Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021009	A. BUILDING: _____ B. WING _____	R 04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON HOUSE	323 MEDICAL ARTS DRIVE EDENTON, NC 27932

(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 an annual survey, follow up survey, and complaint investigation on April 14, 2026 through April 16, 2026, and April 20, 2026. The complaint investigation was initiated by the Chowan County Department of Social Services on April 9, 2026.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#6) in accordance with the residents assessed needs and current care plan required supervision for bathing. The findings are: Review of the facility undated Incident and accident policy revealed: -When an accident or incident occurs staff should call 911. -Check the resident for injuries.	D 270	10A NCAC 13F .0901(b) Personal Care and Supervision- Edenton House will assure supervision of all resident's based on the assessed care plan need and current symptoms. The Regional Clinical Director (RCD), RN conducted an in-service with staff on supervision of resident's to include the resident's individual assessed care plan need on 5/13/26. The State Ombudsman conducted a Resident Rights in-service with staff on 5/13/26. The Care Coordinator (CC) audited all resident's care plans to ensure the care plan need is in accordance with the assessed needs. Facility managers will ensure ongoing supervision and rounding every 2 hours for visible observation of resident's throughout the day by staff. Facility staff will conduct every 2 hour checks to include visible observation of residents during each shift. A key pad lock has been placed on the spa room bath and will remain closed at all times. Only staff can access the spa room and give access to residents to ensure supervision and resident entrance. Facility managers will review any changes of residents in daily stand up and immediately update the care plans. The Executive Director and/or the CC will ensure notification to the RP and PCP.	5/13/26 5/13/26 5/15/26 5/15/26 5/13/26 4/21/26 5/15/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sandy A. Griffin Sr. Administrative Nurse 5/29/2026

Received via email 5/29/26.
Reviewed and acknowledged. H Lentz, RN

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D 270	Continued From page 1. -If severe injury is apparent, do not move resident until emergency medical services (EMS) arrives. -Determine if the resident is breathing. -Administer cardiopulmonary resuscitation (CPR) as appropriate. -Staff must remain with resident until EMS arrives. -Call/notify the residents physician and responsible party. -Complete the report of accident and incident form. Request for the facility's supervision policy on 04/29/26 at 9:30am revealed the facility did not have a supervision policy. Review of Resident #6's current FL-2 dated 02/16/26 revealed: -Diagnoses included acute systolic heart failure, peripheral vascular disease, generalized anxiety disorder, depression, schizoaffective disorder, myocardial infraction involving other coronary artery of interior wall, and ischemic cardiomyopathy. -Ambulation status was semi-ambulatory. -There was no information for orientation. Review of Resident #6's Resident Register revealed an admission date of 07/09/25. Review of Resident #6's care plan dated 03/02/26 revealed: -He needed limited assistance with toileting -He needed extensive assistance with bathing. -He needed extensive assistance with dressing. -He needed limited assistance with grooming. -He needed limited assistance with transferring. -Care plan was signed by Resident Care Coordinator (RCC) and primary care provider (PCP) on 03/02/26.	D 270	The CC will conduct a minimum of 2 chart audits per week to ensure resident care plans are tailored to the assessed need of the residents.	5/15/26

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D 270	Continued From page 2 Review of Resident #6's record revealed documentation of code status on a goldenrod form as do not resuscitate (DNR) effective 05/12/25. Review of Resident #6's licensed health professional support (LHPS) evaluation dated 03/18/26 revealed: -There were no LHPS tasks identified for Resident #6. -Resident was ambulatory with a wheelchair. -Resident #6 transferred independently with no assistance needed. Review of Resident #6's medical assistance independent assessment for personal care services dated 01/14/26 revealed: -Resident #6 required extensive assistance with tub bath or shower. -Resident #6 required extensive assistance with tub/shower transfer/position. -Resident #6 required 1 hand assistance to stand and take steps from wheelchair and shower chair due to weakness, left sided hemiplegia, and unsteadiness. -Resident #6 required extensive assistance to don and removing clothing/socks/shoes. -Resident #6 had severely impaired endurance with bathing, dressing, mobility, and toileting. -Resident #6 was only able to stabilize with human assistance. -The assessment was completed by a Registered Nurse. Telephone interview with the personal care services assessment Program Manager on 04/20/26 at 12:26pm revealed: -The nurse completed Resident #6's personal care assessment on 01/14/26.	D 270		

