STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001173	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C & M ADULT CARE HOME	422 N MAIN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/31/26.	C 000		
C 059	10A NCAC 13G .0310 (b) Storage Areas 10A NCAC 13G .0310 Storage Areas (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use. This Rule is not met as evidenced by: Based on observations, interviews, and review of labels, the facility failed to ensure the environmental storage room containing hazardous materials was locked and not accessible to residents who were intermittently disoriented. The findings are: Interview with the Administrator on 03/31/26 at 8:45am revealed there was a census of 6 residents. Observation of the storage cabinet on 03/31/26 from 8:10am to 9:45am revealed: -The storage cabinet was a stand-alone cabinet. -The storage cabinet was in a hallway which led to the residents' bathroom. -The hallway was located next to the dining room. -At 8:10am, the storage cabinet was unlocked and the storage cabinet door was partially opened. -There was no direct supervision of the staff while the storage cabinet door was unlocked and opened.	C 059		

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C 059	Continued From page 1 -There was a bottle of bleach which could cause minor redness and irritation with contact to skin. -A can of disinfectant spray which could cause minor eye irritation. -Two bottles of liquid hand soap which could cause moderate to severe eye irritation, and if swallowed, it could cause nausea, vomiting, and diarrhea. -A large bottle of liquid washing detergent which could cause skin irritation and respiratory issues. -At 8:45am, the storage cabinet door remained unlocked. -At 9:38am, the storage cabinet door remained unlocked. -At 9:45am, the storage cabinet door was locked. Review of three residents' FL-2 revealed 3 of 3 residents were intermittently confused and 1 of 3 had a diagnosis of dementia. Interview with the Administrator on 03/31/26 at 2:30pm revealed: -The residents could get into the cleaning products in the storage cabinet. -If the residents digested the liquid, they would become sick. -She had removed a cleaning product for the bathroom and forgot to lock the storage cabinet. -She should keep the storage cabinet locked when there was no direct supervision.	C 059		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise	C 069		

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C 069	Continued From page 2 observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to 3 of 3 sampled residents (#1, #2, and #3) who were intermittently disoriented, had working continuous audible alarms that could be heard by staff for the safety of the residents. The findings are: Observation of the facility on 03/31/26 at various times from 8:00am to 2:00pm revealed: -At 8:00am, when the front entrance/exit door to the facility was opened, there was no continuous audible alarm. -At 8:30am, when the back entrance/exit door to the facility was opened, there was no continuous audible alarm. -There was no visible alarm mechanism attached to the wooden door or the screened door of the front or back entrance/exit doors.	C 069		

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C 069	Continued From page 3	C 069		

-There were four residents ambulating in the facility throughout the day.
-Two of the residents went in and out the front entrance/exit door multiple times during the day and sat on the front porch.

Interview with a resident on 03/31/26 at 1:45pm revealed:
-He would go outside multiple times a day.
-He had not heard any door alarms when he went in and out of the doors.

1. Review of Resident #1's current FL-2 dated 01/14/26 revealed:
-Diagnoses included mental retardation, hyperlipidemia, depression, and anxiety.
-She was intermittently disoriented.
-She was ambulatory.

Review of Resident #1's care plan dated 01/14/26 revealed:
-She was ambulatory.
-She was sometimes disoriented.
-She was forgetful and needed reminders.

Interview with Resident #1 on 03/31/26 at 2:10pm revealed:
-She stayed in the facility most days.
-There were no alarms on the doors during the day, but the staff set the alarms for the doors at night.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 03/31/26 at 11:20am was unsuccessful.

Refer to the interview with the Administrator on 03/31/26 at 2:30pm.

2. Review of Resident #2's current FL-2 dated

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C 069	Continued From page 4	C 069		

11/21/15 revealed:
-Diagnoses included dementia, schizophrenia disorder, and bipolar disorder.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #2's care plan dated 11/21/25 revealed:
-He was ambulatory.
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Interview with Resident #2 on 03/31/26 at 2:00pm revealed:
-He went outside and sat on the porch when the weather was pretty.
-The doors were not alarmed during the day.
-The doors were alarmed each night at bedtime.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 03/31/26 at 11:25am was unsuccessful.

Refer to the interview with the Administrator on 03/31/26 at 2:30pm.

3. Review of Resident #3's current FL-2 dated 03/31/25 revealed:
-Diagnoses included hypertension, hyperlipidemia,
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #3's medical record revealed there was no care plan to review.

