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 05/07/2026

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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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation from 05/05/26 to 05/07/26.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards as evidenced by furniture, a bed frame, a mattress, a wheelchair, paint cans and painting supplies that were stored in a resident's room. The findings are: Observations of resident room 137 on the special care unit (SCU) on 05/05/26 at 8:33am, 9:14am, and 12:07pm revealed: -The door was unlocked and easy to open. -The room was unoccupied.	D 079		

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D 079	Continued From page 1 -There was a metal bed frame with headboard attached and a mattress leaning against two nightstands. -There was one closed paint can and one empty paint can without a top, along with a dustpan on top of the nightstand. -There was a locked wheelchair with the leg rest on the seat. -There was a third nightstand with a closed can of paint, small artificial Christmas tree, a canvas painting and a partial roll of toilet tissue sitting on top of the nightstand. -There was a two-seater sofa and a portable electric fan with a cord located on the floor. -There was one aluminum painter's stick and an aluminum paint shield leaning against the wall. -There was a closet door that had a decorative heart on the doorknob leaning against the wall. -A single upright chair faced the wall. Interview with a personal care aide (PCA) on 05/05/26 at 3:18pm revealed residents wandered in and out of rooms throughout the shift. Interview with a second PCA on 05/06/26 at 1:55pm revealed there was increased wandering in and out of rooms when residents "sun downed" required close observation. Interview with the Maintenance Director on 05/06/26 at 11:40am revealed: -The couch was stored in resident room 137 after another resident passed away. -The paint and other work-related items were stored in that room while he repaired an adjacent room. -The room door should be closed and always locked. -He was mostly concerned with trip hazards with the bed and couch.	D 079		

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D 079	Continued From page 2 -The paint was not a concern because it was non-toxic. -He would educate staff on closing and locking doors of unused rooms. -There should not be any unsafe rooms in the building. -He checked all resident rooms every Tuesday for unsafe items. -He had been in and out of resident room 137 during the week of 05/05/26 while repairing an adjacent room. Interview with the Special Care Unit Coordinator (SCC) on 05/06/26 at 3:28pm revealed: -She was not aware of the resident room with items stored in it. -She did not check empty rooms. -She was concerned that a resident could get into the room, be injured or exposed to toxic chemicals. -She was concerned with any chemicals being in the building and felt that items that could be harmful such as paint and supplies used for painting should be stored outside of the building. Interview with the interim Administrator on 05/07/26 at 4:14pm revealed: -The Maintenance Director should use the storage shed to store items. -Empty rooms should be locked. -Paint was ingestible and could be harmful.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care	D 269		

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D 269	Continued From page 3	D 269		

plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#3) who was unshaven and had long fingernails.

The findings are:

Review of Resident #3's FL-2 dated 03/16/26 revealed diagnoses included hypertension, schizophrenia, and Parkinson's disease.

Review of Resident #3's care plan dated 01/02/25 revealed he required limited staff assistance with bathing, grooming, and personal hygiene.

Observation of Resident #3 on 05/05/26 at 8:35am revealed:
-His fingernails were long, extending about ½ inch beyond the tips of his fingers and were thick, straight and yellow with black debris underneath.
-His face was unshaved with heavy stubble about 1cm in length.

Observation of Resident #3 on 05/06/26 at 8:06am revealed his fingernails remained uncut and he had not been shaved.

Interview with a personal care aide (PCA) on 05/07/26 at 11:30am revealed:
-Resident #3 was scheduled to receive showers on Tuesdays and Thursdays on day shift.
-The PCA shaved the resident with scheduled showers.
-The Activity Director cut the residents' nails.
-Resident #3 did not always allow his nails to be

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D 269	Continued From page 4 cut. -Staff did not document resident refusals to have nails cut or to be shaved. Interview with a medication aide (MA) on 05/07/26 at 11:45am revealed: -Resident #3 was cooperative most of the time. -Resident #3 had been known to refuse to have his nails trimmed. -The Activity Director could usually get Resident #3 to cooperate with nail cutting. Interview with the Activity Director on 05/07/26 at 3:41pm revealed: -Resident #3 was scheduled to have his nails cut every Monday. -If Resident #3 refused to allow her to cut his nails, she would attempt it again later. -She could not recall when Residents #3's nails were cut last. Interview with the interim Special Care Unit Coordinator (SCC) on 05/07/26 at 3:11pm revealed the expectation was that residents would be shaved, and have their nails cut on scheduled shower days. Interview with the Administrator on 05/07/26 at 4:00pm revealed: -Scheduled bathing with nails cleaned and cut, should be done every 3 days. -Residents should be shaved with bathing. -If a resident refused personal care, staff should try again later and if the resident refused again, staff should offer the next shower day or ask a PCA from second shift to attempt bathing. -If the resident refused after three attempts, the SCC should be notified. Attempted telephone interview with Resident #3's	D 269		

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D 269	Continued From page 5 family member on 05/07/26 at 12:21pm was unsuccessful. Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable.	D 269		
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. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the resident's assessed needs for 2 of 8 sampled residents (#1 and #9), including a resident (#1) who wandered into other residents' rooms, removed items, and attempted to open residents' locked bedroom doors and a resident (#9) who wandered into other residents' rooms, removed items and laid in other residents' beds.	D 270		

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D 270	Continued From page 6 The findings are: 1. Review of Resident #1's current FL-2 dated 10/22/25 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -She wandered. -She was ambulatory. Review of Resident #1's care plan dated 03/16/26 revealed: -She wandered. -She was ambulatory. -She was always disoriented. Review of Resident #1's mental health after visit summary dated 03/30/26 revealed: -Resident #1 had dementia that included behavioral disturbances that presented as agitation and aggressiveness. -Resident #1 was seen for dementia and increased agitation. -Resident #1 had episodes of aggression towards peers and staff. -No medication changes were made during the visit. Review of Resident #1's mental health after visit summary dated 04/13/26 revealed: -Resident #1 had dementia that included behavioral disturbances that presented as agitation and aggressiveness. -Staff reported Resident #1 had been difficult to redirect. -Buspirone (a medication used to treat anxiety) 5 mg twice daily was ordered. Review of Resident #1's electronic progress notes revealed: -On 03/19/26, Resident #1 was agitated and	D 270		

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angry with staff for being redirected away from another resident's room.
-On 04/17/26, Resident #1 was agitated and was redirected from going in and out of other residents' room.
-On 04/18/26, Resident #1 was overly agitated and would not leave the medication cart alone, the resident was redirected away from the medication cart.
-On 04/18/26, Resident #1 was trying to "pick the lock" to another resident's room and became agitated when redirected.

Observation of the hallway on 05/07/26 at 11:19am revealed:
-Resident #1 was ambulating in the hallway carrying a shoe.
-The medication aide (MA) took the shoe from Resident #1 and placed the shoe behind the workstation.

Interview with the MA on 05/07/26 at 11:19am revealed:
-Resident #1 took things out of other residents' rooms all the time.
-Resident #1 took clothes, shoes, or anything sitting around in the room.
-On Monday, 05/04/26, she found Resident #1 in the unlocked salon removing hair rollers.
-Resident #1 walked all night; she would go into other residents' rooms at night and jiggle the door handles of the residents' who kept their doors locked at night.

Interview with a resident on 05/05/26 at 8:15am revealed:
-Residents wandered into her room all the time.
-The wandering residents would take whatever they saw.
-She followed them to their rooms and took the

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D 270	Continued From page 8 items back. -Resident #1 would come into her room and take things. -Resident #1 would try to open her door at night because Resident #1 was a "night owl". -She kept her door locked at night so Resident #1 could not get in. Interview with a second resident on 05/05/26 at 8:25am revealed: -Resident #1 came into her room all the time. -She had to keep her room locked. -Resident #1 knew how to "pick the lock" and open the door. -Resident #1 would come into her room and take things like clothes and shoes. -Resident #1 would basically take anything she saw. -Resident #1 got into her room two days ago and would not leave. -Resident #1 would not listen when she was asked to leave her room. -To get Resident #1 out of her room she had to push Resident #1 out of her room and down the hallway. Interview with the second resident on 05/07/26 at 9:07am revealed: -At night, Resident #1 would jiggle the door handle and try to come into her room. -Resident #1 would yell at her to open the bedroom door. -Resident #1 woke her up most nights. Telephone interview with a representative from Resident #1's mental health provider's (MHP) office on 05/07/26 at 3:09pm revealed: -Staff made him aware that Resident #1 wandered in the facility at all times of the day and night.	D 270		

