STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 000	Initial Comments The Adult Care Licensure Section and the Orange County Department of Social Services conducted an Annual survey on December 4, 2025.	C 000	DEFICIENCY #1 10A NCAC 13G .0312(g) – Outside Entrances and Exits Rule Type: B	
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had a sounding device engaged that was continuously audible when the doors were opened which was accessible two residents who were intermittently disoriented (#1, #4), two residents who were constantly disoriented (#2,	C 069	Corrective Action and Resident Protection: Effective immediately on 12/4/2025, staff implemented 15-minute documented safety checks of the front, side, and rear exits and all residents. All staff, including Med Techs and CNAs, documented and verified completion of these checks from 12/4/2025 through 12/8/2025. On 12/8/2025, the Executive Direc and Eldercare Home Director purchased and installed a continuous alarm system on all exterior exits. Systemic Changes: A permanent continuous alarm system is now installed on all exterior doors. Monitoring: Weekly alarm functionality checks will be conducted and documented by the Household Coordinator.	To be Completed By: 1/16/2026

Reviewed and acknowledged SW 01/08/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 1 #3), and a resident who wandered (#4). The findings are: Observation of the entrance/exit door to the facility on 12/04/25 at various times between 8:15am-3:00pm revealed the alarm sounded when the doors to the facility were opened and closed but did not continuously sound. Observation of a second entrance/exit door to the facility on 12/04/25 at 9:42am revealed the door was located in the dayroom, towards the patio, and did not continuously sound when the door was opened and closed. Observation of a third entrance/exit door to the facility on 12/04/25 at 9:44am revealed the door located down the hallway, did not continuously sound when the door was opened and closed. 1. Review of Resident #4's current FL2 dated 03/20/25 revealed: -Diagnoses included dementia, hyperlipidemia, osteoporosis and was a falls risk. -She was intermittently disoriented. -The resident wandered. Review of Resident #4's resident record revealed there was no Resident Register available to review. Review of a charting note dated 07/23/25 at 11:20am from Resident #4's resident record revealed: -The resident was not observed in the facility around 7:54am. -The personal care aide (PCA) informed the medication aide (MA) that the resident was missing.	C 069	STAFF TRAINING – ELOPEMENT PREVENTION All staff will complete: MCF104 Elopement ResponseSDV106 Wandering and Elopement Training will be completed within 60 days of hire, then documented in personnel files. INCIDENT REPORTING All injury incident reports will be completed per protocol and emailed to the County Monitor within 24 hours.	To be Complete By: 1/16/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 2 -The MA observed the resident on the sidewalk, down the street. -The resident appeared confused and had to be redirected to return to the facility. Review of Resident #4's care plan dated 06/02/25 revealed: -Wandering was selected in mental and social history. -She was always disoriented. -She had significant memory loss and had to be directed. Interview with a PCA on 12/04/25 at 9:51am revealed: -Resident #4 was disoriented. -Resident #4 eloped from the facility in July 2025. -She was serving breakfast and could not find Resident #4. -She and the MA searched the facility and were not able to locate Resident #4. -The MA found Resident #4 walking on the sidewalk, a street over and away from the facility, near the Fire Department. -The MA walked with her back to the facility. -Resident #4 was away from the facility for about 20 minutes. -She did not hear the alarm when Resident #4 left the facility. -She may have been getting other residents dressed for breakfast. -Resident #4's supervision was increased from every 2-hour rounds to every 1-hour rounds after the elopement. Interview with the MA on 12/04/25 at 10:11am revealed: -Resident #4 had dementia. -Resident #4 eloped from the facility on 07/23/25 for about 10 minutes.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 3 -The PCA told her that she was not able to locate Resident #4. -She and the PCA searched for Resident #4 inside of the facility. -She called the House Coordinator to inform her that the resident could not be located. -The House Coordinator told her to search for Resident #4 on the outside of the facility. -She found Resident #4 walking down the sidewalk, a street over from the facility. -She walked with Resident #4 back to the facility. -The resident was not accounted for, for 10 minutes. -She informed the primary care provider (PCP) and the resident's responsible party of the elopement. -Supervision was increased from every 2-hour rounds to every 1-hour rounds. Interview with the House Coordinator on 12/04/25 at 10:36am revealed: -She supervised the PCA and MA. -Elopements were reported to her. -She was responsible for contacting the residents' responsible party and PCPs as needed. -Resident #4 had dementia and was disoriented. -She received a phone call in July 2025 from the MA when Resident #4 could not be located within the facility. -She told the MA to search in the neighborhood for Resident #4. -The MA found Resident #4 walking on the sidewalk, a street over from the facility. Interview with the Administrator on 12/04/25 at 11:13am revealed: -Resident #4 was disoriented. -She was informed Resident #4 left the facility and was found walking on a sidewalk by the MA.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 4	C 069		

