PRINTED: 05/22/2025
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
	FCL017064	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HORIZONS	1111 YARBOROUGH ROAD MILTON, NC 27305

(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 and the Caswell County Department of Social Services conducted an annual survey and complaint investigation on May 14, 2025.	C 000		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the residents evacuated the facility when the smoke detector was activated without verbal prompting, resulting in 2 of 3 residents not responding to a fire drill. The findings are: Review of the facility's State of North Carolina Department of Health and Human Services, Division of Health Service Regulation license certificate revealed: -The facility's license was issued on 01/01/25. -The facility's licensed capacity was 6 ambulatory	C 100	There is a fire rehearsal conducted (3) times quarterly, it is recorded & placed in a book maintained in the facility. 5/28/25 The fire rehearsal has not been conducted via the smoke detector but moving forward all rehearsal will be conducted via the smoke detector & recorded in the fire drill book. As the administrator I will continue to ensure that all staff will adhere to this practice. All residents will be comfortable with this practice. 5/28/25	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Gregory Newman TITLE Administrator (X6) DATE 5/28/2

Reviewed and acknowledged 05/28/25 with addendum added on page 14 of the SOD. kg

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C 100	Continued From page 1 residents. Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 05/14/25 at 8:05am revealed the current census was 3 residents. Review of the facility's undated policy on fire safety revealed: -The fire and disaster plan was reviewed with each resident following admission. -Fire drills were conducted monthly, were unannounced, and at various times in the month and at varying times of the day to include normal sleep time. -Residents and staff were to treat the fire drill as though the fire drill were an actual fire; new residents would be oriented to the fire drill procedure on the day of admission. Review of the facility's fire drill form revealed: On 02/24/25, at 6:30pm, a fire drill was conducted, all 3 residents evacuated the facility, and evacuation time was 1 minute. On 03/27/25, at 3:45pm, a fire drill was conducted, all 3 residents evacuated the facility, and evacuation time was 1 minute. On 04/24/25, at 6:37pm, a fire drill was conducted, all 3 residents evacuated the facility, and evacuation time was 35 seconds. Observation of a fire drill conducted on 05/14/25 at 8:20am-8:22am revealed: -There were 2 male residents in one resident room, and a third resident was in her bed. -The MA/SIC activated the smoke alarm. -One of the two residents left his room and exited the facility. -The second male resident remained in his bed. -The female resident remained in her bed.	C 100		

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C 100	Continued From page 2 -When the smoke alarm was no longer sounding, the second male exited his room and went outside the facility. Interview with the male resident on 05/14/25 at 9:53am revealed: -He heard the smoke alarm today, 05/14/25, but no one had told him to leave the facility. -The facility had fire drills. -When the staff "hollered, fire, fire, fire drill" he left the facility. Interview with the female resident on 05/14/25 at 10:00am revealed: -She heard the smoke detector this morning, 05/14/25. -The facility staff did not use the smoke alarm for fire drills. -The facility staff did not tell her to go outside when she heard the smoke alarm. -When they had fire drills, the staff told the residents to go outside. Interview with a MA/SIC on 05/14/25 at 3:46pm revealed: -He told the residents when there was a fire drill. -He had not used the smoke alarm to conduct a fire drill. Interview with the Administrator on 05/14/25 at 2:49pm revealed: -He was always at the facility when a fire drill was conducted. -He was made aware yesterday, 05/13/25, that he should use the smoke detector when conducting fire drills. -He was telling residents it was a fire drill, and the residents knew what to do. -He had not practiced a fire drill with the smoke detector or told the residents what to do since he	C 100		

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C 100	Continued From page 3 was told on 05/13/25.	C 100		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff sampled (A), who administered medications, had passed the medication aide written exam. The findings are: Review of the facility's Medication Administration Policy (undated) revealed: -The medication aide (MA) would need to successfully pass the written standardized test established by the Department of Health Service Regulation. -Only a qualified MA designated by the Administrator would administer medications. Review of Staff A's, medication aide, personnel record revealed: -Staff A's hire date was 06/25/24.	C 131		