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D 270	Continued From page 9 -On 04/13/26, he ordered buspirone (a medication used to treat anxiety) 5 mg twice daily. Interview with a personal care aide (PCA) on 05/07/26 at 2:39pm revealed: -Resident #1 always wandered in and out of other residents' rooms and needed to be redirected. -The other residents would become upset when Resident #1 entered their rooms. -The staff were told to redirect Resident #1 when she went into other residents' rooms. Telephone interview with Resident #1's Power of Attorney (POA) on 05/05/26 at 12:18pm revealed: -She was aware Resident #1 wandered in and out of other residents' rooms. -Resident #1 had an order for a glass of wine during dinner to calm the resident so she would not wander as much. Refer to the interview with the PCA on 05/06/26 at 11:45am. Refer to the interview with another PCA on 05/07/26 at 11:21am. Refer to the interview with a MA on 05/07/26 at 12:04pm. Refer to the interview with the Activity Director on 05/07/26 at 2:45pm. Refer to the interview with the SCC on 05/06/26 at 3:26pm. Refer to the interview with the Administrator on 05/07/26 at 4:02pm. 2. Review of Resident #9's FL-2 dated 08/15/25 revealed:	D 270		

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D 270	Continued From page 10 -Diagnoses included Alzheimer's disease, chronic sleep apnea, anxiety, and hypertension. -She was constantly disoriented and she wandered. -She was ambulatory. Review of Resident #9's incident report dated 03/17/26 at 6:04pm revealed: -Resident #9 was observed with a change in behavior; yelling at residents and hitting care staff. -There were no injuries. -Resident #9 was transported by Emergency Medical Services (EMS) to the Emergency Department (ED) on 03/17/26. Review of Resident #9's electronic progress notes revealed: -On 03/17/26, Resident #9 was very combative with staff and other residents at 6:23pm. -Staff attempted to redirect Resident #9 but were unsuccessful. -EMS was called. Review of Resident #9's Mental Health Provider's (MHP) note dated 03/23/26 revealed they were contacted on 03/23/26 at 9:09pm regarding Resident #9's behaviors and would follow up with the resident during their next facility visit. Observation of Resident #9 on 05/07/26 at 8:50am revealed Resident #9 and a [named] resident were ambulating in the hallway and Resident #9 did not have shoes on. Interview with a personal care aide (PCA) on 05/07/26 at 9:01am revealed: -She was looking for Resident #9's shoes. -Resident #9 and another resident walked in the facility every day.	D 270		

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-Resident #9 wandered into other residents' rooms and took her shoes off in the other residents' rooms and walked away with only her socks on.
-This happened several times a day.

Second observation of Resident #9 on 05/07/26 at 11:15am revealed she was ambulating in the hallway with another resident, wearing her shoes and holding another resident's shoe in her hand.

Second interview with a PCA on 05/07/26 at 11:15am revealed:
-Resident #9 took her shoes off again; they were found in a [named] resident's room.
-It was a daily occurrence for Resident #9 to go into other residents' rooms and remove her shoes and the staff would have to find them.

Interview with a housekeeper on 05/07/26 at 9:12am revealed:
-Resident #9 took her shoes off several times a day.
-The staff would find Resident #9's shoes in other residents' rooms.
-Resident #9 and two other [named] residents would take residents' clothes, and the staff would locate the clothes in other residents' rooms.
-Resident #9 and two other [named] residents wandered into other residents' rooms multiple times a day and would remove items that did not belong to them.

Interview with the medication aide (MA) on 05/07/26 at 11:19am revealed:
-About 1.5 weeks ago, she found Resident #9 in another resident's room sleeping.
-She was told by another MA to leave Resident #9 alone and let her sleep.
-After 2.5 hours, Resident #9 woke up and came

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D 270	Continued From page 12 out of the other resident's room Interview with Resident #9's MHP on 05/07/26 at 12:10pm revealed: -The MHP visited Resident #9 on 03/30/26 and made changes to her medications. -She made biweekly visits to the facility to educate the staff and to assess the resident. Refer to the interview with the PCA on 05/06/26 at 11:45am. Refer to the interview with another PCA on 05/07/26 at 11:21am. Refer to the interview with a MA on 05/07/26 at 12:04pm. Refer to the interview with the Activity Director on 05/07/26 at 2:45pm. Refer to the interview with the SCC on 05/06/26 at 3:26pm. Refer to the interview with the Administrator on 05/07/26 at 4:02pm. _____ Interview with a PCA on 05/06/26 at 11:45am revealed the interim SCC told her to keep a close eye on the residents who wandered and to redirect them. Interview with another PCA on 05/07/26 at 11:21am revealed she was told to redirect the residents when they were having behaviors or wandering into other residents' rooms. Interview with a medication aide (MA) on 05/07/26 at 12:04pm revealed she was told by the interim SCC to redirect residents when they were	D 270		

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D 270	Continued From page 13 having behaviors or wandered in and out of other residents' rooms. Interview with the Activity Director on 05/07/26 at 2:45pm revealed: -She redirected the residents to engage in activities when they were having behaviors. -Most behaviors occurred during second shift and staff were told to keep the residents busy. Interview with the interim SCC on 05/06/26 at 3:26pm revealed: -The residents had an increase in behaviors in March 2026 and early April 2026. -She told staff to redirect the residents and to provide an as-needed (PRN) medication if they had an order. -The PCAs should offer activities to residents to keep them from wandering into other residents' rooms. -The PCAs should have monitored the residents at all times. Interview with the Administrator on 05/07/26 at 4:02pm revealed: -The interim SCC made her aware of residents wandering in and out of other residents' rooms. -Interventions of redirecting residents who wandered were in place. -If the intervention was not working, they needed to look at other ways to prevent residents from wandering into other residents' rooms. -The PCAs made 2-hour rounds to supervise the residents. -Staff were supposed to be seated where they were able to see down the hallways at all times. -A chair was placed in the hallways during third shift to monitor the residents. -The PCAs should provide adequate supervision for the residents who wandered.	D 270		

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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 3 of 5 sampled residents (#4, #5, and #7) related to a resident who's physician made multiple requests for results from lab work (#4); a resident who had a heart rate below 60 beats per minute and the physician was not notified (#5); and a residents who had an order for blood draws (#7). The findings are: 1. Review of Resident #4's current FL-2 dated 02/26/26 revealed diagnoses included chronic kidney disorder, Alzheimer's disease, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's primary care provider's (PCP) after visit report dated 03/12/26 revealed: -She was seen for routine laboratory (lab) work, cognitive decline, decreased self-feeding, and pocketing medications. -There was an order for a repeat basic metabolic panel (BMP) (used to screen for or monitor fluid/electrolyte balance) on 03/18/26. Review of Resident #4's PCP after visit report dated 03/12/26 revealed: -The report was re-faxed to the facility on 03/20/26 at 4:50pm.	D 273		

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D 273	Continued From page 15 -The nurse from the PCP's office spoke with [named] staff on 03/20/26 at 3:30pm about the 03/12/26, after visit report that was originally faxed on 03/13/26; this was a re-fax of those orders. -There was an order to repeat BMP on Wednesday, 03/18/26. Review of Resident #4's lab results revealed: -On 03/04/26 Resident #4's sodium level was 146 millimoles per liter of blood (mmol/L) (the normal range for sodium was 134 to 144 mmol/L). -On 03/13/26 her sodium level was 151 mmol/L. -On 03/25/26 her sodium level was 146 mmol/L. Telephone interviews with the nurse from Resident #4's PCP's office on 05/06/26 at 10:42am and 12:33pm revealed: -Resident #4 had a routine and follow up visit with the PCP on 03/12/26. -Resident #4 had a BMP lab done at the appointment on 03/12/26. -The PCP reviewed the lab results on 03/13/26, and Resident #4 had hypernatremia; her sodium level was 151. -The PCP wanted to monitor Resident #4's sodium levels because they were higher than they should be. -The PCP wrote an order on 03/13/26 for Resident #4 to repeat the BMP lab on Wednesday, 03/18/26. -The PCP requested she fax the repeat BMP orders to the facility and to also call to inform them the additional orders were based on the lab results on 03/13/26. -On the front page of the fax sent to the facility on 03/13/26 she wrote a list of the orders the PCP wrote on the visit on 03/12/26 and the additional orders written on 03/13/26. -The orders she wrote on the fax cover sheet	D 273		

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included the order for repeat BMP labs scheduled on 03/18/26.
-On 03/20/26, she called the facility to ask about Resident #4's BMP lab work results from 03/18/26.
-She spoke to the interim Special Care Unit Coordinator (SCC) who told her the order for the repeat BMP was not done on 03/18/26 because the facility did not get the fax with the orders on 03/13/26.
-The interim SCC requested she refax all the orders from 03/12/26 and 03/13/26; she re-faxed all the orders to the facility on 03/20/26.
-On 03/25/26, she called the facility and spoke to the previous SCC who told her the repeat BMP was done on 03/24/26; she requested the SCC fax the PCP's office the results from the BMP.
-On 03/27/26 she called the facility and spoke to a staff member who told her there were no lab results for Resident #4.
-On 03/30/26, she called the facility and was given the previous SCC's personal cell phone number who told her the results had been faxed to the PCP's office.
-The SCC did not give a date the results were faxed and the PCP's office still did not have the results on 03/30/26.
-On 03/31/26, she called Resident #4's Power of Attorney (POA) and asked for her assistance in getting a copy of Resident #4's lab results.
-On 04/01/26, the PCP received a fax from the facility with Resident #4's repeat BMP lab results.
-The PCP was concerned about Resident #4's sodium level and was trying to be precautionary because sodium was an electrolyte and could become critically high very quickly.
-Resident #4 had chronic kidney disease which was a concern if her sodium levels became too high.
-High sodium levels could cause increased

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confusion, muscle twitching and seizures.
-The PCP was trying to catch the sodium levels before they became critical and caused any issues.
-The PCP expected the facility to follow the orders she wrote and to start them in 24 to 48 hours.

