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
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation from 02/17/26 to 02/19/26.	D 000	10A NCAC 13F .0403(a) Qualifications of Medication Staff	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 sampled medication aides (MA) (Staff C) had completed the 5-hour, 10-hour or 15-hour MA training and a Clinical Skills Competency Validation Checklist prior to administering medications. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 07/29/25 and worked as a MA. -Staff C had taken and passed the written MA examination on 10/31/25. -There was no documentation Staff C had completed the MA 5-hour, 10-hour or 15-hour MA training course.	D 125	Staff C was immediately removed from medication administration duties on 02/19/2026 and reassigned to On 2/202026 the Administrator and Business Office Manager conducted 100% audit of all medication aides personnel files to verify documentation of Mediation Aide training and competency validation. Any missing documentation To prevent recurrence, a medication Aide credential verification checklist has been added to the employee onboarding process. Med aides will not administer medications until documentation of training and competency is verified by the SCC and BOM. The Administrator will Audit medication aide personnel files with the BOM for three months and quarterly thereafter. Results will be	2/19/26 2/20/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3-16-26

Reviewed and Acknowledged 03/20/26

Janet Thornburg

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D 125	Continued From page 1 -There was no employment verification Staff C had worked as a MA in the previous 24 months. -There was no documentation Staff C had a Clinical Skills Competency Validation Checklist completed. Review of January 2026 electronic medication administration records (eMAR) revealed there was documentation Staff C administered medication 9 days from 01/01/26 to 01/31/26. Review of February 2026 eMAR revealed there was documentation Staff C administered medication 9 days from 02/01/26 to 02/17/26. Interview with Staff C on 02/19/26 at 4:01pm revealed: -She took a 15-hour on-line MA course at the community college. -She was given a certificate from the community college that she had successfully completed the 15-hour MA on-line course. -She had worked as a MA at another Assisted Living (AL) facility prior to working at this facility. -She was trained on the medication cart by a previous employee of the facility. -She did not remember a Registered Nurse (RN) reviewing Clinical Skills Competency Validation Checklist. -She did not sign a Clinical Skills Competency Validation Checklist. Interview with the Business Office Manager (BOM) on 02/19/26 at 4:00pm revealed: -The BOM was responsible for auditing the personnel records every month. -She knew to look for the 15-hour certificate for the MA training and the Clinical Skills Competency Validation Checklist when she audited.	D 125	reviewed in the facility Quality Assurance Performance Improvement QAPI meetings	3/19/2026

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D 125	Continued From page 2 -She had worked at the facility for less than two weeks and had not had an opportunity to audit the personnel records. Interview with the Administrator on 02/19/26 at 4:08pm revealed: -The Administrator did not know Staff C did not have a certificate for the 5-hour, 10-hour or 15-hour MA training course or employment verification from a previous employer. -The BOM was responsible for auditing the personnel records. -The Administrator did not know how often the personnel records were audited. -The MAs were expected to complete the 5-hour, 10-hour or 15-hour MA training course, have a certificate of the completed MA training course and a completed Clinical Skills Competency Validation Checklist before administering medications. -The BOM was expected to audit the personnel records and report any missing forms to him.	D 125		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 3 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the resident's assessed needs for 3 of 8 sampled residents (#5, #6, and #8), including a resident (#5) who wandered in other residents' rooms and had altercations with other residents; a resident (#6) who wandered in the facility and had altercations with other residents; and a resident (#8) who wandered in other residents' rooms, removed personal items and had altercations with other residents. The findings are: Review of the facility's undated special care unit (SCU) disclosure statement revealed: -Residents were monitored closely by the Special Care Unit Coordinator (SCC), the medication aids (MA), and the personal care aids (PCA) for safety related to incidents such as aggressive behaviors and potential wandering. -The MAs and PCAs documented and reported resident changes through daily communication. -Residents who could benefit from the quiet room would be encouraged to spend time in that space to separate the residents from other residents and to reduce stimulation. 1. Review of Resident #5's current FL-2 dated 07/30/25 revealed: -Diagnoses included malignant neoplasm of prostate, peripheral vascular disease, and diabetes mellitus type 2. -He was constantly disoriented. -He wandered. -He was ambulatory.	D 270	10A NCAC 13F..0901(b) Personal Care and Supervision - Type A2 Residents #5, #6,and #8 were reassessed on 2/19/2026 by the SCC following the survey findings. Care Plans were reviewed and updated to include supervision, monitoring, and re-direction interventions related to wandering behaviors and resident interactions. Staff were re-educated on supervision expectations, redirection techniques, and interventions to prevent resident to resident altercations. To increase staff presence and supervision during evening hours, all residents baths and showers will be scheduled and completed before 5:00 p.m. Structured Activities will continue until 7:00 p.m. to promote resident engagement and reduce wandering behaviors Between the hours of 9:00 p.m. and 7:00 a.m., staff will remain stationed in	3/19/26

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D 270	Continued From page 4 Review of Resident #5's care plan dated signed 07/14/25 revealed: -He wandered. -He was ambulatory. Review of Resident #5's Primary Care Provider's (PCP) progress notes dated 12/03/25 revealed: -Resident #5 was seen for dementia, psychotic disturbances, mood disturbance and anxiety. -Resident #5 had episodes of agitation. Review of Resident #5's electronic progress notes dated 12/27/25 revealed: -Resident #5 was agitated and would not let staff change his soiled briefs. -Staff told the Administrator who advised the staff to let the resident calm down and try again later. -Resident #5 pushed another resident. Review of Resident #5's accident/incident reports revealed there was no incident report dated 12/27/25 to review related to Resident #5 pushing another resident. Review of Resident #5's electronic progress notes dated 12/28/25 revealed: -Resident #5 hit another resident in the face with his hand. -The Assistant SCC requested a MH evaluation for Resident #5 but the PCP was unable to order the MH evaluation because there was no signed consent from the Power of Attorney (POA). Review of Resident #5's accident/incident report dated 12/28/25 revealed: -At 3:25pm, Resident #5 hit another resident in the face. -Intervention was to monitor Resident #5 for behaviors and obtain an order for a mental health (MH) evaluation.	D 270	Continued, designated hallway monitoring areas to increase observations of resident movement and reduce the risk of residents entering other residents rooms The SCC and E.D. will review resident care plans quarterly to ensure supervision levels are appropriate The E.D. and SCC will review incident reports weekly for three months to ensure interventions are implemented and followed. Findings will be reviewed in the facility Quality Assurance Performance Improvement (QAPI) meetings.	

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D 270	Continued From page 5 Review or Resident #5's PCP progress note dated 12/29/25 revealed: -The staff reported Resident #5 had increased agitation after lunch. -Resident #5 was currently ordered clonazepam 0.5mg (used to treat anxiety) twice daily. -The plan of treatment was to increase clonazepam to 1mg twice daily and monitor for signs of over-sedation. Review of Resident #5's electronic progress notes dated 12/29/25 revealed: -The Assistant SCC attempted to reach Resident #5's POA regarding the change in Resident #5's behavior and to complete a MH consent form for MH services. -The POA did not reach back out to the facility. -The PCP could not make the referral to MH without the signed consent form from the POA. Interview with a PCA on 02/18/26 at 11:32am revealed: -Resident #5 had an altercation with a resident in the hallway in late December 2025. -Resident #5 walked throughout the facility most of the time. -Another resident was walking in the hallway also and that resident told Resident #5 to get out of his building. -They said a few words to each other and before she could get to them, Resident #5 hit the other resident in the face and Resident #5 walked away. -The other resident was scratched on the face when Resident #5 hit him. -The staff were told to redirect the residents when the residents were arguing or going into other resident rooms.	D 270		

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D 270	Continued From page 6 Interview with the Assistant SCC on 02/18/26 at 10:14am revealed: -Resident #5 had a resident-to-resident altercation on 12/28/25 in the hallway. -The other resident was talking to Resident #5 and Resident #5 hit the resident in the face, causing a scratch on his face. -She notified the POA and left messages, but the POA did not return any phone calls. -Resident #5 needed to be referred to MH services and the consent needed to be signed by the POA. -She called the PCP, but the PCP would not order the MH consult because there was no signed consent for MH services. -She did not try to reach the POA by mail or certified letter. -She had not received an order for Resident #5 to have a MH evaluation. Attempted telephone interviews with Resident #5's POA on 02/18/26 at 8:30am and on 02/19/26 at 8:59am were unsuccessful. Review of Resident #5's accident/incident report dated 02/15/26 revealed: -At 6:12pm, Resident #5 was observed in a physical altercation with another resident. -There was no other information on the accident/incident report. Review of Resident #5's accident/incident report dated 02/16/26 revealed: -At 6:45pm, Resident #5 was entering other residents' rooms. -When Resident #5 was redirected by staff, Resident #5 threatened to jump on the staff. -At 7:00pm, Resident #5 was transported by Emergency Medical Services (EMS) to the Emergency Department (ED) for evaluation.	D 270		

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D 270	Continued From page 7 -Resident #5 returned to the facility later that evening, 02/16/26, with a diagnosis of memory problems. -Staff intervention would be to discuss behavioral medications with Resident #5's PCP. Review of Resident #5's electronic progress notes dated 02/16/26 revealed the SCC was notified that Resident #5 was sent to the hospital for altered mental status and changes in behavior. Review of Resident #5's hospital discharge summary dated 02/16/26 revealed: -Resident #5 was seen in the ED for behavioral health concern. -Resident #5 was administered olanzapine (used to manage mood swings) in the ED. -There was no evidence of urinary tract infection or electrolyte abnormality. -Resident #5 was discharge back to the facility. Review of Resident #5's electronic progress notes dated 02/17/26 revealed: -Resident #5 returned to the facility; no new orders were received. -Resident was observed walking through the hallways of the facility, quiet and to himself. -Continue to monitor Resident #5 for changes and report immediately. Interview with a PCA on 02/17/26 at 4:46pm revealed: -Resident #5 grabbed his wrist during a behavioral episode on 02/16/26 and Resident #5 led him down the hallway. -Resident #5 told him to "get those people away" from him. -Resident #5 had become combative because the staff were trying to keep him out of other	D 270		

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D 270	Continued From page 8 residents' rooms. Interview with a MA on 02/17/26 at 4:15pm revealed: -On 02/16/26, Resident #5 was pacing the floor and exit seeking. -The staff tried to redirect Resident #5. -Resident #5 told the MA to get out of his way or he would hurt her. -Resident #5 grabbed another staff's arm. -The Assistant SCC notified the SCC and she was instructed to call EMS because of a combative resident; he was transported to the ED. -Resident #5 returned to the facility later that evening; he did not have any new orders. -The ED said Resident #5 was calm in the ED so Resident #5 was returned to the facility. Telephone interview with a second MA on 02/18/26 at 10:50am revealed: -She worked on 02/16/26, when Resident #5 and a resident had an altercation. -A resident confronted Resident #5 because he had been in her bathroom and bedroom and had spread feces in the room. -The resident pushed Resident #5 and Resident #5 pushed the resident back causing the resident to lose her balance and fall. Interview with the Assistant SCC on 02/18/26 at 10:14am revealed: -On 02/16/26, Resident #5 was not himself; he was trying to hit and punch the staff that were trying to change his soiled briefs and he was exit seeking. -She called the Administrator and was directed to send Resident #5 to the ED. -Resident #5 was transported to the ED via EMS for altered mental status.	D 270		

