1 sampled residents (#2) who had an injury of unknown origin and a broken arm. The findings are: Review of Resident #2's current FL-2 dated 08/13/25 revealed: -Diagnoses included dementia, chronic respiratory failure, generalized anxiety, hyperthyroidism, macular degeneration, and gastric-esophageal reflux disease (GERD). -She was ambulatory. -She wandered. -She was incontinent of bowel and bladder. Review of Resident #2's care plan dated 09/24/25	D 271		

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D 271	Continued From page 3	D 271		

revealed:
-She was totally dependent on staff with toileting, bathing, dressing, and grooming.
-She required limited staff assistance with transfers.
-She was independent with eating and ambulation.

Review of Resident #2's accident/incident report for an injury of unknown origin dated 10/17/25 revealed:
-Resident #2 was lying in bed with a bruised and swollen right wrist.
-Resident #2 was sent to the Emergency Department (ED) on 10/17/25 at 11:20am.
-Resident #2's responsible party was notified on 10/17/25 at 11:15am of Resident #2 being transferred to the ED for evaluation for a swollen and bruised right wrist.
-Resident #2 was discharged from the ED with right wrist pain, localized collection of blood and a closed fracture of the distal end of the right radius.

Review of Resident #2's electronic progress notes revealed:
-On 10/16/25, staff reported bruising and swelling of Resident #2's right inner wrist, base of her right thumb, back of her right hand and her right wrist was tender to touch.
-Resident #2's responsible party was notified, and a message was left for the Primary Care Provider (PCP).
-On 10/17/25, Resident #4 had a fractured wrist and was wearing a splint.
-On 10/18/25, Resident #4 had a splint on her right forearm; no pain or discomfort noted.
-On 10/22/25, Resident #4's responsible party was notified that Resident #4 returned to the facility with a fractured right wrist.

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D 271	Continued From page 4 Interview with Resident #2 on 10/21/25 at 2:40pm revealed: -She thought she had a broken arm, but she was not sure. -She did not know how she hurt her arm. Telephone interview with Resident #2's responsible party on 10/22/25 at 9:45am revealed: -She received a telephone call on Thursday evening, 10/16/25, that Resident #2 had a bruise and swelling above her right wrist. -The staff could not tell her what happened. -She received a second phone call on Friday morning, 10/17/25, that Resident #2 was being sent to the ED because of the swelling and bruising on her right arm. -No one from the facility had called her since she received the phone call the morning of 10/17/25, when Emergency Medical Services (EMS) picked Resident #2 up and took her to the ED. Interview with a personal care aide (PCA) on 10/22/25 at 4:29am revealed: -She worked second shift on Thursday, 10/16/25. -Resident #2 was on an outing when she arrived to work; Resident #2 returned to the facility around 4:00pm. -Resident #2 walked to the dining room to eat dinner when she returned from the outing. -After dinner, she walked Resident #2 to her room for her shower. -As she was undressing Resident #2, she noticed her right arm looked like it had been twisted; it was dark blue and swollen. -She notified two other PCAs and the medication aide (MA), who came to Resident #2's room and saw the injury. -The MA called the Special Care Coordinator	D 271		

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D 271	Continued From page 5	D 271		

(SCC), but she did not hear the conversation.
-Resident #2's arm continued to swell from the time she noticed the injury, around 6:00pm, until the end of her shift, around 11:00pm.
-When she arrived to work on second shift on Friday, 10/17/25, Resident #2 was out of the facility at the ED but Resident #2 returned to the facility before the end of her shift at 11:00pm.
-Resident #2 returned from the ED with a cast on her right arm.
-She did not know what happened to Resident #2's right arm.

Interview with a second PCA on 10/21/25 at 3:16pm revealed:
-She worked second shift the evening of 10/16/25, when Resident #2 was seen with an injury to her arm.
-Another PCA was getting Resident #2 ready for a shower, when that PCA came and got her and a third PCA to come look at Resident #2's right arm.
-The MA looked at Resident #2's arm and called the SCC.
-She overheard the conversation between the MA and the SCC.
-The MA described to the SCC what she saw and the SCC responded that Resident #2 was not injured on first shift, nothing happened to her on the outing that day, and that second shift needed to figure out what happened to Resident #2, then the SCC hung up the telephone on the MA.
-The following morning, the Administrator walked with her to Resident #2's room to look at Resident #2's right arm.
-The Administrator asked why Resident #2 was not sent out the evening before when the injury was noticed.
-She told the Administrator that the MA called the SCC, and what was said by the SCC, and the MA

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D 271	Continued From page 6 was not told to send the resident to the ED. Interview with a third PCA on 10/22/25 at 11:08am revealed: -She worked second shift on 10/16/25. -She and a second PCA were called to Resident #2's room from the PCA caring for Resident #2 because Resident #2 had a bruise and swelling on her right arm. -Resident #2 complained of pain when her right arm was touched. -The MA saw Resident #2's arm, then she called the SCC. -She overheard the SCC on the phone tell the MA that nothing happened to Resident #2 on first shift, they had to figure it out, and then the SCC hung up on the MA. -Resident #2 was not sent to the ED until the following morning, 10/17/25. -She came back later the same day; her arm was wrapped up and she complained of her right arm hurting. Interview with a fourth PCA on 10/22/25 at 11:53am revealed: -She worked first shift on Thursday, 10/16/25, before Resident #2 went on the outing with 7 other residents to the pumpkin patch. -Resident #2's arm was not bruised or swollen when she left the facility for the pumpkin patch. -When she left work that day, Thursday 10/16/25, at 3:00pm, Resident #2 had not returned from the pumpkin patch. -She worked first shift the morning of Friday, 10/17/25. -Resident #2's right arm was swollen and bruised from her wrist to just below her elbow. -Resident #2 was not using her right hand/arm; she complained of her right arm hurting. -The MA sent Resident #2 to the ED.	D 271		