Telephone interview with a representative from the facility's contracted laboratory on 05/07/26 at 2:55pm revealed:
-They visited the facility every Wednesday and did blood draws for lab work orders.
-The facility faxed lab work orders to them prior to the Wednesday visits.
-There was also a book at the facility that lab work orders could be placed into and the technician from the laboratory would pick the orders up while at the facility.
-Once the lab work was complete, the laboratory sent the results to the facility via fax in a couple of days or they could be accessed electronically through a patient portal.
-On 03/24/26, the laboratory received a faxed order for Resident #4 for a BMP from the facility; the order was marked STAT (used in urgent situations to prioritize).
-Resident #4's repeat BMP labs were done on 03/25/26 and faxed to the facility on 03/30/26.

Telephone interview with Resident #4's POA on 05/07/26 at 2:25pm revealed:
-She took Resident #4 to her PCP appointment on 03/12/26.
-Resident #4 had lab work done and her sodium level came back high and it was critical.
-The PCP wrote an order for Resident #4's sodium levels to be checked one week after her appointment on 03/12/26.
-The PCP kept calling her and asking her if she

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had Resident #4's lab results because they had not gotten them from the facility.
-She went to see Resident #4 on 03/19/26, after the labs were scheduled to be done and the SCC had the orders for the lab work in her hand.
-The SCC told her the orders were just found in a stack of faxes on someone's desk.
-On 03/20/26 she called the SCC to follow-up on the appointment for the repeat lab work and she was told by the SCC it was scheduled to be done the following week.
-The PCP's office called her on 03/31/26 and told her they still did not have Resident #4's lab results and asked again for her to help get them.
-She set up a patient portal for Resident #4 on 04/01/26 and when she called the PCP to give them Resident #4's results, the nurse told her the facility faxed the results that same day, 04/01/26.

Telephone interview with the facility's previous SCC on 05/06/26 at 4:45pm revealed:
-The facility's lab company came to the facility once a week on Wednesdays.
-She would fax orders for lab work to the lab company to schedule the labs to be done at their next visit.
-She recalled trying to get Resident #4's lab work scheduled with the facility's contracted laboratory but recalled there was a delay; she did not recall the dates.
-She faxed the contracted laboratory Resident #4's orders for the repeat labs and the fax confirmation said the fax went through.
-Resident #4's orders were not processed on the laboratory's end and she did not know it until the laboratory came out to draw labs on the following Wednesday.
-It should have only taken 24 hours to schedule Resident #4's lab work but instead it took a week.
-Resident #4's PCP called a couple of times

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looking for her lab results but due to the delay, she did not have results to fax.
-She let Resident #4's PCP know she was having an issue scheduling the lab work with the laboratory.
-She faxed the lab results to the PCP's office as soon as they were received from the laboratory.

Interview with the interim SCC on 05/07/26 at 10:45am revealed:
-Resident #4's PCP called multiple times looking for results from the lab work.
-She spoke to the nurse from the PCP's office once about the repeat lab work; the PCP gave orders for a very specific date for Resident #4 to have the lab work done.
-The PCP's nurse called the facility to get the results of the lab work; she looked on the scheduled lab draws and did not see the lab results.
-She told the nurse she could not find the lab results.
-She told the previous SCC that Resident #4's PCP's office called and they were looking for the lab work results.
-Resident #4's BMP should have been done as soon as the facility received the order.

Interview with the Administrator on 05/07/26 at 3:10pm revealed:
-She was not aware of the delay with Resident #4's lab work being done until today, 05/07/26.
-She was not the Administrator at the time Resident #4's BMP orders were written.
-The SCC should have sent the PCP the results from Resident #4's lab work as soon as the facility received them.

2. Review of Resident #5's current FL-2 dated

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D 273	Continued From page 20 04/27/26 revealed diagnoses included dementia, congestive heart failure, diabetes mellitus 2, chronic obstructive pulmonary disease, and depression. Review of Resident #5's signed physician orders dated 04/27/26 revealed there was an order to check Resident #5's heart rate (HR) twice a week and notify the Primary Care Provider (PCP) if the HR was less than 60 beats per minute (BPM). Review of Resident #5's signed physician order dated 12/09/25 revealed there was an order to check Resident #5's HR twice a week and notify the PCP if the HR was less than 60 BPM. Review of Resident #5's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check and record Resident #5's HR twice a week on Tuesday and Thursday and notify the PCP if the HR was less than 60 BPM with a scheduled time of 9:00am. -There was documentation that Resident #5's HR was below 60 BPM three times in April 2026; on 04/21/26 at 51 BPM, 04/23/26 at 58 BPM, and 04/28/26 at 50 BPM. Review of Resident #5 electronic progress notes dated 04/21/26, 04/23/26, and 04/30/26 revealed there was no documentation that Resident #5's PCP was notified of the HR readings below 60 BPM. Telephone interview with a medication aide (MA) on 05/06/26 at 9:45am revealed: -She was employed by a sister facility of the Assisted Living (AL) facility. -The Administrator asked her to work as a MA in the AL facility.	D 273		

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-She worked one day, 04/28/26, as a MA in the AL facility.
-She knew Resident #5's pulse was below 60.
-She told the personal care aide (PCA) who worked with her that day about Resident #5's HR being below 60, and asked the PCA if Resident #5's HR was usually below 60; the PCA did not know.
-She did not know anyone in the facility and there was no management in the facility to speak with about the low HR.

Interview with a second MA on 05/07/26 at 11:19am revealed:
-She did not remember taking Resident #5's HR that morning.
-Those were her initials on the eMAR dated 04/23/26.
-She did not remember seeing the order on the eMAR to notify Resident #5's PCP for a HR less than 60 the day she worked.

Telephone interview with Resident #5's PCP on 05/06/26 at 11:22am revealed:
-She was not notified that Resident #5's HR was below 60 BPM.
-She expected to be notified when Resident #5's HR was below 60 BPM as ordered.
-Resident #5 could become dizzy, light-headed and fall, causing injury.

Interview with the Special Care Unit Coordinator (SCC) on 05/07/26 at 7:46am revealed:
-She was not aware of Resident #5's HR reading until yesterday, 05/06/26.
-The Administrator audited Resident #5's record after the survey team requested Resident #5's record for review.
-She called the PCP yesterday, 05/06/26, and reported the HR readings below 60 BPM from

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April 2026.
-The PCP decreased the frequency of a medication from twice a day to daily.
-When an abnormal reading was entered into the eMAR, an alert would pop up that the value was out of range.
-The MA should notify the SCC and the PCP when the HR was outside of the ordered range.

Interview with the Administrator on 05/07/26 at 11:30am revealed:
-She expected the MAs to follow all orders as written.
-She was concerned that the residents were being put in danger if the orders were not being followed.

3. Review of Resident #7's current FL-2 dated 04/10/26 revealed diagnoses included dementia, hypertension, protein-calorie malnutrition.

Review of Resident #7's after visit summary dated 03/25/26 revealed there were laboratory (lab) orders for a complete blood count (CBC), B12, and folate to be drawn.

Review of Resident #7's electronic progress notes dated 03/27/26 revealed Resident #7 was seen by the Primary Care Provider (PCP) on 03/25/26 and ordered labs for CBC, B12, and folate.

Telephone interview with a representative from the facility's contracted laboratory on 05/07/26 at 2:55pm revealed:
-They visited the facility every Wednesday and obtained blood draws for lab work orders.
-The facility faxed lab work orders to them prior to the Wednesday visits.
-Orders could be received up to seven days prior

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to the blood draw.
-There was also a book at the facility that lab work orders could be placed into and the technician from the laboratory would pick the orders up while at the facility.
-Once the lab work was complete, the laboratory sent the results to the facility via fax or could they could be accessed by a patient portal.
-Resident #7 did not have orders for lab work dated 03/27/26.
-The laboratory did not have any current or outstanding orders for lab work for Resident #7.
-The last time Resident #7 had lab work orders was in 2025.

Interview with Resident #7 on 05/07/26 at 10:00am revealed she did not know if labs had been drawn as ordered.

Interview with the interim Special Care Unit Coordinator (SCC) on 05/07/26 at 3:42pm revealed:
-The PCP sent the lab order to the facility's contracted laboratory.
-The order was not sent to the facility.
-The SCC would see that there was an order for labs when the after visit summary was reviewed.
-The facility's contracted laboratory kept a logbook at the facility and would document when a lab was drawn.
-If the previous SCC had been aware the labs were ordered, she would have checked the logbook.
-If the labs were not documented as being drawn in the logbook, the SCC would contact the facility's contracted laboratory.
-She could not locate the logbook to see if the labs had been drawn.
-It was the responsibility of the SCC to ensure the labs were drawn as ordered.

