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 07/01/2026

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 a follow up survey on June 30, 2026 through July 1, 2026.	{D 000}	In response to the cited deficiences 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 Correction is prepared solely as a matter of compliance with State Law.	
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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents be treated with respect, consideration, and dignity for 1 of 5 sampled residents (#2) who required extensive staff assistance with personal care. The findings are: Review of Resident #2's current FL-2 dated 01/05/26 revealed diagnoses included dementia, arthritis, and hypertension. Review of Resident #2's Resident Register revealed an admission date of 11/28/12. Review of Resident #2's care plan dated 04/24/26 revealed: -Resident #2 needed extensive assistance with toileting. -Resident #2 needed extensive assistance with bathing. -Resident #2 needed extensive assistance with grooming and personal hygiene. Observation of Resident #2 on 06/30/26 from	D 338	10A NCAC 13F .0909 Resident Rights Residents have a right to be treated with respect, consideration, dignity and full recognition of their individuality. This right is guaranteed by federal and state laws as well as the constitution of the United States of America. To treat an individual disrespectfully is a violation of Residents' Rights and is some cases may be considered abuse, including verbal, psychological, emotional and mental. The Regional Nurse conducted an in-service with staff on supervision of resident's to include the resident's individual assessed care plan need as of 7/2/26. The State Ombudsman has conducted a Resident Rights Inservice with all staff on 8/3/2026 The Care Coordinator audited all resident's care plans to ensure the care plans 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 hours checks to include visible observation of residents during each shift and ensure that the personal care needs are met. 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. Facility care manager will be responsible for random reviews of skin assessments to ensure appropriate care and follow up. Facility PCA and MA staff are responsible for providing personal care to all residents while providing personal care related to toileting, bathing grooming and personal hygiene.	7/2/2026 8/3/2026 7/2/2026 7/2/2026 7/2/2026 7/2/2026 7/2/2026

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

8/7/2026

Jamaal Willis Reviewed and Acknowledged 08/17/26

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D 338	Continued From page 2	D 338		

-She had witnessed Resident #2 rubbing feces into her hair.
-She had observed Resident #2 with plastic cups filled with urine.
-Resident #2 had thrown the urine on staff members who tried to take the cup from her.
-Resident #2 would hide cups of urine throughout her bedroom, in her dresser drawers, in her closet, and under her bed.
-All staff and management were aware of Resident #2's behaviors.
-Resident #2 had been having these behaviors come and go for at least a year.

Interview with a second PCA on 06/30/26 at 2:45pm revealed:
-For at least three and a half years Resident #2 had been rubbing feces in her hair and urinating in plastic cups.
-All of the staff members and management were aware of Resident #2's behaviors.
-Management informed staff members when they saw Resident #2 rubbing feces in her hair or smelled feces on her they should have cleaned her up immediately.
-Staff members removed plastic cups from Resident #2's bedroom when they found them.
-Resident #2 had been observed walking through the facility holding a plastic cup with urine.
-The facility did not have enough staff members to properly care for Resident #2.
-Resident #2 probably needed a higher level of care.

Interview with the Resident Care Coordinator (RCC) on 07/01/26 at 9:05am revealed:
-Resident #2 used to mix snuff and spit in her hand and rub it in her hair.
-She believed that Resident #2 began to rub feces in her hair because she no longer had the

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D 338	Continued From page 3 snuff available. -Resident #2 began rubbing feces in her hair in 2026. -Housekeeping went into Resident #2's bedroom daily to check for plastic cups filled with coffee and feces. -Staff members were informed to increase checks on Resident #2 and to check on her when she was in her bathroom to ensure she flushed her toilet immediately after use. -Staff tried to keep Resident #2 out of her bedroom and in the front of the facility near staff offices so they could observe her more often. -The Administrator had been attempting to get Resident #2 placed in a memory care facility so she could have more supervision. Interview with the Administrator on 07/01/26 at 11:45am revealed: -Resident #2 had been urinating in plastic cups and rubbing feces in her hair all of 2026. -He had informed staff at the Department of Social Services about Resident #2's behaviors in order to get her moved to a memory care facility. -Staff members attempted to keep Resident #2 busy and active in order to stop her from being left alone to urinate in cups and rub feces in her hair. -Staff members were told to call for assistance when Resident #2 was having these behaviors because it usually took two staff members to shower Resident #2. -Staff were told to shower Resident #2 immediately once they noticed she had rubbed feces in her hair. -He should have called staff members immediately to provide personal care when he was made aware that Resident #2 had rubbed feces in her hair the previous day. -Resident #2 needed a higher level of care.	D 338		

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D 338	Continued From page 4 Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/01/26 at 9:45am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	D 338		