STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 08/19/2026

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 08/18/26 - 08/19/26.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new	D 254		

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D 254	Continued From page 1	D 254		

onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) when a resident has been enrolled in hospice;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
(I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident.
(2) Significant change does not include the following:
(A) changes that resolve with or without intervention;
(B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;

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D 254	Continued From page 2 (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a significant change care plan was completed for 1 or 1 resident who was admitted to hospice (#2). The findings are: Review of Resident #2's current FL2 dated 07/29/26 revealed: -Diagnoses included dementia, atrial fibrillation and anemia. -She required total assistance from staff with bathing, feeding, and dressing. -She was ambulatory. Review of Resident #2's care plan dated 03/16/26 revealed: -She was independent with ambulation and transferring. -She required supervision from staff when eating. -She required extensive assistance from staff for bathing, toileting, dressing, and grooming Review of Resident #2's record revealed:	D 254		

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D 254	Continued From page 3 -Resident #2 was admitted to hospice services on 07/10/26. -There was no significant change care plan completed after Resident #2 was admitted to hospice. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:13pm revealed: -She knew she needed to complete a significant change care plan when Resident #2 was admitted to hospice. -She had not completed Resident #2's significant change care plan because she thought she had 30 days to complete it. Interview with the Administrator on 08/19/26 at 3:43pm revealed: -She was responsible for completing Resident #2's significant change care plan. -She thought she completed the significant change care plan for Resident #2.	D 254		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#2) who required extensive assistance with showering and was on	D 269		

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hospice.

The findings are:

Review of Resident #2's current FL2 dated 07/29/26 revealed:
-Diagnoses included dementia, atrial fibrillation and anemia.
-She required total assistance from staff with bathing, feeding, and dressing.
-She was ambulatory.

Review of Resident #2's care plan dated 03/16/26 revealed:
-She was always disoriented.
-She required extensive assistance from staff for bathing 7 days a week.

Observation of Resident #2 on 08/18/26 at 8:42am revealed her hair appeared greasy.

Review of Resident #2's skin observation sheet dated 08/10/26 revealed:
-There was no skin information checked off as observed.
-There was a comment box with hospice written inside the box.
-There was an area for the Resident Care Coordinator (RCC) and the personal care aide (PCA) to sign.
-The skin observation sheet was not signed by the RCC or PCA.
-There were no other skin observation sheets available for review.

Review of the facility's shower sheet revealed:
-Resident #2 was to get a shower on Monday, Wednesday and Friday on second shift.
-Skin assessments were to be completed on the resident's shower days.

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D 269	Continued From page 5 Interview with a PCA on 08/18/26 at 10:23am revealed: -She did not complete Resident #2's shower because she was on hospice. -She thought if a resident was on hospice, then hospice completed the showers. Interview with a second PCA on 08/18/26 at 3:46pm revealed: -She did not complete Resident #2's showers because she was on hospice. -She was unsure how often hospice came to assist Resident #2 with a shower. -The PCAs were supposed to fill out a skin observation sheet after each shower. Interview with Resident #2's hospice certified nursing assistant (CNA) on 08/18/26 at 5:07pm revealed: -She was scheduled to assist Resident #2 with a shower once weekly. -She expected the staff to assist Resident #2 with showers on the days she was not there. Interview with a third PCA on 08/19/26 at 8:36am revealed: -Hospice completed Resident #2's showers. -He was not sure how often hospice came. -He did not assist Resident #2 with showers. Interview with the RCC on 08/19/26 at 3:13pm revealed: -She thought Resident #2 was getting showers from the hospice CNA 3 times weekly. -She was responsible for reviewing the skin observation sheets but was behind on her review. -The staff were expected to fill out the skin observation sheets after each completed shower. -She expected the staff to assist Resident #2 with	D 269		

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D 269	Continued From page 6 showers on the days hospice was not scheduled. Interview with the Administrator on 08/19/26 at 3:43pm revealed: -The staff were expected to fill out the skin observation form after each completed shower. -She had educated the staff several times and she expected them to assist the residents with showers even though they were on hospice. -She expected the staff to assist Resident #2 with showers on the days hospice was not scheduled and to fill out a skin observation sheet after each shower.	D 269		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record observations, record reviews, and interviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) related to a medication used to treat	D 344		

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hypertension, a medication used to treat insomnia, and a medication used to treat dementia related behaviors when they were not signed or returned by the provider.

The findings are:

Review of Resident #3's current FL2 dated 07/15/26 revealed diagnoses included dementia, hypertension, major depressive disorder, and anxiety disorder.

a. Review of Resident #3's current FL2 dated 07/15/26 revealed there was no order for losartan 50mg (used to treat high blood pressure).

Review of Resident #3's July 2026 electronic medication administration record (eMAR) from 07/15/26-07/31/26 revealed:
-There was an entry for losartan 50mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation losartan was administered daily.

Review of Resident #3's August eMAR from 08/01/26-08/18/26 revealed:
-There was an entry for losartan 50mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation losartan was administered daily.

Refer to telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/19/26 at 11:20am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:13pm.