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D 270	Continued From page 3 -The nurse conducted the assessment through demonstration by Resident #6. -Resident #6 was assessed to require limited assistance which meant the assistance of one person. -Resident #6 was able to mimic washing his upper body and needed help with washing his lower body, back, and legs down to his feet. -Resident #6 needed one hand assistance to stand and take three steps to the shower chair and back to the wheelchair. -Resident #6 was assessed to require limited assistance with transferring, bathing, mobility, and toileting. -Resident #6 was assessed to require extensive assistance with dressing. -Resident assessments were completed yearly unless there was a change of status. -The facility would submit a request for a new assessment if there was a change in the resident's status. Review of Resident #6's incident and accident report dated 04/09/26 revealed: -Staff reported the incident on 04/09/26 at 6:36am. -The location of the incident was in the spa room. -At 6:36am staff reported they found Resident #6 unresponsive with no pulse in the whirlpool tub. -Staff called 911. -Medication Aides (MAs) stayed with the resident until EMS arrived. Review of the local EMS Communications Record dated 04/09/26 revealed: -The call type was cardiac respiratory arrest or death. -The call was made on 04/09/26 at 6:35am. -EMS arrived on the scene at 6:39am.	D 270		

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D 270	Continued From page 4 Review of the local EMS incident report dated 04/09/26 revealed: -EMS was dispatched to the facility on 04/09/26 at 6:36am. -EMS arrived to the facility on 04/09/26 at 6:39am. -Resident #6 was found supine with legs bent at the knees and upper half leaning right in a bathtub full of hot water. -The water was off at the time. -Room temperature was noted to be steamy and hot. -Resident #6 was unresponsive with portions of skin scalded by hot water and sloughing off on his arms, legs, and back. -Resident #6 had a small amount of blood that had come from his nose. -Resident #6 was noted to be in rigor mortis (a term meaning stiffening of the joints and muscles of a body a few hours after death). -Resident was pronounced deceased at 6:43am. Observation of spa bathroom on 04/14/26 at 11:32am revealed: -The spa bathroom tub was located in the right corner of the room. -There were 5 grab bars stationed on the walls around the bath tub. -The emergency call bell system was located on the wall to the left of the bath tub within arm's length. -The call bell cord was tied up in a knot and hanging approximately 6-8 inches from the device. Observation of water temperatures in the spa bathroom on 04/14/26 at 8:40am revealed: -The temperature in the sink was 113.5 degrees Fahrenheit (F). -The temperature in the bathtub after the water	D 270		

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D 270	Continued From page 5 ran for approximately 5 minutes was 113.7 degrees F. Observation of water temperatures in the spa room on 04/16/26 at 9:15am revealed the temperature in the bathtub after the water ran for approximately 10 minutes was 107.1 degrees F. Review of the facility's water temperature inspection reports revealed: -On 03/02/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 03/09/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 03/16/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 03/23/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 03/30/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 04/06/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 04/13/26 the water temperature in 9 resident rooms were documented as 110 degrees. -On 04/13/26 the water temperature in the spa tub was documented as 116 degrees. Telephone interview with Resident #6's family member on 04/14/26 at 3:45pm revealed: -Resident #6 was admitted to the facility because he had major surgery and a pacemaker was placed. -Resident #6 needed assistance with medications and food preparation. -Resident #6 was not able to walk for long distances and needed a wheelchair for mobility. -Resident #6 was not independent enough to bathe himself without staff supervision. -She received a call from the Business Office Manager (BOM) on 04/09/26 at 7:30am and was	D 270		