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D 271	Continued From page 7 -Resident #2 returned from the ED later in the day with a cast on her right lower arm. Interview with a MA on 10/22/25 at 4:10pm revealed: -She was the MA on second shift on Thursday, 10/16/25. -The PCA asked her to look at Resident #2's arm because it was swollen and bruised. -After she looked at Resident #2's arm, she called the SCC. -The SCC said to find out what happened to Resident #2. -The SCC did not say to send her to the ED. -She did not know whether to send Resident #2 to the ED or not; the SCC did not tell her to send Resident #2 to the ED. -Resident #2 was sent to the ED on Friday morning, 10/17/25. -Resident #2 had a broken arm and a cast was put on her right arm. -She did not know what happened to Resident #2. Telephone interview with a second MA on 10/22/25 at 4:20pm revealed: -She worked with Resident #2 on Friday, 10/17/25. -The PCA told her on Friday morning about Resident #2's arm. -She told the Administrator, who looked at Resident #2's arm. -Resident #2's right arm was swollen and bruised; her arm was blue. -She sent Resident #2 to the ED. -Resident #2 should have been sent to the ED on Thursday evening, 10/16/25; she should not have stayed in the facility that night. Interview with the Activities Director (AD) on 10/21/25 at 3:44pm revealed:	D 271		

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D 271	Continued From page 8 -The Administrator, the SCC and the AD took 8 residents to the local pumpkin patch for an outing on Thursday, 10/16/25. -Resident #2 was 1 of 8 residents who went to the pumpkin patch that day. -She helped Resident #2 put her coat on before leaving the facility on 10/16/25. -They were out of the facility for 2 to 2.5 hours. -The residents looked at the animals, had a hayride, and a train ride. -Resident #2 did not have any falls or injuries while she was out of the facility. -She assisted with the dinner meal on 10/16/25; she thought Resident #2 fed herself without problems. -On 10/17/25, during breakfast, the MA asked her to come look at Resident #2's arm. -When the Administrator arrived she was taken to Resident #2's room to see Resident #2's right arm. -The Administrator had Resident #2 sent to the ED. Interview with the SCC on 10/22/25 at 2:10pm revealed: -She did not know what happened to Resident #2's right arm. -She was off work on Friday, 10/17/25, and received a phone call from the Administrator, who wanted to know if she was aware of Resident #2's right arm. -She told the Administrator she did not know anything about Resident #2's right arm. -She saw Resident #2 on Monday, 10/20/25, when she returned to work. -She did not receive a telephone call from the MA at the facility on Thursday, 10/17/25, regarding Resident #2's arm. Interview with the Administrator on 10/02/25 at	D 271		

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D 271	Continued From page 9 2:35pm revealed: -On Friday, 10/17/25, the MA reported to her that Resident #2 had a bruise on her right hand and that she did not know what happened to Resident #2. -She saw Resident #2 and looked at her right arm and had Resident #2 sent to the ED. -She thought Resident #2 had a fall or that someone told her Resident #2 had a fall. -She did not know that the staff on second shift the day before, 10/16/25, had noticed the injury to Resident #2's right arm. -She could not recall who told her Resident #2's injury was first noticed on second shift on 10/16/25. -Resident #2 had not returned from the ED when she left on Friday; she thought she returned to the facility on Saturday. -She called the facility on Sunday morning, and the MA reported that Resident #2 was in the facility. -She did not know what happened to Resident #2. -She went on an outing with the SCC, the AD, and 8 residents on Thursday, 10/16/25; Resident #2 went also. -Resident #2 was fine the entire time they were gone; she did not have any injuries or falls. Attempted telephone interview with Resident #2's PCP on 10/22/25 at 3:00pm was unsuccessful. _____ The facility failed to contact Emergency Medical Services when a resident (#2) was noticed to have swelling, bruising, and a knot on her right lower arm, and the swelling progressed through the evening. The resident was sent to the ED the next day and it was determine the resident sustained a fractured arm that required casting. This failure resulted in neglect and injury of the resident and constitutes a Type A1 Violation.	D 271		

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D 271	Continued From page 10 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/22/25. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2025.	D 271		
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: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#5) including failing to ensure the resident was seen for a follow-up appointment after being seen in the emergency room for left shoulder pain. The findings are: Review of Resident #5's FL-2 dated 04/25/25 revealed diagnoses included unspecified dementia, hypertension, major depression disorder, and anxiety. Review of Resident #5's progress note dated 09/26/25 at 7:32pm revealed Resident #5 had another resident pinned down on the floor, and was then sent to the hospital to be evaluated. Review of Resident #5's emergency department (ED) visit note dated 09/26/25 revealed: -She was seen for left shoulder pain with a	D 273		

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D 273	Continued From page 11	D 273		

discharge diagnosis of left shoulder strain.
-There was an order to follow up with Resident #5's primary care provider (PCP).

Review of an incident report dated 09/26/25 revealed that Resident #5 had a follow-up appointment scheduled with her PCP on 10/08/25.

Review of Resident #5's chart revealed there was no after visit summary dated 10/08/25.

Interview with the interim PCP on 10/22/25 at 11:23am revealed:
-She was filling in for the regular PCP.
-She could not find an after visit note that Resident #5 had been seen for a follow-up after the ED discharge on 09/26/25.
-The last visit Resident #5 had with the PCP was on 09/30/25 and that was for chronic disease management for hypertension and cerebrovascular disease, not the ED follow-up.
-She expected that if the resident was seen in the ED, that a PCP follow-up be completed to ensure Resident #5 was no longer in pain.
-She may have ordered physical therapy if Resident #5 had been seen.

Interview with Resident #5 on 10/22/25 at 8:36am revealed:
-She knew she went to the ED but could not remember why.
-She did not complain of any pain in the left shoulder.
-She did not remember seeing her PCP after the ED visit.