Attempted telephone interview with Resident #4's responsible party on 12/04/25 at 11:54am was unsuccessful.

Attempted telephone interview with Resident #4's PCP on 12/04/25 at 11:59am was unsuccessful.

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

Refer to the interview with the PCA on 12/04/25 at 9:51am.

Refer to the interview with the MA on 12/04/25 at 10:52am.

Refer to the interview with the House Coordinator on 12/04/25 at 10:36am

Refer to the interview with the Administrator on 12/04/25 at 11:13am.

2. Review of Resident #1's current FL2 dated 06/20/25 revealed:
-Diagnoses included moderate dementia with anxiety, and senile osteoporosis.
-She was intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 07/01/25.

Review of Resident #1's resident record revealed there was no care plan available for review.

Interview with a personal care aide (PCA) on 12/04/25 at 9:51am revealed:
-Resident #1 was disoriented.
-Resident #1 had not left the facility without staff knowledge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 5 Interview with the medication aide (MA) on 12/04/25 at 10:11am revealed: -Resident #1 had dementia but was not exit seeking. -Resident #1 had not left the facility without staff knowledge. Interview with the House Coordinator on 12/04/25 at 10:36am revealed: -Resident #1 had dementia and was disoriented. -Resident #1 had not left the facility without staff knowledge. Interview with the Administrator on 12/04/25 at 11:13am revealed: -Resident #1 was disoriented. -Resident #1 had not left the facility without staff knowledge. Telephone interview with Resident #1's responsible party on 12/04/25 at 11:26am revealed: -The resident had dementia and should be supervised when outside of the facility. -She observed an audible alarm in the facility, but the alarm did not sound continuously when the door was opened. Attempted telephone interview with Resident #1's primary care provider (PCP) on 12/04/25 at 11:41am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the PCA on 12/04/25 at 9:51am.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 6	C 069		

Refer to the interview with the MA on 12/04/25 at 10:52am.

Refer to the interview with the House Coordinator on 12/04/25 at 10:36am

Refer to the interview with the Administrator on 12/04/25 at 11:13am.

3. Review of Resident #2's FL2 dated 10/04/24 revealed:
-Diagnoses included Alzheimer's disease, hypertension, anxiety, and hyperlipidemia.
-The resident was constantly disoriented.

Review of Resident #2's Resident Register revealed an admission date of 08/18/22.

Review of Resident #2's care plan dated 10/04/24 revealed:
-He was always disoriented.
-He had significant memory loss and had to be directed.

Interview with a personal care aide (PCA) on 12/04/25 at 9:51am revealed Resident #2 had dementia.

Interview with the medication aide (MA) on 12/04/25 at 10:11am revealed Resident #2 had dementia but was not exit seeking.

Interview with the House Coordinator on 12/04/25 at 10:36am revealed Resident #2 had dementia and was disoriented.

Interview with the Administrator on 12/04/25 at 11:13am revealed Resident #2 was disoriented.

Based on observations, interviews, and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 7	C 069		

reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's responsible party on 12/04/25 at 10:47am was unsuccessful.