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D 273	Continued From page 24 Interview with the Administrator on 05/07/26 at 4:08pm revealed: -Resident #7's order for labs should have been sent to the laboratory so the labs could be drawn. -She was concerned about Resident #7's health since the labs were not drawn as ordered. -The SCC was responsible for ensuring that the labs were drawn.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 5 sampled residents (#4 and #9) including an order for a mechanical soft (MS) diet (#4), an order to increase fluids (#4), and an order for daily blood pressure checks (#9). The findings are: 1. Review of Resident #4's current FL-2 dated 02/26/26 revealed diagnoses included chronic kidney disorder, Alzheimer's disease,	D 276		

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D 276	Continued From page 25 hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's primary care provider's (PCP) after visit report dated 03/12/26 revealed she was seen for routine labs, cognitive decline, decreased self-feeding, and pocketing medications. a. Review of Resident #4's PCP after visit report dated 03/12/26 revealed: -The report was faxed to the facility on 03/13/26 at 6:20pm. -The fax was marked urgent and dated 03/13/26. -There was an order to increase fluids. -On the third page of the report there was a message/note by the PCP dated 03/13/26. -Resident #4's BMP results from 03/12/26 showed her sodium levels were high. -High sodium levels were usually caused by dehydration and the PCP wanted the resident to drink more fluids each day. -The report was re-faxed to the facility on 03/20/26 and marked urgent. -The nurse from the PCP's office spoke with [named] staff on 03/20/26 about the faxed orders on 03/13/26; the order was a re-fax of the orders were written 03/12/26 and originally faxed on 03/13/26. Review of the facility's electronic resident diet list dated 05/05/26 revealed there was no order to increase fluids for Resident #4. Observation of Resident #4 on 05/05/26 from 11:45am to 1:00pm revealed: -She was served 8 ounces of iced tea, 8 ounces of water and 8 ounces of milk. -Resident #4 was not encouraged or cued by staff to drink during the meal.	D 276		

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D 276	Continued From page 26 -Resident #4 drank 50 percent of her milk, none of her water and 25 percent of her iced tea. Observation of Resident #4 on 05/06/26 from 8:00am to 8:30am revealed: -She was given 6 ounces of water with her medications and she drank 75 percent of the water. -She was served 8 ounces of orange juice, milk and water. -She was not encouraged or cued by staff to drink during the meal. -She drank 100 percent of her milk, 25 percent of her orange juice and none of her water. Telephone interviews with the nurse from Resident #4's PCP's office on 05/06/26 at 10:42am and 12:41pm revealed: -Resident #4 had a routine and follow up visit with the PCP on 03/12/26. -Resident #4 had a BMP lab done at the appointment on 03/12/26. -The PCP reviewed the lab results on 03/13/26, and Resident #4 had hypernatremia; her sodium level was 151. -Hypernatremia was usually caused by dehydration. -On 03/13/26, Resident #4's PCP wrote an order to increase daily fluids. -On 03/13/26, she faxed the order to increase fluids to the facility per the PCP's request and also called to confirm the orders. -On the front page of the fax she wrote a list of the orders the PCP wrote from the visit on 03/12/26 and the additional orders written on 03/13/26, including the order to increase fluids. -On 03/13/26, she called the facility and spoke to a [named] staff member to confirm the orders written on 03/12/26 and to inform them the PCP wrote Resident #4 additional orders on 03/13/26.	D 276		

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-The staff member she spoke to told her to fax Resident #4's orders to the facility so she did.
-On 03/20/26, she called the facility and spoke to the interim Special Care Unit Coordinator (SCC); the SCC told her the facility did not get the fax with the orders on 03/13/26.
-The interim SCC requested she refax all the orders from 03/12/26 and 03/13/26; she refaxed all the orders to the facility on 03/20/26.
-On 03/20/26, she called Resident #4's Power of Attorney (POA) to let her know there was a delay with the Resident #4's orders at the facility.
-The POA told her she was at the facility on 03/19/26 and asked the former SCC about the orders from 03/13/26.
-The former SCC told the POA they only received the fax with the orders from 03/13/26, that day, 03/19/26.
-Resident #4's high sodium level was most likely caused by dehydration and the PCP wanted the facility to increase her fluids because a high sodium level could become critical very quickly.
-The PCP expected the facility to follow the orders she wrote and to start them in 24 to 48 hours.

Telephone interview with Resident #4's POA on 05/07/26 at 2:25pm revealed:
-She took Resident #4 to the PCP for a routine visit on 03/12/26.
-The PCP did lab work at the visit and Resident #4's sodium level came back high.
-The PCP wrote an order for Resident #4 to have increased fluids because her sodium level was high.
-The order for increased fluids was written on the orders for 03/12/26 and faxed to the facility.
-The orders were supposed to start immediately.

Telephone interview with a medication aide (MA)

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on 05/06/26 at 10:57am revealed:
-Resident #4 did not have an order to increase fluids or encourage her to drink more fluids.
-They always gave fluids at meals and snacks and would give more if the resident wanted more.
-She would remind Resident #4 to drink during her meals; she reminded all the residents to drink their beverages.
-Resident #4 drank her milk and juice at her meals but had to constantly be reminded to drink her water at meals and snack times.

Interview with a personal care aide (PCA) on 05/05/26 at 3:30pm revealed:
-Resident #4 would drink all of her beverages at her meals and at snack time.
-The residents were served water with snacks and Resident #4 did not like to drink water.
-He would pour Resident #4 a cup of water with snacks but she would not drink it.
-He was not told to encourage Resident #4 to drink her beverages during her meals or at snack time.

Interview with a second PCA on 05/06/26 at 1:50pm revealed:
-The residents got water three times a day with snacks and three times a day with meals.
-The residents also got other beverages at meals.
-Resident #4 sipped on her milk and sometimes she would drink all of her water or iced tea at meals.
-She would tell Resident #4 to drink her beverages at meals.
-She had not been told to increase Resident #4's fluids or to encourage her to drink more fluids.

Telephone interview with the facility's previous SCC on 05/06/26 at 4:45pm revealed:
-She was not sure if the order to increase

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Resident #4's fluids was put into place and started because they were trying to increase hydration for all the residents and staff were supposed to encourage the residents to drink more beverages when they were served.
-Residents were served beverages at all three meals and at three snacks a day.
-The order to increase fluids would not have been put on the electronic medication administration record (eMAR) or on the diet order.

Interview with the interim SCC on 05/07/26 at 10:45am revealed:
-The facility did not do anything with an order to increase fluids because there was no way of monitoring a resident's intake and output.
-The facility could enforce a recommendation to encourage fluids.
-An order to increase residents' fluids would be sent to the PCP and asked to change it to a recommendation to increase fluids.
-Resident #4 did not have a current order in place to increased fluids or a recommendation to encourage fluids.
-If the recommendation to increase fluids had been put into place, she could ask the staff if they were encouraging fluids.
-Orders should be started as soon as possible and monitored because the PCP wrote the order for a purpose and a delay could hinder the resident's care in some way if not done timely.

Interview with the Administrator on 05/07/26 at 3:10pm revealed:
-She was not aware of Resident #4's order to increase fluids until today, 05/07/26.
-She was not the Administrator at the time Resident #4's order was written.
-The facility did not implement orders for increased fluids for residents because there was

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no way to monitor intake or output.
-Staff encouraged fluids to all residents by queuing them to drink their beverages at meals and at snack time.
-She would have reached out to the corporate clinical team and the PCP if she had been at the facility when the order was received in March 2026.

c. Review of Resident #4's PCP after visit report dated 03/12/26 revealed:
-The report was faxed to the facility on 03/13/26 at 6:20pm.
-There was an order for a Mechanical Soft diet dated 03/12/26.
-The report was re-faxed to the facility on 03/20/26.
-The comment section on the first page included the comment, spoke with [named] staff on 03/20/26 at 3:30pm about faxed orders on 03/13/26; the order dated 03/12/26 was re-faxed to the facility on 03/20/26 per the request of the facility's staff.

Review of the facility's electronic resident diet list dated 05/05/26 revealed Resident #4 was on a MS diet with a start date of 03/19/26.

Review of the kitchen's diet order logbook on 05/05/26 revealed Resident #4 had a diet order/diet communication dated 04/22/26 for a MS diet.

Observation of Resident #4 on 05/05/26 at 12:00pm revealed she was served a MS diet.

Telephone interview with Resident #4's POA on 05/07/26 at 2:25pm revealed:
-She took Resident #4 to the PCP for a routine visit on 03/12/26.

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-She told the PCP Resident #4 was pocketing food and medications and was having difficulty chewing her food.
-The PCP ordered Resident #4 a MS diet and wrote it on the same sheet as other orders from the visit.
-She went in to see Resident #4 on 03/19/26 and observed Resident #4 eating a whole hamburger and French fries.
-She asked staff about her MS diet and they did not know her diet had been changed.
-The diet order should have been changed immediately but Resident #4 went a week and a half without the diet order change.
-She complained to the staff about Resident #4's diet not being changed and she was told they could not change the diet without a written order.
-She went to complain to the SCC about the diet orders not being started and the SCC was standing in the hallway with the MS diet order in her hand.
-The SCC told her the orders were just found in a stack of faxes on someone's desk.
-The SCC told her she would have the diet orders started that day, 03/19/26.