Interview with Resident #5's power of attorney (POA) on 10/22/25 at 4:08pm revealed:
-She was aware of the altercation with Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 12 #5 and another resident on 09/26/25 and that Resident #5 was sent to the ED. -She was aware that Resident #5 was supposed to follow up with her PCP after her ED visit. -She was not aware that Resident #5 did not have a follow-up visit. Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:15pm revealed: -She was responsible for reviewing the ED discharge paperwork. -She was aware that Resident #5 was supposed to be seen by the PCP after the ED discharge. -She called the PCP's office and let them know. -She did not follow up to make sure Resident #5 was seen by the PCP. Interview with the Administrator on 10/22/25 at 2:40pm revealed: -The SCC was responsible for reviewing the ED discharge paperwork. -She was not aware that Resident #5 had a PCP follow-up order. -She expected that Resident #5 be seen by the PCP if ordered by the ED.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 286	Continued From page 13 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon in the Special Care Unit (SCU). The findings are: Observation of the lunch meal service on 10/21/25 from 12:00pm to 12:23pm revealed: -There were 32 residents and 8 of those residents did not have a knife. -At 12:05pm, a resident used her fork to pick up a ravioli. -The resident stated, "Where is my knife". -The resident picked up an unused knife from another resident's place setting and used the knife to cut her ravioli. Observation of the breakfast meal on 10/22/25 from 7:58 to 8:30am revealed: -At 8:15am, there were 31 residents in the dining room. -Twenty-three of thirty-one residents did not have a knife. Interview with a personal care aide (PCA) on 10/22/25 at 11:08am revealed: -The PCAs wrap the utensils in the napkins. -There were not enough knives for each resident to have a knife. -When she asked the dietary aide (DA) for more knives, the DA would tell her they did not have anymore.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 286	Continued From page 14 Interview with a PCA on 10/22/25 at 3:20pm revealed: -She helped prepare the utensils and napkins for the dining tables. -She prepared the utensils that each resident needed. -If the resident did not need a knife, she did not give a knife to that resident. -She had to ask the DA for more utensils at times, sometimes they would have what was needed and sometimes they did not. Interview with the Special Care Coordinator (SCC) on 10/22/25 at 10:47am revealed: -The PCAs prepared the silverware for each place setting prior to each meal being served. -The PCAs wrapped the silverware in a clothe napkin and placed them on the dining room tables. -The PCAs used the silverware that was sent out of the kitchen. -There was not enough utensils for each resident to have a knife. -She had spoken with the Dietary Manager (DM) about not having enough knives. -They asked for more knives and the dietary staff would say they did not have any more knives. -She did not know if the DM had ordered any additional knives. Interview with the DM at 11:47am revealed: -The facility had enough utensils for each resident to have a full set at each meal. -The PCAs told me a few months ago that more spoons were needed and he ordered those. -He had a drawer full of silverware that was available for the PCAs to use for each place setting. -He did not know they needed more knives in the dining room; he had more knives in the kitchen.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

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D 286	Continued From page 15 Interview with the Administrator on 10/22/25 at 11:52am revealed: -No one had told her there were not enough knives for each resident to have a knife. -She had not noticed that each place setting did not have enough knives. -She expected the residents to have a full set of utensils at each meal.	D 286		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy servings were served three times daily to the residents. The findings are: Review of the facility's current census on	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 299	Continued From page 16 10/22/25 revealed there were 43 residents residing in the facility. Based on the recommended servings of 8 ounce of milk three times a day the facilty would use 8 gallons of milk per day to serve 43 residents. Review of the weekly menu for 10/21/25 and 10/22/25 revealed: -Milk was to be served at breakfast and dinner everyday. -There was no dairy items on the menu for lunch on 10/21/25 and 10/22/25. Review of the facility's purchase order dated 10/13/25 revealed there was no milk ordered for delivery on 10/14/25. Review of the facility's purchase order dated 10/20/25 revealed there were four units or 16 gallons of milk ordered for delivery on 10/21/25. Observation of the kitchen on 10/21/25 at 9:00am revealed there was no milk in the reach in cooler. Observation of the contracted food delivery company on 10/21/25 at 11:20am revealed milk was delivered to the facility. Observation of snack being served on 10/21/25 at 11:07am revealed water was served with snacks an no other dairy products. Observation of the lunch meal on 10/21/25 between 11:55am and 12:20pm revealed: -There were 31 resident in the dining room. -The residents were served ravioli, vegetable medley, creamed potatoes, garlic toast, and sherbet. -Milk was not offered or served.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 299	Continued From page 17 Observation of the breakfast meal on 10/22/5 between 7:58am and 8:22am revealed: -There were 32 residents in the dining room. -The residents were served scrambled eggs, corn hash, toast, cereal, and oatmeal. -A 4-ounce serving of milk was served to each resident. Interview with a personal care aide (PCA) on 10/22/25 at 11:08am revealed: -She worked first and second shifts. -The PCAs served the drinks at each meal. -Milk was served to the residents each morning with the breakfast meal. -Milk was not served at the lunch or supper meal. -The dietary staff would prepare what drinks would be served for each meal. -For breakfast they had pitchers of milk to be served. -The dietary staff did not prepare pitchers of milk for the lunch or the dinner meal. -Milk was not served with snacks; only water was served with snacks. -The residents may have ice cream once a week. Interview with the Dietary Manager (DM) on 10/22/25 at 9:57am revealed: -He ordered 16 gallons of milk each week. -He had about 2 gallons left from each week. -The cook used 2 gallons of milk on 10/21/25 for breakfast, and there was no more milk in the facility. -He did not know why they ran out of milk a day earlier. -He was expecting the food deliver truck today, 10/21/25. -Milk should be served at each meal. -Each resident should receive 4 ounces of milk at each meal.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 299	Continued From page 18 -He did not know each resident should be offered or receive three servings of a dairy product daily. -He did not know a serving of mild was 8-ounces. Interview with the Special Care Coordinator (SCC) on 10/22/25 at 10:47am revealed: -Each resident should receive 2 servings of dairy a day. -The residents were served milk for breakfast and a serving of ice cream or yogurt with another meal or snack. -The PCAs served the milk to the residents, and milk was only served at the breakfast meal. -The PCAs would serve milk at other meals if the resident requested milk. -She was not aware residents should receive 3 servings of dairy a day. Interview with the Administrator on 10/22/25 at 11:52am revealed: -The residents were to be served 8 ounces of milk twice daily. -The residents were served 8 ounces of milk every morning and 8 ounces of milk at lunch or dinner. -She did not know the residents were served 4 ounces of milk when they were served milk. -She did not know the residents should receive 3 servings of dairy a day.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 19	D 310		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 5 sampled residents (#4, #6, and #7) including two residents who were ordered a mechanical soft diet (#4 and #6) and a resident who was ordered pureed diet (#7).