Interview with Resident #3 on 03/31/26 at 1:50pm revealed:
-He stayed in his room most days.
-He did not remember hearing door alarms during

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C 069	Continued From page 5 the day. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 03/31/26 at 11:20am was unsuccessful. Refer to the interview with the Administrator on 03/31/26 at 2:30pm. _____ Interview with the Administrator on 03/31/26 at 2:30pm revealed: -The doors were alarmed each night from 10:00pm to 7:30am or 8:00am each morning. -The alarm was set for both exit doors and when the exit doors were opened there was an audible sounding alarm. -When the wooden doors at the front and back entrance/exits were opened, there was a beep, but it was not a continuous sound. -When the screen doors at the front and back entrance/exits were opened, there was no sounding alarm. -She did not know she needed continuous sounding alarms on the doors during the day because she had residents that were intermittently disoriented. -None of the residents had wandered away from the facility. _____ The facility failed to ensure the exit doors had continuous and audible sounding devices activated when the doors were opened, which resulted in 3 residents who were intermittently disoriented being at risk for leaving the facility without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/31/26.	C 069		

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C 069	Continued From page 6 CORRECTION DATE FOR THE TYPE B VIOLATIONS SHALL NOT EXCEED MAY 15, 2026.	C 069		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with	C 236		

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C 236	Continued From page 7 associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 sampled residents (#3) had a completed care plan within 30 days of admission and annually. The findings are: Review of Resident #3's current FL-2 dated 03/31/25 revealed: -Diagnoses included hypertension, hyperlipidemia, diabetes mellitus type 2, vitamin B-12 deficiency, and osteoarthritis. -He was intermittently disoriented. -He required staff assistance with bathing and dressing. -He required assistance with chopping/cutting his food. -He was ambulatory. -He was occasionally incontinent of bladder. Review of Resident #3's record revealed there was no care plan available to review. Interview with the Administrator on 03/31/26 at	C 236		

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C 236	Continued From page 8 2:30pm revealed: -She did not complete a care plan for Resident #3. -He was assessed for personal care service (PCS) hours by an outside agency. -She thought since he was getting PCS hours, she did not need to do a care plan. -She was not aware Resident #3's care plan should have been done within 30-days of admission and annually. -She was responsible for completing the care plans. Attempted telephone interview with Resident #3's Primary Care Provider on 03/31/26 at 11:15am was unsuccessful.	C 236		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed residents take their morning medications that were left on the	C 341		

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C 341	Continued From page 9 dining room table. The findings are: Observation of the dining room on 03/31/26 at 9:05am revealed: -There were three residents sitting at the dining room table. -Each resident has a medication cup placed by their plate of food. -The cup of first resident was empty. -There were 5 pills in the second resident's medication cup and 9.5 pills in the third resident's cup. -There was no supervising staff in the dining room. -The second resident was observed taking her medication after she ate her breakfast. -The third resident was observed taking his medications before he ate breakfast. -There was no supervising staff in the dining room that observed the second or third resident take their medications. Interview with the first resident on 03/31/26 at 1:15pm revealed -He had taken his medications before the surveyor entered the dining room. -The staff put the morning pills in a cup and place the cup on the dining room table with our plate of food. -He took his medication before he ate each morning. -He did not remember if the staff was in the dining room when he took his medications or not. Interview with the second resident on 03/31/26 at 1:40pm revealed: -The staff always put her pills in a cup and sit them on the dining room table.	C 341		

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C 341	Continued From page 10 -She knew she took 5 pills every morning and she made sure she had 5 pills in her cup. -She took her medications after she ate breakfast each morning. -The MA would be "around" when she took her medications. -If the MA was not in the dining room, she would be in the kitchen. Interview with the third resident on 03/31/26 at 1:55pm revealed: -His morning medications were placed on the dining room table each morning for breakfast. -He took his medications each morning before he ate breakfast. -He did not know if the MA was in the room when he took his medications or not. Interview with the Administrator/MA on 03/31/26 at 2:30pm revealed: -She sat the cup of medications on the table after the residents were seated at the table. -Several residents took their medications before they ate breakfast; one resident took their medication after eating breakfast. -She did not observe the residents taking their medications this morning. -She was in and out of the dining room while the residents were eating breakfast. -The residents could take someone else's medication. -She should administer one resident their medication and watch them take the medication before preparing another resident's medication.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration	C 342		

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C 342	Continued From page 11 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 2 of 3 residents (#2 and #3) related to cholesterol medication and a medication to control blood sugars (#2), and a supplement (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 11/21/25 revealed Diagnoses included hyperlipidemia and diabetes mellitus type 2. a. Review of Resident #2's current FL-2 dated 11/21/25 revealed there was an order for rosuvastatin 10mg (used to lower cholesterol)	C 342		

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C 342	Continued From page 12 daily. Review of Resident #2's January 2026 medication administration record (MAR) revealed: -There was no entry for rosuvastatin 10mg daily. -There was no documentation rosuvastatin 10mg was administered daily from 01/01/26 to 01/31/26. Review of Resident #2's February 2026 MAR revealed: -There was no entry for rosuvastatin 10mg daily. -There was no documentation rosuvastatin 10mg was administered daily from 02/01/26 to 02/28/26. Review of Resident #2's March 2026 medication administration record (MAR) revealed: -There was no entry for rosuvastatin 10mg daily. -There was no documentation rosuvastatin 10mg was administered daily from 03/01/26 to 03/31/26. Observation of Resident #2's medication on hand revealed there was a bottle of 25 of 90 rosuvastatin tablets dispensed on 01/24/26 available for administration. Interview with the Administrator on 03/21/26 at 2:30pm revealed: -She had to hand write his MARs because his medication came from a different pharmacy than the other residents. -She failed to enter rosuvastatin 10mg daily onto the MARS for January 2026, February 2026, and March 2026. -She did administer Resident#2 his rosuvastatin every day. -She needed to be careful when writing the medications on the MARs and ensure all	C 342		

