STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035035	A. BUILDING: _____ B. WING _____	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE FAMILY CARE HOME III AT MASON ST	108 EAST MASON ST FRANKLINTON, NC 27525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/09/26.	C 000		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 2 exit doors had a continuously audible alarm when the doors were opened, which were accessible to two residents known to be disoriented (#1, #2). The findings are: Review of the facility's current license effective	C 069		

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C 069	Continued From page 1 01/01/26 revealed the facility was licensed for 6 non-ambulatory residents. Observation of the entrance/exit door to the facility on 06/09/26 at various times between 8:05am and 4:00pm revealed: -When the front door opened, there was a chime and an announcement, "front door". -When the back door opened, there was a chime and an announcement,"back door" . -There was no continuous alarm heard when the doors were opened. 1. Review of Resident #1's current FL2 dated 03/30/26 revealed: -Diagnoses included severe early-onset Alzheimer's dementia with agitation. -She was constantly disoriented. -She was semi-ambulatory. Review of Resident #1's Resident Register dated 04/08/26 revealed she had significant memory loss and had to be redirected. Review of Resident #1's care plan dated 04/09/26 revealed: -She was always disoriented. -She had significant memory loss and had to be redirected. Observation of Resident #1 on 06/09/26 at various times between 8:05am and 4:00pm revealed she ambulated with a cane and transferred independently. Interview with Resident #1 on 06/09/26 at 3:22pm revealed: -She went outside every day as long as the weather was good. -She could go outside without staff if she told the	C 069		

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C 069	Continued From page 2	C 069		

staff she was going to the porch.
-She could not leave the porch when she went outside, because staff needed to be able to look out the door and see her.
-She liked the facility staff, but she wanted to go home.

Telephone interview with Resident #1's guardian on 06/09/26 at 1:38pm revealed:
-Resident #1 had good days and bad days as far as her memory.
-Having a poor memory was why Resident #1 had been placed at the facility.
-Resident #1 wandered away from her home in the fall of 2025.
-Resident #1 always needed supervision.

Telephone interview with Resident #1's mental health provider on 06/09/26 at 1:46pm revealed:
-Resident #1 was not exit-seeking per the staff at the facility.
-Resident #1 should not be allowed to exit the facility without supervision because the resident was so intent on going home.
-Every conversation she had with Resident #1, the resident was talking about going home.
-She would worry that Resident #1 was an elopement risk.

Interview with a personal care aide (PCA) on 06/09/26 at 2:59pm revealed that Resident #1 was not confused, but was forgetful.

Interview with the Supervisor-in-Charge (SIC) on 06/09/26 at 11:32am revealed:
-Resident #1 was ambulatory and transferred independently.
-Resident #1 would get "mixed up" and confused.
-She usually just sat and watched television during the day.

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C 069	Continued From page 3 -Resident #1 did need supervision. -Resident #1 had not attempted to leave the facility. -Resident #1 had said she wanted to go home. Telephone interview with the Owner on 06/09/26 at 2:01pm revealed: -Resident #1 was not a wanderer. -Staff walked with Resident #1 outside the facility daily. Refer to the interview with a PCA on 06/09/26 at 2:59pm. Refer to the interview with the SIC on 06/09/26 at 11:32am. Refer to the interview with the Owner on 06/09/26 at 2:01pm. Refer to the telephone interview with the Administrator on 06/09/26 at 3:36pm. 2. Review of Resident #2's current FL2 dated 12/11/25 revealed: -Diagnosis included Alzheimer's dementia. -She was intermittently disoriented. -She was ambulatory. Review of Resident #2's Resident Register dated 10/28/25 revealed she had significant memory loss and had to be redirected. Review of Resident #2's care plan dated 10/30/25 revealed: -She had wandering behavior. -She was always disoriented. -She had significant memory loss and had to be redirected. -She required limited assistance from staff with	C 069		

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C 069	Continued From page 4 ambulation and transferring. Observation of Resident #2 on 06/09/26 at various times between 8:05am and 4:00pm revealed staff assisted her to stand, and she ambulated with staff holding her arm. Telephone interview with Resident #2's mental health provider on 06/09/26 at 1:46pm revealed: -Resident #2 needed supervision because she had wandered at times. -Resident #2's memory was severely impaired. -Resident #2 was not exit-seeking, but if the staff were not so attentive to her, she would need to be in a special care unit. -Resident #2 was not as mobile as she once was. -Resident #2 could not take more than 2-3 steps without staff assistance. Interview with a personal care aide (PCA) on 06/09/26 at 2:59pm revealed that Resident #2 was confused. Interview with the Supervisor-in-Charge (SIC) on 06/09/26 at 11:32am revealed: -Resident #2 had dementia, "really bad". -Resident #2 needed supervision from staff. -Resident #2 was ambulatory, but staff walked with her because she was a fall risk. -Resident #2 did not try to get out of the chair without assistance. -Resident #2 had a bed alarm on her bed so staff would know if she was attempting to get out of the bed. -Resident #2 had not attempted to leave the facility. -Resident #2 had said she wanted to go home. Telephone interview with the Owner on 06/09/26 at 2:01pm revealed Resident #2 had declined	C 069		

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C 069	Continued From page 5 since admission to the facility, and staff supervision was needed outside the facility to prevent falls. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. Attempted telephone interview with Resident #2's family member on 06/09/26 at 2:36pm was unsuccessful. Refer to the interview with a PCA on 06/09/26 at 2:59pm. Refer to the interview with the SIC on 06/09/26 at 11:32am. Refer to the interview with the Owner on 06/09/26 at 2:01pm. Refer to the telephone interview with the Administrator on 06/09/26 at 3:36pm. _____ Interview with a PCA on 06/09/26 at 2:59pm revealed: -If she heard a door alarm, she went to the door to make sure no residents had left the facility. -None of the residents had left the facility without staff assistance. -All of the residents were confused, but no one had tried to leave; the staff always kept an eye on the residents, too. Interview with the SIC on 06/09/26 at 11:32am revealed: -When the door was opened, a loud alarm was heard, and staff checked to see if someone was leaving the facility. -The door that was opened would be announced	C 069		

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C 069	Continued From page 6 to know which door was opened. -None of the residents had ever even opened an exit door. Telephone interview with the Owner on 06/09/26 at 2:01pm revealed: -Door alarms were installed because the construction division of the Department of Health Service Regulation had instructed him to install door alarms to signal when someone was entering or exiting the facility. -There were residents with dementia residing at the facility, but he had two staff members in the facility to monitor the residents in addition to the door alarms. -The facility did not have any residents who wandered. -The door alarms alerted staff to the door that was opened, and staff would know if someone had gone outside. Telephone interview with the Administrator on 06/09/26 at 3:36pm revealed: -The facility had door alarms that alerted staff when the door was opened and which door was opened. -The staff would respond to the open door to ensure no residents had walked out of the facility. -She did not know the door alarms had to be continuous until the staff turned the alarm off. _____ The facility failed to ensure the alarms on the exit doors to the facility had a continuous audible sounding device to alert staff when a door was opened and continued sounding until staff responded, checked the exit door, and verified the whereabouts of the residents to ensure no resident had exited the facility without supervision. There were 2 of 3 sampled residents who needed supervision due to cognitive	C 069		

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C 069	Continued From page 7 impairments, including Resident #1, who was ambulatory and constantly disoriented, and Resident #2, who was intermittently disoriented and had exhibited wandering behaviors. This failure placed the residents at risk of elopement and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/09/26. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2026.	C 069		