The findings are:

1. Review of the facility's therapeutic diet menu for 10/21/25 revealed the mechanical soft menu for lunch listed 4 cheese ravioli with marinara sauce, ½ cup of sliced carrots, a dinner roll and sherbet.

Review of the facility's therapeutic diet menu for 10/22/25 revealed the mechanical soft menu for breakfast listed scrambled eggs, 1 sausage patty, and two slices of bread.

a. Review of Resident #4's current FL-2 dated 07/01/25 revealed diagnoses of pneumonia, malnutrition, hypertension, chronic obstructive pulmonary disease (COPD), and dementia.

Review of Resident #4's diet order dated 07/01/25 revealed there was an order for a mechanical soft diet.

Review of Resident #4's electronic progress notes dated 08/11/25 at 5:48pm revealed:
-Resident #4 was observed choking while in the dining room during the supper meal.
-The Heimlich maneuver was performed, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 20 Resident #4 was doing well. Observation of the lunch meal on 10/21/25 from 11:55am to 12:32pm revealed: -Resident #4 was served mechanical soft cheese ravioli, mechanical soft mixed vegetables, mashed potatoes with gravy, a ground roll, water, and tea. -Resident #4 ate 100% of her meal. -Resident #4 did not have any coughing while eating lunch. Observation of the breakfast meal on 10/22/25 at 8:07am to 8:35am revealed: -Resident #4 was served a plate with scrambled eggs, corn beef hash with chunks of beef and potatoes, and shredded bread. -Resident #4 consumed 100% of her breakfast. -Resident #4 did not have any coughing while eating breakfast. Interview with a personal care aide (PCA) on 10/22/25 at 3:02pm revealed: -She worked second shift the evening Resident #4 choked at the dinner meal. -A former medication aide (MA) performed the Heimlich maneuver and dislodged the food. -She thought Resident #4 ate pineapple chunks off of another resident's plate. -Resident #4 was on a mechanical soft diet and should not have eaten pineapple chunks. -She did not know if Resident #4 had choked on food since the incident on 08/11/25. Interview with a former MA on 10/22/25 at 4:42pm revealed: -Resident #4 was ordered a mechanical soft diet. -Resident #4 was in the dining room for dinner the evening she choked on some fruit. -Resident #4 was choking and turning blue.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 21	D 310		

-She performed the Heimlich maneuver on Resident #4 and dislodged pieces of fruit.
-Resident #4 had picked the fruit off of the resident's plate sitting next to her.
-She notified the Administrator of the incident by text and telephone call.
-She did not know if Resident #4 had choked on food since the incident on 08/11/25.

Interview with the Special Care Coordinator (SCC) on 10/22/25 at 2:56pm revealed she was not made aware of any resident choking.

Interview with the Administrator on 10/22/25 at 4:20pm revealed she was not aware of Resident #4 choking and the Heimlich maneuver needing to be performed.

Attempted telephone interview with resident #4's Primary Care Provider (PCP) on 10/21/25 at 1:39pm was unsuccessful.

b. Review of Resident #6's current FL-2 dated 08/21/25 revealed diagnoses of dementia and hypertension.

Review of Resident #6's current diet order dated 04/09/25 revealed there was an order for a mechanical soft diet.

Observation of the lunch meal on 10/21/25 between 12:12pm and 12:35pm revealed:
-Resident #6 was served a plate with partially pureed ravioli with chunks of pasta, creamed potatoes, vegetable medley with carrots, green beans, that were clumped together, and shredded bread.
-Resident #6 consumed 90% of her lunch.
-Resident #6 did not have any coughing while eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 22 Observation of the breakfast meal on 10/22/25 at 8:10am to 8:35am revealed: -Resident #6 was served a plate with scrambled eggs, corn beef hash with chunks of beef and potatoes, and shredded bread. -Resident #6 consumed 100% of her breakfast. -Resident #6 did not have any coughing while eating. Interview with two PCAs on 10/22/25 between 12:05pm and 12:30pm revealed they had not noticed Resident #6 having any coughing during mealtime. Interview with the Administrator on 10/22/25 at 11:52am revealed Resident #6's lunch plate looked partly pureed but with chunks of food. Attempted telephone interview with resident #6's Primary Care Provider (PCP) on 10/21/25 at 1:39pm was unsuccessful. _____ Interview with the dietary aide (DA) on 10/22/25 at 8:24am revealed: -She placed the ravioli in the food processor to soften the ravioli for the mechanical soft diet. -She added thickener to the ravioli so it would not be "runny". -She used the food processor to prepare the food for the mechanical soft diets. -She made the food soft enough for the residents to eat. -She used the food processor to shred bread for the mechanical soft diets. -She prepared the mechanical soft food because the residents had difficulty chewing their food. Interview with the Dietary Manager (DM) on 10/22/25 at 9:57am revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 23 -The ravioli was soft enough; it did not need to go in the food processor. -The medley of vegetables should have been replaced with carrots, and the garlic bread should have been replaced with a dinner roll. -The DA prepared the mechanical soft diets as ordered. -The mechanical soft diets were prepared in the food processor. -The DA would add thickener to the food to ensure the texture was mechanically soft. -The mechanical soft diet should "hold together" when it was served. Interview with the Special Care Coordinator (SCC) on 10/22/25 at 10:47am revealed: -She had sent mechanical soft diet plates back to the kitchen when the food was not chopped up enough. -The mechanical soft diets appeared to be pureed with a thickener added. Interview with the Administrator on 10/22/25 at 11:52am revealed: -Mechanical soft food should not be pureed. -Mechanical soft diets should be cooked to a consistency where the food was soft. -She was concerned because residents ordered mechanical soft diets could become choked or aspirate food that was not prepared properly. Refer to the interview with the DA on 10/22/25 at 10:30am. Refer to the interview with the DM on 10/22/25 at 9:57am. Refer to the interview with the SCC on 10/22/25. Refer to the interview with the Administrator on	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 24 10/22/25 at 11:52am. 3. Review of the facility's therapeutic diet menu for 10/21/25 revealed the pureed menu for lunch listed 6 ounces of pureed cheese ravioli, ½ cup of pureed sliced carrots, one slice of pureed bread, and a pureed ice cream sandwich. Review of the facility's therapeutic diet menu for 10/22/25 revealed the pureed menu for breakfast listed ¼ cup of pureed scrambled eggs, ½ cup of pureed sausage, and 2 ounces of pureed bread. Review of Resident #7's current FL-2 dated 01/15/25 revealed diagnoses of type 2 diabetes mellitus, dementia, anxiety disorder, Alzheimer's disease, hypertension, and chronic kidney disease stage 3. Review of Resident #7's diet order dated 04/09/25 revealed there was an order for a pureed diet. Observation of the lunch meal on 10/21/25 from 12:15pm to 12:40pm revealed: -Resident #7 was served partially pureed ravioli that had chunks of pasta, shredded bread, pureed vegetable medley that was watery and had chunks of carrots, green beans, and cauliflower, and creamed potatoes with gravy. -Resident #7 consumed 50% of the lunch meal. -Resident #7 was not observed coughing during the lunch meal. Observation of the breakfast meal on 10/22/25 from 8:15am to 8:30am revealed: -Resident #7 was served oatmeal and corn beef hash that had not been prepared to a pureed consistency. -Resident #7 was not served pureed sausage or	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 25	D 310		