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Refer to the interview with the Administrator on 08/19/26 at 3:43pm.

b. Review of Resident #3's current FL2 dated 07/15/26 revealed there was no order for trazodone (used to treat difficulty sleeping) 50mg nightly.

Review of Resident #3's July 2026 eMAR from 07/15/26-07/31/26 revealed:
-There was an entry for trazodone 50mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm.
-There was documentation trazodone was administered nightly.

Review of Resident #3's August eMAR from 08/01/26-08/18/26 revealed:
-There was an entry for trazodone 50mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm.
-There was documentation trazodone was administered nightly.

Refer to telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/19/26 at 11:20am.

Refer to the interview with the RCC on 08/19/26 at 3:13pm.

Refer to the interview with the Administrator on 08/19/26 at 3:43pm.

c. Review of Resident #3's current FL2 dated 07/15/26 revealed there was no order for quetiapine (used to treat dementia related behaviors) 200mg at bedtime.

Review of Resident #3's July 2026 eMAR from

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D 344	Continued From page 9 07/15/26-07/31/26 revealed: -There was an entry for quetiapine 200mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation quetiapine 200mg was administered nightly. Review of Resident #3's August eMAR from 08/01/26-08/18/26 revealed: -There was an entry for quetiapine 200mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation quetiapine 200mg was administered nightly. Refer to telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/19/26 at 11:20am. Refer to the interview with the RCC on 08/19/26 at 3:13pm. Refer to the interview with the Administrator on 08/19/26 at 3:43pm. d. Review of Resident #3's current FL2 dated 07/15/26 revealed there was no order for quetiapine (used to treat dementia related behaviors) 25mg daily. Review of Resident #3's July 2026 eMAR from 07/15/26-07/31/26 revealed: -There was an entry for quetiapine 25mg take 1 tablet at daily with a scheduled administration time of 8:00am. -There was documentation quetiapine 25mg was administered daily. Review of Resident #3's August eMAR from 08/01/26-08/18/26 revealed: There was an entry for quetiapine 25mg take 1	D 344		

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D 344	Continued From page 10 tablet at daily with a scheduled administration time of 8:00am. -There was documentation quetiapine 25mg was administered daily. Refer to telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/19/26 at 11:20am. Refer to the interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:13pm. Refer to the interview with the Administrator on 08/19/26 at 3:43pm. _____ Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/19/26 at 11:20am revealed: -They had not received Resident #2's FL2 dated 07/15/26. -If they had, they would have called the facility to clarify the orders that were missing from the FL2. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:13pm revealed: -There was a 2nd page that included Resident #2's missing orders. -She did not notice the 2nd page of the FL2 was not signed or returned by the Primary Care Provider (PCP). -She should have clarified with the PCP why the 2nd page was not signed and returned. Interview with the Administrator on 08/19/26 at 3:43pm revealed: -The RCC was responsible for reviewing the FL2 for accuracy and PCP signature. -She expected the FL2 to be reviewed and ensured the PCP signed both copies of the FL2.	D 344		

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D 344	Continued From page 11 Attempted telephone interview with Resident #3's PCP on 08/19/26 at 9:18am was unsuccessful.	D 344		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled resident (#1 and #2). The findings are: 1. Review of Resident #1's current FL2 dated 04/22/26 revealed diagnoses included diabetes mellitus type 2, Alzheimer's disease, and dementia without behavior. Review of Resident #1's pharmacy review dated 07/23/26 revealed: -Resident #1 had an order for minerin cream (a moisturizer used to treat extremely dry, rough or sensitive skin) to upper body daily (arms, chest, and back). -There was a recommendation to change the order to apply minerin cream to upper body on shower days only. -The document was signed by the primary care provider (PCP) on 08/19/26.	D 406		

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D 406	Continued From page 12 Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:16pm revealed: -She saw the new pharmacy recommendation for Resident #1 last month. -She should have had the PCP sign the new pharmacy recommendation within 24 to 48 hours. -She was not sure why she had not had the PCP sign the pharmacy recommendation until today, 08/19/26. Refer to the interview with the RCC on 08/19/26 at 3:16pm Refer to the interview with the Administrator on 08/19/26 at 3:45pm. 2. Review of Resident #2's current FL2 dated 07/15/26 revealed diagnoses included dementia, anemia, and atrial fibrillation. Review of Resident #2's pharmacy review dated 07/23/26 revealed: -Resident #2 had an order for quetiapine (used to treat symptoms of dementia) 12.5mg take twice daily. -There was a recommendation to decrease quetiapine to once daily at bedtime in case the morning dose was contributing to Resident #2's unsteadiness and falls. -The recommendation was not signed by the primary care provider (PCP). Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:13pm revealed: -She started to review the pharmacy recommendations from the 07/23/26 pharmacy review last week and had not finished her review yet. -She should have had the PCP sign the new	D 406		