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C 131	Continued From page 4 -Staff A completed the 15-hour MA training course on 07/03/24. -Staff A was validated via the Medication Administration Clinical Skills Validation Checklist on 07/03/24. -There was no documentation of Staff A taking and passing the MA written exam. Interview with two residents on 05/14/25 at various times between 9:00am-11:00am revealed Staff A administered medications when he worked at the facility. Review of residents' March 2025-May 2025 medication administration records (MARs) from 05/01/25-05/14/25 on 05/14/25 revealed that it could not be determined which initials belonged to Staff A. Interview with Staff A on 05/14/25 at 4:30pm revealed: -He administering medications when he worked. -He had not taken the MA written exam because he had been in the hospital (2024). -He started back working at the facility in January 2025 or February 2025. -He was scheduled to take the written exam, which he thought was next Friday, 05/24/25. -He identified his initials (he thought) on the MARs for 04/10/25, 04/11/25, 04/21/25, 04/22/25, 4/23/25, 04/24/25, 05/09/25, and 05/10/25. Telephone interview with the facility's contracted Registered Nurse (RN) on 05/14/25 at 4:34pm revealed: -She was not aware Staff A had not taken and passed the MA written exam. -Once she had checked a MA off on the medication cart, the MA was told they had 60 days to take the MA written exam.	C 131		

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C 131	Continued From page 5 -Staff A should not be on the medication cart administering medications until he had passed the MA written exam. Interview with the Administrator on 05/14/25 at 4:56pm revealed: -Staff A told him he took the MA written exam and did not pass. -He thought Staff A had taken the MA written exam in March 2025. -He had been monitoring Staff A on the medication cart, but not every medication pass. -He did not know Staff A could not be on the medication cart. The facility failed to ensure 1 of 3 medication aides sampled met the qualifications to administer medications to residents. Staff A had not taken and passed the medication aide written exam within 60 days of hire and he continued to administer medications to all residents in the facility after 60 days of hire and not taking and passing the written exam. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 28, 2025.	C 131	Staff in question has been immediately removed from dispensing meds until the MedTech exam has been taken, passed. Moving forward, all staff/potential staff will take & pass the MedTech exam before dispensing meds in the facility. As the administrator, I will ensure of this practice.	
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service	C 257		

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C 257	Continued From page 6 (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the refrigerator was free from contamination, including expired food, food not labeled and dated, and debris in the drawer with raw vegetables. The findings are: Review of the Environmental Health Inspection report dated 01/09/24 revealed: -No thermometer was observed in the refrigerator. -The facility currently had no residents, and staff were reminded that a thermometer had to be placed in the refrigerator before residents moved in. Review of the Environmental Health Inspection	C 257	The refrigerator was thoroughly cleaned and all expired items were disposed of. Better storage containers & jugs replaced bad containers. Open food will be dated once opened. As the administrator, I will continue to check behind all staff ensuring compliance with this Rule.	5/28/25

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C 257	Continued From page 7 report dated 05/14/25 revealed: -Total demerits were 6. -No thermometer was observed in the refrigerator. Observation of the refrigerator on 05/14/25 at 8:08am and 4:00pm revealed: -There was a pack of pork chops dated as used by 05/05/25. -There was a non-reusable jug labeled as tea that had a red liquid inside. -At 4:00pm, the non-reusable jug had been filled with water. -There was a container of macaroni salad purchased from the deli that had been opened; there was no label with the date opened. -There was a container of potato salad purchased from the deli that had been opened; there was no label with the date opened. -There was a bottle of salad dressing with an expiration date of 10/16/24. -There was a second bottle of salad dressing with an expiration date of 03/17/25. -There was a drawer with tomatoes and cucumbers; the inside of the drawer had various food crumbs/particles, splatters, and stains. -There was a second drawer with cucumbers and tomatoes and two bags of salad mix. -The inside of the drawer contained dark brown juices at the bottom of the drawer. -All the shelves had dried substances splattered on them and crumbs of food. Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 05/14/25 at 3:46pm revealed: -Staff took turns cleaning the refrigerator. -He had not noticed the expired salad dressings. -He had just come to work today, 05/14/25, and when he went into the refrigerator, he would have	C 257	There was a thermometer in the freezer but not the refrigerator. A new thermometer was purchased a placed in the refrigerator	5/22/25