bread with her breakfast meal.
-Resident #7 refused to eat breakfast and was removed from the dining room table.

Interview with two personal care aides (PCA) on 10/22/25 between 12:05pm and 12:30pm revealed they had not noticed Resident #7 coughing during mealtime.

Observation of a dietary aide (DA) preparing the lunch meal for 10/22/25 at 8:28am revealed:
-There was a can of vegetable soup that had been opened and placed in individual sized serving bowls.
-There were two individual sized serving bowls that had a red pureed substance with lumps in them.
-The DA had a serving size spoon, and she was "pureeing" the vegetable soup by "mashing" the vegetable up in the soup.

Interview with a DA on 10/22/25 at 8:28am revealed:
-The pureed food should be "baby food" texture and should not be watery.
-She pureed the ravioli for the pureed diet so the residents would not get choked.
-Some foods were soft enough and did not need to be pureed, such as the eggs and oatmeal.
-She did not know the pureed diets were suppose to get a pureed sausage patty instead of the corn beef hash.
-She was preparing pureed soup for lunch that day, 10/22/25.
-She was using the serving spoon to "smash up" the vegetables in the soup.
-She removed "clumps or particles" that could not be "smashed".
-Residents on a pureed diet could not eat "bulky" food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 26 -This was one way she broke down the food to pureed. -She used the food processor to pureed some foods, like eggs, bread, and meats. -If the pureed food had too much liquid, she added a thickener. -She made sure the pureed food was soft enough for the residents to eat; she did not want the residents to get choked. Interview with the Dietary Manager (DM) on 10/22/25 at 9:57am revealed: -Resident #7 was not served a pureed diet for the lunch meal on 10/21/25 or the breakfast meal on 10/22/25. -Resident #7 was served a mechanical soft diet; the food had lumps. -A pureed diet would not have lumps: it should be creamy. -Resident #7's oatmeal was watery with lumps, and she should not have been served corn beef hash. -Resident #7 should have received a pureed sausage patty and a piece of pureed bread. -The DA prepared the pureed diets as ordered. -The pureed diets should be prepared in the blender. -The DA should add thickener to the food if the pureed had too much liquid in the food. Interview with the Special Care Coordinator (SCC) on 10/22/25 at 10:47am revealed: -She had sent plates of pureed food back to the kitchen because the food was too thick. -Resident #7's plates of food for lunch on 10/21/25 and breakfast on 10/22/25 did not appear to be pureed; the food was either too thick with lumps or watery. -Pureed food should have no lumps and a very soft consistency.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 310	Continued From page 27 Interview with the Administrator on 10/22/25 at 11:52am revealed: -Resident #7's lunch plate on 10/21/25 and breakfast plate on 10/22/25 could possibly be pureed but it still had chunks of food. -Pureed should be creamy and not watery or lumpy. -She was concerned because residents ordered pureed diets could become choked or aspirate food that was not prepared properly. Attempted telephone interview with resident #7's Primary Care Provider (PCP) on 10/21/25 at 1:39pm was unsuccessful. Refer to the interview with the DA on 10/22/25 at 10:30am. Refer to the interview with the DM on 10/22/25 at 9:57am. Refer to the interview with the SCC on 10/22/25. Refer to the interview with the Administrator on 10/22/25 at 11:52am. _____ Interview with a DA on 10/22/25 at 10:30am revealed: -She did not have a therapeutic menu to follow. -She knew what a therapeutic menu was, but she did not need one. -She knew how to prepare pureed and mechanical soft diets. Interview with the DM on 10/22/25 at 9:57am revealed: -The facility had a therapeutic menu; he could print it off the computer. -The therapeutic menu was not posted for the DA	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 28	D 310		

to use to prepare the food.
-The DAs knew how to prepare the meals for the residents on therapeutic diets.
-The residents sat at the same table for each meal, and each table was numbered.
-The PCAs would ask the DA for the plates for a certain table number.
-The DAs would refer to the dietary list posted at the serving line.
-The dietary list indicated which type of diets were to be served for that specific table number.
-The DA would prepare the plates for that table, including any therapeutic diets listed on the dietary list.
-It was the responsibility of the PCA to serve the correct diet to the correct resident.
-He did not see the therapeutic diets served at the breakfast meal on 10/22/25; the staff had served the plates most mornings before he arrived.
-He saw the therapeutic diet plates prepared on 10/21/25 for lunch; he did not notice any problems with the diets served.