Refer to the interview with the PCA on 12/04/25 at 9:51am.

Refer to the interview with the MA on 12/04/25 at 10:52am.

Refer to the interview with the House Coordinator on 12/04/25 at 10:36am

Refer to the interview with the Administrator on 12/04/25 at 11:13am.

4. Review of Resident #3's current FL2 dated 01/06/25 revealed:
-Diagnoses included schizophrenia and hypertension.
-She was intermittently disoriented.

Review of Resident #3's resident record revealed there was no Resident Register available for review.

Review of Resident #3's care plan dated 01/05/25 revealed:
-She was always disoriented.
-She had significant memory loss and had to be directed.

Interview with a personal care aide (PCA) on 12/04/25 at 9:51am revealed Resident #3 was disoriented.

Interview with the MA on 12/04/25 at 10:11am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 8 revealed Resident #3 had dementia but was not exit seeking. Interview with the House Coordinator on 12/04/25 at 10:36am revealed Resident #3 had dementia and was disoriented. Interview with the Administrator on 12/04/25 at 11:13am revealed Resident #3 was disoriented. Attempted telephone interview with Resident #3's responsible party on 12/04/25 at 11:00am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 12/04/25 at 11:02am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to the interview with the PCA on 12/04/25 at 9:51am. Refer to the interview with the MA on 12/04/25 at 10:52am. Refer to the interview with the House Coordinator on 12/04/25 at 10:36am Refer to the interview with the Administrator on 12/04/25 at 11:13am. _____ Interview with a personal care aide (PCA) on 12/04/25 at 9:51am revealed: -None of the residents went outside alone. -All of the residents needed to be supervised while outside. -The doors had alarms but stopped sounding	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 9 when the doors were closed. A second interview with the MA on 12/04/25 at 10:52am revealed: -She could hear the alarm sound throughout the facility when the doors opened. -The doors did not sound continuously when the doors were opened. -She was not aware the doors were to sound continuously when opened. Interview with the House Coordinator on 12/04/25 at 10:36am revealed: -None of the residents were to be outside of the facility unsupervised. -All of the residents had dementia. -She was not aware the alarm should sound continuously when the doors were opened. Interview with the Administrator on 12/04/25 at 11:13am revealed: -There residents were not allowed outside unsupervised. -She was not aware the alarm was to sound continuously when the doors were opened. _____ The facility failure to ensure the alarms on the exit doors to the facility had a continuous audible sounding device when the doors opened which enabled a resident to leave the facility without staff knowledge (#4). Two residents were constantly disoriented (#2, #3) and two residents who were intermittently disoriented (#1, #4). 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 12/04/25 for this violation.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 069	Continued From page 10 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 18, 2026.	C 069	DEFICIENCY #2 10A NCAC 13G .0801(a)(– Resident Assessment	
C 230	10A NCAC 13G .0801 (a) (b) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications;	C 230	Corrective Action: All residents received updated Plan of Care Assessments, FL-2s, Standing Orders, Diet Orders, and Physician Orders. Documentation was sent to physicians for review and approval. Systemic Changes: Assessments will be completed annually and upon significant cha Monitoring: Quarterly chart audits by the Director. ADMISSION PROCESS IMPROVEMENT A two-person admission checklist ensures all documentation is received 72 hours prior to admission, including physician signatures and assessmentdue dates.	To be Completed By: 1/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 230	Continued From page 11 (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf. at no cost. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 4 sampled residents (#1, #2) had a care plan completed annually. The findings are: 1. Review of Resident #1's current FL2 dated 06/20/25 revealed: -Diagnoses included dementia with anxiety, senile osteoporosis, and esophageal reflux.	