Telephone interviews with the nurse from Resident #4's PCP's office on 05/06/26 at 10:42am and 12:41pm revealed:
-Resident #4 had a routine and follow up visit with the PCP on 03/12/26.
-Resident #4's POA reported the resident was having difficulty with chewing and not eating well so the PCP wrote an order for a MS diet on 03/12/26.
-The PCP requested she fax the facility the diet order to the facility and to also call to verbally confirm the orders.
-The orders she wrote on the fax cover sheet included the MS diet order written on 03/12/26.

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-On 03/13/26, she called the facility and spoke to a staff member to confirm orders including the diet order.
-The staff member she spoke to told her to fax the orders to the facility so she did.
-On 03/20/26, the POA told her she was at the facility on 03/19/26 and the POA asked the former SCC about the MS diet.
-The former SCC told the POA the facility only received the fax dated 03/13/26 with the MS diet order that day, 03/19/26.
-The PCP ordered a MS diet for Resident #4 because she would be able to chew and swallow better.
-The PCP expected the facility to follow the orders she wrote and to start them in 24 to 48 hours.

Telephone interview with Resident #4's dentist on 05/06/26 at 12:15pm revealed:
-Resident #4 had a hard time chewing because her teeth were in very rough condition; she had missing teeth, teeth with chips and broken roots.
-She was monitoring Resident #4's teeth closely because she was not able to communicate.
-She wanted to know how well Resident #4 was eating at meals.
-If Resident #4 was taking a long time to eat, she would benefit from a MS diet.
-A MS diet would help Resident #4 eat better and eat more.

Telephone interview with a MA on 05/06/26 at 10:57am revealed:
-Someone from Resident #4's PCP's office called and told her about the MS diet order.
-She could not take a verbal order over the telephone so she told the PCP's office to fax the order.
-She remembered seeing the MS diet order for

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Resident #4 but could not recall the date.
-She was off for a few days and when she returned to work, Resident #4 had a MS diet.
-Resident #4 ate very slowly and took a long time to finish a meal before the order for a MS diet.
-She ate much better and faster after her diet was changed.

Interview with a PCA on 05/06/26 at 1:50pm revealed:
-Resident #4 did not eat as good with a regular diet as she did with the MS diet.
-She was eating so much better since her diet was changed.
-She thought Resident #4 had been on a MS diet for a couple of months.
-Resident #4 would chew very slowly and took a long time to eat so now she was eating better and faster.

Interview with the Dietary Manager on 05/06/26 at 3:45pm revealed:
-The SCC gave him the diet orders when there was a new diet order or diet change.
-He put the copy of the signed diet orders in a diet book in the kitchen.
-He got the new diet orders on the day they were changed.
-The SCC entered the diet orders into the electronic menu system; he verified the orders with the order in the diet book.
-He started the diet the day the order entered into the electronic record.
-The electronic date on the diet list was the date the order was started.

Telephone interview with the facility's previous SCC on 05/06/26 at 4:45pm revealed:
-She or the Assistant SCC would change the order in the electronic menu system.

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D 276	Continued From page 34 -Resident #4 had a diet order change from her PCP in the middle of March 2026. -The diet order change should have been placed into diet system immediately after the order was received at the facility. -Resident #4's diet order was not faxed to the pharmacy, there was no communication between staff and it was not put into the system so it was not started when it was received. -The facility's corporate staff did a diet audit around the middle of April 2026, that was when they noticed Resident #4 did not have a communication order for a MS diet. Interview with the interim SCC on 05/07/26 at 10:45am revealed: -She did not process diet orders she only faxed them to the pharmacy. -She did not do anything with Resident #4's diet orders from the PCP on 03/13/26. Interview with the Administrator on 05/07/26 at 3:10pm revealed: -She was not aware of Resident #4's MS diet order until the corporate staff completed a dietary order audit on 04/22/26. -She was not the Administrator at the time Resident #4's the order was written in March 2026. -The diet orders should have been faxed to the pharmacy and scanned into the resident's record the day they were received or the day after and a copy handed to the Dietary Manager. -The previous SCC put the order in the electronic diet system on 03/19/26. -The signed order was placed in the diet logbook on 04/22/26. -There should not have been a delay in the start of Resident #4's MS diet because the delay could have been detrimental to the resident's care.	D 276		

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D 276	Continued From page 35 -Resident #4's MS diet should have started the day of the order or the next day. Based on observations, interviews and record reviews it was determined Resident #4 was not interviewable. 2. Review of Resident #9's current FL-2 dated 08/21/25 revealed: -Diagnoses included Type 2 diabetes, depression, Alzheimer's disease, and hypertension. -There was an order for blood pressure checks once daily. Review of Resident #9's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check blood pressure daily scheduled at 10:00am. -Blood pressures were not documented 6 out of 30 opportunities. -Blood pressure values ranged from 124/70 to 145/70. Review of Resident #9's May 2026 eMAR from 05/01/26 through 05/07/26 revealed: -There was an entry to check blood pressure daily scheduled at 10:00am. -Blood pressures were not documented 2 out of 6 opportunities. -Resident's #9's blood pressure was documented as 138/72 on 5/02/26, 05/03/26, 05/04/26 and 05/06/26. Interview with a medication aide (MA) on 05/07/26 at 11:45am revealed: -There was an order to document Resident #9's blood pressure daily on the eMAR. -Today was the first day she had worked on the	D 276		

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medication cart.
-The MA was supposed to contact the primary care provider (PCP) if the blood pressure was over 120/80.

Interview with Resident #9's PCP on 05/07/26 at 12:04pm revealed:
-The order for daily blood pressure checks for Resident #9 was current and should continue until discontinued by a written order.
-She expected blood pressure checks to be done daily as ordered.

Interview with the interim Special Care Unit Coordinator (SCC) on 05/06/26 at 3:43pm revealed:
-The MAs should be documenting Resident #9's blood pressure daily on the eMAR.
-Her concern was that the PCP's orders were not being followed.
-Resident #9's blood pressure medication could need to be held if her blood pressure was too low.

Interview with the Administrator on 05/07/26 at 4:14pm revealed:
-Missing blood pressure documentation should show up on daily reports.
-The daily summary reports were pulled by the Interim SCC to make sure blood pressures were not missed.
-The expectation was that the summary reports were reviewed daily by the Interim SCC.

Based on observations, record reviews and interviews, Resident #9 was not interviewable.

Refer to the telephone interview with a medication aide (MA) on 05/06/26 at 10:57am.

Refer to the telephone interview with the previous

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D 276	Continued From page 37 Special Care Unit Coordinator (SCC) on 05/06/26 at 4:45pm. Refer to the interview with interim SCC on 05/07/26 at 10:45am. Refer to the interview with the Administrator on 05/07/26 at 3:10pm. _____ Telephone interview with a medication aide (MA) on 05/06/26 at 10:57am revealed: -The MAs placed any orders from the PCP in a bin for the SCC to review. -The MAs would pass telephone messages from the PCP or pharmacy on to the SCC. -She would send the SCC a text message, call her on her cell phone or verbally tell her when she saw her about orders and lab results. -The SCC faxed orders to the pharmacy. Telephone interview with the previous SCC on 05/06/26 at 4:45pm revealed: -All orders from physicians were faxed to the facility's contracted pharmacy and they kept a backup electronic record of the orders including medication orders, diet orders, orders for lab work and treatments. -When a physician sent orders to the facility the SCC or the MA could fax orders to the pharmacy. -The facility had a colored folder system for orders where the orders were processed and progressed through the system. -She could review the orders and monitor what step of the process the orders where in and into the resident's records. -The orders were received and put into one folder, then placed into the next folder after they were faxed to the pharmacy. -She checked the folders everyday she worked to make sure the orders had been faxed and put on	D 276		

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D 276	Continued From page 38 the eMAR, and to see if any lab work or appointments needed to be scheduled. -All orders were put into place within 24 to 48 hours after receiving them. -If an order came in on a Friday or Saturday, they were started the next Monday. Interview with the interim SCC on 05/07/26 at 10:45am revealed: -She faxed all orders to the pharmacy when she received them, including diet orders, and orders for lab work. -If the PCP faxed orders to the facility she then faxed them to the pharmacy as soon as she got them. -She saved the confirmations from the faxed orders and attached them to the orders and scanned them into the resident's record. -The MAs could also fax orders to the pharmacy. Interview with the Administrator on 05/07/26 at 3:10pm revealed: -All orders were faxed to the pharmacy because they kept an electronic back up for the facility. -She and the SCC entered orders into the electronic resident records. -Orders should be faxed to the pharmacy and scanned into the resident's record the day they were received or the day after.	D 276		
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.	D 338		

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D 338	Continued From page 39 This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A2 VIOLATION Based on these findings, the Type A2 violation was abated. Non compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that 4 of 4 sampled residents (#1, #6, #7, and #15) were treated with dignity and respect and protected from harm from other residents including a resident who had her hair pulled by another resident (#1); a resident who had various items tied to the door handle in her room which prevented the door from opening (#6); a resident whose belongings were removed from her room (#7); a resident who was slapped by another resident (#15); and multiple residents who were upset and complained about residents who wandered in their room, removed their belongings, and attempted to open their locked bedroom door at night which woke the residents up. The findings are: 1. Review of Resident #6's current FL-2 dated 07/01/25 revealed: -Diagnoses included dementia, leukocytosis, protein calorie malnutrition, hypertension, and chronic obstructive pulmonary disorder (COPD). -She was constantly disoriented. -She was incontinent of bladder and bowel. Review of Resident #6's care plan dated 08/19/25 revealed: -She wandered and was verbally abusive. -She was totally dependent on assistance from	D 338		

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staff with toileting, bathing, dressing, and grooming.
-She did not require staff assistance with eating, ambulating and transferring.
-She was always disoriented.
-She had significant memory loss and must be directed.

