STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001144	A. BUILDING: _____ B. WING _____	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B AND N FAMILY CARE HOME	301 HOMEWOOD AVENUE BURLINGTON, NC 27217

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C 000	Initial Comments The Adult Care Licensure Section and the County Department of Social Services conducted an annual survey on 01/13/26.	C 000		
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 to a resident who (#3) had a neurocognitive disorder and had wandered from the facility.	C 069		

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C 069	Continued From page 1 The findings are: Observation of the entrance/exit door at the front of the facility on 01/13/26 at various times between 8:30am-6:00pm revealed: -The door led from the common resident television room to the front porch that was also the smoking area for residents. -Residents entered and exited the door multiple times during the day. -The alarm sounded with a single chime when the door to the facility was opened but did not continuously sound. Observation of a second entrance/exit door to the facility on 01/13/26 at various times between 8:30am-6:00pm revealed: -There was a solid door and a storm door in the kitchen that opened to a small back stoop. -At various times during the day the solid door was left open, and the storm door was closed, and staff exited and entered the facility from the kitchen doors. -Residents were not observed exiting or entering the door. -The alarm was on the solid door and sounded with a single chime when the door to the facility was opened but did not continuously sound. -The storm door did not have an alarm. Observation of a third entrance/exit door to the facility on 01/13/26 at various times between 8:30am-6:00pm revealed: -The door was in the laundry room at the end of a hallway; the door was locked. -Residents and staff were not observed going in or out of the door. -The alarm sounded with a single chime when the door was opened but did not continuously sound.	C 069		

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C 069	Continued From page 2 Review of Resident #3's current FL2 dated 09/11/25 revealed: -Diagnoses included neurocognitive disorder and schizoaffective-bipolar type. -There was nothing documented for orientation. Review of Resident #3's Resident Register dated 09/10/25 revealed: -Resident #3 was admitted to the facility on 09/11/25. -Resident #3's memory was documented as forgetful and needed reminders. Review of Resident #3's Care Plan dated 09/11/25 revealed: -There was nothing selected in mental and social history. -He required limited assistance from staff with toileting, bathing, dressing and grooming. Review of the facility's sign out log for January 2026 revealed there was an illegible signature on the log sheet without a date and a time. Interview with Resident #3 on 01/13/26 at 4:20pm revealed: -He went for a walk last Friday, 01/09/26. -He was " just going for a walk to see a relative". -He did not know where the relative lived but he knew he worked about two miles from the facility in a big building. -While on his walk he saw the building where his relative worked but he decided to return the facility, so he turned around to go back. -He was almost back at the facility when the police picked him up; he could not see the facility from where the police picked him up. -He had not gone for a walk from the facility before. -He had to sign and date the sign out sheet and	C 069		

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C 069	Continued From page 3	C 069		

tell the staff if he went for a walk.
-He told the Supervisor-in-Charge (SIC) he was "just going walking", and she told him to "go on".
-He signed and dated the sign out sheet when he went for his walk last week.
-He knew the address of the facility but not the name of the facility.
-He recited an [incorrect] address.
-Going forward, if the staff told him not to go for a walk, then he would not go for a walk.

Interview with a resident on 01/13/26 at 5:15pm revealed:
-He saw Resident #3 walk away from the facility last week; Resident #3 said he was going for a walk.
-He told the SIC when Resident #3 walked down the street.
-The SIC said Resident #3 signed out and to let him go.
-The police brought Resident #3 back to the facility.
-Resident #3 was gone for longer than ten minutes.

Telephone interview with Resident #3's primary care provider (PCP) on 01/13/26 at 3:35pm revealed:
-He had only been Resident #3's PCP since 12/01/25.
-The facility let him know when Resident #3 walked away from the facility last Friday.
-He could not say how good Resident #3's memory was.
-He did not want Resident #3 to walk away from the facility for his safety, but the facility was not a "locked community".
-He thought Resident #3 could let someone know where he lived.

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C 069	Continued From page 4 Interview with Resident #3's guardian on 01/13/26 at 10:50am revealed: -Last Friday, 01/09/26, Resident #3 walked away from the facility. -The facility staff called her the day he walked away. -The police located him and brought him back to the facility. -Resident #3 told her he was going to visit his cousin. -Resident #3 had once lived in the area but it had been several years ago. -She did not think Resident #3 would remember his way around the area. -Resident #3 had not walked away from the facility before. -Resident #3 would not remember his address or be able to tell anyone where he lived. -He would be able to recognize the facility. -Resident #3 was not allowed to leave the facility due to his mental health condition and was not safe by himself. -She did not think he was disoriented or confused. -When Resident #3 returned to the facility she told him he was not allowed to leave the facility without her permission. -She was going to get an air tag (a tracking and location device) for Resident #3 to keep so he could be located if he did walk away again. Interviews with the SIC on 01/13/26 at 9:20am and 11:58am revealed: -Resident #3 walked away from the facility on 01/09/26. -He was gone for thirty minutes. -She knew Resident #3 was outside because he told her he was going to sit on the porch. -Another resident was sitting on the porch and saw Resident #3 walk down the street.	C 069		