C 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 230	Continued From page 12 -Resident #1 was ambulatory. -Resident #1 needed assistance from staff with bathing and dressing. Review of Resident #1's Resident Register revealed an admission date of 07/01/25. Review of Resident #1's resident record revealed there was no care plan available for review. Refer to the interview with the House Coordinator on 12/04/25 at 10:36am Refer to the interview with the Administrator on 12/04/25 at 11:13am. 2. Review of Resident #2's FL2 dated 10/04/24 revealed: -Diagnoses included Alzheimer's disease, hypertension, anxiety, and hyperlipidemia. -Resident #2 was ambulatory. -Resident #2 needed assistance from staff with bathing and dressing. Review of Resident #2's Resident Register revealed an admission date of 08/18/22. Review of Resident #2's care plan dated 09/27/24 revealed: -Resident #2 was ambulatory with the aide of an assistive device. -He needed supervision from staff with eating, ambulation, and transferring. -He needed limited assistance from staff with bathing, dressing, and grooming, and extensive assistance for toileting. Review of Resident #2's care plans revealed there were no other care plan completed after 09/27/24 available for review.	C 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 230	Continued From page 13 Refer to the interview with the House Coordinator on 12/04/25 at 10:36am Refer to the interview with the Administrator on 12/04/25 at 11:13am. _____ Interview with the House Coordinator on 12/04/25 at 10:36am revealed she was not responsible for completing care plans, the Administrator was. Interview with the Administrator on 12/04/25 at 11:13am revealed: -She was responsible for ensuring care plans were completed annually. -She was not aware the two residents did not have current care plans. Based on record reviews and interviews, the facility failed to ensure 2 of 4 sampled residents (#1, #2) had a care plan completed annually. The findings are: 2. Review of Resident #2's FL2 dated 10/04/24 revealed: -Diagnoses included Alzheimer's disease, hypertension, anxiety, and hyperlipidemia. -Resident #2 was ambulatory. -Resident #2 needed assistance from staff with bathing and dressing. Review of Resident #2's Resident Register revealed an admission date of 08/18/22. Review of Resident #2's care plan dated 09/27/24 revealed: -Resident #2 was ambulatory with the aid of an assistive device. -He needed supervision from staff with eating, ambulation, and transferring. -He needed limited assistance from staff with	C 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 230	Continued From page 14 bathing, dressing, and grooming, and extensive assistance for toileting. Review of Resident #2's care plans revealed there were no care plans completed after 09/27/24 available for review. Refer to the interview with the House Coordinator on 12/04/25 at 10:36am Refer to the interview with the Administrator on 12/04/25 at 11:13am. Interview with the House Coordinator on 12/04/25 at 10:36am revealed she was not responsible for completing care plans, the Administrator was. Interview with the Administrator on 12/04/25 at 11:13am revealed: -She was responsible for ensuring care plans were completed annually. -She stated that knew she was behind completed careplans due to being busy but did not realize how far behind.	C 230		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 257	Continued From page 15 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food was protected from contamination related to foods stored in the refrigerator that were not labeled or dated, expired food, and infection control during meal preparation. The findings are: Observation of the refrigerator on 12/04/25 at 8:40am revealed: -There was a large container of yogurt with an expiration date of 11/30/25. -There was a zip-lock bag with an egg mixture that was not labeled or dated. -There was a container with tuna salad with the date 12/04 with no year handwritten. -There was a large half-filled bag of shredded cheese that was unzipped that did not have an open date. -There were two glasses filled with liquid that were not covered and were not labeled or dated. -There were 4 containers of cooking base that did not have an opened date. Observation of a medication aide (MA) on 12/04/25 at 8:35am revealed the MA was	C 257	DEFICIENCY #3 10A NCAC 13G .0904 – Nutrition and Food Service Corrective Action: All staff will complete mandatory one-on-one training covering dining procedures, food safety, nutrition, and infection co Required Trainings: SCU603 Mealtime SCU Nutrition and Meals FSE101 Dining FSE102 Sanitation and Food Safety FSE103 Therapeutic Diets NC DHHS Infection Control Series DEFICIENCY #4 10A NCAC 13G .0904(d)(3) Dairy Requirements Corrective Action: Staff will complete mandatory training which includes (SCU 210 Nutrition and Meals). Staff will follow the menu and document on staff log verifying what 8oz dairy option was served. Monitoring: Monitored Daily by HC	To be Completed By: 