Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure section and the Cabarrus County Department of Social Services conducted a follow up survey on 12/10/25 through 12/11/25.	{D 000}	Reponses to the cited deficiencies do not constitute and admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state law.	1/30/26
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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local Department of Social Services (DSS) for an incident involving 1 of 5 sampled residents (Resident #4) who sustained an injury from a fall and was sent to the hospital. The findings are: Review of Resident #4's Resident Registered revealed she was admitted 07/21/23. Review of Resident #4's current FL2 dated 07/21/25 revealed: -Diagnoses included dementia, failure to thrive, anxiety, and psychotic mood disturbance. -Resident #4 was constantly disoriented.	D 451		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 1/27/26

Reviewed and Acknowledged by SSD on 01/30/26 Sharon Dunton RN

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D 451	Continued From page 1 -Resident #4's level of care was Special Care Unit (SCU). Review of the facility's event summary report on 12/11/25 revealed: -Resident #4 had a fall with injury in her bedroom on 11/22/25 at 6:30am. -Resident #4's Primary Care Provider (PCP) was notified on 11/22/25 at 6:47am. -Resident #4's family was notified on 11/22/25 at 6:47am. Review of the hospital discharge summary 11/23/25 revealed: -Resident #4 was admitted with a laceration to her right forehead/eyebrow region after an unwitnessed fall. -Resident #4 was to have vital signs checked every shift for 72 hours. -Resident #4 was to be monitored every shift for 72 hours for bruising, change in mental status/condition and pain. -Resident #4 was to be assessed by Physical Therapy and Occupational Therapy. Interview with the Adult Home Specialist (AHS) on 12/11/25 at 10:18am revealed: -She kept all the Incident and Accident reports she received from all facilities on her computer. -She did not remember getting an Incident and Accident report for Resident #4 on or around 11/22/25 and when she checked her computer she did not have one. -The facility had been trying to catch up, sending her the Incident and Accident reports she did not received when the past Administrator left on 11/19/25. Interview with the Resident Care Coordinator (RCC) on 12/11/25 at 9:35am revealed:	D 451	Resident #4 Incident and Accident Report was submitted to DSS on 12/02/2025. Incidents and Accidents reported were reviewed to ensure submission to DSS, no additional reports were found to be out of reporting compliance.	

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D 451	Continued From page 2 -The medication aide (MA) starts the Incident and Accident reports and if they do not finish them, the RCC does. -Once the RCC completes the Incident and Accident report, they turn the report over to the Administrator who sends the report to DSS. -She stated she was aware if more than first aid was applied, the report was always sent to DSS within 48 hours. -She only handled the Incident and Accident reports on the Assisted Living side of the facility, and the SCC handled the reports on the Special Care Unit side. -She did not know why the Incident and Accident report was not sent to DSS as Resident #4 had a laceration. Interview with the Special Care Coordinator (SCC) on 12/11/25 at 9:55am revealed: -She had only been with the facility one and a half weeks. -She did remember finishing the Incident and Accident report for Resident #4's fall on 11/22/25. -She knew the reports had to be turned in to DSS within 48 hours after an incident or accident with an injury. -She turned Resident #4's Incident and Accident report into the Administrator for her to sign and send to DSS on 12/02/25. -She knew it was late, but she was catching up from the last SCC who left about 2 weeks ago. Interview with the Administration on 12/11/25 at 10:16am revealed: -She did not realize Resident #4's Incident and Accident report was not sent to DSS. -She was responsible for sending the reports to DSS. -The MA began the report and the RCC and/or the SCC reviewed and finished the report.	D 451	Care staff will receive training on reporting of Incidents and Accidents. Resident and Special Care Coordinators will receive training on Incident and Accident reporting timeline requirements, who and when to notify of an Incident or Accident, when to close a report, and who is responsible for submitting the report to the Department of Social Services. A process has been established to ensure timely reporting of Incidents and Accidents to the Department of Social Services. All Incidents and Accident reports should be initiated by the medication aide, or designee, and be reported to the resident care coordinator (RCC) if the event occurred on the assisted living unit, or the special care coordinator (SCC) if the event occurred on the special care unit. The resident care coordinator and/or special care coordinator review for accurateness and submit to the clinical nurse consultant and the administrator for final review and approval to close the report and submit to the Department of Social Services.	

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D 451	Continued From page 3 -The reports are signed by me and sent to DSS, regional VP, regional nurse and the company attorney.	D 451	The lastly, the administrator, or designee will submit the report to the Department of Social Services within 48-hours of initial discovery or knowledge by staff. The Executive Director, or designee, will conduct weekly audits of all incidents and accidents to ensure compliance related to reporting to the Department of Social Services for 6 weeks. Any immediate concerns will be corrected and reported as APPROPRIATE.	

JOSHUA SEARS - EXECUTIVE DIRECTOR

Josh Sears 1/27/26