Interview with the SCC on 10/22/25 at 10:47am revealed:
-The PCAs requested the plates for a certain table, the DA prepared the plates, and the PCAs served the plates
-The PCAs knew the diets of each resident and served them correctly.
-She observed meals being served.
-She had sent plates back to the kitchen when they were not prepared correctly.
-The DM should oversee the meals and see they were served correctly.

Interview with the Administrator on 10/22/25 at 11:52am revealed:
-The DM should print the therapeutic menu each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 29 week and make it available to the DA when she prepared food. -The DA should refer to the therapeutic menu to know how to prepare the food for each therapeutic diet. -She monitored meals at lunch; if she saw a problem she would send the plate back to the kitchen. -She expected therapeutic diets to be served as ordered. The facility failed to ensure therapeutic diets were served as ordered for mechanical soft and pureed diets, including a resident on a mechanical soft diet who choked on a piece of fruit and the Heimlich maneuver was performed (#4). This failure resulted in substantial risk of serious injury of the resident and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/22/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2025.	D 310		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 438	Continued From page 30 Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reports within 24 hours of an allegation of physical abuse for 2 of 3 residents (#4 and #10) by a staff member (Staff D); and not reporting an injury of unknown origin for 1 of 1 sampled residents (#2). The findings are: 1. Review of Resident #4's current FL2 dated 07/01/25 revealed: -Diagnoses included leukocytosis, severe protein-caloric malnutrition, hypertension, chronic obstructive pulmonary disease (COPD), and dementia. -The resident was documented as constantly disoriented. -The resident was documented as having wandering behaviors. -The resident was ambulatory and required staff assistance with bathing, feeding, and dressing. Review of video footage of Resident #4 dated 09/30/25 from 8:32am to 8:41am revealed: -Staff D, a personal care aide (PCA), was seen aggressively gripping Resident #4's right arm while briskly walking down the hallway towards the dayroom. -Staff D firmly placed the resident backwards into the recliner. -The resident attempted to get out of the recliner. -Staff D forcefully pushed the back of the recliner backwards; the excessive force caused the resident's lower limbs to be lifted into the air as the chair reclined. -The resident was able wiggle her body out of the recliner. -Staff D aggressively grabbed the resident's right	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 438	Continued From page 31	D 438		

arm and shirt, forcing the resident backwards into the recliner.
-The resident got out of the chair again and Staff D grabbed the resident's left arm and forced the resident backwards into the recliner.

Review of a 24-hour HCPR Initial Allegation Report revealed there was no 24-hour HCPR initial allegation report to review.

Review of the 5-day Investigation Report revealed there was no 5-day Investigation Report to review.

Attempted telephone interview with Staff D on 10/22/25 at 5:39pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

2. Review of Resident #10's current FL2 dated 08/11/25 revealed:
-Diagnoses included hypertension, neurocognitive disorder with Lewy bodies, osteoporosis, and gastro-esophageal.
-The resident was documented as constantly disoriented.
-The resident was semi-ambulatory and required staff assistance with bathing.

Review of video footage of Resident #10 dated 09/30/25 from 8:36am to 8:52am revealed:
-Resident #10 was seated in her wheelchair in the dayroom while using her legs to move her wheelchair forward.
-Staff D, a personal care aide (PCA), placed her hand on the resident's shoulder and her other hand on the arm of the wheelchair and in a swift motion, pulled the wheelchair backwards and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 438	Continued From page 32	D 438		

towards the wall.
-The resident attempted to move the wheelchair forward and Staff D locked the wheels to the wheelchair.
-The resident continued to attempt to move the wheelchair forward when the Staff D planted her left foot in front of the right wheel of the wheelchair, preventing movement.
-The resident attempted to move the wheelchair again, when Staff D pushed the wheelchair forward facing and against an armchair.
-The resident's wheelchair was facing the right side of the armchair and Staff D locked the resident's wheelchair, preventing movement.

Interview with the Administrator on 10/22/25 at 2:18pm revealed:
-She was responsible for reporting to HCPR.
-All HCPRs completed by her would be on file at the facility.
-She reported the incidents in the video footage to the Regional Vice President of Operations (RVPO).
-She did not report the incidents to HCPR because she saw the incidents as a critical offense, but not abuse.

Review of a 24-hour HCPR Initial Allegation Report revealed there was no 24-hour HCPR initial allegation report to review.

Review of the 5-day Investigation Report revealed there was no 5-day Investigation report to review.

Attempted telephone interview with Staff D on 10/22/25 at 5:39pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #10 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 438	Continued From page 33 3. Review of Resident #2's current FL-2 dated 08/13/25 revealed: -Diagnoses included dementia, chronic respiratory failure, generalized anxiety, hyperthyroidism, macular degeneration, and gastric-esophageal reflux disease (GERD). -She was ambulatory. -She was a wanderer. -She was incontinent of bowel and bladder. Review of Resident #2's accident/incident report for an injury of unknown origin dated 10/17/25 revealed: -Resident #2 was lying in bed with a bruised and swollen right wrist. -Resident #2 was sent to the Emergency Department (ED) on 10/17/25 at 11:20am. -Resident #2 was discharged from the ED with right wrist pain, localized collection of blood and a closed fracture of the distal end of the right radius. Review of Resident #2's electronic progress notes revealed: -On 10/16/25, staff reported bruising and swelling of Resident #2's right inner wrist, base of her right thumb, back of her right hand and her right wrist was tender to touch. -On 10/16/25, Resident #2's responsible party was notified, and a message was left for the Primary Care Provider (PCP). -On 10/17/25, Resident #4 had a fractured wrist and was wearing a splint. -On 10/18/25, Resident #4 had a splint on her right forearm; no pain or discomfort noted. -On 10/22/25, Resident #4's responsible party was notified that Resident #4 returned to the facility with a fractured right wrist. Telephone interview with a medication aide (MA)	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 438	Continued From page 34	D 438		

on 10/22/25 at 4:20pm revealed:
-She worked with Resident #2 on Friday, 10/17/25.
-She was told to complete the incident report on 10/17/25.
-Resident #2's right arm was swollen and bruised; her arm was blue.
-The personal care aide (PCA) told her on Friday morning about Resident #2's arm.
-She told the Administrator, who looked at Resident #2's arm.
-She sent Resident #2 to the ED.
-Resident #2 should have been sent to the ED on Thursday evening, 10/16/25; she should not have stayed in the facility that night.

