STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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 June 16 - June 17, 2026.	C 000		
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the	C 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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 415	Continued From page 1	C 415		

resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.
When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to maintain records that were readily available for review for 3 of 3 sampled residents (Resident #1, # 2, #3).

The findings are:

Review of the facility's license dated 01/01/26 revealed:
-The facility was licensed for a capacity of 6.
-The facility was licensed as a Family Care Home.

Review of the facility's census report on 06/16/26 revealed there were 4 residents living in the facility.

Records for Resident #2 and Resident #3 were requested on 06/16/26 at 10:00am, 11:30am, and 2:00pm.

Review of resident records on 06/16/26 at 10:45am revealed:
-The facility provided resident records for Resident #1.
-There were no records provided for Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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 415	Continued From page 2 or Resident #3. Interview with the Supervisor-In-Charge (SIC) on 06/17/26 at 10:00am revealed she called the Administrator and requested Resident #1, Resident #2, and Resident #3's records for review at 9:00am. Interview with the SIC on 06/17/26 at 2:00pm revealed she called the Administrator and requested Resident #2 and Resident #3's records for review at 1:00pm. Interview with the Administrator on 06/16/26 at 2:50pm revealed: -The residents' records were not on site because she had difficulty getting work completed in the records when she was at the facility. -She kept residents records at her house in a locked office. -Resident #2 and Resident #3's records had to be thinned before she brought them to the facility. -When a resident goes out of the facility for an emergency the medication aide (MA) used the transfer form in their system to send with the resident. -The transfer form consisted of a picture of the resident, current physician orders, and diagnoses.	C 415		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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 444	Continued From page 3 accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of accidents or incidents (A/I) for 1 of 3 sampled residents requiring emergency evaluation (#2). The findings are: Review of Resident #2's current FL-2 dated 04/27/26 revealed diagnoses included dementia, cerebrovascular accident, nonrheumatic aortic valve stenosis, heart failure with preserved ejection fraction, hypothyroid, and chronic respiratory failure with hypoxia and hypercapnia. Review of Resident #2's Resident Register revealed the resident's admission date was 10/04/24. Review of Resident #2's accident or incident (A/I) report dated 03/18/26 revealed: -A staff member was transferring Resident #2 to the toilet and as she turned her leg went out and she fell. -She sustained injuries to the right ankle. -The resident was sent to the emergency department (ED) for further evaluation on 03/18/26. -Resident #2's responsible party was notified. -There was no documentation of an A/I report sent to the county DSS.	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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 444	Continued From page 4 Review of Resident #2's hospital after visit summary (AVS) record dated 03/18/26 revealed: -The reason for the visit was an open fracture of right ankle. -Resident #2's testing consisted of an x-ray of right ankle, chest, right tibia fibula, and right knee, computed axial tomography (CAT) scan of the extremity lower right without intravenous (IV) contrast, and an electrocardiogram (ECG). -Resident #2 had surgery on her right ankle on 03/24/26. -She was discharged back to the facility on 03/30/26. Interview with county Department of Social Services (DSS) Adult Home Specialist (AHS) on 06/17/26 at 12:45pm revealed: -She did not receive an Accident/Incident (A/I) report in March 2026 regarding Resident #2's fall on 03/18/26 requiring emergency evaluation. -The facility should fax or electronic mail (email) her A/I report within 24 hours. Interview with the Administrator on 06/17/26 at 12:30pm revealed: -She was aware Resident #2 fell in the bathroom on 03/18/26. -She was aware to notify the county DSS regarding any resident who needed medical attention other than first aid. -She sent A/I reports to the county DSS after she received the paperwork from the ED or hospital because DSS would ask for the discharge summary. -A staff member informed her that she would send the A/I report to DSS, but she did not know if that happened. -She was responsible to notify the county DSS of A/I reports.	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092216	A. BUILDING: _____ B. WING _____	R 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RETREAT AT CARY	309 TWEED CIRCLE CARY, NC 27511

(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