Review of undated photos from the phone of a confidential source revealed:
-The photos were of the inside door handle in Resident #6's room.
-There was a plastic bag tied to the inside door handle.
-There was another photo with a plastic glove tied to the inside door handle.

Interview with a personal care aide (PCA) on 05/05/26 at 3:19pm revealed:
-He observed a brief tied to the inside door handle in Resident #6's room last week at the beginning of second shift, he could not recall the date.
-The brief was used to keep other residents from entering Resident #6's room.
-The brief caused the outside of the door to be locked.
-He reported it to a medication aide (MA) and she removed the brief.
-He was not sure if Resident #6 was able to exit the room.
-He had not observed a trash bag, a plastic glove, or tape tied to the door handle in Resident #6's room.
-There was a meeting in April 2026, when the interim Special Care Unit Coordinator (SCC) told staff about the trash bag, glove, and tape tied to the door handle in Resident #6's room.
-The interim SCC told staff in a meeting in April 2026 not to place anything on the door handle

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D 338	Continued From page 41 because it was considered a restraint. Interview with a second PCA on 05/06/26 at 1:45pm revealed: -She saw the plastic glove on the door handle in Resident #6's room about a month ago when she worked second shift. -Resident #6 was not able to get out of her room when the glove was tied to the door handle. -She was not aware of who placed the glove on the door handle. -Resident #6 walked back and forth down the hallways all day and night. -There was a meeting in April 2026 and staff were told not to tie anything to the doors because it was considered a restraint. Interview with a third PCA on 05/06/26 at 4:53pm revealed: -She saw the trash bag tied to the door handle in Resident #6's room last month and reported it to the previous SCC. -The trash bag was removed from the door, but a glove was placed on the door the next day by the third shift staff. -Resident #6 always walked throughout the facility during the day and night. -Resident #6 was not able to leave her room with the trash bag and glove tied to the door handle. Interview with a fourth PCA on 05/07/26 at 6:10am revealed: -He had not observed anything tied to the door handle in Resident #6's room. -The Activity Director (AD) told him a few weeks ago not to place anything on the door handle in Resident #6's room because it was a restraint. -He had not placed anything on the door handle in Resident #6's room.	D 338		

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D 338	Continued From page 42 Interview with a fifth PCA on 05/07/26 at 6:17am revealed: -He placed tape on the door handle in Resident #6's room to prevent other residents from entering her room. -Resident #6 was able to exit the room. -The previous SCC and the previous Administrator told staff to put the tape on the door handle. -He had not seen plastic wrap, a brief, a plastic glove, or a trash bag on the door handle in Resident #6's room. -During an in-service at the end of April 2026, staff were told not to place anything on the door handle in Resident #6's room. Interview with a MA on 05/07/26 at 6:30am revealed: -She had not seen a trash bag, a plastic glove, a brief, or plastic wrap on the door handle in Resident #6's room. -She was told by the previous SCC to place tape on the door handle in Resident #6's room to keep other residents from entering the room. -Resident #6 was able to exit the room. -She did not place tape on the door handle of Resident #6's room. -The interim SCC told her to make rounds at the beginning of her shift to ensure nothing was tied to the door handle in Resident #6's room. -She did not believe staff that worked first or second shift placed items on the door handle; she believed it occurred during third shift. -She was not aware of who was placing the items on the door handle. Interview with a second MA on 05/07/26 at 2:12pm revealed: -She had not seen anything tied to the door handle in Resident #6's room.	D 338		

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D 338	Continued From page 43 -She would have reported it to the interim SCC. -There was an in-service in late April 2026 and staff were told not to place anything on the door handle in Resident #6's room because it was a restraint. Interview with the Activity Director on 05/06/26 at 3:59pm revealed: -The previous SCC told her a glove was tied on the door handle in Resident #6's room in April 2026. -The previous SCC had a meeting with staff to inform staff not to tie anything to door handles. -She made rounds at 7:00am daily and had not seen anything tied to the door handle in Resident #6's room. Telephone interview with the previous SCC on 05/05/26 at 3:48pm revealed: -Staff observed a trash bag and a plastic glove tied to the inside door handle in Resident #6's room at the end of March 2026. -Staff told her the trash bag and glove were used to keep Resident #6 in her room. -Resident #6 walked constantly and wandered throughout the night. -She did not report seeing the trash bag and glove tied to the door handle to anyone. -She was not sure who she should have reported it to. Interview with the interim SCC on 05/06/26 at 3:26pm revealed: -The previous SCC told her there was a trash bag and a plastic glove tied to the door handle in Resident #6's room in March 2026. -She saw a brief tied to the door handle in Resident #6's room one day last week when she was making rounds. -Two weeks ago while making rounds on first	D 338		

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shift, she saw plastic wrap tied to the door handle in Resident #6's room.
-She asked who placed the brief on the door handle, but staff would not admit to tying the brief on the handle.
-Staff told her third shift staff were tying items on the door handle in Resident #6's room.
-The items were being tied to the door handle to keep other residents from entering Resident #6's room during the night.
-Resident #6 was able to exit her room but other residents were not able to enter the room.
-She talked to staff last week about not placing items on the door handle in Resident #6's room.
-She started making daily rounds two weeks ago at 7:00am to ensure nothing was being tied on Resident #6's door handle.
-She was concerned that if there was a fire, Resident #6 would not be able to exit the room with the items tied to the door handle.

Interview with the Administrator on 05/07/26 at 4:02pm revealed:
-Last month (April 2026) the interim SCC made her aware staff placed tape on the door handle in Resident #6's room to keep other residents from entering the room.
-She thought Resident #6 was able to exit the room.
-She was not aware a trash bag, a plastic glove, plastic wrap, or a brief was placed on the door handle in Resident #6's room.
-She did not know who placed the items on the door handle.
- She did not think staff realized it was an issue.
-She told staff yesterday 05/06/26; not to place anything on the door handle in Resident #6's room.
-Her concern would be if Resident #6 was not able to exit the room when items were placed on

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her door handle.

2. Review of Resident #15's current FL-2 dated 09/24/25 revealed:
-Diagnoses included dementia, hypertension, and major depressive disorder.
-She was ambulatory.
-She was constantly disoriented.

Review of Resident #15's care plan dated 10/22/25 revealed:
-She was always disoriented.
-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.

Review of Resident #15's incident report dated 03/07/26 at 5:20pm revealed:
-Resident #15 was observed being slapped by another resident.
-There were no injuries.

Review of Resident #15's electronic progress note dated 03/07/26 revealed:
-Resident #15 was involved in an altercation with another resident during dinner.
-Resident #15 was slapped in the neck by another resident.
-Resident #15 was not injured.
-Resident #15 was redirected to disengage in interaction with the other resident.

Interview with a personal care aide (PCA) on 05/05/26 at 3:19pm revealed:
-Resident #15 walked next to another resident's table in the dining room and was slapped on the

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neck by the other resident.
-Staff redirected Resident #15 way from the aggressive resident.
-Resident #15 had redness to her neck but there was no injury.
-The other resident had not had an issue with Resident #15 before.

Telephone interview with the previous Special Care Unit Coordinator (SCC) on 05/05/26 at 3:26pm revealed:
-Another resident was agitated and slapped Resident #15 on the neck on 03/07/26.
-Staff redirected Resident #15 to sit in her chair to be served dinner.
-Resident #15 was not injured.

Interview with the House Manager on 05/07/26 at 2:00pm revealed:
-He asked the staff to notify him of accidents/incidents when residents were sent to the hospital.
-He did not recall being notified of the accident/incident where Resident #15 was slapped on the neck.
-He had not instructed the staff in ways to protect residents privacy and divinity; the previous Administrator, who completed the Plan of Correction, did training with the staff of residents' rights, dignity, and privacy.