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C 342	Continued From page 13 medications are listed. b. Review of Resident #2's current FL-2 dated 11/21/25 revealed there was an order for Jardiance 12.5mg take ½ tablet daily. Review of a physician order dated 2/24/25 revealed there was an order for Jardiance 25mg take ½ tablet daily. Review of Resident #2's January 2026 medication administration record (MAR) revealed: -There was an entry for Jardiance 12.5mg take ½ tablet daily with a scheduled administration time of 8:00am -There was documentation Jardiance 12.5mg ½ tablet daily was administered daily from 01/01/26 to 01/31/26. Review of Resident #2's February 2026 MAR revealed: -There was an entry for Jardiance 12.5mg take ½ tablet daily with a scheduled administration time of 8:00am -There was documentation Jardiance 12.5mg ½ tablet daily was administered daily from 02/01/26 to 02/28/26. Review of Resident #2's March 2026 medication administration record (MAR) revealed: -There was an entry for Jardiance 12.5mg take ½ tablet daily with a scheduled administration time of 8:00am -There was documentation Jardiance 12.5mg ½ tablet daily was administered daily from 03/01/26 to 03/31/26. Observation of Resident #2's medication on hand revealed there was a bottle of 32 of 90 Jardiance 25mg 1/2 tablets dispensed on 01/24/26 available	C 342		

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for administration.
Interview with the Administrator on 03/21/26 at 2:30pm revealed:
-Resident #2 was taking Jardiance 25 mg ½ tablet.
-The PCP decreased Resident #2's Jardiance from 25 mg daily to ½ tablet about a year ago.
-Resident #2's MAR was hand written; she wrote the entry on the MAR incorrectly.
-She completed the FL-2 dated 11/21/25 and entered the Jardiance order incorrectly on the FL-2.
-Resident #2 was getting the correct Jardiance dose based on the PCP's order written in February 2025.
-She needed to be careful when hand writing orders on the MAR and FL-2.

Attempted telephone interview with Resident #2's pharmacy on 03/21/26 at 11:45am was unsuccessful.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 03/21/26 at 11:20am was unsuccessful.

3. Review of Resident #3's current FL-2 dated 03/31/25 revealed:
-There was a diagnosis of vitamin B-12 deficiency.
-There was an order for vitamin B-12 1000mg (used to treat vitamin B-12 deficiency) daily.

Review of Resident #3's February 2026 medication administration record (MAR) revealed:
-There was an entry for vitamin B-12 1000mg daily with a scheduled administration time of 8:00am.
-There was no documentation that vitamin B-12 was administered as ordered from 02/01/26 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001173	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C & M ADULT CARE HOME	422 N MAIN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 15 02/28/26. Review of Resident #3's March 2026 MAR revealed: -There was an entry for vitamin B-12 1000mg daily with a scheduled administration time of 8:00am. -There was no documentation that vitamin B-12 was administered as ordered from 03/01/26 to 03/31/26. Observation of Resident #3's medication on hand on 03/31/26 at 10:15am revealed there was a monthly box dispensed that had vitamin B-12 dispensed daily for administration. Interview with the Administrator on 03/21/26 at 2:30pm revealed: -Resident #3 was administered vitamin B-12 as ordered. -She forgot to document on the MAR that his vitamin B-12 was administered. -She needed to make sure she documented correctly on the MARs.	C 342		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security except when	C 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 353	Continued From page 16 under the direct physical supervision of the staff in charge of the medication cart. The findings are: Interview with the Administrator on 03/31/26 at 8:45am revealed there was a census of 6 residents. Observation of the medication cabinet on 03/31/26 from 8:10am to 9:45am revealed: -The medication cabinet was a stand-alone cabinet. -The medication cabinet was in a hallway which led to the residents' bathroom. -The hallway was located next to the dining room. -At 8:10am, the key to the medication cabinet was in the key lock on the medication cabinet door, and the medication cabinet door was open. -There was no direct supervision of the staff while the medication cabinet door was unlocked. -At 8:45am, the medication cabinet door remained unlocked with the key in the key lock while three residents were eating breakfast in the dining room. -At 9:38am, the medication cabinet door remained unlocked with the key in the key lock. -At 9:45am, the medication cabinet door was locked, but the key remained in the key lock. Interview with the Administrator/MA on 03/31/26 at 9:45am revealed: -Resident could take medications from the medication cabinet when the door was unlocked. -The medication cabinet door should be locked when she was not administering medications. -She should always keep the key to the medication cabinet door with her.	C 353		