Interview with a PCA on 10/22/25 at 4:29am revealed:
-She worked second shift on Thursday, 10/16/25.
-As she was undressing Resident #2, she noticed her right arm looked like it had been twisted; it was dark blue and swollen.
-Resident #2's arm continued to swell from the time she noticed the injury, around 6:00pm, until the end of her shift, around 11:00pm.
-She worked on second shift on Friday, 10/17/25, and Resident #2 was out of the facility at the ED but she returned to the facility before the end of her shift at 11:00am.
-Resident #2 returned with a cast on her right arm.
-She did not know what happened to Resident #2's right arm.

Interview with the SCC on 10/22/25 at 2:10pm revealed:
-She did not know what happened to Resident #2's right arm.
-She was off on Friday, 10/17/25, and received a phone call from the Administrator, who wanted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 438	Continued From page 35	D 438		

know if she was aware of Resident #2's right arm.
-She told the Administrator she did not know anything about Resident #2's right arm.
-She saw Resident #2 on Monday, 10/20/25, when she returned to work.
-She did not know an incident report was not completed when the injury was found, until 10/21/25.
-She had the MA completed the incident report on 10/22/25.

Interview with the Administrator on 10/22/25 at 2:35pm revealed:
-On Friday, 10/17/25, the MA reported to her that Resident #2 had a bruise on her right hand and that she did not know what happened to Resident #2.
-She saw Resident #2 and looked at her right arm and had Resident #2 sent to the ED.
-She thought Resident #2 had a fall or that someone told her Resident #2 had a fall.
-She did not know that second shift staff the day before, 10/16/25, had noticed the injury to Resident #2's right arm.
-She did not know what happened to Resident #2.
-She had not reported the injury of unknown origin to the HCPR because she thought the resident had fallen.
-She knew the SCC had the MA complete the incident report yesterday, 10/21/25, but she failed to read the report and had not started an investigation, because she thought Resident #2 was injured from a fall.

Review of a 24-hour HCPR Initial Allegation Report revealed there was no 24-hour HCPR initial allegation report to review.

Review of the 5-day Investigation Report revealed there was no 5-day Investigation Report to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 438	Continued From page 36 review. _____ The facility failed to report to the HCPR within 24 hours regarding an allegation of physical abuse by Staff D to two residents (#4, #10) by aggressively grabbing the resident's arms and forcing the resident backwards in a chair and forcing the resident to sit in a recliner with the footrest highly elevated (#4); locking the wheels to a resident's wheelchair while placing her foot in front of the wheel to prevent movement (#10), who did not have an order for restraints (#10); and delayed reporting an injury of unknown origin of a resident who suffered a broken arm (#2). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/22/25. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2025.	D 438		
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.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 451	Continued From page 37	D 451		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 4 sampled residents who was sent to the hospital for an injury of unknown origin (#2).

The findings are:

Review of Resident #2's current FL-2 dated 08/13/25 revealed:
-Diagnoses included dementia, chronic respiratory failure, generalized anxiety, hyperthyroidism, macular degeneration, and gastric-esophageal reflux disease (GERD).
-She was ambulatory.
-She wandered.
-She was incontinent of bowel and bladder.

Review of Resident #2's electronic progress note revealed on 10/16/25, staff reported bruising and swelling of Resident #2's right inner wrist, base of her right thumb, back of her right hand and her right wrist was tender to touch.

Review of Resident #2's accident/incident report for an injury of unknown origin dated 10/17/25 revealed:
-Resident #2 was lying in bed with a bruised and swollen right wrist.
-Resident #2 was sent to the Emergency Department (ED) on 10/17/25 at 11:20am.
-Resident #2's responsible party was notified on 10/17/25 at 11:15am of Resident #2 being transferred to the ED for evaluation for a swollen and bruised right wrist.
-The status of Resident #2 after the ED visit was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 451	Continued From page 38	D 451		

Resident #2 was discharged from the ED with right wrist pain, localized collection of blood and a closed fracture of the distal end of the right radius.

Telephone interview with the Adult Home Specialist (AHS) on 10/22/25 at 9:20am revealed:
-The facility should report injuries of unknown origin within 24 hours.
-She received incident/accident reports through electronic mail or fax.
-She received an incident/accident report from the facility on Monday, 10/20/25, but it was not about Reisdent #2.
-She had not received any incident/accident reports from the facility since 10/20/25.
-She had not received an incident/accident report for Resident #2 for a broken arm of unknown origin.

Telephone interview with a medication aide (MA) on 10/22/25 at 4:20pm revealed:
-She worked with Resident #2 on Friday, 10/17/25.
-The personal care aide (PCA) told her on Friday morning about Resident #2's arm.
-She told the Administrator, who looked at Resident #2's arm.
-She was told to complete the incident report on 10/17/25.
-Resident #2's right arm was swollen and bruised; her arm was blue.
-She sent Resident #2 to the ED.
-Resident #2 should have been sent to the ED on Thursday evening, 10/16/25; she should not have stayed in the facility that night.

Interview with the Special Care Coordinator (SCC) on 10/22/25 at 2:10pm revealed:
-When an incident/accident happened and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 451	Continued From page 39 resident was sent to the hospital, an incident/accident report would be completed. -Resident #2's incident report from 10/17/25 was completed on 10/21/25 and sent to the AHS on 10/21/25. Interview with the Administrator on 10/22/25 at 2:35pm revealed: -She was responsible for sending the reportable incident/accident reports to the AHS with 24 hours of the incident. -She did not realize the incident report was not completed on 10/16/25 when the injury was noted. -The incident/accident report was completed yesterday, 10/21/25 by the MA who sent Resident #2 to the ED. -The incident/accident report was sent to the AHS yesterday, 10/21/25.	D 451		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by:	D 453		

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	HAL035024	A. BUILDING: _____ B. WING _____	10/22/2025

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D 453	Continued From page 40	D 453		

Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an allegation of physical abuse for 2 of 4 sampled residents (#4 and #10).