1/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 257	Continued From page 16 preparing breakfast when she grabbed a hand full of cut up food and placed it in a serving bowl with no gloves on. Interview with the MA on 12/04/25 at 12:52pm revealed: -She was aware that she should have worn gloves when preparing food. -She was not aware that she did not have any gloves on when she was preparing breakfast. -She was not aware that food should be labeled and dated when opened. Interview with the House Coordinator on 12/04/25 at 2:16pm revealed: -She was aware that food should be labeled and dated when opened. -The 3rd shift staff were responsible for checking the refrigerator for expired food. -She would check for expired foods and foods not labeled or dated once weekly. -She did not have a set day when she would check the refrigerator. -She last checked the refrigerator last Friday, 11/30/25. -She did not realize there was expired foods, food not labeled and not dated currently in the refrigerator. -She was not sure who trained the staff regarding labeling and dating open food. -The MA should be wearing gloves when preparing meals. -She was not aware the MA was touching the residents' food with bare hands. -She expected the MA to wear gloves during meal preparation. Interview with the Administrator on 12/04/25 at 2:40pm revealed: -The House Coordinator was responsible for	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 257	Continued From page 17 checking for expired foods, and foods that were not labeled or dated. -She was not aware that there were expired foods and foods that were not labeled or dated. -Opened food items should be discarded after 3 days. -She was not sure what personal protective equipment (PPE) the MAs should wear when preparing food. -The House Coordinator was responsible for teaching the MAs about wearing PPE during the meal preparations.	C 257		
C 273	10A NCAC 13G .0904(d)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family 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, at no cost. This Rule is not met as evidenced by:	C 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 273	Continued From page 18 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 3 times daily to the residents. The findings are: Review of the weekly menu for 12/04/25 revealed: -Eight ounces of milk was to be served at breakfast. -There were no dairy items on the menu for lunch or dinner on 12/04/25. -There was a drink selection which included milk as an option. Observation of the kitchen on 12/04/25 at 8:42am revealed there was no milk in the refrigerator. Observation of the breakfast meal on 12/04/25 at 8:45am revealed: -There were 5 residents in the dining room. -The residents were served French toast, and fresh fruit. -The residents were served a glass of water and juice. -Milk or a dairy equivalent was not served. Observation of the lunch meal on 12/04/25 at 12:00pm revealed: -There were 5 residents in the dining room. -The residents were served meatloaf, mashed potatoes and carrots. -The residents were served a glass of water and juice. -Milk or a dairy equivalent was not served. Interview with a medication aide (MA) on 12/04/25 at 12:41pm revealed:	C 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068030	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES HOUSE - WINMORE ELDERCARE HOME	121 DELLA ST CARRBORO, NC 27510

(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
C 273	Continued From page 19 -Milk was served to the residents each morning with the breakfast meal if they asked for it. -She was not aware the residents should be served at least 8oz of dairy 3 times a day. -She did not let anyone know they ran out of milk of milk on Monday 12/03/25. Interview with second MA on 12/04/25 at 2:14pm revealed: -It was her understanding that the residents should be served milk two times daily. -She was not aware the residents should be served at least 8oz of milk or dairy equivalent 3 times a day. Interview with the House Coordinator on 12/04/25 at 2:30pm revealed: -It was her understanding the residents should be served milk once daily. -She was not aware the residents should be served at least 8oz of dairy 3 times a day. -She was not aware there was no milk available to serve to the residents. -She expected the MA to notify her there was no milk available. Interview with the Administrator on 12/04/25 at 2:40pm revealed: -The residents were offered milk if they requested it. -She did not know the residents should receive 3 servings of dairy a day. -She was not aware there was no milk available to be served. -She expected the MA to notify her so she could go to the store and purchase milk.	C 273		