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D 270	Continued From page 6 told about the incident that occurred with Resident #6. -The BOM told her that the police were opening an investigation into the death of Resident #6. -The Medical Examiner (ME) told her that there were things that were inconsistent with a regular drowning. Interview with a personal care aide (PCA) on 04/15/26 at 8:30am revealed: -She arrived at the facility at 6:00am on 04/09/26. -At 6:30am she heard the MA yelling "he is dead". -She went to the spa room and saw Resident #6 sitting in the tub with about half of his body submerged in water. -The MA touched Resident #6 and said that "he was stiff". -She did not observe staff attempt cardiopulmonary resuscitation on Resident #6. -Resident #6 was independent. -Resident #6 could walk sometimes but usually used a wheelchair to ambulate. -It was normal for Resident #6 to take baths and showers without supervision on the second shift (3:00pm-11:00pm). -The residents in the facility were supposed to be checked on every 2 hours. Telephone interview with a second PCA on 04/15/26 at 9:20am revealed: -He worked as a PCA on third shift on 04/09/26, which started at 11:00pm on 04/08/26 and ended at 7:00am on 04/09/26. -He saw Resident #6 in the hall at 11:00pm when his shift began. -He saw Resident #6 again sometime between 12:30am and 1:00am in the hallway sitting in his wheelchair on his phone. -He did not see Resident #6 after that. -Staff was supposed to check on residents every	D 270		

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D 270	Continued From page 7 2 hours. -He did not check on Resident #6 after 1:00am because he was independent. Telephone interview with a medication aide (MA) on 04/15/26 at 8:55am revealed: -She worked as a MA on third shift on 04/09/26, which started at 11:00pm on 04/08/26 and ended at 7:00am on 04/09/26. -She last observed Resident #6 in the hallway approximately 2:00am. -At 5:45am, she went to the spa to assist a resident with a shower and the door was locked. -A PCA told her that Resident #6 was in the spa room taking a bath. -At 6:30am, she and the PCA went to the spa room and knocked on the door and got no answer. -She unlocked the door and the PCA said she thought Resident #6 was dead. -Another MA went to Resident #6 and checked for a pulse. -They did not attempt to let the water out of the bathtub or do CPR. -Resident #6 was independent with activities of daily living (ADLs). -Resident #6 did not need transfer assistance and was able to shower and bathe independently. -She did not check on Resident #6 throughout the night because he was independent. Telephone interview with a second MA on 04/15/26 at 9:10am revealed: -She worked as a PCA on third shift on 04/09/26, which started at 11:00pm on 04/08/26 and ended at 7:00am on 04/09/26. -The MA came to her at 5:30am and told her she was waiting on Resident #6 to get out of the spa room so she could give another resident a shower.	D 270		

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D 270	Continued From page 8 -At 6:25am, the MA told her that they should check on Resident #6 because he was still in the spa room. -They knocked on the door and did not get an answer. -The MA unlocked the door to check on Resident #6. -When they went into the spa room they thought Resident #6 was asleep. -His head was leaning against the wall, his mouth and nose were not submerged in the water. -She shook him and called his name and he did not respond. -The second MA came into the spa room and checked Resident #6's pulse. -The water in the bathtub was lukewarm. -Resident #6 was independent and did not need assistance with his baths and showers. -She never observed Resident #6 taking baths or showers that early before, he usually took his showers on second shift. Interview with a third MA on 04/15/26 at 9:35am revealed: -She began her shift as a MA at 6:30am on 04/09/26. -A PCA came to her and told her to come check on Resident #6. -When she entered the spa room she observed Resident #6 in the bathtub. -Resident #6's head was leaned against the wall, his head and face were not submerged in water. -She checked his pulse on his neck and wrist and could not find a pulse. -The other MA called 911 and EMS was at the facility within five minutes. -She put her hand under the water to check for a pulse on Resident #6's hand and the water was warm. -She was rubbing his chest in order to attempt to	D 270		

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D 270	Continued From page 9 wake him up because he had a pacemaker. -She did not notice any discoloration on Resident #6. -Resident #6 was very independent. -Resident #6 did not need assistance with baths or showers. -Resident #6 normally took his baths in the afternoon. -Staff were supposed to check on residents every 2 hours. Interview with Resident #6's physical therapist on 04/15/26 at 10:55am revealed: -Resident #6 began physical therapy on 03/17/26. -Resident #6 received physical therapy 3 times each week. -Resident #6 was receiving physical therapy because he had adhesive capsulitis which caused severe stiffness and pain in his left shoulder. -Resident #6 could stand for short periods of time to complete exercises for his shoulder. -Resident #6 propelled himself in his wheelchair. -She observed Resident #6 walking in the hallway with a cane and told him it was not safe for him to walk and he should be in his wheelchair. -She was planning on working on strengthening his legs once his shoulder improved. -She observed Resident #6 transfer from his bed to his wheelchair with no difficulties. -She did not have any concerns with Resident #6 taking a bath independently. -She believed Resident #6 could have reached the call bell near the bathtub if he needed assistance. Telephone interview with emergency medical services paramedic on 04/14/26 at 1:55pm revealed: -He was dispatched to the facility and arrived at	D 270		