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D 270	Continued From page 9 -She was not aware of any other behaviors before today, 02/16/26, except on 12/28/25. -Resident #5 returned to the facility with no new orders. -Resident #5 walked in and out of other residents' rooms. -Sometimes he could be found lying in residents' beds. -A few of the residents tried to get Resident #5 out of their beds, which would cause an altercation. -Most residents would tell the staff, and the staff would remove Resident #5 from the residents' rooms. -The staff were instructed to redirect Resident #5 when he was seen going into a residents' room and if the staff had not seen Resident #5 in 10 to 15 minutes, the staff should go look for him. -If Resident #5 was not walking the halls, he could be found in another resident's bed. Interview with the SCC on 02/19/26 at 2:15pm revealed: -She reviewed the accident/incident report dated 12/15/26. -Resident #5 needed close supervision by the staff to prevent resident to resident altercations and to keep Resident #5 out of other residents' rooms. -She found out this week the Assistant SCC could not get Resident #5's POA on the telephone to receive a signed authorization for Resident #5 to receive MH services. -She sent Resident #5's POA an email on 12/18/26 requesting the POA to notify the facility. -Resident #5's POA notified the facility the morning of 02/19/26 as requested via email. -Management was having a meeting with Resident #5's POA that evening, 02/19/26.	D 270		

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D 270	Continued From page 10 Interview with the Administrator on 02/17/26 at 5:20pm revealed: -On 02/15/26, there was an incident between Resident #5 and another resident, whose room he had entered. -Resident #5 had used the resident's bathroom and had spread feces on the bathroom and the bedroom floor. -The resident confronted Resident #5 regarding the incident in her bathroom/bedroom and Resident #5 pushed the resident and she fell. -The staff were told to increase supervision for Resident #5. -On 02/16/26, he was notified by the Assistant SCC that Resident #5 was telling the staff that he was going to hit them if the staff put their hands on him. -Resident #5 ambulated through the facility; he entered other resident's rooms and would exit seek. -He spoke with the Assistant SCC and expected the Assistant SCC to educate staff on increased supervision and document the increased supervision in the electronic progress notes. -If the staff did not see Resident #5, the staff were to look for him. Attempted telephone interviews with Resident #5's POA on 02/18/26 at 8:30am and on 02/19/26 at 8:59am were unsuccessful. Interview with a PCA on 02/18/26 at 11:32am revealed: -She had found Resident #5 in other residents' rooms and in residents' beds sleeping. -She woke Resident #5 up and removed him from the residents' rooms without incident. -Resident #5 would use other residents' restrooms. -Resident #5 refused showers.	D 270		

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D 270	Continued From page 11 -The residents would tell Resident #5 he stunk when he had not showered or when he wore soiled briefs, causing Resident #5 to become agitated. -Resident #5 would become increasingly agitated when he was spoken too. -It was difficult to change and shower Resident #5. -He was on the shower schedule three times a week, but he refused showers and only received one shower a week. -Resident #5 would hit, grab her arm or wrist, and pushed her out of the way when she tried to assist him. -Sometimes the staff had to walk away and try to shower or change Resident #5 after he had calmed down. -Some staff could handle Resident #5 better than others. -Resident #5 did not have any skin breakdown as of 02/13/26. Interview with a PCA on 02/19/26 at 9:18am revealed: -She worked with Resident #5. -She was able to change his soiled briefs and shower him at times. -She talked to Resident #5 about his hometown and family; once he felt comfortable with her, Resident #5 would let her change his soiled briefs. -Resident #5 easily became agitated and would start cursing. -Resident #5 would exit seek and became upset when he could not get out of the building. -She took Resident #5 to the courtyard sometimes; Resident #5 seemed to like that. -She had found Resident #5 in other residents' beds. -She removed Resident #5 from residents' room	D 270		

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D 270	Continued From page 12 and redirected him. -Management instructed the staff to redirect residents who wandered into other residents' rooms. Interview with a MA on 02/17/26 at 4:15pm revealed: -Resident #5 was incontinent with bowels and bladder, but occasionally Resident #5 would use the bathroom. -Resident #5 would hit the staff and curse when the staff attempted to give him a shower or change his soiled briefs. -Sometimes the staff walked away from Resident #5, let him calm down, and approached him about getting his shower after he had calmed down. -Resident #5 let certain staff members shower him and change him when he was soiled. -Resident #5 had slapped her when she attempted to give him a shower. -Resident #5 wandered into resident's rooms. -Resident #5 would urinate on the floor or in the trashcans in residents' rooms. -Resident #5 had been found sleeping in other residents' beds. -If residents found Resident #5 sleeping in their bed, some residents would come and tell the staff, other residents attempted to get Resident #5 out of their bed themselves. -When the residents attempted to get Resident #5 out of their bed themselves, there would be an altercation between the two residents. -She did not know if the SCC or Assistant SCC had spoken to the PCP about Resident #5's behaviors. Interview with a MA on 02/19/26 at 11:45am revealed: -Resident #5 got upset and agitated when he was	D 270		

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D 270	Continued From page 13 spoken to loudly. -It was difficult to change Resident #5's soiled briefs. -Resident #5 got upset and tried to hit or push the staff away. -Resident #5 hit her one day on her arm; he had pushed her away several times. -She had found Resident #5 in residents' rooms. Telephone interview with Resident #5's PCP's on 02/19/26 at 12:06pm revealed: -She wanted MH to evaluate Resident #5, but she was unaware that he did not have signed consent and the staff had not been able to get in touch with the POA. -Resident #5 needed a MH evaluation if there were resident-to-resident altercations. -All the residents should be kept safe. Interviews with the Administrator on 02/19/26 at 3:30pm and 5:06pm revealed: -Resident #5 walked around the facility daily. -Resident #5 appeared to get more agitated in the evening hours. -The staff needed to pay more attention to Resident #5 and be proactive in preventing behaviors. -The staff should engage Resident #5 in activities, walk with him, and have conversations with him. -He expected the staff to get back to basics, overseeing all care and safety of the residents. -The staff must position themselves throughout the facility so they could intervene quickly when there was a potential for resident-to-resident altercations. -The facility had re-implemented care planning meetings with Resident #5 family/POA to discuss the behavioral problems. -He was concerned that if the aggressive	D 270		

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D 270	Continued From page 14 behavior of residents and resident-to-resident altercations continued that a resident was going to be injured. 2. Review of Resident #6's current FL-2 dated 10/02/25 revealed: -There was a diagnosis of severe dementia with agitation. -She was constantly disoriented. -She was ambulatory. ADD #^6's CP Review of Resident #6's accident/incident report dated 01/19/26 revealed: -At 3:15pm, Resident #6 was walking throughout the facility. -Resident #6 walked into the dining room and started swinging her arms at a resident that was playing bingo. -Then she moved to another resident and started fighting with that resident. -Resident #6 was separated from the residents and administered an as needed (PRN) medication for agitation. Review of Resident #6's mental health provider (MHP) evaluation dated 12/19/25 revealed: -Resident #6's diagnoses included dementia with agitation, major depressive disorder, chronic insomnia and anxiety disorder. -Resident #6 was being seen for increased aggression and agitation. -Resident #6 was administered a PRN medication 5 times from 12/06/26 to 12/17/26 that was effective. -Staff reported that Resident #6 had been aggressive, fighting with staff and visitors. -The MH provider found Resident #6 in another resident's room and Resident #6 was agitated	D 270		

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D 270	Continued From page 15 upon approach. -Resident #6 repeatedly said, "no", and began to stand up and move towards the provider, leading to the decision to discontinue the interview. -No new orders at this time. Review of Resident #6's MH evaluation dated 01/29/26 revealed: -Staff reported that Resident #6 exhibited agitation and aggression with staff and other residents. -On 01/20/26, staff reported that Resident #6 was in another resident's room lying on their bed. -Resident #6 was administered a PRN medication 7 times from 01/03/26 to 01/18/26. -Staff reported that Resident #6 had episodes of spitting in people's faces and being aggressive and agitated with staff and other residents. -A new medication for major depressive disorders was ordered. Review of Resident #6's electronic progress notes revealed at 8:15pm on 01/20/26, Resident #6 was found in another resident's bed; Resident #6 was led out of the room with encouragement. Interview with a PCA on 02/18/26 at 11:32am revealed: -Resident #6 was ambulating in the dining room while the residents were playing bingo. -Resident #6 walked up to a resident and mumbled something and hit the resident on her shoulder. -The resident tried to stand up and fell on the floor. -The resident complained of her leg hurting after Resident #6 hit her and she fell, and was sent to the Emergency Department (ED). -Resident #6 walked away. -Another resident heard the noise in the dining	D 270		

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D 270	Continued From page 16 room and said something to Resident #6, and Resident #6 hit that resident. -The only thing the staff had been told by the management staff was to redirect the residents when there were altercations or when residents were going into other resident's rooms. -No one from management had told the staff to monitor Resident #6 more frequently. Interview with a PCA on 02/19/26 at 9:18am revealed: -Resident #6 liked to walk. -Resident #6 became verbally abusive and cursed. -Resident #6 had flared her arms up once as if Resident #6 was going to hit her, but never hit her. Interview with a MA on 02/17/26 at 4:15pm revealed: -Resident #6 punched another resident in the head while that resident was playing bingo. -She did not know why Resident #6 punched the other resident in the head. -Resident #6 had been in altercations with multiple residents. Telephone interview with Resident #6's Power of Attorney (POA) on 02/19/26 at 8:51am revealed: -On 01/28/26, she spoke with someone at the facility, she could not remember who, about starting Resident #6 on a medication for her combativeness. -Resident #6 was started on a medication to help with depression and anxiety. -She thought the medication was helping, but she was not sure. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed:	D 270		

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D 270	Continued From page 17 -She was aware of Resident #6's aggressive behavior. -She found out about Resident #6's aggressive behaviors and altercations when she arrived at the facility for her monthly visits. -She had adjusted Resident #6's medications to help with the aggressive behaviors about two months ago. Interview with the Administrator on 02/17/26 at 5:20pm revealed: -Resident #6 had been in a couple of altercations in the dining room with other residents. -He could not remember the specifics at this time. Interview with the Administrator on 02/19/26 at 5:06pm revealed: -Resident #6 wandered in the hallways. -The staff were to monitor and redirect Resident #6. 3. Review of Resident #8's current FL-2 dated 08/13/25 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -She wandered. -She was ambulatory. CP #8 Review of Resident #8's accident/incident report dated 12/09/25 revealed: -At 9:20am, another resident grabbed Resident #8's face. -The residents were separated. Review of Resident #8's Mental Health Provider (MHP) note dated 12/19/25 revealed: -Resident #8 was seen for major depressive disorder, generalized anxiety disorder, and	D 270		