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D 406	Continued From page 13 pharmacy recommendation within 24 to 48 hours. Refer to the interview with the RCC on 08/19/26 at 3:16pm Refer to the interview with the Administrator on 08/19/26 at 3:45pm. _____ Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 3:16pm revealed: -She was responsible for faxing the pharmacy review recommendations to the PCP. -Once the pharmacy review recommendations had been reviewed and signed by the PCP she would fax any new orders to the pharmacy if needed. -She was responsible for ensuring the pharmacy review recommendations were reviewed and returned to the facility by the PCP. -The pharmacy would add the new orders to the electronic medication administrator record (eMAR). Interview with the Administrator on 08/19/26 3:45pm revealed: -The RCC was responsible for getting the pharmacy medication review recommendations to the PCP for review. -If the PCP did not return the pharmacy medication review form, she expected the RCC to follow up on the recommendations. -The RCC was responsible for sending the recommendations to the PCP to sign within 24 hours. -Once the recommendation was returned to the facility and there were orders on the recommendation, the RCC would send the recommendations to the pharmacy to be entered onto the eMAR.	D 406		

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FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 438	Continued From page 14	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reports within 24 hours of an injury of unknown origin for 1 of 1 resident (#5). The findings are: Review of Resident #5's current FL2 dated 07/15/26 revealed: -Diagnoses included dementia and anxiety disorder. -Resident #5 was intermittently disoriented. -Resident #5 was ambulatory. -Resident #5 required staff assistance with bathing and dressing. Review of Resident #5's accident/incident report dated 08/17/26 revealed Resident #5 had a skin tear on her left arm. Review of Resident #5's electronic progress notes revealed: -On 08/17/26, Resident #5 was pulling clothes out of her basket and scraped her left bottom arm and had a skin tear. -On 08/19/26, the progress note from 08/17/26 was edited due to incorrect data; the resident	D 438		

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 438	Continued From page 15 stated she was pulling clothes from her basket. Observation of Resident #5's arm on 08/19/26 at 9:44am revealed: -She had a 3 inch by 1 inch dark, reddish, purple bruise on the to the right side of her left elbow. -There was a 1 inch skin tear on the left elbow with reddness with slight bleeding and an area of dried blood on the edge. Review of a 24-hour HCPR Initial Allegation Report revealed the 24-hour HCPR initial allegation report was not completed until 08/19/26. Interviews with the Administrator on 08/17/26 at 2:16pm and on 08/19/26 at 3:45pm revealed: -She saw the Resident #5's arm on 08/17/26 but did not think it was a bruise and was just a skin tear. -She had not completed the 24-HCPR Initial allegation Report because she did not know the resident had an injury of unknown origin. -She did not ask staff if they had witnessed the injury; she thought it was just a skin tear and was not reportable. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 438		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of	D 456		

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D 456	Continued From page 16	D 456		

a resident, the facility shall immediately:
(1) seek the assistance of the local law enforcement authority;
(2) provide additional supervision of the threatening resident to protect others from harm;
(3) seek any needed emergency medical treatment;
(4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
(5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to immediately seek assistance from local law enforcement for 2 of 5 sampled residents (#3 and #6) following a resident physically assaulting another resident.

The findings are:

1. Review of Resident #3's current FL2 dated 07/15/26 revealed diagnoses included dementia, major depressive disorder, and anxiety disorder.

Review of Resident #3's Resident Register revealed an admission date of 08/12/25.

Review of Resident #3's accident and incident reports from May 2026 to August 2026 revealed:
-On 05/28/26, she hit another resident in the head with her fist in the dining room at 4:45pm.
-On 06/10/26, she slapped another resident in the face 3 times in face at 10:50pm.
-On 08/14/26, she hit another resident and pulled

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D 456	Continued From page 17	D 456		

the resident across the dining room table at 8:02pm.

Review of Resident #3's care notes from May 2026 to August 2026 revealed:
-There was no care note available for review for 05/28/26.
-There was a care note dated 06/10/26 revealed she went into another resident's room and slapped the resident in the face 3 times.
-There was a care note dated 08/14/26 revealed she had an altercation with another resident; hit the resident and pulled the resident across the table.

Interview with Resident #3 on 08/19/26 at 1:56pm revealed the resident did not want to answer questions.

Refer to the interview with the Administrator on 08/18/26 at 2:16pm.

Attempted telephone interview with Resident #3's Behavioral Health Nurse Practitioner (NP) on 08/18/26 at 3:26pm was unsuccessful.

2. Review of Resident #6's current FL2 dated 07/15/26 revealed diagnoses included dementia with mood disturbance and anxiety disorder.

Review of Resident #6's Resident Register revealed an admission date of 08/13/25.

Review of Resident #6's accident and incident report dated 05/23/26 revealed she slapped another resident in the face in the dining room at 12:11pm.

Review of Resident #6's care notes revealed there was no care note available for review for

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D 456	Continued From page 18 05/28/26. Attempted telephone interview with Resident #6's Behavioral Health Nurse Practitioner (NP) on 08/18/26 at 3:26pm was unsuccessful. Refer to the interview with the Administrator on 08/18/26 at 2:16pm. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. _____ Interview with the Administrator on 08/18/26 at 2:16pm revealed: -The residents were in a special care unit, and she did not think she needed to contact law enforcement. -She was not aware that she should have contacted law enforcement when there was a resident-to-resident assault.	D 456		