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D 270	Continued From page 10 6:36am on 04/09/26. -He entered the facility spa room and observed Resident #6 in the bathtub mostly submerged in water. -The water in the bathtub was not running. -It was warm and steamy in the spa room. -Resident #6's body was slumped and he was leaning towards the wall. -Resident #6's head was leaning towards his right armpit. -Resident #6's body below the water was purple and his body was pale above the water. -He checked Resident #6 for a pulse on his neck and his left wrist and did not find a pulse. -Resident #6's skin was sloughing off on his gloves. -The water in the bathtub was very hot to the touch. -He believed the water was 130-140 degrees. -There were bits and pieces of skin floating in the bath water. -Resident #6's body appeared to be in rigor mortis. -In his experience rigor mortis took 4 to 6 hours to set in after death. Telephone interview with the local police captain on 04/15/26 at 3:00pm revealed: -He arrived at the facility at 7:15am on 04/09/26. -When he arrived there was condensation on the walls and the spa bathroom was steamy. -He called the State Bureau Investigation (SBI) because the position of the wheelchair and Resident #6's skin was peeling was suspicious. -The wheelchair was positioned 5-6 feet away from the bathtub in front of a cabinet. -The EMS personnel said rigor mortis had already set in. Telephone interview with the local medical	D 270		

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D 270	Continued From page 11	D 270		

examiner on 04/14/26 at 1:50pm revealed:
-He could not give any information about Resident #6.
-He had not gotten the results of the autopsy.

Telephone interview with Resident #6's primary care provider (PCP) on 04/14/26 at 2:20pm revealed:
-Resident #6 used a wheelchair to ambulate.
-Resident #6 needed stand-by assistance for bathing.
-Resident #6 could have called out for assistance if he needed it, he was very vocal.
-It could take 2 to 6 hours for rigor mortis to set in after death.
-She expected staff to check on residents every 2-4 hours.

Interview with the facility Maintenance Manager on 04/15/26 at 2:50pm revealed:
-He checked water temperatures every Monday in random bathrooms.
-He had not had any water temperatures out of range.

Interview with the RCC on 04/16/26 at 8:45am revealed:
-Resident #6's level of care was extensive when he first arrived at the facility.
-Within the past couple of months Resident #6 was getting stronger and was able to walk with a cane occasionally.
-Resident #6 completed all activities of daily living including bathing and grooming independently.
-She completed the care plan for Resident #6 and a nurse did the ADL assignments.
-If a resident did not need assistance, staff did not follow the care plan.
-New staff members got to know the needs of the residents before they were able to work alone on

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D 270	Continued From page 12 the floor. -She did not expect staff to assist Resident #6 with his bathing because he was independent. -Staff was expected to walk through the facility every 30 minutes and observe each resident. -Staff was supposed to check on residents every 2 hours. -Staff did not check on Resident #6 every 2 hours like they should have. -Resident #6 usually took his baths on the second shift. -Staff should have realized that Resident #6 was not doing his normal routine and checked on him. -Staff failed to provide proper supervision to Resident #6 the morning of 04/09/26. Interview with the Administrator on 04/16/26 at 9:20am revealed: -Resident #6 was very independent and very vocal about his needs and wants. -The RCC and the PCP completed the care plans for the residents in the facility. -Resident #6 was in a wheelchair because walking caused him pain. -Resident #6 could stand up from his wheelchair and take some steps. -The care plan was not accurate to the level of care and supervision Resident #6 needed. -He expected staff to do rounds and observe each resident at least every 2 hours. -Staff members did not supervise Resident #6 the morning of 04/09/26. -Staff was probably busy assisting other residents, doing laundry, and paperwork. Attempted telephone interview with Licensed Healthcare Professional Support nurse on 04/16/26 at 12:05pm was unsuccessful. The facility failed to ensure supervision was	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021009	A. BUILDING: _____ B. WING _____	R 04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON HOUSE	323 MEDICAL ARTS DRIVE EDENTON, NC 27932