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D 270	Continued From page 18 dementia. -Staff reported that Resident #8 was wandering and going into other residents' rooms taking their things. -Resident #8 continued to wander and took other residents' items. -Resident #8 was to continue with her current medication regimen. Interview with a PCA on 02/18/26 at 11:32am revealed: -Resident #8 went into other residents' rooms and removed items that did not belong to her. -She saw Resident #8 with clothes and briefs that belonged to other residents. -Resident #8 gave her the items that Resident #8 had picked up in other residents' rooms without difficulty and she replaced the items back into the residents' rooms. -Resident #8 had been in several resident-to-resident altercations because Resident #8 went into other residents' rooms and took residents' personal items. -One resident had grabbed Resident #8 by the cheeks with her hand, and another resident had hit Resident #8 because she had gone in their bedrooms. Review of Resident #8's accident/incident report dated 01/18/26 revealed: -At 3:55pm, another resident grabbed Resident #8's hair and pulled it. -The intervention was the staff should watch Resident #8 and keep Resident #8 from taking things out of other residents' rooms. Review of Resident #8's MHP's note dated 01/29/26 revealed: -Staff reported that Resident #8 was pushed by another resident on 12/27/25 and on 01/18/26	D 270		

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D 270	Continued From page 19 another resident grabbed Resident #8 by the hair on top of her head and pulled it. -Continue medication regimen as ordered. Review of Resident #8's accident/incident report dated 02/17/26 revealed: -At 10:30pm, Resident #8 was messing with another resident and the resident hit Resident #8 on the arm. -Resident #8 was redirected and staff were to increase supervision. Interview with a PCA on 02/19/26 at 9:18am revealed: -Resident #8 was a walker; she walked through the facility and in and out of residents' rooms. -Resident #8 made up resident's beds, she picked up things in the resident's rooms and brought the items out of the room. -A staff took the items from Resident #8 and returned the items to the correct rooms. -Some residents got upset when Resident #8 went into their rooms. -Several residents kept their doors locked to keep Resident #8 out of their bedroom. -Management told the staff to redirect residents when needed; no other instructions were given. Interview with a second PCA on 02/18/26 at 3:20am revealed: -Resident #8 tried to go into a resident's room and the resident came out of her room and hit Resident #8 on top of the head. -She saw what happened and she redirected Resident #8. -Resident #8 was not injured. -Resident #8 agitated other residents because she went into their rooms and removed items. Interview with a MA on 02/19/26 at 11:45am	D 270		

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D 270	Continued From page 20 revealed: -Resident #8 went in and out of residents' rooms. -She tried to keep an eye of Resident #8, and she would redirect Resident #8 when she saw Resident #8 entering residents' rooms. -Resident #8 would pick up things in residents' rooms and bring them out of the room. -Resident #8 would attempt to open closed doors. -Some residents did not want Resident #8 in their room because Resident #8 took things that did not belong to her. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed: -She found out about accident/incident reports when she arrived at the facility for her monthly visits. -Resident #8 was not the aggressor in the resident-to-resident altercations. -Other residents got upset with Resident #8 because she wandered into their rooms and took items. -She was worried a resident could become injured with resident-to-resident altercations. Interview with the Administrator on 02/19/26 at 5:06pm revealed: -He was aware Resident #8 wandered into residents' rooms. -The staff must be proactive when monitoring Resident #8 and redirect her when Resident #8 was going into other resident's rooms. -Resident #8's behaviors were manageable with guidance. -Resident #8 rummaged through other resident's rooms and removed items from the resident's rooms. -Interventions of redirecting wanderers were in place. -If the intervention was not working, they needed	D 270		

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D 270	Continued From page 21 to look at other ways to prevent Resident #8 from wandering into other residents' rooms. -The staff must communicate with him if there were ongoing problems with behaviors and wandered. Attempted telephone interview with a previous MA on 02/19/26 at 8:30am was unsuccessful. Attempted interview with Resident #8's Power of Attorney (POA) on 02/19/26 at 11:05am was unsuccessful. The facility failed to ensure supervision was provided according to the resident's assessed needs for a resident (#5) who wandered in and out of residents' rooms, used their bathrooms and laid in their beds, who was in resident-to-resident and resident-to-staff altercations; a resident (#6) who wandered in the facility and was in resident-to-resident altercations, one of which resulted in a resident being injured and having to be seen in the emergency department; and a resident (#8) who wandered in an out of other residents' rooms, and removed their personal items, resulting in resident-to-resident altercations. The facility's failure resulted in substantial risk for physical harm, which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/17/26 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2025.	D 270		

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D 273	Continued From page 22	D 273	10A NCAC 13F .0902 (b) Health Care	
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 5 of 9 sampled residents (#3, #5, #6, #7, and #8) regarding notifying the Mental Health Provider (MHP) and the Primary Care Provider (PCP) when accident/incidents occurred. The findings are: Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -He worked triage and responded to the calls from the facility. -When the staff called and left a message and the triage personnel would call them back. -Once there was verbal communication about the initial call, the triage personnel would document in the resident record a triage note. -There would be documentation in the resident electronic record for every call received to the PCP's office. 1. Review of Resident #5's current FL-2 dated 07/30/25 revealed diagnoses included malignant neoplasm of prostate, peripheral vascular disease, and diabetes mellitus type 2. a. Review of Resident #5's accident/incident report dated 12/28/25 at 3:25pm revealed: -Resident #5 hit another resident in the face.	D 273	Residents #3, #5, #6, #7, #8 were reviewed on 2/20/26 to ensure appropriate notification of Primary Care Providers and Mental Health Providers following incidents and Behavioral concerns. Provider notifications were completed and documented in the residents records. On 2/21/2026 The E.D. and SCC conducted a 30-day audit of accident and incident reports to verify provider notification was completed and documented. Staff were educated on reporting incidents and accidents electronically through the Perfect Serve communication Portal system with Eventus. Staff were instructed to attach the provider notification documentation to the incident report to demonstrate that the provider was notified. The E.D. and SCC audited residents who showed behavioral concerns and did not have mental health services providers immediatly obtained consents for services made the appropriate referral to Eventus Psychiatric services.	

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D 273	Continued From page 23 -There was documentation that a message was left for the PCP on 12/28/25 at 3:56pm. -There was no documentation that the PCP returned the call. Review of Resident #5's electronic progress notes dated 12/28/25 revealed: -Resident #5 hit another resident in the face with his hand. -There was documentation that a message was left for the PCP. -There was no documentation that the PCP returned the call. Review of Resident #5's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 12/28/25. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of accident/incident reports dated 12/28/26 for Resident #5. -The PCP expected to be notified of the accident/incident dated 12/28/25 when it occurred. Attempted interview with the medication aide (MA) on 02/19/26 at 8:30am was unsuccessful. b. Review of Resident #5's accident/incident report dated 02/15/26 at 6:12pm revealed: -Resident #5 was observed in a physician altercation with another resident. -There was no documentation that the PCP was notified of the accident/incident report dated 02/15/26 Review of Resident #5's electronic progress notes dated 02/15/26 revealed there was no	D 273	Cont. The E.D. or designee will review incident reports weekly for three months to ensure provider notifications are completed and documented. Findingswill be reviewed during Quality Assurance Performance Improvement (QAPI) meetings	3/19/26

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D 273	Continued From page 24 documentation regarding the incident dated 02/15/26 or the PCP being notified. Review of Resident #5's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 02/15/26. Interview with the MA on 02/18/26 at 10:50am revealed: -She notified the PCP's office of the accident but did not receive a return call. -She failed to document the notification of the PCP. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of accident/incident reports dated 02/15/26 for Resident #5. -The PCP expected to be notified of the accident/incident dated 02/15/26 when it occurred. c. Review of Resident #5's accident/incident report dated 02/16/26 at 6:45pm revealed: -Resident #5 was entering other residents' rooms. -When Resident #5 was redirected by other staff, Resident #5 threatened to jump on the staff. -At 7:00pm, Resident #5 was transported by Emergency Medical Services (EMS) to the Emergency Department (ED) for evaluation. -There was documentation that a message was left for the PCP on 02/16/26 at 7:30pm. -There was no documentation that the PCP returned the call. Review of Resident #5's electronic progress notes dated 02/16/26 revealed there was documentation that the PCP was notified of the accident/incident dated 02/16/26.	D 273		

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D 273	Continued From page 25 Review of Resident #5's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 02/16/26. Interview with the MA on 02/17/26 at 4:15am revealed she called the after-hours telephone number and left a message for the PCP, but she did not get a return call. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of accident/incident reports dated 02/17/26 for Resident #5. -There was a hospital discharge summary in Resident #5's electronic record dated 02/17/26. -The PCP expected to be notified of accident/incident dated 02/16/26 when it occurred. Refer to the interviews with the assistance Special Care Unit Coordinator (SCC) on 02/19/26 at 10:37am and 4:20pm. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 2. Review of Resident #6's current FL-2 dated 10/02/25 revealed there was a diagnosis of severe dementia with agitation. Review of Resident #6's accident/incident report dated 01/19/26 at 3:15pm revealed: -Resident #6 was walking throughout the facility. -Resident #6 ambulated into the dining room and started swinging her arms at a resident that was	D 273		

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 _____	R-C 02/19/2026

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D 273	Continued From page 26 playing bingo. -Then she moved to another resident and started fighting that resident. -There was documentation that the MHP was notified; there was no date or time of notification. Review of Resident #6's electronic progress notes dated 01/19/26 revealed there was no documentation regarding the incident dated 01/19/26 or the PCP was notified. Review of Resident #5's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 01/19/26. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of the accident/incident on 01/19/26 for Resident #6. -The PCP expected to be notified of accident/incident dated 01/19/26 when it occurred. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed: -She was aware of Resident #6's aggressive behavior. -There was no documentation that she had been notified of the resident-to-resident altercation on 01/19/26. -She would have wanted to know about the altercations with Resident #6 so she could address the issues. Attempted interview with the medication aide (MA) on 02/19/26 at 8:30am was unsuccessful. Refer to the interviews with the assistance Special Care Unit Coordinator (SCC) on 02/19/26	D 273		

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D 273	Continued From page 27 at 10:37am and 4:20pm. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 3. Review of Resident #8's current FL-2 dated 08/13/25 revealed diagnoses included dementia and hypertension. a. Review of Resident #8's accident/incident report dated 12/09/25 at 9:20am revealed: -Another resident grabbed Resident #8's face. -There was documentation a message was left for Resident #8's PCP on 12/09/25 at 9:37am. -There was no documentation the PCP returned the call. Review of Resident #8's electronic progress notes dated 12/09/25 revealed: -Another resident grabbed Resident #8's face. -A message was left for the PCP. Review of Resident #8's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 12/09/25. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of the accident/incident on 12/09/25 for Resident #8. -The PCP expected to be notified of accident/incident reports for Resident #8 when they occurred. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed	D 273		

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D 273	Continued From page 28 there was no documentation that the MHP was notified of Resident #8's altercation with another resident on 12/09/26. Attempted interview with the medication aide (MA) on 02/19/26 at 8:30am was unsuccessful. b. Review of Resident #8's accident/incident report dated 02/17/26 10:30pm revealed: -Resident #8 was messing with another resident and the resident hit Resident #8 in the arm. -There was documentation a message was left for the PCP on 02/17/26 at 11:00pm. -There was no documentation the PCP returned the call. -There was no documentation the MHP was notified of the incident on 02/17/26. Review of Resident #8's electronic progress notes dated 02/17/26 revealed: -Staff reported that Resident #8 was seen being punched all over the body by another resident. -Resident #8's face and arms were red. -There was no documentation the PCP or MHP was notified. Review of Resident #8's record revealed there were no triage notes from the PCP's office regarding the accident/incidents dated 02/17/26. Interview with the MA on 02/19/26 at 3:15pm revealed: -She notified the PCP's office, but did not receive a call back from the PCP. -She did not remember calling the MHP. Telephone interview with a representative from the PCP's office on 02/19/26 at 9:45am revealed: -There was no documentation the PCP's office was notified of the accident/incident 02/17/25 for	D 273		

