PRINTED: 06/22/2026
FORM APPROVED

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
	FCL001173	A. BUILDING: _____ B. WING _____	R 06/03/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey with an exit date of 06/03/26.	{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: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to 3 of 3 sampled residents (#1, #2, and #3) who were intermittently disoriented, had working continuous audible alarms.	{C 069}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Loretta R. Wilson — TITLE: Administrator — (X6) DATE: 7-9-26

Reviewed and Acknowledged 07/09/26 JT

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{C 069}	Continued From page 1	{C 069}		

The findings are:

Observation of the front door of the facility on 06/03/26 at 8:04am revealed:
-The screened door and the wood door were closed.
-The Administrator opened the doors for the surveyor to enter the facility.
-An audible alarm sounded when the screened door was opened.
-The audible alarm stopped when the screened door was closed; the alarm was not silenced by the Administrator.
-There was a two-piece alarm in place; one piece was on the screened door, and the other piece was on the door frame.
-There was a resident in the living room which was adjacent to the front door.

Review of the instructions for the two-piece audible alarm system revealed:
-Peel and stick the product to the door with double-sided tape.
-The magnetic sensor should be positioned on the right side, and the arrows should be parallel between the product and the sensor.
-Slide the switch on to arm the device.
-When the protected entryway was opened while the alarm was armed, a loud alarm would immediately and continuously sound.

1. Review of Resident #1's current FL-2 dated 02/17/26 revealed:
-Diagnoses included learning disability, generalized anxiety disorder, and major depressive disorder.
-He was intermittently disoriented.
-He was ambulatory.

on 6/3/2026
During my State
Survey ~~and~~ I still
Was Cited for my
Type B Violation

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{C 069}	Continued From page 2 Review of Resident #1's care plan dated 03/15/26 revealed: -He was independent with ambulation and transfers. -He was oriented. -He was forgetful and needed reminders. Observation of the dining room on 06/03/26 at 8:16am revealed: -There were three residents eating breakfast at the dining room table. -The Administrator was administering medications to the residents at the dining room table. -Resident #1, who was in the living room, hollered to the Administrator who was in the dining room that he was leaving for the day. -The Administrator responded, OK. -The resident exited the front door, an audible alarm sounded when the resident opened the screened door and the audible alarm stopped when the resident closed the screened door upon exiting the facility. Interview with the Administrator at 11:01am revealed: -She knew Resident #1 left the facility; she heard the audible door alarm. -Resident #1 hollered to her when she was in the dining room, that he was leaving. -The audible alarm sounded when Resident #1 opened the front door and the audible alarm stopped when Resident #1 closed the front door. -She did not silence the audible alarm. -Resident #1 left most mornings at the same time to go to work. -Resident #1 owned a car and drove himself to work. -On Sundays, Resident #1 drove himself to church.	{C 069}	30 immediately for there safety as well as Verification for me and my staff We asked all of the residents to Please make all staff aware of them going outside front or back, but I still have my Chime alarm on my doors and my Ring camera up and running just in case they forget to notify the staff about there Where abouts.	4/3/26

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{C 069}	Continued From page 3 Attempted interview with Resident #1 on 06/03/26 at 10:30am was unsuccessful. Attempted telephone interview with Resident 1's Primary Care Provider (PCP) on 06/03/26 at 10:15am was unsuccessful. Refer to the interview with the Administrator at 11:01am. 2. Review of Resident #2's current FL-2 dated 06/10/25 revealed: -There was a diagnosis of mild mental retardation. -He was intermittently disoriented. -He was ambulatory. Review of Resident #2's care plan dated 06/10/25 revealed: -He was independent with ambulation and transfers. -He was disoriented at times. -He was forgetful and needed reminders. Observation of the back door of the facility on 06/03/26 at 8:21am revealed: -The back door was adjacent to the dining room. -The wood door was opened, and the screened door was closed. -There was a two-piece alarm in place; one piece was on the screened door, and the other piece was on the door frame. -Resident #2, who was sitting at the dining room table, exited out of the back door. -An audible alarm sounded when Resident #2 opened the screened door and exited the facility. -The audible alarm stopped when the screened door was closed. -Resident #2 re-entered the facility a few minutes	{C 069}	I the Administrator 7/7/26 also on 7/7/26 submitted a request for an IDR and they did notify me that they received my request and they will be getting back to me.	

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{C 069}	Continued From page 4	{C 069}		

later, and again the audible alarm sounded when the screened door was opened and stopped when the screened door was closed.
-The audible alarm was silenced by the closing of the screened door; the audible alarm was not silenced by the Administrator.

Interview with Resident #2 on 06/03/26 at 9:30am revealed:
-The door alarms sounded every time someone opened the doors.
-He thought the alarms stopped when the door was closed.
-He went out of the back door this morning after breakfast and the alarm sounded.
-He thought the alarm would stop when he closed the door, but he was not sure.
-The Administrator knew he went out the back door; he took the trash out.

Interview with the Administrator at 11:01am revealed:
-She knew Resident #2 went out the back door; she was in the kitchen, next to the dining room when Resident #2 went out.
-There was an audible alarm that sounded when the door was opened and the alarm stopped when the door was closed.
-She did not silence the audible alarm.

Attempted telephone interview with Resident 2's Primary Care Provider (PCP) on 06/03/26 at 10:15am was unsuccessful.

Refer to the interview with the Administrator at 11:01am.

3. Review of Resident #3's current FL-2 dated 11/21/25 revealed:
-Diagnoses included dementia with behavioral

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problems, schizophrenia disorder, and bipolar disorder.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #3's care plan dated 11/21/25 revealed:
-He was ambulatory.
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Observation of the front door of the facility on 06/03/26 at 9:50am revealed:
-The was an audible alarm sounding at the front door.
-The Administrator called Resident #3 by his name and asked if he was going outside to sit on the porch and Resident #3 responded yes.
-The audible alarm stopped once the screened door was closed; the Administrator did not silence the audible alarm.

Interview with Resident #3 on 06/03/26 at 10:05am revealed:
-He went outside to sit on the porch most days.
-He did not tell the Administrator when he went outside.
-The alarm sounded when he opened the door.
-The Administrator knew he was going outside; he went outside every day to sit on the porch.

Interview with the Administrator at 11:01am revealed:
-She was in the dining room when Resident #3 went outside.
-She heard the audible alarm sounding when the door was opened.
-She could see down the hallway from the dining room to the front door and saw Resident #3 go outside.

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{C 069}	Continued From page 6 -Resident #3 went outside most days to sit on the front porch. -She did not silence the audible door alarm; it was silenced when the door was closed. Attempted telephone interview with Resident 3's Primary Care Provider (PCP) on 06/03/26 at 10:15am was unsuccessful. Refer to the interview with the Administrator at 11:01am. Interview with the Administrator at 11:01am revealed: -She ordered the audible sounding alarms. -She placed the alarms on the front and back doors of the facility. -The instructions read, the alarm would continuously sound when the alarm was armed. -She thought she was in compliance of the regulation for door alarms since their was an audible sound when the door was opened. The facility failed to ensure the exit doors had continuous sounding devices activated when the doors were opened, and the sounding device continued until the device was silenced by staff, ensuring all residents were safe and accounted for, which resulted in 3 residents who were intermittently disoriented being at risk for leaving the facility without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/03/2026.	{C 069}		