The findings are:

1. Review of Resident #4's current FL2 dated 07/01/25 revealed:
-Diagnoses included leukocytosis, severe protein-caloric malnutrition, hypertension, chronic obstructive pulmonary disease (COPD), and dementia.
-The resident was documented as constantly disoriented.
-The resident was documented as having wandering behaviors.
-The resident was ambulatory and required assistance from staff with bathing, feeding, and dressing.

Review of Resident #4's Resident Register revealed an admission date of 07/21/25.

Review of the facility's recorded video footage on 10/22/25 at 3:38pm revealed there was video footage dated 09/30/25 from 8:32am to 8:41am of a staff person being physically abusive to Resident #4.

There was no Accident and Incident Report to review for Resident #4 dated 09/30/25.

Interview with the Adult Care Home Specialist with the County DSS on 10/22/25 at 9:22am revealed she had not received an Accident and Incident Report for Resident #4 dated 09/30/25.

Attempted telephone interview with resident #4's

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D 453	Continued From page 41	D 453		

primary care provider (PCP) on 10/21/25 at 1:39pm was unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

Refer to the interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 5:10pm.

2. Review of Resident #10's current FL2 dated 08/11/25 revealed:
-Diagnoses included hypertension, neurocognitive disorder with Lewy bodies, osteoporosis, and gastro-esophageal.
-The resident was documented as constantly disoriented.
-The resident was semi-ambulatory and required assistance from staff with bathing.

Review of Resident #10's Resident Register revealed an admission date of 05/23/22.

Review of the facility's recorded video footage on 10/22/25 at 3:38pm revealed there was video footage dated 09/30/25 from 8:36am to 8:52am of a staff person being physically abusive to Resident #10.

There was no Accident and Incident Report to review for Resident #10 dated 09/30/25.

Interview with the Adult Care Home Specialist with the County DSS on 10/22/25 at 9:22am revealed she had not received an Accident and Incident Report for Resident #10 dated 09/30/25.

Attempted telephone interview with resident #10's primary care provider (PCP) on 10/21/25 at 1:39pm was unsuccessful.

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D 453	Continued From page 42 Based on observations, interviews, and record review, it was determined that Resident #10 was not interviewable. Refer to the interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 5:10pm. Interview with the SCC on 10/22/25 at 5:10pm revealed she was responsible for reporting the allegations of abuse to DSS.	D 453		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification	D 454		

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D 454	Continued From page 43 according to Rule .0906(f)(4) of this Subchapter.	D 454		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the responsible party of 1 of 4 sampled residents related to a broken arm of unknown origin (#2).

The findings are:

Review of Resident #2's current FL-2 dated 08/13/25 revealed:
-Diagnoses included dementia, chronic respiratory failure, generalized anxiety, hyperthyroidism, macular degeneration, and gastric-esophageal reflux disease (GERD).
-She was ambulatory.
-She wandered.
-She was incontinent of bowel and bladder.

Review of Resident #2's care plan dated 09/24/25 revealed:
-She was totally dependent on staff with toileting, bathing, dressing, and grooming.
-She required limited staff assistance with transfers.
-She was independent with eating and ambulation.

Review of Resident #2's accident/incident report for an injury of unknown origin dated 10/17/25 revealed:
-Resident #2 was lying in bed with a bruised and swollen right wrist.
-Resident #2 was sent to the Emergency Department (ED) on 10/17/25 at 11:20am.

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D 454	Continued From page 44	D 454		

-Resident #2's Power of Attorney (POA) was notified on 10/17/25 at 11:15am of Resident #2 being transferred to the ED for evaluation for a swollen and bruised right wrist.
-The status of Resident #2 after the ED visit was Resident #2 was discharged from the ED with right wrist pain, localized collection of blood and a closed fracture of the distal end of the right radius.

Review of Resident #2's electronic progress note revealed:
-On 10/16/25, staff reported bruising and swelling of Resident #2's right inner wrist, base of her right thumb, back of her right hand and her right wrist was tender to touch.
-Resident #2's responsible party was notified, and a message was left for the primary care provider (PCP).
-On 10/17/25, Resident #4 had a fractured wrist and was wearing a splint.
-On 10/18/25, Resident #4 had a splint on her right forearm; no pain or discomfort noted.
-On 10/22/25, Resident #4's POA was notified that Resident #4 returned to the facility with a fractured right wrist.

Telephone interview with Resident #2's POA on 10/22/25 at 9:45am revealed:
-She received a telephone call on Thursday evening, 10/16/25, that Resident #2 had a bruise and swelling above her right wrist.
-The staff could not tell her what happened.
-She received a second phone call on Friday morning, 10/17/25, that Resident #2 was being sent to the ED because of the swelling and bruising on her right arm.
-She did not know what happened at the ED; no one from the facility called her.
-No one from the facility had called her since she

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D 454	Continued From page 45 received the phone call the morning of 10/17/25, when Emergency Medical Services (EMS) picked Resident #2 up and took her to the ED. Interview with the Special Care Coordinator (SCC) on 10/22/25 at 2:10pm revealed: -On 10/16/25, Resident #2's POA should have been notified when the injury was found. -On 10/17/25, Resident #2's POA should have been notified when Resident #2 was sent to the ED. -On 10/17/25, Resident #2's POA should have been notified of Resident #2's broken arm. -The MAs were responsible for contacting the POA. Interview with the Administrator on 10/22/25 at 2:35pm revealed: -The MA who received Resident #2 from the ED on 10/17/25 should have notified the POA that Resident #2 had a broken arm. -She expected the MAs to notify the POAs when there were changes with the residents.	D 454		