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D 273	Continued From page 29 Resident #8. -The PCP expected to be notified of accident/incident reports for Resident #8 when they occurred. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed there was no documentation that the MH provider was notified of Resident #8's altercation with another resident on 12/09/26 or 02/17/26. Telephone interview with a representative from the MHP's office on 02/19/26 at 2:00pm revealed: -She would want to know about the altercation, especially if Resident #8 was the aggressor. -She was worried a resident could become injured with aggressive behavior and resident to resident altercations. Refer to the interviews with the assistance Special Care Unit Coordinator (SCC) on 02/19/26 at 10:37am and 4:20pm. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 4. Review of Resident #3's current FL-2 dated 01/24/26 revealed diagnoses included dementia, type 2 diabetes, anxiety, major depressive disorder, pseudobulbar affect, inflammatory spondylopathies, and respiratory disorder. a. Review of Resident #3 incident report dated 02/15/26 revealed Resident #3 pulled another resident's hair and accused the resident of removing personal items from her room.	D 273		

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D 273	Continued From page 30 Review of Resident #3's electronic progress notes revealed: -On 01/18/26, Resident #3 grabbed another resident by the hair and pulled it. -Resident #3 was administered an as needed medication (PRN) for her behavior. -There were no injuries reported. -Resident #3's primary care provider (PCP) was notified. -There was no documentation her mental health provider (MHP) was notified. Telephone interview with a representative from Resident #7's PCP's office on 02/19/26 at 9:55am revealed: -There was no documentation the PCP's office was notified of the accident/incident on 01/18/26 for Resident #3. -The PCP expected to be notified of accident/incident dated 01/18/26 when it occurred. Attempted telephone interview with a medication aide (MA) on 02/19/26 at 8:30am was unsuccessful. b. Review of Resident #3 incident report dated 02/15/26 revealed: -Resident #3 was observed being pushed by another resident. -She fell face forward and hit the left side of her head. -She was transported to the local hospital via emergency medical services (EMS). -She was diagnosed with a urinary tract infection (UTI). -Resident #3's primary care provider (PCP) was notified. Review of Resident #3's electronic progress	D 273		

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D 273	Continued From page 31 notes revealed: -There was no documentation of an incident on 02/15/26. -There was no documentation Resident #3's primary care provider (PCP) was notified. Telephone interview with a representative from Resident #3's primary care provider's (PCP) office on 02/19/26 at 9:55am revealed: -There was no documentation the PCP's office was notified of the accident/incident on 02/15/26 for Resident #3. -The PCP received hospital discharge information on 02/17/26, for emergency services on 02/15/26. -The PCP expected to be notified of accident/incident dated 02/15/26 when it occurred. Telephone interview with Resident #3's mental health provider (MHP) on 02/19/26 at 2:35pm revealed: -She was not made aware of the incident between Resident #3 and another resident. -If Resident #3 had an incident or an issue with another resident it could be behavior based and she would like to be notified. Interview with a medication aide (MA) on 02/19/26 at 10:35am revealed: -She completed Resident #3's incident report for the incident on 02/15/26. -She spoke to someone at Resident #3's PCP's office and told them about the incident. Refer to the interviews with the Assistant Special Care Unit Coordinator (SCC) on 02/19/26 at 10:37am and 4:20pm. Refer to the interview with the SCC on 02/19/26 at 2:15pm.	D 273		

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D 273	Continued From page 32 Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 5. Review of Resident #7's current FL-2 dated 07/01/25 revealed diagnoses included dementia, hypertension, gastroesophageal reflux disease (GERD), major depression disorder, and anxiety. Review of Resident #7's incident reports revealed there were no incident reports for 02/17/26. Review of Resident #7's electronic progress notes revealed: -On 02/17/26, Resident #7 was seen punching another resident all over the resident's body. -There was no documentation Resident #7's mental health provider (MHP) was notified. Telephone interview with a representative from Resident #7's primary care provider's (PCP) office on 02/19/26 at 9:55am revealed: -There was no documentation the PCP's office was notified of the accident/incident on 02/17/26 for Resident #7. -The PCP expected to be notified of accident/incident dated 02/17/26 when it occurred. Telephone interview with Resident #7's MHP on 02/19/26 at 2:20pm revealed: -The facility did not make her aware of the incident with Resident #7 and another resident on 02/17/26. -Resident #7's guardian contacted her today, 02/19/26, and told her about the incident. -She had been making medication adjustments for Resident #7's behaviors and would like to have know about the incident.	D 273		

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D 273	Continued From page 33 Interview with a medication aide (MA) on 02/18/26 at 11:51am revealed she contacted Resident #7's PCP for the incident on 02/17/26 and left a message with someone. Refer to the interviews with the Assistant Special Care Unit Coordinator (SCC) on 02/19/26 at 10:37am and 4:20pm. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. Interviews with the assistance SCC on 02/19/26 at 10:37am and 4:20pm revealed: -The staff was to report all accident/incident reports to the PCP when the accident/incident happened. -If the resident was seen by MH, the MH provider should also be notified of the accident/incident. -Notification of the PCP and MHP of an accident/incident was documented on the accident/incident report. -The PCP needs to be made aware of the accident/incidents because there may be something going on with the residents that needs to be evaluated, like a UTI. -The MHP needed to be notified of the accident/incident reports because the residents behavior and altercations could cause injury. Interview with the SCC on 02/19/26 at 2:15pm revealed: -If the staff left a message for the PCP when an accident/incident occurred and there was no return phone call from the PCP, the SCC should follow up with the PCP the next day. -She was not aware messages were left for the	D 273		

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D 273	Continued From page 34 PCP with no return call and no follow up call. -The staff should notify the PCP and the MH provider if appropriate, when the accident/incident occurs. -If a voice mail was left for the PCP, the SCC should follow up with the PCP and/or the MHP the next day. -Documentation of the notification should be in the electronic progress notes and on accident/incident reports. -Residents who wandered should be in sight of staff all the time. -When a resident wandered into a room, the staff should redirect the resident, -She did not know what the facility policy for wanderers was other than redirecting the resident; she had been employed with the facility for 2 weeks. -Some residents pace and were easily agitated. -These residents were watched closely by the staff and should be engaged in activities. -If behaviors continue, the resident should be administered an as needed medication if there was an order. -She thought some of the MAs were afraid to administer an as needed medication because the MAs think it is a chemical restraint, and they were not clear on what to look for when residents become agitated. Interview with the Administrator on 02/19/26 at 3:30pm revealed: -He expected the staff to notify the PCP of the accident/incidents that occurred and document on the incident. -He did not know that voice messages were being left for the PCP and the PCP was not returning the call. -He was concerned the calls were not being made to the PCP.	D 273		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 02/17/26 revealed there were 41 residents residing in the facility. Review of the week at a glance menu for the week of 02/15/26 revealed milk was to be served for breakfast and dinner but was not listed to be served for lunch. Review of the U.S. Department of Agriculture Dietary Guidelines for Americans revealed: -Adults aged 19-59 and 60+ should consume a	D 299	10A NCAC 13F .0904(d)(3) Nutrition and Food Service On 2/19/2026 The E.D. and Dietary Manager reviewed meal service and menu requirements to ensure residents receive 8 ounces of milk or equivalent dairy servings three times daily. The Menu was revised to ensure milk or dairy equivalent is offered at breakfast, lunch, and dinner. Eight-ounce cups were implemented to ensure proper portion sizes. Dietary staff were re-educated on milk portion requirements and meal service expectations. The Dietary Manager will observe meal service weekly for four weeks and audit menus weekly to ensure compliance. The E.D. or his designee will observe compliance daily.	3/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 299	Continued From page 36 minimum of the equivalent of 3 cups of a dairy item daily for a 1600-calorie diet. -Recommendations for daily dairy servings included 1 cup (8 ounces) of whole milk, 2% milk, 1% milk, non-fat/skim milk, buttermilk, lactose free milk, evaporated milk, and fortified soy milk. -Milk based dessert included in dairy servings were 1 cup of frozen yogurt, pudding, sherbet, ice cream and a dairy-based smoothie. -Yogurt included in dairy servings were 1 cup of milk-based yogurt, soy yogurt and kefir. -Cheese included in dairy servings were one and a half ounces of sliced or cubed hard or soft natural cheese or one-third of a cup of shredded hard or soft natural cheese, cottage cheese was a 2 cups serving, and ricotta cheese was a half a cup serving. -The dairy serving equivalent of processed American cheese was 2 one-ounce slices or 2 ounces. -Cream cheese, sour cream, and cream were not included as a dairy equivalent due to their low calcium content. -Plant based milks other than soy milk were not included in an equivalent in the dairy group even though they may contain calcium because their overall nutritional content was not similar enough to dairy milk and soy milk. Observation of the breakfast meal on 02/17/26 at 8:15am revealed: -The residents were served milk, water, fruit juice, oatmeal, sausage and waffles for breakfast. -The milk was served in a six ounce glass. Observation of the lunch meal on 02/17/26 from 12:05pm to 12:55pm revealed: -The residents were served milk, an orange flavored drink, water, roast beef, spinach, mashed potatoes, and cake.	D 299		

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D 299	Continued From page 37 -The milk was served in a six ounce glass. -Staff offered seconds on beverages to the residents. Interview with three residents on 02/18/26 at 8:40am revealed: -They liked milk to drink with their meal. -Milk was always served in the small glasses. -Sometimes they were offered more milk to drink at meals and sometimes they were not. -They were not offered milk with snacks. Interview with a personal care aide (PCA) on 02/18/26 at 8:50am revealed: -The PCAs poured the residents' milk. -Every resident was served milk. -The kitchen staff provided the small glasses to for the milk. Interview with the Dietary Manager on 02/18/26. -He started working at the facility one week ago. -He purchased five gallons of milk a week. -Milk was served even when there was another dairy item on the menu. -A four ounce serving of milk was served to each resident three times a day with meals. -The cups were only four ounce cups. -He thought the required portion size was a four ounce serving. Interview with the Administrator on 02/18/26 at 10:55am revealed: -He monitored the dining rooms during meals at dinner. -He looked for milk to be sure it was served to the residents. -He was not aware what the portion size was for a glass of milk until today, 02/18/26. -The Dietary Manager told him the portion size for milk was eight ounces.	D 299		