Interview with the Administrator on 05/07/26 at 4:02pm revealed:
-She was not aware of the accident/incident report dated 03/07/26.
-If she had known about the Resident #15 being slapped by another residents, she would have intervened by reviewing the accident/incidents, observing the behaviors of the residents involved and put a plan in place to try and prevent the

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D 338	Continued From page 47 situation from occuring again. Based on observations, interviews and record reviews it was determined Resident #15 was not interviewable. 3. Review of Resident #1's current FL-2 dated 10/22/25 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -She wandered. -She was ambulatory. Review of Resident #1's care plan dated 03/16/26 revealed: -She was always disoriented. -She had significant memory loss and required directions. -She was independent with ambulation and transferring. -She required supervision from staff with eating. -She required limited assistance from staff with dressing. -She required extensive assistance from staff with toileting, bathing, and grooming. Review of Resident #1's incident report dated 03/10/26 at 9:13pm revealed: -Resident #1 was observed having her hair pulled by another resident. -There were no injuries. Review of Resident #1's electronic progress note dated 03/10/26 revealed the resident's hair was pulled by another resident. Interview with the interim Special Care Unit Coordinator (SCC) on 05/06/26 at 3:31pm revealed: -She could not recall the date but there was an	D 338		

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incident between Resident #1 and another resident.
-She observed the incident and completed the incident report.
-Resident #1's hair was pulled by another resident who was agitated.
-Resident #1 was redirected away from the other resident.

Interview with the House Manager on 05/07/26 at 2:00pm revealed:
-He asked the staff to notify him of accidents/incidents when residents were sent to the hospital.
-He did not recall being notified of the accident/incident where Resident #1's hair was pulled.
-He had not instructed the staff in ways to protect residents privacy and divinity; the previous Administrator, who completed the Plan of Correction, did training with the staff of residents' rights, dignity, and privacy.

Interview with the Administrator on 05/07/26 at 4:02pm revealed:
-She was not aware of the incident report dated 03/10/26.
-If she had known about the Resident #1's hair being pulled by another resident, she would have intervened by reviewing the accident/incidents, observing the behaviors of the residents involved and put a plan in place to try and prevent the situation from occuring again.

Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.

4. Review of Resident #7's current FL-2 dated 04/10/26 revealed diagnoses included dementia,

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D 338	Continued From page 49 hypertension, and protein-calorie malnutrition. Interview with Resident #7 on 05/05/26 at 8:15am revealed: -Residents wandered into her room all the time. -The wandering residents would take whatever they saw. -She followed them or would go to their rooms and take her items back. -A [named] resident would come into her room and take things. -A [named] resident tried to open her door at night because the [named] resident was a "night owl". -She kept her door locked at night so the [named] resident could not get in. Interview with Resident #7 on 05/07/26 at 8:51am revealed: -Other residents came in her room and took her clothing and items sitting around. -She had a shoe missing and it had not been found. -She tried to keep her door locked, but sometimes she did not lock her door because her roommate could not get into the room. -A [named] resident came into her room, took her clothes and lay in her bed. -The two tall residents came into her room also and picked up items and left. -She wanted the other residents to stay out of her room. Interview with Resident #7's Power of Attorney (POA) on 05/07/26 at 2:38pm revealed: -Resident #7 complained about the same two residents who walked into and out of her room daily. -Resident #7 complained about the same two residents taking her clothes and shoes. -Resident #7 became frustrated with the same	D 338		

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two residents because they kept coming into her room and removing things.
-She visited with Resident #7 on 05/01/26 and 05/04/26 and Resident #7 verbalized the frustration of the other residents coming into her room.
-She thought Resident #7 would be less frustrated if Resident #7 had a key for her room and she could keep her room locked.

Interview with the interim SCC on 05/07/26 at 7:46am revealed:
-Resident #7 had an issue with other residents going in her room.
-Resident #7 was instructed by the previous Administrator in March 2026, to keep her door locked.
-Resident #7 had not had any issues with other residents going in her room since she started locking her door.
-She did not know Resident #7 left her bedroom door unlocked because her roommate could not get into the bedroom.
-She did not know other residents were still going into Resident #7's bedroom and removing Resident #7's items.

Interview with the House Manager on 05/07/26 at 2:00pm revealed:
-Resident #7 had not complained to him about other residents coming into her room.
-He visited the residents daily and encouraged the residents to keep their bedroom doors locked to keep other residents out of their bedrooms.
-He had not instructed the staff in ways to protect residents privacy and divinity; the previous Administrator, who completed the Plan of Correction, did training with the staff of residents' rights, dignity, and privacy.

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 05/07/2026

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 338	Continued From page 51 Interview with the Administrator on 05/07/26 at 1:30pm revealed: -She was aware that residents had been instructed to keep their bedroom doors locked to keep other residents out of their rooms. -She knew the residents and staff had been instructed to keep residents' bedroom doors locked to keep other residents out of their rooms by the previous Administrator. -She had not given staff any other directives related to residents' rooms being entered and their personal belongings being removed. Based on observations, interviews and record reviews it was determined Resident #7 was not interviewable. 5. Interview with a resident on 05/05/26 at 8:35am revealed: -She kept her bedroom door locked. -There were residents who walked in and out of other residents' rooms and took things from the rooms. -She did not want anyone in her room, so she kept her bedroom door locked. -She heard residents at night trying to open her bedroom door after she had gone to bed. Interview with a second resident on 05/05/26 at 8:20am revealed: -Residents wandered in and out of her room all the time. -The residents went into her room daily and at all hours of the day and night. -She pulled her call bell to alert staff so they could remove the resident from her room. Observation of a third resident speaking to a personal care aide (PCA) on 05/07/26 at 8:50am revealed the third resident was upset about other	D 338		

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D 338	Continued From page 52 residents going into her room and removing her things. Interview with a third resident on 05/07/26 at 8:59am revealed: -There was one [named] resident and two other residents who went into other residents' rooms and took things. -She had seen them come out of other residents' room with things from that room. -She saw one of the residents wearing another resident's clothes. -She used to lock her bedroom door, but someone took her key. -She did not want anyone in her room when she was not in there. Interview with a PCA on 05/07/26 at 1:50pm revealed: -The third resident came to breakfast that morning and told the PCA she could not lock her room. -The third resident pointed to the two residents and said those two residents would go in her room. -The third resident said if something went missing from her room there "was going to be a problem" and she would not be blamed for it. -The staff had been told to redirect the residents who went into other residents' rooms, give them a snack, or get the residents involved in an activity which only lasted a few minutes. Interview with a fourth resident on 05/05/26 at 8:25am revealed: -A [named] resident came into her room all the time. -She had to keep her bedroom door locked. -A [named] resident knew how to "pick the lock" and open the door.	D 338		

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D 338	Continued From page 53 -A [named] resident would come into her room and take things like clothes and shoes. -A [named] resident would basically take anything she saw. -A [named] resident got into her room two days ago and would not leave. -A [named] resident would not listen when she was asked to leave her room. -To get the [named] resident out of her room she had to push the [named] resident out of her room and down the hallway. A second interview with the fourth resident on 05/07/26 at 9:07am revealed: -At night, a [named] resident would jiggle the door handle and try to come into my room. -A [named] resident would yell at her to open the bedroom door. -A [named] resident woke her up most nights. -Somebody was going to get hurt. Interview with a fifth resident's Power of Attorney (POA) on 05/07/26 at 2:45pm revealed: -She had seen other residents in the fifth resident's room when she visited. -She had noticed things missing from the fifth resident's room -She had purchased three sets of bedding since October 2025, because the fifth resident's bedding disappeared. -The fifth resident was admitted to the facility in October 2025 and other residents going into her bedroom had been happening since she was admitted to the facility. -She had spoken to the previous Administrator about residents wandering into the the fifth resident's room and that items were missing, but nothing had changed. -She did not know how the facility should manage other residents wandering in the fifth resident's	D 338		

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D 338	Continued From page 54 room but it needed to be resolved. Interview with the interim SCC on 05/07/26 at 7:46am revealed: -Some residents had issues with other residents going in their room and removing their personal items. -Residents were instructed by the previous Administrator in March 2026, to keep their door locked. -Residents were going to jiggle door handles; she thought it was impossible to stop. Interview with the House Manager on 05/07/26 at 2:00pm revealed: -Resident #7 had not complained to him about other residents coming into her room. -He visited the residents daily and encouraged the residents to keep their bedroom doors locked to keep other residents out of their bedrooms. -He had not instructed the staff in ways to protect residents privacy and divinity; the previous Administrator, who completed the Plan of Correction, did training with the staff of residents' rights, dignity, and privacy. Interview with the Administrator on 05/07/26 at 1:30pm revealed: -She was aware that residents had been instructed to keep their bedroom doors locked to keep other residents out of their rooms. -She knew the residents and staff had been instructed to keep residents' bedroom doors locked to keep other residents out of their rooms by the previous Administrator. -She had not given staff any other directives related to residents' rooms being entered and their personal belongings being removed. -If she had known residents were still being bothered by other residents going into their rooms	D 338		