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C 069	Continued From page 5 -She was inside when the resident informed her Resident #3 had walked away and which street he was walking down. -She could not leave the facility to go after Resident #3. -After ten minutes had passed and Resident #3 had not returned she called the police. -She did not know if Resident #3 was allowed to leave the facility alone, so she called the local police, Resident #3's guardian and the Administrator. -Resident #3 was found on another street by the police; he was walking in the direction of the facility. -Resident #3 had not wandered away from the facility before he walked away on 01/09/26. -She did not know why he decided to take a walk on 01/09/26. -Resident #3 would not be able to tell anyone where he lived or his address. -There were alarms on the doors that made a chiming sound when they were opened. -She could hear the door alarms from anywhere in the facility. -The residents went in and out the front door all day. -The residents did not use the door in the kitchen or the door in the laundry room. -The door in the laundry room stayed locked. -Sometimes she opened the door in the kitchen to let some air and light into the kitchen or to go outside to sit on the stoop. -She was the only facility staff; she stayed overnight in the staff room and slept. -She could hear the door alarms in her room. -She locked the doors at 8:00pm and unlocked them at 6:30am; the residents did not go outside after it got dark. Interview with the Administrator on 01/13/26 at	C 069		

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C 069	Continued From page 6 1:20pm revealed: -The SIC called her around 3:00pm on 01/09/26 to inform her Resident #3 was not on the porch or in the house. -She told the SIC to call the police and let them know he had walked off. -She wanted the police notified because Resident #3 was under a guardianship and residents under a guardianship were not allowed to leave the facility on their own. -Residents with guardians were not allowed to leave the facility because they were proven incompetent. -Resident #3 had not left the facility before, it was the first time. -After Resident #3 walked away from the facility on 01/09/26, she decided to get Resident #3 an air tag and had told him not to walk away from the facility again. -Resident #3's memory was not good, that was why they were getting him an air tag. -She did not think Resident #3 would be able to say where he lived. -Resident #3 was more forgetful than confused. -Resident #3 had insomnia and used to walk out onto the porch in the middle of the night and just stand, but he had never walked off the porch. -Resident #3 was on a medication to help him sleep so he was no longer going outside or standing on the porch at night. -The doors were locked at 8:00pm and the residents were not allowed to go outside until they were unlocked in the morning. -The doors had alarms on them all the time, but they were not continuous. -The door alarms had the ability to be converted to a continuous alarm that required a code to turn them off. -There had not an been an instance of a resident walking away from the facility before.	C 069		

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C 069	Continued From page 7 -She thought the air tag would be enough to locate Resident #3 if he wandered away so she had not turned the continuous alarms on. -She was not aware of the rule for the continuous sounding door alarms. -She did not think it would be fair to the rest of the residents and staff to hear the continuous alarm each time they went in and out of the facility or whenever the door was opened. _____ The facility failed to ensure the alarms on the exit doors to the facility had a continuous audible sounding device when the doors opened after a resident diagnosed with cognitive impairment (#3) left the facility and was returned by the local police. 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 01/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2026.	C 069		
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	C 257		

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C 257	Continued From page 8 conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the food labeled and dated in the refrigerator, and freezer. The findings are: Observation of the refrigerator on 01/13/26 at 8:35am revealed: -There was a resealable food storage bag with multiple thawed fillets of fish in a reddish liquid; there was no label or date on the bag. -There was ground meat in a foam tray with clear wrap on a shelf in the refrigerator. -The meat was partially frozen; there was no label identifying the food in the wrapped tray and there was no date. -There was a bowl with a thick white liquid with foil wrapped around the bowl; there was no date or label on the bowl. Observation of the freezer on 01/13/26 at 8:35am revealed: -There were two resealable food storage bags, each with multiple corndogs in them; the bags did not have a date or a label.	C 257		

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C 257	Continued From page 9 -There was a clear plastic bag with breaded mozzarella cheese sticks in them; there was no date and no label on the bag. Interview with the Supervisor -In-Charge (SIC) on 01/13/26 at 4:00pm revealed: -She had only begun working at the facility a few weeks ago. -She was trying to clean out the food storage areas, including the refrigerator and freezer. -She knew food stored in the refrigerator and freezer needed to be dated and labeled. -She knew food not stored in the original package needed to be dated and labeled. -She had pulled the package of ground beef out of the freezer the day before, 01/12/26, so it would thaw for the lunch meal today, 01/13/26. -She did not know why she had not dated and labeled the package of ground beef; it looked like it was packaged from a store so maybe that was why she did not date and label it. -She had prepared the fish three days ago for a meal and she had a few pieces left over. -She did not know what she should do with the remaining fish, so it was still in the refrigerator. -She knew she should have dated and labeled the fish. -The bowl of liquid was leftover hushpuppy batter from three days ago. -She should have dated and labeled the bowl of batter. -She did not know why she had not labeled and dated the batter, and she should have discarded the leftover batter. -She had not placed the bags of corndogs in the freezer, they were in the freezer when she started working at the facility, so she did not date them because she did not know a date. -The cheese sticks were in the freezer when she started to work at the facility.	C 257		

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C 257	Continued From page 10 -The cheese sticks were still in the original bag, so she thought they had been removed from the box to save space in the freezer. -She did not know how long they had been in the freezer. Interview with the Administrator on 01/13/26 at 5:45pm revealed: -She knew the food in the refrigerator was supposed to have a label and a date if it was leftover or removed from the original packaging. -Any food removed from the original packaging was supposed to be dated and labeled. -The ground beef came in a larger box with dates and labels, and she did not realize the individual packages were not dated and labeled. -The fish was originally packaged in a larger bag of frozen fish and the SIC placed the pieces she did not cook into a resealable storage bag. -The SIC should have put a date and labeled the bag of fish. -The SIC told her she threw the hushpuppy batter away that morning, but it should have been dated and labeled as well. -Another staff member had removed the corndogs and the cheese stick from the original boxes to save freezer space. -The bags of food in the freezer should have been dated and labeled since they had been removed from the original package. -She would periodically check the food in the refrigerator and the freezer for dates and labels. -She was concentrating on other things in the facility and had not checked for dates in a while. -She ordered markers today so the SIC could write dates and label food.	C 257		