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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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 3 of 3 sampled residents (#1, #2 and #5), who had an order for a pureed diet (#1), an order for mechanical soft (MS) finger foods (#2) and an order for a MS diet (#5). The findings are: Review of the facility's regular menu for 02/17/26 revealed: -The breakfast meal to be served included French toast sticks with syrup, sausage patty, cereal of choice, juice, milk, and coffee. -The lunch meal to be served included roast beef, spinach, mashed potatoes, bread, frosted cake, water and a beverage of choice. 1. Review of Resident #1's current FL-2 dated 08/15/25 revealed diagnoses included neurocognitive disorder and Lewy bodies dementia. Review of Resident #1's diet order dated 12/03/25 revealed an order for a pureed diet. Review of the facility's therapeutic diet menu for	D 310	10A NCAC 13F .0904 (e)(4) Therapeutic Diets Residents #1,#2 and #5 diet orders were reviewed on 2/19/2026. Dietary staff were instructed to follow the physician diet orders on therapeutic diet preparation guidelines. A 100% audit of residents receiving therapeutic diets waws conducted to verify compliance with physician diet ordrs. Dietary staff were re-educated on preperation of pureed, mechanical, soft and finger food diets. Written preparation guidelines were placed in the kitchen for staff reference. The E.D. and SCC will observe meal preparation five times per week to audit proper diet consistency for residents receiving therapeutic diets. The Dining Services Manager will oversee therapeutic diet preparation and tray delivery to assure all residents on therapeutic diets are served what is on the menu or the equivalent.	3/19/26

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	HAL035024	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

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D 310	Continued From page 39 02/17/26 revealed: -The pureed diet listed the breakfast meal was pureed French toast with syrup, and pureed sausage. -The pureed diet listed the lunch meal was pureed roast beef, pureed spinach, mashed potatoes, pureed bread and pureed cake. Observation of the breakfast meal on 02/17/26 at 8:30am revealed: -Resident #1 was served pureed sausage that was thick and had paste like consistency. -Resident #1 was served oatmeal that was not pureed, was loose and ran on the plate. -Resident #1 ate 75 percent of her oatmeal and 100 percent of her pureed sausage. Observation of the lunch meal on 02/17/26 at 12:05pm revealed: -Resident #1 was served pureed roast beef, pureed spinach, mashed potatoes and a cake. -The cake was not a smooth pureed consistency but a loose and mealy consistency. -Resident #1 ate 100 percent of her meal. Interview with Resident #1's primary care provider (PCP) on 02/19/26 at 12:15pm revealed: -Resident #1 was ordered a pureed diet because she had issues with swallowing. -If Resident #1 was ordered a pureed diet then the facility staff should be following the diet order. Interview with a dietary aide on 02/18/26 at 10:10am revealed: -She helped puree desserts for the residents' meals. -She pureed the cake for the lunch meal on 02/17/26. -She usually placed the cake in the food processor with some milk and pureed it.	D 310		

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D 310	Continued From page 40 -She put the cake into individual bowls and pour milk on top on 02/17/26. -She took a spoon and stirred the cake with the milk until it was blended together. -She knew she should have used the food processor to puree the cake. -She thought the cake was soft enough to get the same consistency with the cake by mixing by hand. -She knew the cake should have been a mashed potato consistency. -She noticed the cake was not the correct consistency, but it had been served to the residents and she did not have the chance to correct it. Interview with a cook on 02/17/26 at 1:05pm revealed: -She always served oatmeal for breakfast. -Pureed food was put in a food processor and pureed to a smooth baby food consistency. -Puree food should not be "clumpy", and it should not look like applesauce because applesauce was not smooth enough. -Puree food should not be thick. -She did not puree oatmeal; she cooked it until it was a "mushy" consistency and not too thick or clumpy. Interview with the Dietary Manager on 02/18/26 at 9:01am revealed: -He started working at the facility about a week ago. -The cooks should follow the therapeutic diet menu when preparing the meals. -All purred food was placed in a food processor that blended down to a baby food consistency, smooth and not too watery. -If a food was too thick milk could be added to smooth it out.	D 310		

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D 310	Continued From page 41 -If a food was loose and not thick enough bread or food thickener could be added to thicken it up. -Oatmeal should be placed in the food processor to make it smooth. -He had not observed breakfast and had not seen the oatmeal. -Cake should be placed in the food processor and pureed with milk. -He had not observed the cake for the pureed diet at the lunch meal. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the Administrator on 02/18/26 at 10:55am. 2. Review of Resident #2's current FL-2 dated 07/01/25 revealed diagnoses included pneumonia, leukocytosis, sever protein and calorie malnutrition, hypertension, dementia and chronic obstructive pulmonary disorder (COPD). Review of Resident #2's signed physician's order dated 12/04/25 revealed there was an order for a mechanical soft (MS) diet. Review of Resident #2's signed physician's order dated 02/10/26 revealed there was an order for a finger foods. Review of the facility's therapeutic diet menu for 02/17/26 revealed: -The MS diet listed to be served for the breakfast meal was a cake donut, ground sausage patty and syrup. - The MS diet listed to be served for the lunch meal was ground roast beef, spinach, mashed potatoes, bread and frosted cake.	D 310		

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D 310	Continued From page 42 -The finger foods diet listed for the breakfast meal was French toast bites with syrup, and a sausage patty. -The finger foods diet listed for the lunch meal was roast beef, French green beans, steak fries, bread, and cake bites with frosting on the side. Observation of the breakfast meal on 02/17/26 at 8:30am revealed: -Resident #2 was served ground sausage, a half of a banana, and raisin toast. -Resident #2 shook as she ate her food and attempted to use her fork to eat the ground sausage. -The ground sausage did not stay on Resident #2's fork and it shook off the fork before she got it to her mouth. -Resident #2 ate 100 percent of her banana, and raisin toast but ate less than 25 percent of the ground sausage. Observation of the lunch meal on 02/17/26 at 12:05pm revealed: -Resident #2 was served a chicken salad sandwich cut into quarters and cake with frosting. -Another resident on a finger food diet was served French cut green beans, steak cut potato fries, roast beef, a roll, and cake. -Resident #2 was shaking while she ate; she shook some of the chicken salad out of the sandwich. -She leaned forward and licked the cake; a staff member showed her how to use her hands to eat the cake. -Resident #2 used her hands but was also using her fork to eat the cake and the chicken salad. -Resident #2 ate 100 percent of her sandwich and her cake. -She was not served the green beans or the steak fries.	D 310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 43 Interview with Resident #1's hospice nurse on 02/18/26 at 11:50pm revealed: -She ordered resident #2 a MS and finger food diet on 02/10/26 after staff told her resident number to shook so hard that the food fell off her spoon. -Resident #2 still needed a MS diet in addition to the finger foods. -She was told by the facility staff that the finger food would be the same as the MS she could just pick it up with her hands. -Resident #2 walked all day and used a lot of calories and would sometimes eat seconds. -Resident #2 was supposed to get a full meal. Interview with a cook on 02/17/26 at 12:58pm revealed: -Resident #2 had an order for MS and finger foods. -Her diet included foods that were soft and could be held. -Soft foods were served on a sandwich so she could pick it up. -She was served chicken salad on a bread. -Pasta was soft and could be a finger food. -Vegetables were boiled and soft and put into a bowl for Resident #2 so it was easier to pick up. -The finger foods were a new order for Resident #2, so they were still figuring it out. Interview with a second cook on 02/17/26 at 1:05pm revealed: -She served the residents on a MS diet a banana, ground sausage, and raisin toast because they could not have waffles. -Resident #2 was served the same diet as the MS menu at breakfast because she could pick it up if she needed to.	D 310		

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D 310	Continued From page 44 Interview with the Dietary Manager on 02/18/26 at 9:01am revealed: -Resident #2 had an order for a MS and finger food diet. -The cooks could follow both therapeutic menus to prepare Resident #2's meals. -Ground sausage was not an acceptable finger food alone; it could have been mixed with mayonnaise and put on bread and cut up so the resident could pick it up. -The other residents with finger food orders were served green beans and steak fries. -Resident #2 should have been served the whole meal including the green beans. -She should not have just been served the chicken salad sandwich. -It was important for Resident #2 to be served the entire meal because she needed the calories. -He would follow up with the cooks and do more training. Interview with the Administrator on 02/18/26 at 10:55am revealed: -The cooks and the dietary manager should look at Resident #2's meals to be sure they are nutritionally sound and balanced. -There should not be anything missing from her plate. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the Administrator on 02/18/26 at 10:55am. 3. Review of Resident #5's current FL-2 dated 07/30/25 revealed diagnoses included diabetes mellitus type 2, chronic kidney disease stage III, malignant neoplasm of prostate, benign prostatic	D 310		

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D 310	Continued From page 45 hyperplasia (BPH), and peripheral vascular disease. Review of Resident #5's signed physician orders dated 12/04/25 revealed: -Diagnoses included anxiety disorder, Alzheimer's disease, dementia with agitation. -There was a diet order for a mechanical soft (MS) diet. Review of Resident #5's diet order form dated 10/20/25 revealed there was an order for a MS diet. Review of the facility's therapeutic diet menu for 02/17/26 revealed: -The MS diet listed to be served for the breakfast meal was a cake donut, ground sausage patty and syrup. - The MS diet listed to be served for the lunch meal was ground roast beef, spinach, mashed potatoes, bread and frosted cake. Observation of the breakfast meal on 02/17/26 at 8:30am revealed: -Resident #5 was served ground sausage, a half of a banana, and raisin toast. -Resident #5 ate 100 percent of his meal. Observation of the lunch meal on 02/17/26 at 12:05am revealed: -Resident #5 was served ground roast beef, spinach, mashed potatoes, a dinner roll and cake with frosting. -Resident #5 ate 100 percent of his meal. Interview with Resident #5 on 02/17/26 at 12:31pm revealed his food was good and he liked it.	D 310		

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D 310	Continued From page 46 Interview with Resident #5's primary care provider (PCP) on 02/19/26 at 12:15pm revealed: -She was not sure why resident number 5 was ordered a MS Diet. -Typically, residents were ordered a diet because they were having trouble with swallowing or chewing. -Resident #5 had an order for a MS diet and it should have been followed. Interview with a cook on 02/17/26 at 1:05pm revealed: -She served the residents on a MS diet a banana, ground sausage, and raisin toast because they could not have waffles. -The therapeutic menu had donuts for the MS diet, but she could not get to the freezer due to a food delivery, so she served the raisin toast instead. -She did not know if the MS diet included raisin toast, she thought it was a good replacement for the waffles. Interview with the Dietary Manager on 02/18/26 at 9:01am revealed: -He did not see the breakfast meal on 02/17/26. -He knew the residents on a MS diet were not supposed to be served the waffles. -The cooks were supposed to follow the therapeutic diet menu. -He did not know if there were donuts available to serve for the MS diet. -He could put a food item into the computer program, and it would spread the food item across the therapeutic diet menu. -He did not know if the raisin toast was a good substitute for the waffles for a MS diet. Refer to the interview with the Administrator on 02/18/26 at 10:55am.	D 310		