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D 338	Continued From page 55 and removing items and jiggling door handles and waking residents up at night, she would have intervened by observing the situation and putting a plan in place to try and prevent the situations. _____ The facility failed to ensure residents were treated with dignity and respect and were free from physical and emotional abuse related to a resident (#6) who was not free to move about the facility and was confined to her room when items were tied to her bedroom door handle, a resident (#1) whose hair was pulled by another resident, a resident (#15) who was slapped on the neck by another resident, a resident (#7) whose items were removed from her room by other residents who wandered into her room, and multiple residents who complained about residents who wandered in their rooms, removed personal items, and who were awaken at night by residents who attempted to enter their locked bedroom door. The facility's 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 05/06/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2026.	D 338		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 56 (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 observation, record reviews, and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3) who was ordered a vaccine to be administered by pharmacy staff. The findings are: Review of Resident #3's FL-2 dated 03/16/26 revealed diagnoses including schizophrenia, hypertension, and Parkinson's disease. Review of Resident #3's record on 05/05/26 revealed there was no order for Shingrix vaccine available for review.	D 367		

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D 367	Continued From page 57 Review of Resident #3's April and May 2026 eMARs revealed: -There was an entry for Shingrix (varicella-zoster) vaccine 50mcg/0.5ml administer intramuscularly (IM). -There was documentation Shingrix was administered 22 times during the month of April. -There was documentation Shingrix was administered 5 times during the month of May. Observation of medications on hand for Resident #3 on 05/05/26 at 4:47pm revealed there was no Shingrix vaccine available for administration. Interview with a medication aide (MA) on 05/07/26 at 3:11pm revealed: -The MAs did not administer IM injections, either a nurse or pharmacy staff did. -The vaccine was never in the medication cart. -The Special Care Unit Coordinator (SCC) should check the eMAR for accuracy. -The MAs normally verified the eMAR against the primary care provider's (PCP) orders. Interview with a second MA on 05/07/26 at 12:30pm revealed: -The previous SCC checked orders against the eMARs. -The PCP's orders were sent to the pharmacy. -If there was a question regarding the eMARs, the SCC was responsible to investigate. Interview with the interim SCC on 05/06/26 at 3:43pm revealed: -The previous SCC was notified that the Shingrix Vaccine order remained on the eMAR. -The MA's were told by the previous SCC to document vaccines as administered on the eMAR, rather than leaving the blanks on the eMAR.	D 367		

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D 367	Continued From page 58 Telephone interview with a Pharmacist from the facility's contracted pharmacy on 05/06/26 at 10:42am revealed: -Resident #3's Shingrix vaccine order was obtained by the pharmacy directly from the PCP. -The vaccine was entered on the eMAR for billing purposes. -A nurse from the pharmacy brought the vaccine to the facility and administered it to Resident #3 on 04/01/26. -The entry for the vaccine for Resident #3 should have been discontinued from the eMAR after it was administered. -The expectation was for the SCC to call the pharmacy, and the Pharmacist would take the vaccine entry off the eMAR. Interview with the Administrator on 05/07/26 at 4:00pm revealed: -The expectation was for the MA to ask the SCC to check the eMAR if they saw an entry on the eMAR for a medication that they did not administer, or that had already been administered and needed to be discontinued. -The SCC should contact the pharmacy to correct the eMAR. -The MAs should not be signing the Shingrix vaccine as administered if the vaccine was not administered.	D 367		
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	D 451		

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D 451	Continued From page 59 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 for 1 of 4 residents (#6) who was found lying on the floor and required emergency treatment at the local hospital. The findings are: Review of Resident #6's current FL-2 dated 07/01/25 revealed: -Diagnoses included dementia, leukocytosis, protein calorie malnutrition, hypertension, and chronic obstructive pulmonary disorder (COPD). -She was constantly disoriented. Review of Resident #6's incident report dated 04/03/26 revealed: -Resident #6 had an unwitnessed fall and was found lying on the floor in the hallway at 1:16pm. -She had a small cut on her upper eyebrow and was bleeding. -First aid was administered; a bandage was applied at the facility. -Resident #6 was transported by local emergency medical services (EMS) to the local emergency department (ED). -Dermabond was applied to the cut above the eye and Resident #6 returned from the local ED on 04/03/26 at 7:53pm.	D 451		

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D 451	Continued From page 60 Review of Resident #6's ED discharge report dated 04/03/26 revealed: -Resident #6 was seen at the ED for an unwitnessed fall and a facial laceration. -Resident #6 had Dermabond and Steri-strips applied to the facial laceration. -She was discharged to the facility on 04/03/26 at 7:32pm. Telephone interview with the Adult Home Specialist (AHS) on 05/06/26 at 8:34am revealed: -She received an email on Friday, 04/03/26, from the previous Special Care Unit Coordinator (SCC) related to an incident with Resident #6 and that the incident report would be emailed to her on Monday, 04/06/26. -She never received the incident report related to Resident #6. -She did not know Resident #6 was found on the floor causing a laceration above her eyebrow requiring treatment at the local ED. Interview with the interim SCC on 05/07/26 at 7:46am revealed: -She was not responsible for sending incident reports to the AHS; she thought the House Manager was responsible. -She worked as a medication aide (MA) when the incident on 04/03/26 happened to Resident #6. Interview with the Administrator on 05/07/26 at 11:30am revealed: -She was not aware of Resident #6 being sent to the ED related to a laceration from a fall. -She expected to be notified of all incidents. -The SCC should report incidents that required treatment to the AHS within 72 hours of the incident. -She expected the SCC to notify the AHS with 72 hours of any incident requiring emergency	D 451		

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D 451	Continued From page 61 medical care.	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 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 (RP) for 1 of 11 sampled residents (#6) regarding an	D 454		

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D 454	Continued From page 62 injury resulting from an accident requiring emergency medical evaluation and treatment at a local hospital. The findings are: Review of Resident #6's current FL-2 dated 07/01/25 revealed: -Diagnoses included dementia, leukocytosis, protein calorie malnutrition, hypertension, and chronic obstructive pulmonary disorder (COPD). -She was constantly disoriented. Review of Resident #6's incident report dated 04/03/26 revealed: -Resident #6 had an unwitnessed fall and was found lying on the floor in the hallway at 1:16pm. -She had a small cut on her upper eyebrow and was bleeding. -First aid was administered; a bandage was applied at the facility. -Resident #6 was transported by local emergency medical services (EMS) to the local emergency department (ED). -A message was left with Resident #6's RP on 04/03/26 at 1:21pm. -Dermabond was applied to the cut above the eye and Resident #6 returned from the local ED on 04/03/26 at 7:53pm. Review of Resident #6's ED discharge report dated 04/03/26 revealed: -Resident #6 was seen at the ED for an unwitnessed fall and a facial laceration. -Resident #6 had Dermabond and Steri-strips applied the facial laceration. -She was discharged to the facility on 04/03/26 at 7:32pm. Interview with a medication aide (MA) on	D 454		

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D 454	Continued From page 63	D 454		

05/06/26 at 2:10pm revealed:
-On 04/03/26, Resident #6 was found by a personal care aide (PCA) on the floor in her room.
-Resident #6 fell out of the bed and hit her head on the nightstand.
-Resident #6 was bleeding above her eye.
-She sent Resident #6 out to the hospital.
-She called the RP and left a message.
-Resident #6 came back from the ED with Steri-strips on her cut.

Telephone interview with Resident #6's RP on 05/06/26 at 4:10pm revealed:
-She knew Resident #6 had to be sent out to the hospital on 04/03/26 for a fall.
-The facility called her and left a message about sending the resident to the hospital.
-She did not know if Resident #6 had any injuries from the fall on 04/03/26.
-On 04/07/26, she called the facility and spoke to the Administrator.
-She was told Resident #6 had a computed tomography (CT) scan of her head while at the ED; she was not told about any injuries from the fall on 04/03/26.
-She requested Resident #6's ED discharge information from 04/03/26 be sent to her and the Administrator told her she would email them.
-She never received the ED discharge information from the visit on 04/03/26.
-If Resident #6 had any injuries from any falls she expected the facility to notify her of the injury and what it was even if it was after she was discharged from the ED.

Interview with the interim Special Care Unit Coordinator (SCC) on 05/07/26 at 11:55am revealed:
-The MA or the SCC called the RP when a

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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 64 resident was sent to the hospital or had any injury. -If the RP wanted the facility to call them back after the hospital visit then they would call them; usually the hospital called the RP and told them of any injuries. -The facility would tell the RP what the injury was and that they were going to the hospital, the injury was usually why the resident would be sent to the ED. -She faxed Resident #6's RP the ED discharge paperwork after she returned from the hospital. -She did not have the confirmation sheet because some documents had been displaced when the prior SCC left. Interview with the Administrator on 05/07/26 at 3:30pm revealed: -A resident's RP was supposed to be notified if the resident went to the hospital. -When Resident #6 fell on 04/03/26 the RP should have been called and told she was going out to the hospital and about the laceration on her eye. -She was concerned some communication was not being done by the staff. -About two weeks ago she and other staff went through the incident and accident reports from as far back as March 2026. -They called the residents' RPs to confirm they had been contacted about any incidents and injuries the residents had since March 2026. -They continued to call the RPs until they were able to speak to each one; she thought they had spoken to each RP.	D 454		