(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 270	Continued From page 13 provided for a resident (#6) who was semi-ambulatory, utilized a wheelchair for mobility, and was receiving physical therapy for strengthening. Resident #6 was last seen by facility staff at 2:00am on 04/09/26 and was discovered at 6:30am in the facility spa room in a bathtub full of water over 4 hours later. When emergency medical services (EMS) arrived to the facility Resident #6's body was partially submerged in water, with skin sloughing off his arms back, and legs and was in rigor mortis which occurs several hours after death. This failure resulted in neglect of the resident, which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/26. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 20, 2026.	D 270	Type text here	Type text here
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents.	D 317	10A NCAC 13F .0905(d) Activities Program- Edenton House will assure that residents have activities and/or programming available 14 hours a week to include variety. The Executive Director has hired an Activities Director for the community and will ensusre that resident activities are planned monthly and implementation daily. The Executive Director will ensure the Activities Calendar is posted on the first day of each month and that resident's have availability of the activities calendar to know daily activities planned and times. The Executive Director will ensure a Resident Council meeting is held every month so that resident's can express concerns and identify needs. The Executive Director will follow up on any concerns identified and ensure corrections.	4/21/26 5/01/26 5/01/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021009	A. BUILDING: _____ B. WING _____	R 04/20/2026

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D 317	Continued From page 14 The findings are: Observation of the facility on 04/14/26 from 8:30am to 4:00pm revealed there was no April 2026 activities calendar posted in the common areas or in residents' rooms. Observation of the facility on 04/14/26 at 1:52pm revealed there were residents in the activity room playing bingo. Observation of the facility on 04/15/26 at 9:11am revealed there were residents in the activity room tossing a ball. Observation of the facility on 04/15/26 at 10:08am revealed there were residents in the activity room playing bingo. Observation of the facility on 04/15/26 at 11:45am revealed there was an April 2026 activities calendar posted on the wall across from the activity room. Interview with a resident on 04/14/26 at 9:17am revealed there needed to be more activities offered in the facility. Interview with a second resident on 04/14/26 at 9:30am revealed: -There were no activities offered in the facility because there was not an Activities Director (AD). -There used to be activities offered in the facility, but they stopped. -It would be nice to have activities again. Interview with a third resident on 04/14/26 at 9:46am revealed: -Everything is not well in the facility because there were no activities; "we sit in our rooms to dry up	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 317	Continued From page 15 and die." -The Administrator stopped activities. Second interview with the second resident on 04/14/26 at 3:16pm revealed the residents played bingo today but the Administrator could be more efficient with finding other activities. Interview with an anonymous staff person on 04/15/26 at 11:56am revealed there were no daily activities offered but activities were offered on 04/14/26 and 04/15/26 due to state surveyors being in the facility. Interview with the Administrator on 04/15/26 at 3:31pm revealed: -There was not an AD for the facility. -There were activities offered on 04/15/26 to assist the staff with obtaining hours. -He posted the activities calendar on 04/14/26 because it needed to be posted. -The last time activities were offered in the facility were 2 days last week. -Activities were not consistently offered.	D 317		

Forte, Hope

From: Edenton House, ED - Randy Griffin <director@edentonseniors.com>
Sent: Friday, May 29, 2026 3:06 PM
To: Forte, Hope
Cc: Deanna Lanier; Nina Warwick-Joyner; Laurie Harp
Subject: [External] Plan of Correction
Attachments: Edenton House POC 04202026.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Report suspicious emails with the Report Message button located on your Outlook menu bar on the Home tab.

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Good afternoon,

Here is the plan of corrections for Edenton House May 2026.

Thank you,

Randy Griffin Sr.

Randy N. Griffin |Executive Director|Edenton House| E: director@edentonseniors.com | P: (252) 482-1113 | F: (252) 482-3273; C: (919) 931-8189

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