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D 310	Continued From page 47 Interview with the Administrator on 02/18/26 at 10:55am revealed: -He observed one meal a day; usually dinner. -He looked for plate presentation and at meal tickets to be sure the therapeutic diets were supposed to be what was ordered. -He was still learning how food was supposed to be prepared for each therapeutic diet and what it should look like when served. -He expected the Dietary Manager to train the cooks and make sure they were following the therapeutic diet menu.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the rights of three residents (#3, #7, and #9) were maintained including residents, who were injured during altercations with another resident (#3, #9), and a resident who had residents attempting to open her door at night (#7). The findings are: 1. Review of Resident #3's current FL-2 dated 01/24/26 revealed: -Diagnoses included dementia, type 2 diabetes,	D 338	10A NCAC 13F .0909 Residents Rights Protection from Harm (Type A2) Residents #3,#7, and #9 were assessed following the incidents and care plans were updated to include supervison and behavioral interventions to prevent resident to resident altercations. Staff were instructed to monitor residents with wandering or intrusive behaviors and intervene promptly to prevent altercations. A review of all residents in the Special Care Unit was conducted to identify residents who may require additional supervision or behavioral interventions.	3/19/26

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	HAL035024	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 48 anxiety, major depressive disorder, pseudobulbar affect, inflammatory spondylopathies, and respiratory disorder. -She was ambulatory. -She was constantly disoriented. Review of Resident #3's care plan dated 10/09/25 revealed: -She was disoriented sometimes. -She was forgetful and needed reminders. -She was independent with eating and ambulation. -She required supervision from staff with transferring. -She required limited assistance from staff with toileting, bathing, dressing and grooming. Observation of Resident #3 on 02/17/26 at 8:20am revealed she had a dark blue and purple ring under her left eye. Review of Resident #3's incident report dated 02/16/26 at 6:12pm revealed: -Resident #3 was observed being pushed down. -She fell face forward and hit the left side of her head. -She was transported to the local hospital by emergency medical services (EMS) at 6:27pm. Review of Resident #3's progress notes revealed: -On 02/16/26, Resident #3 returned from the local hospital at 4:14am, she was communicating well and was not complaining of any pain or discomfort. -On 01/18/26, Resident #3 confronted another resident stating the resident took adult briefs out of her room, she was given an as needed medication (PRN) for agitation. Telephone interview with Resident #3's power of	D 338	Continued. The E.D. and SCC or their designee will conduct daily rounds and weekly audits for 3 months. Findings will be reviewed during QAPI Meetings.	

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D 338	Continued From page 49 attorney (POA) on 02/17/26 at 6:00pm revealed: -There was a [named] resident who walked around the facility. -He had seen the resident when he visited Resident #3, and the resident wandered into Resident #3's room while he was visiting. -He was able to redirect the resident out of Resident #3's room. -On 02/15/26, the resident used Resident #3's bathroom and made a mess. -Resident #3 got upset and "skirmished" with the resident in her room. -Resident #3 fell and hit her forehead and was sent to the hospital. -He was not aware of any other issues with Resident #3 and any other residents. -He mentioned getting Resident #3 a key to her room to the Administrator on 02/16/26. -The Administrator was okay with a key so Resident #3 and her roommate could lock their room. -He did not know when the lock and key would be put into place. Interviews with Resident #3 on 02/17/26 at 8:20am and 3:50pm revealed: -She had a black eye because someone punched her in the face. -A [named] resident was in her bathroom and had a bowel movement. -"It was all over the place" and she got mad at him. -She was in the hallway in her room and the [named] resident got mad at her and he punched her. -She was afraid of him coming back to her room. Interview with another resident on 02/17/26 at 3:40pm revealed: -There was a male resident who went into	D 338		

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D 338	Continued From page 50 Resident #3's room. -She was in the dining room and could hear and see Resident #3 "hollering". -She saw the male resident hit Resident #3 and knock her down onto the floor. Interview with a personal care aide (PCA) on 02/18/26 at 10:20am revealed: -Resident #3 found [named] resident in her room and was upset. -The resident hit Resident #3 in the eye. -The resident had not had an issue with Resident #3 before. -There was another resident that went in and out of the residents' rooms and touched their belongings and Resident #3 got upset and would complain about that resident. Interview with a medication aide (MA) on 02/17/26 at 4:30pm revealed: -There was a resident who wandered the halls at night and jiggled door handles. -There was a second resident who constantly walked and got into other residents' beds, urinated in trashcans and made a mess when he used other residents' bathrooms. -The second resident would become agitated when residents tried to remove him from their room. -Resident #3 did not like other residents in her room. Interview with a second MA on 02/19/26 at 10:35am revealed: -Another staff member came and got her on 02/15/26, when she saw Resident #3 she was sitting on the floor in the hallway outside her room. -Resident #3 started to hyperventilate, her face turned red and she started to have a panic attack.	D 338		

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D 338	Continued From page 51 -Resident #3 said a male resident went in her bathroom and messed it all up. -Resident #3 said a male resident pushed her and hit her. -The male resident was known for going in and out of residents' rooms and beds. -Resident #3 was sent to the local ED because she hit her head when she fell. -Resident #3 had complained about other residents going into her room and jiggling her door handle. -Resident #3 had not complained about other residents taking her things. Interview with the Assistant Special Care Unit Coordinator (SCC) on 02/19/26 at 3:50pm revealed: -Resident #3's cognition was higher than most of the other residents, so she was more aware of other residents going in and out of rooms. -Resident #3 was paranoid about residents going in her room. -Resident #3 could lock the door to her room while she was in the room, but the room did not have a keyed lock on the door. -The doors to all the residents' rooms could be locked from the inside, the door locks could not be locked from the outside. Interview with the SCC on 02/19/26 at 3:00pm revealed: -Resident #3 approached a resident about going into her bathroom. -The resident was in her room and Resident #3 blocked his path. -The resident pushed Resident #3, and she fell, so she was sent to the hospital. -The resident walked the hallways and did not mess with the other residents. -Staff told her Resident #3 said the resident went	D 338		

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	HAL035024	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 52 in her room. -Resident #3 liked to keep her door closed. -She did not know if Resident #3's door could be locked. Interview with the Administrator on 02/17/26 at 5:20pm revealed: -There was a [named] resident who would walk the hallways, go into other residents' rooms and push on exit doors. -Resident #3 had an incident over the weekend when the resident used her bathroom. -On 02/15/26, the resident got feces all over himself and Resident #3's bathroom. -Resident #3 confronted the resident about her bathroom. -The residents shoved each other and Resident #3 fell in the hallway. -Resident #3 was sent to the local hospital due to the fall because she hit her head and her eye. Refer to the interview with a PCA on 02/18/26 at 10:43am. Refer to the interview with a second PCA on 02/18/26 at 11:51am. Refer to the interview with the SCC on 02/19/26 at 3:00pm. Refer to the interview with the Administrator on 02/17/26 at 5:20pm. 2. Review of Resident #9's current FL-2 dated 08/13/25 dated 08/13/25 revealed: -Diagnoses included dementia, chronic respiratory failure, gastroesophageal reflux disease (GERD), mild cognitive impairment, hyperthyroidism, anxiety, and hyperlipidemia. -She was ambulatory.	D 338		

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D 338	Continued From page 53 -She wandered. -There was no information for disorientation. Review of Resident #9's care plan dated 09/18/25 revealed: -She was always disoriented. -She had significant memory loss and required directions. -She was independent with eating and ambulation. -She required limited assistance from staff with transferring. -She required total assistance from staff with toileting, bathing, dressing and grooming. Review of Resident #9's progress notes revealed: -On 11/16/25, at 1:25pm, Resident #9 was hit and kicked by another resident. -The other resident threw water on her. Interview with a personal care aide (PCA) on 02/18/26 at 10:20am revealed: -There was a resident who wandered and talked nonstop. -Resident #9 would get upset with the resident when she would not stop walking. -Resident #9 would tell the wandering and talking resident to stop. -She would see other residents getting agitated by the resident when she wandered so she would give the wandering resident something to do. -She would redirect the resident and give her something to do like folding napkins, folding laundry or sweeping. -She would keep the wandering resident busy for as long as she could. Interview with a second PCA on 02/19/26 at 2:45pm revealed: -Resident #9 did not talk.	D 338		

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D 338	Continued From page 54 -Resident #9 was "sweet and cooperative". -She did not know of an incident where Resident #9 was hit by another resident. Interview with a medication aide (MA) on 02/19/26 at 10:35am revealed: -Resident #9 stayed in her room a lot. -Resident #9 was sweet with a good disposition. -She had never seen Resident #9 having an issue with other residents. Interview with a second MA on 02/19/26 at 11:20pm revealed: -Resident #9 was quiet and did not bother other residents. -She would walk around and not bother other residents. -She did not remember Resident #9 being hit by another resident or having water thrown on her. Interview with the Assistant Special Care Unit Coordinator (SCC) on 02/19/26 at 4:15pm revealed: -Resident #9 could be very combative if she became agitated. -She could not remember the date but there was an incident between Resident #3 and another resident. -Resident #9 was banging on an exit door near the other resident's room. -The other resident came out into the hall and yelled at Resident #3 for banging on the exit door. -The other resident turned and went back into her room after she yelled at Resident #3. -Resident #9 followed the resident into her room. -The other resident threw a cup of water in Resident #3's face and dragged her into the hallway by her hair. -Resident #9 was kept away from the other resident and the other resident's room.	D 338		

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D 338	Continued From page 55 Interview with the SCC on 02/19/26 at 3:10pm revealed: -She had only worked at the facility for two weeks. -She was not familiar with Resident #9. -She could not speak to an incident that happened with Resident #9 in November 2025 because she did not work at the facility at that time. Attempted telephone interview with Resident #9's power of attorney (POA) on 02/19/26 at 2:40pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #9 was not interviewable. Refer to the interview with a PCA on 02/18/26 at 10:43am. Refer to the interview with a second PCA on 02/18/26 at 11:51am. Refer to the interview with the SCC on 02/19/26 at 3:00pm. Refer to the interview with the Administrator on 02/17/26 at 5:20pm. 3. Review of Resident #7's current FL-2 dated 07/01/25 revealed: -Diagnoses included dementia, hypertension, gastroesophageal reflux disease (GERD), major depression disorder, and anxiety. -She was ambulatory. -She was intermittently disoriented. Review of Resident #7's care plan dated 09/18/25	D 338		

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D 338	Continued From page 56 revealed: -She had significant memory loss and needed to be directed. -She was always disoriented. -She was independent with eating, toileting, ambulation, dressing and transferring. -She required limited assistance from staff with bathing and grooming. Observation of Resident #7's room on 02/17/26 at 8:55am revealed: -Resident #7 was in her room with the door closed and locked. -She spoke through the closed door and asked who was at the door before she opened the door. Review of an incident report dated 01/19/26 revealed: -Resident #7 was playing bingo in the day room when another resident came up and punched Resident #7 in the head. -Resident #7 stood up and started swinging back when she ended up falling hard on the ground. -Resident #7 was sent to the local emergency department (ED). -Interventions were to watch behaviors. Review of Resident #7's progress notes revealed: -On 01/20/26, no signs of pain or discomfort were noted. -There was nothing documented in the progress notes for 01/19/26. Interviews with Resident #7 on 02/17/26 at 8:55am and 3:40pm revealed: -She kept her door locked at all times, even when she was in her room. -She had a key for her door. -She locked her door because she was scared of some of the residents in the facility.	D 338		