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C 257	Continued From page 8 noticed the refrigerator needed to be cleaned and would have cleaned it. Interview with a second MA/SIC on 5/14/2025 at 3:47pm revealed: -He cleaned the refrigerator every other week when he worked or when he noticed it needed to be cleaned. -The staff were responsible for labeling the containers with the date and time. -The gallon tea jug was washed thoroughly, and water was put in the jug. Interview with the Administrator on 05/14/25 at 2:49pm revealed: -Staff were responsible for cleaning the refrigerator. -The refrigerator should be cleaned monthly or more often if needed. All foods should be labeled when opened. -Staff should look at the label to make sure there was no expired food. -He did not know that non-reusable food containers could not be washed and reused.	C 257	The refrigerator will be cleaned weekly as the administrator will ensure this is done as instructed by all staff.	5/28/25
C 259	10A NCAC 13G .0904(a)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero	C 259		

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C 259	Continued From page 9 degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on reviews, observations, and interviews, the facility failed to have a 5-day supply of non-perishable foods based on the census and the menus in the facility, as evidence of the food pantry having limited food items stored. The findings are: There were 3 residents residing in the facility. Observations of the food pantry/cabinets in the facility on 05/14/25 at 8:14am revealed: -There were 3 cans of tuna, and each can was labeled as one serving per can. -There was a 2-pound bag of dried beans; there were 18 one-fourth-cup (dry) servings per bag. -There was 1 can of lima beans with a serving of 3.5 one-half cup servings. -There were 2 cans of beefaroni in tomato sauce, and each can was labeled as one serving per can. -There was 1 can of spaghetti in tomato and cheese sauce labeled as one serving. -There was 1 can of cream of chicken soup labeled as 2.5 one-half cup servings. -There were 2 cans of cream of tomato soup labeled as 2.5 one-half cup servings per can.	C 259	After shopping, more non-perishable foodwere 5/28/25 purchased to meet the extra food requirements & stored in the facility. As the facility administrator, I will continue to add-on to the non-perishable stock pile.	

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C 259	Continued From page 10 -There was 1 can of condensed chicken noodle soup labeled as 2.5 one-half cup servings. -There was 1 can of sliced water chestnuts. -There were 12 individual cups of diced peaches. -There were 12 individual cups of mandarin oranges. -There were 2 containers of peanut butter. Review of the facility's breakfast menu for one week revealed: -On Monday, 1/2 cup of prune juice was to be served. -On Tuesday, 1/2 cup of apricot nectar was to be served. -On Wednesday, 1/2 cup of grapefruit juice was to be served. -On Thursday, 1/2 cup of apple juice was to be served. -On Friday, 1/2 cup of pineapple juice was to be served. -On Saturday, 1/4 section of cantaloupe was to be served -On Sunday, 1/2 cup of orange juice was to be served. -A total of 3 cups of fruit juice were needed to be served to each resident for the breakfast menu for one week. Review of the facility's lunch menu for one week revealed: -On Monday, 3 ounces of meatloaf, ½ cup of buttered noodles, ½ cup of three-bean salad, 1 slice of wheat bread, and ½ cup of chocolate pudding were to be served. -On Tuesday, 3 ounces of baked haddock, ½ cup of onion rings, ½ cup of spinach, ½ cup of slaw, 1 slice of wheat bread, and 1 slice of watermelon were to be served. -On Wednesday, 3 ounces of grilled ham, ½ cup of scalloped potatoes, ½ cup of buttered carrots,	C 259		

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C 259	Continued From page 11 1 piece of cornbread, and ½ cup of vanilla ice cream were to be served. -On Thursday, 1 beef burrito, 1 cup of spinach salad with dressing, ½ cup of Mexican rice, and ½ cup of peaches were to be served. -On Friday, 3 ounces of barbeque chicken, ½ cup of buttered peas, ½ cup of pasta salad, 1 biscuit, and 1 slice of blueberry pie were to be served. -On Saturday, 1/3 cup of tuna salad, with lettuce and tomato served in pita bread, 1 cup of cold spinach with yogurt, and sliced orange salad and lemon squares were to be served. -On Sunday, 3 ounces of breaded pork patty, ½ cup of mashed potatoes, ½ cup of pickled beets, 1 dinner roll, ½ cup of cinnamon applesauce, and 1 slice of sweet potato pie were to be served. -A total of 4 cups of vegetables and a minimum of 12 ounces of meat were needed to be served for each resident for the lunch menu for one week. Review of the facility's dinner menu for the week revealed: -On Monday, 3/4 cup of vegetable beef soup, a turkey sandwich with cheese, 1 stalk of celery, 1 medium carrot, ½ cup of peach slices, and 2 cookies were to be served. -On Tuesday, 3/4 cup of macaroni and cheese, ½ cup of cottage cheese, 1 bran muffin, 1 peach half, and approximately 15 grapes were to be served. -On Wednesday, 3/4 cup of bean soup, a grilled cheese sandwich with tomato slices, 2 sweet pickles, and ½ cup of apple sauce and ½ cup of pudding were to be served. -On Thursday, 3/4 cup of minestrone soup, a peanut butter and jelly sandwich, sliced tomato and cucumber, and 1 medium banana were to be served. - On Friday, 1 and ¼ cups of chef salad with turkey and cheese, 6 crackers, and ½ cup of Jello	C 259		

