| 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 |
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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow up survey on June 30, 2026 through July 1, 2026. | {D 000} | | |
| D911 | G.S. 131D-21(1) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 01/05/26 revealed diagnoses included dementia, arthritis, and hypertension.<br><br>Review of Resident #2's Resident Register revealed an admission date of 11/28/12.<br><br>Review of Resident #2's care plan dated 04/24/26 revealed:<br>-Resident #2 needed extensive assistance with toileting.<br>-Resident #2 needed extensive assistance with bathing.<br>-Resident #2 needed extensive assistance with grooming and personal hygiene.<br><br>Observation of Resident #2 on 06/30/26 from | D911 | | |

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| D911 | Continued From page 1<br><br>1:45pm to 1:55pm revealed:<br>-Resident #2 was in her bathroom with the door open.<br>-Resident #2 urinated into a plastic cup and set it on the floor.<br>-Resident #2 removed feces from her incontinence brief, rubbed the feces between her hands and rubbed it into her hair.<br>-The Administrator was informed by the surveyor that Resident #2 had a plastic cup filled with urine and that she had rubbed feces into her hair.<br>-The Administrator asked Resident #2 for the plastic cup and poured the urine into the toilet.<br>-Resident #2 put a beanie cap onto her head and walked out into the hallway.<br><br>Observation of Resident #2 on 06/30/26 from 2:00pm to 3:00pm revealed Resident #2 was observed walking through the hallway and into the activity room for an hour and 30 minutes without any staff member providing assistance with grooming and personal hygiene.<br><br>Interview with a housekeeper on 06/30/26 at 2:00pm revealed:<br>-Resident #2 had been urinating in cups and rubbing feces in her hair for the two years she had been employed at the facility.<br>-All of the staff members were aware that Resident #2 urinated in plastic cups regularly and rubbed feces into her hair.<br>-Staff was told by management to take any cups with urine in them that was observed in Resident #2's bedroom.<br>-Staff members avoided Resident #2 so they would not have to clean her when she rubbed feces in her hair.<br><br>Interview with a personal care aide (PCA) on 06/30/26 at 2:15pm revealed: | D911 | | |

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| D911 | Continued From page 2 | D911 | | |

-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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| D911 | Continued From page 3 | D911 | | |

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.

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| D911 | Continued From page 4<br><br>Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/01/26 at 9:45am was unsuccessful.<br><br>Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. | D911 | | |