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D 338	Continued From page 57 -There were residents who tried to open the door during the day and at nighttime. -There was a resident who wandered in and out of residents' rooms and touched, moved and took their belongings. -She did not sleep at night because there was a resident who would "jiggle" the handle to her bedroom door and try to come in. -There was a male resident who wandered in and out of the residents' rooms; he was strong and the staff could not control him. -A female resident found the male resident in her room, and she got upset and he hit the female resident. -She saw the male resident hit another female resident. -She was afraid the male resident would wander into her room and hit her. -A few months ago, a female resident come into her room and knocked a cup of water off the table and hit her. -Another resident told her she was going to steal Resident #7's favorite pair of shoes so she told her family to take the shoes home. Interview with Resident #7's guardian on 02/19/26 at 11:45am revealed: -Resident #7 locked the door to her room. -Resident #7 did not like the other residents wandering around the facility. -Resident #7 frequently complained about two certain residents checking her door to see if it was locked. -The residents wandering and checking her door agitated Resident #7. -Resident #7 asked her to take a pair of shoes home because there was another resident who was trying to take them. -Resident #7 had not had anything taken from her room.	D 338		

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D 338	Continued From page 58 -Resident #7 was pushed out of her chair by another resident; she could not recall when. -Resident #7 had not said she was scared of any of the residents. Interview with a personal care aide (PCA) on 02/18/26 at 10:20am revealed: -There was a resident who went into other residents' rooms. -Resident #7 would complain about the resident trying to get into her room. -She would redirect residents away from Resident #7's room so she would not get upset. Interviews with a second PCA on 02/18/26 at 11:35am and 11:51am revealed: -Resident #7 was hit by another resident while playing bingo in the day room. -She could not remember when. -Resident #7 was playing bingo when another resident who was not playing walked up to Resident #7. -The resident said something to Resident #7 and Resident #7 said, "Leave me alone I am playing bingo." -The [named] resident hit Resident #7 in the arm or shoulder, not her face or head. -Some of the other residents would get upset when certain residents wandered or bothered them. -She would redirect the residents who wandered away from the residents who got upset. -Resident #7 complained about another resident trying to get into her door. -She was only told to redirect residents to their side of the facility after Resident #7 complained about them. -She would tell the medication aide (MA) when there was a complaint from a resident. -Resident #7 complained about a female resident	D 338		

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D 338	Continued From page 59 who would go into her room and take things. -The female resident went into other residents' rooms and took their belongings. -The resident would also try to open other residents' doors. -She would always go get the female resident out of other residents' rooms. -She would take the female resident back to her own room, but she would just walk right back out. Interview with a MA on 02/17/26 at 4:30pm revealed: -Resident #7 complained about residents trying to get into her room at night. -Resident #7 locked her door. -Resident #7 had arguments with other residents. -The staff redirected residents away from Resident #7's room. -There was a resident who wandered the halls and would jiggle the door handles to the other residents' rooms. -There was a second resident who constantly walked and would get into other residents' beds, urinate in trashcans and would make a mess when he used other residents' bathrooms. -The second resident would become agitated when residents tried to remove them from their room. -Resident #7 was one of the higher functioning residents and would complain because she did not want other residents in her room. Interview with a second MA on 02/19/26 at 10:40am revealed: -Resident #7 complained about other residents trying her door handle and trying to get into her room. -She had seen residents trying to get into Resident #7's room. -Resident #7's cognition was higher than the rest	D 338		

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D 338	Continued From page 60 of the residents. -She would complain about a male resident trying to get into her room, but she never said she was scared of him. -Resident #7 kept her door locked. Interview with the Activity Director on 02/19/26 at 9:40am revealed: -She did not recall an incident between Resident #7 and another resident at a bingo game. -Resident #7 was outspoken and would complain about residents. -Resident #7 complained about residents walking too much, trying to get into her room and getting into things. -When Resident #7 complained to her she would tell the resident the staff would take care of it. -Resident #7 wanted her door locked when she found out other residents locked their doors. Interview with the Assistant Special Care Unit Coordinator (SCC) on 02/19/26 at 3:50pm revealed: -Resident #7 had a room with a keyed lock. -Resident #7 kept a key when she was outside of her room. -Resident #7 fixated on a named resident. -The resident checked door handles and wandered into other residents' rooms. -Resident #7 complained about residents trying to get into her room but her door was always locked. -Resident #7 did not understand that when the door was locked no one could get into her room. -Resident #7 had never said she was scared of another resident. -Resident #7 did not normally sleep at night. -The staff would try to stop problems between residents before they escalated. -The staff redirected residents away from Resident #7's door.	D 338		

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D 338	Continued From page 61 -The staff needed to brainstorm some ideas on what to do to keep residents away from Resident #7's door. Interview with the SCC on 02/19/26 at 3:10pm revealed: -Resident #7 kept her door locked. -Resident #7 complained about other residents in her room and trying the door handle to see if it was open. -Resident #7 said residents were beating on her door at all hours of the night. -She told staff to redirect residents or move them away from Resident #7's door as best as possible. Refer to the interview with a PCA on 02/18/26 at 10:43am. Refer to the interview with a second PCA on 02/18/26 at 11:51am. Refer to the interview with the SCC on 02/19/26 at 3:00pm. Refer to the interview with the Administrator on 02/17/26 at 5:20pm. Interview with a PCA on 02/18/26 at 10:43am revealed: -There were two residents that would go in and out of other residents' rooms and one would mess with the other residents' personal belongings. -There were some residents who would get upset when other residents were in their rooms. -She was trained to redirect the residents away from each other when one would upset the other. -She reported complaints about residents to the MA.	D 338		

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D 338	Continued From page 62 -She would dance with one resident to redirect the resident. -She would tell the [named] resident it was not her room when she found the resident in someone else's room and lead her out of the room. -The [named] resident was easy to redirect. Interview with a second PCA on 02/18/26 at 11:51am revealed: -There was a [named] resident who would wander the hallways. -The resident would bite, hit and scratch the staff. -There were no complaints from the other residents about the resident hurting them or her behaviors. Interview with the SCC on 02/19/26 at 3:00pm revealed: -She told the staff to redirect residents or move them away from situations the best they could. -She told staff to make a quick distraction by making a loud noise or a noise on their cell phone. -She told the staff to lower their voices and make themselves very quiet so the resident would have to listen. -The staff should notice patterns in the residents' behaviors before something happened and be more proactive and not reactive. -She wanted to learn from the staff, and she wanted them to tell her what they saw and did with the residents that worked when redirecting. -There were activities during the day, but the activities needed to be increased to keep residents engaged. -Residents wandered out of boredom and lack of structure. -Increased activities would help resident behaviors, but it might not deter everyone.	D 338		

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D 338	Continued From page 63 -Different things would need to be tried and kept trying until whatever worked was found. Interview with the Administrator on 02/17/26 at 5:20pm revealed: -The facility tried to prevent resident to resident altercations by redirecting the residents. -There were multiple residents who wandered the hallways and there were high functioning residents that were irritated by the wandering residents. -The entire facility was a SCU and the residents were there because they had a diagnosis of dementia. -There were going to be residents who wandered due to their dementia, that was why they were in the facility, and he did not know how to stop them from wandering. -Wandering included going into other residents' rooms and sometimes personal items would be removed. -The staff were trained on redirecting residents who wandered and who became agitated. -It was the facility's responsibility to protect all the residents. The facility failed to ensure residents were free of mental anguish and injuries cause by other residents who had a resident to resident altercation (#3) when she discovered another resident wandered into her bathroom and made a mess, a resident who had water thrown on her and was hit by another resident when she wandered the resident's room (#9) and a resident who had to keep her door locked because other residents tried to go into her room and who had been hit by another resident when she was playing bingo (#7). The facility's failure resulted in substantial risk for physical harm, which constitutes a Type A2 Violation.	D 338		

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D 338	Continued From page 64 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/17/26 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2025.	D 338		
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: Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reports within 24 hours of injury of unknown origin for 2 of 2 residents (#6 and #9). The findings are: 1. Review of Resident #6's current FL-2 dated 10/02/25 revealed: -There was a diagnosis of severe dementia with agitation. -Resident #6 was constantly disoriented. -Resident #6 was ambulatory. -Resident #6 required staff assistance with bathing, dressing, and feeding. Review of Resident #6's accident/incident report dated 01/23/26 revealed Resident #6 had a	D 438	10A NCAC 13F .1205 Health Care Personnel Registry. Residents #6 and #9 incidents were reviewed on 2/19/26 A 30 day audit of incident reports was conducted to identify any additional injuries of unknown origin requiring reporting. None were identified Staff and Management were re-educated on requirements for reporting injuries of unknown origin to HCPR. Per the requirements of reporting within 24 hours the initial investigation and within 5 days of the inital report to either substantiate or unsubstantiate the allegation The E.D. and SCC will review incident reports daily to ensure reporting compliance.	3/19/26

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	HAL035024	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	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 65 purplish bruise of unknown origin on her left buttock. Review of Resident #6's electronic progress notes revealed: -At 7:30pm on 01/23/26, staff noticed a purple bruise on Resident #6's buttock. -Resident #6 did not complain of pain. 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. Interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 2:15pm revealed: -She spoke with Resident #6's Power of Attorney (POA) regarding the bruise to Resident #6's buttock. -She started daily skin checks on Resident #6. -She selected a PCA randomly on all shifts to do a skin assessment and report back to her. -There were no other bruises noted on Resident #6. -She showered and toileted Resident #6 one day and observed Resident #6 falling onto the toilet seat instead of sitting. -When she checked, the bruise on the buttock was where Resident #6 was hitting the toilet when she fell onto the toilet seat.. -She instructed the staff to assist Resident #6 getting onto the toilet to prevent her from falling onto the toilet. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.	D 438		

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D 438	Continued From page 66 Refer to the interview with the assistance SCC on 02/19/26 at 10:37am. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 2. Review of Resident #9's current FL-2 dated 08/13/25 revealed: -Diagnoses included dementia, mild cognitive impairment, generalized anxiety disorder, hyperthyroidism, and hyperlipidemia. -Resident #9 wandered. -Resident #9 was ambulatory. -Resident #9 required staff assistance with bathing and dressing. Review of Resident #9's accident/incident report dated 01/27/26 revealed Resident #9 had a bruise of unknown origin on the back of her left hand. Review of Resident #9's electronic progress notes revealed: -At 10:15pm on 01/27/26, staff noticed a bruise on the back of Resident #9's left hand. -Resident #9 did not complain of pain. 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. Interview with the assistance Special Care	D 438		

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D 438	Continued From page 67 Coordinator (SCC) on 02/19/26 at 10:37am revealed: -She and the SCC observed Resident #9 and realized the staff were grabbing her hand and leading Resident #9 to the dining room and activities. -The staff were educated on transferring Resident #9 and were instructed not to grab Resident #9 by her arm but have Resident #9 hold their arm or place her hand in the staff's hand. -The education for first shift was done in stand up one morning, and second shift was done at the beginning of the shift one afternoon; she did not know about third shift. -She did not know if there was any documentation related to the training and if the information was sent to the HCPR. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. Refer to the interview with the assistance SCC on 02/19/26 at 10:37am. Refer to the interview with the SCC on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. Interview with the assistance SCC on 02/19/26 at 10:37am revealed when a bruise of unknown origin was found on a resident, there was an investigation to see how the resident received the bruise. Interview with the SCC on 02/19/26 at 2:15pm revealed: -She did not know the accident/incident reports	D 438		