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C 259	Continued From page 12 with fruit cocktail were to be served. -On Saturday, 1/4 cup of sloppy joe sandwich meat on a bun, ½ cup of tater tots, 1 cup of raisin salad, and ½ cup of sherbet were to be served. -On Sunday, 3 ounces of breaded fish, ½ cup of buttered broccoli, ½ cup of pineapple slaw, and 1 slice of cake with icing were to be served. -A total of 5 cups of vegetables and 3 cups of fruit were needed to be served to each resident for the dinner menu for one week. Telephone interview with the Administrator on 05/14/25 at 2:49pm revealed: -He thought there was enough fruit, vegetables, and protein in the facility, non-perishable, to be served if needed. -He usually kept the facility "stocked up" with food.	C 259		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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 reviews and interviews, the	C 315	As the administrator, I will ensure that all orders are clear & complete at all times during the initial admission and also readmission to the facility from a hospital. To ensure this is done the PCP will be contacted immediately for clarification. 05/28/25	

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	FCL017064	A. BUILDING: _____ B. WING _____	05/14/2025

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C 315	Continued From page 13 facility failed to clarify orders with the prescribing physician for 1 of 3 sampled residents for an antibiotic, a steroid, and an antipsychotic medication (#2). The findings are: Review of Resident #2's FL-2 dated 04/03/25 revealed diagnoses included acute asthma exacerbation, acute bronchitis, depression/anxiety, and hypokalemia. a. Review of Resident #2's FL-2 dated 04/03/25 revealed no order for Rexulti (an antipsychotic) 2mg once daily. Review of Resident #2's previous FL-2 dated 03/17/25 revealed the medication list was documented as attached. Review of the physician's orders attached to Resident #2's FL-2 dated 03/17/25 revealed an order for Rexulti 2mg once daily. Review of Resident #2's electronically signed hospital discharge summary dated 04/03/25 revealed an order for Rexulti 2mg once daily. Review of Resident #2's April 2025 medication administration record (MAR) revealed: -There was an entry for Rexulti 2mg scheduled at 8:00am. -Rexulti 2mg was documented as administered at 8:00am from 04/04/25-04/30/25. Review of Resident #2's May 2025 MAR from 05/01/25-05/14/25 revealed: -There was an entry for Rexulti 2mg scheduled at 8:00am. -Rexulti 2mg was documented as administered at	C 315		

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C 315	Continued From page 14 8:00am from 05/01/25-05/13/25. Observation of Resident #2's medications on hand on 05/14/25 revealed: -There was a multi-dose package that contained Rexulti 2mg. -Each bubble was dated with the date and time the medication was to be administered. -The medication was punched from 05/01/25-05/14/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's rexulti was filled from a signed physician's order dated 02/06/25. -If Resident #2's FL-2 and discharge summary dated 04/03/25, were sent to the pharmacy, they would have clarified the order for -Rexulti since it was not documented on the FL-2 but was listed on the discharge summary. b. Review of Resident #2's FL-2 dated 04/03/25 revealed an order for doxycycline (an antibiotic) 100mg twice daily. Review of Resident #2's April 2025 medication administration record (MAR) from 04/03/25 to 04/30/25 revealed: -There was an entry for doxycycline 100mg, one tablet twice daily for 5 days. -There was documentation that doxycycline 100mg was administered twice daily from 04/04/25-04/08/25. -There was no other entry for doxycycline. Observation of Resident #2's medications on hand on 05/14/25 at 9:30am revealed that there was no doxycycline on hand to be administered.	C 315		