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D 438	Continued From page 68 about the bruises of unknown origin were not sent to the HCPR. -She thought the Administrator was responsible for sending the information to the HCPR. Interview with the Administrator on 02/19/26 at 3:30pm revealed: -He did not report the bruise of unknown origin to the HCPR. -He did not know he needed to send a report to the HCPR.	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. 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 2 of 4 residents (#10 and #13), who were found lying on the floor and required emergency treatment. The findings are:	D 451	10A NCAC 13F. 1212(a) Reporting of Accidents and Incidents. On 2/20/2026 the E.D. conducted a 30 day audit of all accident and incident reports to determine whether any additional incident reports were required reporting to the DSS. No additional incidents required reporting were identified. To prevent recurrence, the E.D. and management staff were re-educated on reporting requirements related to accidents and incidents that result in hospitalization, emergency medical treatment or injuries requiring treatment beyond first aid. The DSS must be notified within 48 hours of reportable events. A daily incident report review process has been implemented to ensure all incidents requiring reporting are identified promptly A tracking log has been implemented to ensure all required reports are submitted within the required timeframe	3/19/26

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D 451	Continued From page 69 1. Review of Resident #10's current FL-2 dated 05/23/25 revealed: -There was a diagnosis of dementia. -Resident #10 was intermittently disoriented. -Resident #10 was ambulatory. Review of Resident #10's accident/incident report dated 02/06/26 revealed: -At 3:43pm, Resident #10 was found lying on the floor at the entrance of her bedroom. -Resident #10 was transferred to the Emergency Department (ED) via Emergency Medical Services (EMS) at 4:05pm for evaluation. -Resident #10 returned to the facility with a diagnosis of contusion of the forehead. Interview with the Adult Home Specialist (AHS) on 02/18/26 at 8:40am revealed she received the accident/incident report dated 02/06/26 on 02/10/26 for Resident #10. Refer to the telephone interview with the AHS on 02/18/26 at 8:40am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. 2. Review of Resident #13's current FL-2 dated 05/05/25 revealed: -Diagnoses included dementia and Alzheimer's disease. -Resident #13 was constantly disoriented. -Resident #13 was ambulatory. Review of Resident #13's accident/incident report dated 12/28/25 revealed: -At 8:03pm, Resident #13 was sitting on the floor	D 451	Continued The E.D. or the SCC will review all incident reports daily to ensure compliance with reporting requirements. Results will be reviewed during the Quality Assurance Performance Improvement meetings and corrective action will be taken if needed.	

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D 451	Continued From page 70 in front of the couch. -Resident #13 was transported to the Emergency Department (ED) via Emergency Medical Services (EMS) at 8:25pm for evaluation. -Resident #13 was admitted to the hospital. Interview with the Adult Home Specialist (AHS) on 02/18/26 at 8:40am revealed she received the accident/incident report dated 12/28/25 on 01/06/26 for Resident #13. Refer to the telephone interview with the AHS on 02/18/26 at 8:40am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 2:15pm. Refer to the interview with the Administrator on 02/19/26 at 3:30pm. Telephone interview with the AHS on 02/18/26 at 8:40am revealed: -The facility should fax all accident/incident reports that require more than first aid to DSS. -The facility should fax all accident/incident reports that require the resident to be sent to the ED. -She expected to receive the reports within 24 to 48 hours of the accident/incident. Interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 2:15pm revealed: -Reporting accident/incident reports to DSS was the responsibility of the SCC and the Administrator. -She saw that the incident report was completed and faxed it to her regional director for approval. -Once the regional director approved the accident/incident report, she gave it to the Administrator to sign and then the report was	D 451		

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D 451	Continued From page 71 faxed to DSS. -The reportable accident/incident reports should be sent to DSS within 24 to 48 hours. -Reportable accident/incident reports were reported to DSS when a resident required more than first aid or was sent to the ED due to injury. Interview with the Administrator on 02/19/26 at 3:30pm revealed: -The reportable accident/incident reports were faxed to DSS by the SCC or the Administrator. -The accident/incident reports should be faxed within 24 to 48 hours. -Reportable accident/incident reports were anything above first aid. -He was not aware that some accident/incident reports were faxed late to the DSS.	D 451		
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	D 454	10A NCAC 13F .1212(e) Notification of Responsible party. On 2/20/26 the E.D. and SCC conducted a 30 day audit of accident and incident reports to ensure responsible parties were notified when required and that notification was documented. To prevent recurrence, staff were re-educated on the requirement to notify responsible parties following residents incidents including falls with injury, resident to resident altercations and emergency department transfers. Staff was instructed that responsible parties must be notified when the incident occurs and notification must be documented in the resident record.	3/19/26

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D 454	Continued From page 72 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 according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible party of 2 of 9 sampled residents (#2 and #7) who was sent to the hospital after an unwitnessed fall (#2) and a resident who had behaviors (#7). The findings are: 1. Review of Resident #2's current FL-2 dated 07/01/25 revealed diagnoses included pneumonia, leukocytosis, sever protein and calorie malnutrition, hypertension, dementia and chronic obstructive pulmonary disorder (COPD). Review of Resident #2's incident report dated 02/15/26 revealed: -Resident #2 was found lying on the floor in her bedroom. -Resident #2 was transported to the local hospital via emergency medical services (EMS). -A message was left with Resident #2's guardian. -Resident #3 was returned from the hospital; she had a laceration and a closed fracture of the right maxillary sinus. Review of Resident #2's electronic progress notes revealed:	D 454	Continued. If the responsible party cannot be reached, staff must leave a voicemail and make additional attempts and document all attempts. The E.D. and SCC will review incident reports daily to ensure responsible parties are notified and documentation is completed. The SCC or the E.D. will call responsible parties within 24 hours to verify they were notified by staff of the incidents and accidents.	

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D 454	Continued From page 73 -On 02/15/26, she was found on the floor beside her bed. -She was bleeding from a cut on the right side of her forehead and blood was coming from her nose and mouth. -EMS were called and she was sent to the hospital due to her injuries. resident #2 returned to the facility on 02/15/26. Telephone interview with Resident #2's guardian on 02/17/26 at 4:40pm revealed: -She was Resident #2's guardian through the county department of social services (DSS). -The facility had her direct telephone number at the DSS, they could leave her a message, and she would get it when she checked her messages her next day back at work. -There was also a number the facility staff could call if Resident #2 were sent to the hospital, the dispatcher would reach out to DSS, and she or her supervisor would be contacted. -The 911 dispatcher could also contact the DSS office and someone on call would contact her. -She told the facility staff to reach out to her when there was anything she needed to know about Resident #2. -The facility never called her about anything related to Resident #2 and it was an issue. -She was not aware of any incidents on 02/15/26, and the facility had not notified her of any recent hospital visits for Resident #2. -She did not have any messages from the facility on Monday, 02/16/26, when she returned to the DSS office. -She did not have any communication from the facility, not even an email. -There had been other incidents where she was not contacted when Resident #2 had been sent out or had an issue. -She expected the facility to call her when there	D 454		

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D 454	Continued From page 74 was anything going on with Resident #2. -She was Resident #2's guardian and she needed to be told when something was going on with Resident #2. Interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 3:10pm revealed: -She was not aware Resident #2's guardian was not contacted about the injury on 02/15/26. -The staff had not come to her about the incident; they had gone to the ASCC. -Staff were documenting leaving messages but not following through. -She needed to be aware staff were not able to get in touch with guardians so she could follow-up. Attempted telephone interview with a medication aide (MA) on 02/19/26 at 8:30am was unsuccessful. Refer to the interview with the Assistant SCC on 02/19/26 at 4:45pm. Refer to the interview with the SCC on 02/19/26 at 3:10pm. Refer to the interview with the Administrator on 02/19/26 at 5:30pm. 2. Review of Resident #7's current FL-2 dated 07/01/25 revealed diagnoses included dementia, hypertension, gastroesophageal reflux disease (GERD), major depression disorder, and anxiety. Review of Resident #7's incident reports revealed there were no incident reports for 02/17/26. Review of Resident #7's electronic progress notes revealed:	D 454		

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D 454	Continued From page 75 -On 02/17/26, Resident #7 was seen punching another resident all over the resident's body. -There was no documentation Resident #7's mental health provider (MHP) was notified. Interview with a medication aide (MA) on 02/18/26 at 11:51am revealed: -She left a voice mail for Resident #7's guardian on 02/17/26, about the incident with the other resident. -She always called the residents' guardians when there was an incident and documented it on the incident report. Interview with Resident #7 guardian on 02/19/26 at 11:50am revealed: -The facility staff were on top of issues and let her know when Resident #7 had any behaviors, went to the hospital or other issues. -She was not aware of an incident on 02/17/26, involving Resident #7 until the Assistant Special Care Unit Coordinator (SCC) informed her of it when she came to the facility today, 02/19/26. -The Assistant SCC told her that the medication aid had called and left her a message on her cell phone. -The incident on 02/17/26 was the first time she had not been told about something that was going on with Resident #7. -She had no missed calls or messages on her cell phone from 02/17/26. -When the phone rang and it showed the facility's name she answered because she knew it would be something about Resident #7. -She wanted to know anytime there was an incident or anything concerning Resident #7 because she was her guardian. Interview with the SCC on 02/19/26 at 3:10pm revealed:	D 454		

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D 454	Continued From page 76 -She just discovered today, 02/19/26, that Resident #7's guardian was not aware of an incident that happened earlier this week on 02/17/26. -She told Resident #7 about the incident when she saw her today. -She was still investigating to see why Resident #7's guardian was not aware until today; she needed to speak to staff. Refer to the interview with the Assistant SCC on 02/19/26 at 4:45pm. Refer to the interview with the SCC on 02/19/26 at 3:10am. Refer to the interview with the Administrator on 02/19/26 at 5:30pm. Interview with the Assistant SCC on 02/19/26 at 4:45pm revealed: -The MA or whoever filled out the incident report or the progress note was responsible for calling the residents' guardian. -Sometimes she would call the guardian. -Staff could leave a message with the guardian but should do a follow up call for follow through. -Following up with the guardian after a message was not done and was missed. -The guardians should have been called again until they were reached. -It was important to keep the residents' guardians informed and in the loop about what was going on with the resident. -Sometimes the guardians might have information that might be helpful when there's a behavior. -Staff should always be contacting the guardian so that the guardian knows the facility was not trying to hide anything from them concerning a	D 454		

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FRANKLIN MANOR ASSISTED LIVING CENTEF	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 454	Continued From page 77 resident. Interview with the Special Care Unit Coordinator (SCC) on 02/19/26 at 3:10pm revealed: -She was mortified to find out families and guardians were not being notified about incidents with the residents. -The residents' families and guardians needed to know when there was an incident with a resident even if there was no injury. -Leaving a message was not acceptable, the guardian should be called again if there was no response after the message was left. -The families and guardians needed to be informed about anything that involved the resident. Interview with the Administrator on 02/19/26 at 5:30pm revealed: -The medication aides were responsible for notifying the residents' guardians when there was an incident or accident of any kind. -He could not say if the residents' guardians were notified for the incidents. -The reporting to the guardians had to be done because it kept them informed about the residents' safety and wellbeing. -He was not aware the residents' guardians were not being notified.	D 454		