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C 315	Continued From page 15 Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's doxycycline was filled from an electronic prescription for a 5-day supply. -If Resident #2's FL-2 dated 04/03/25, was sent to the pharmacy, they would have clarified the order for doxycycline since there was no time frame documented. c. Review of Resident #2's FL-2 dated 04/03/25 revealed an order for prednisone (a steroid) 10mg daily. Review of Resident #2's April 2025 medication administration record (MAR) from 04/03/25 to 04/30/25 revealed: -There was an entry for prednisone 10mg with the directions to take 4 tablets for 3 days, 3 tablets for 3 days, 2 tablets for 3 days, and 1 tablet for 3 days. -There was documentation that prednisone 10mg was administered daily from 04/04/25-04/10/25. -There was no other entry for prednisone. Observation of Resident #2's medications on hand on 05/14/25 at 9:30am revealed that there was no prednisone on hand to be administered. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's prednisone was filled from an electronic prescription for a 10-day taper. -If Resident #2's FL-2 dated 04/03/25, was sent to the pharmacy, they would have clarified the order for prednisone since there was no time frame documented. Interview with a medication aide (MA) on	C 315		

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C 315	Continued From page 16 05/14/25 at 10:31am and 2:14pm revealed that the Administrator reviewed FL-2's and hospital discharge summaries. Interview with the Administrator on 05/14/25 at 2:49pm revealed: -The MAs did not do anything with the FL-2's and discharge summaries. -He reviewed Resident #2's discharge summary. -He did not match Resident #2's medications with the FL-2 or the discharge summary. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's FL-2 dated 04/03/25 was not on file at the pharmacy. -FL-2s were considered to be signed physician's orders.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer	C 330		

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C 330	Continued From page 17 medications as ordered for 2 of 3 sampled residents (#1, #2) including a medication used to treat chronic obstructive pulmonary disease (COPD) (#1) and a medication used to treat nightmares and an allergy medication (#2). The findings are: 1. Review of Resident #2's FL-2 dated 04/03/25 revealed diagnoses included acute asthma exacerbation, acute bronchitis, depression/anxiety, and hypokalemia. Review of Resident #2's previous FL-2 dated 03/17/25 revealed: -Diagnoses included night tremors and allergies. -The medication list was documented as attached. a. Review of the physician's orders attached to Resident #2's FL-2 dated 03/17/25 revealed an order for prazosin (used to treat high blood pressure and was also prescribed to help manage nightmares) 5mg at bedtime; hold for blood pressure (BP) less than 110/70. Review of Resident #2's electronically signed hospital discharge summary dated 04/03/25 revealed: -Resident #2 was admitted for asthma exacerbation on 04/02/25 and discharged on 04/03/25. -There was an order for prazosin 5mg at bedtime; hold for BP less than 110/70. Review of Resident #2's March 2025 medication administration record (MAR) revealed: -There was an entry for prazosin 5mg, hold if BP was less than 110/70 scheduled at 8:00pm. -Prazosin 5mg was documented as administered	C 330		

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C 330	Continued From page 18 at 8:00pm from 03/01/25-03/30/25. -No BP readings were documented on the MAR. Review of Resident #2's April 2025 MAR revealed: -There was an entry for prazosin 5mg, hold if BP was less than 110/70 scheduled at 8:00pm. -Prazosin 5mg was documented as administered at 8:00pm from 04/04/25-04/30/25. -A line was drawn across the MAR for 04/01/25-04/03/25. -No BP readings were documented on the MAR. Review of Resident #2's May 2025 MAR from 05/01/25-05/14/25 revealed: -There was an entry for prazosin 5mg, hold if BP was less than 110/70 scheduled at 8:00pm. -Prazosin 5mg was documented as administered at 8:00pm from 05/01/25-05/13/25. -No BP readings were documented on the MAR. Observation of Resident #2's medications on hand on 05/14/25 revealed: -There was a multi-dose package that contained prazosin 5mg with the directions to administer one capsule at bedtime and hold for a BP of 110/70. -Each bubble was dated with the date and time the medication was to be administered. -The medication was punched from 05/01/25-05/13/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's order dated 02/26/25 was prazosin 5mg, once capsule at bedtime, hold if BP was less than 110/70. -Prazosin was an alpha blocker (Alpha blockers relax the blood vessels, lowering blood pressure).	C 330		

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C 330	Continued From page 19 -Prazosin could cause the resident's BP to drop, and that was why it was important to take her BP before administering the medication. -Not checking Resident #2's BP before administering the prazosin, could cause the resident to experience dizziness and increase her risk of falls, especially if her BP was already low. -Resident #2 was ordered prazosin for nightmares. Interviews with Resident #2 on 05/14/25 at 10:27am and 11:49am revealed: -The medication aide (MA) had not taken her BP since she moved into the facility. -She had times she felt dizzy, like she was going to pass out. -She would lose her vision; it "got black" when she felt like she was going to pass out. -She had a fall "about one month ago" and hit her nose and mouth. -She had gotten out of bed one evening after taking her medications to get something to drink, and fell at the end of the bed. -A [named] MA was working -She then had a second fall the same night in the hallway. -She felt dizzy when she stood up. -She did not feel dizzy every day. Observation of Resident #2 on 05/14/25 from 11:46am-12:02pm revealed: -At 11:46am, Resident #2 was lying in her bed. -At 11:49am, Resident #2 had moved to a chair, and the MA took her BP; the reading was 91/52. -At 11:57am, Resident #2's BP was checked while standing, the reading was 92/70. -At 11:59am, Resident #2's BP was checked while lying down, the reading was 103/62. -At 12:02pm, the Licensed Health Professional Services (LHPS) nurse took the resident's BP,	C 330		

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C 330	Continued From page 20 and the reading was 107/81. interview with the LHPS nurse on 05/14/25 at 12:30pm revealed she used her stethoscope and manually took Resident #2's BP the second time, and the reading was 100/78. Observation of Resident #2 on 05/14/25 at 12:50pm revealed she was lying on her bed, and when she sat up on the side of the bed, she stated she felt dizzy. Interviews with a MA on 05/14/25 at 10:31am and 2:14pm revealed: -He had not checked Resident #2's BP. -He administered Resident #2's medications. -He compared the MAR to the label on the medication. -He had not noticed the order to hold the prazosin if her BP was less than 110/70. Interview with a second MA on 05/14/25 at 10:39am and 2:20pm revealed: -He checked Resident #2's BP when she returned from the hospital because she was being weaned off oxygen. -He did not document these BP check because he was "just checking it." -It had been over a month since Resident #2 had weaned off her oxygen and he was checking Resident #2's BP. -He administered Resident #2's prazosin before bedtime. -He did not see the order to hold for a BP less than 110/70. Telephone interview with a third MA on 05/14/25 at 4:16pm revealed: -She had not taken Resident #2's BP because there was no order on the MAR.	C 330		

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C 330	Continued From page 21 -She administered Resident #2's prazosin at night. -She did not see the order to hold Resident #2's prazosin if her BP was less 110/70. Interview with the Administrator on 05/14/25 at 2:49pm revealed. -He had seen Resident #2's order to hold the prazosin for BPs less than 110/70. -When he administered Resident #2's medication, he did not pay attention to the part of the entry to hold the medication when the BP was less than 110/70. -He was concerned the medication had been administered without checking her BP because the resident had complained of being dizzy "a few times." -Resident #2 was encouraged to "get up slowly." -He was not aware Resident #2 had any falls. -He recalled the [named] MA calling him to report Resident #2 complained of being dizzy and almost fell; he thought it was in March 2025. Attempted telephone interview with Resident #2's primary care provider (PCP) on 05/14/25 at 1:17pm was unsuccessful. Attempted telephone interview with the [named] MA on 05/14/25 at 2:45pm was unsuccessful. b. Review of the physician's orders attached to Resident #2's FL-2 dated 03/17/25 revealed an order for flonase nasal spray (used to treat allergy symptoms), two sprays in each nostril twice daily. Review of Resident #2's electronically signed hospital discharge summary dated 04/03/25 revealed: -Resident #2 was admitted for an asthma exacerbation on 04/02/25 and discharged on	C 330		

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C 330	Continued From page 22 04/03/25. -There was an order for flonase nasal spray, two sprays in each nostril twice daily. Review of Resident #2's March 2025 MAR revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 03/01/25-03/31/25. -There were no exceptions documented. Review of Resident #2's April 2025 MAR revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 04/04/25-04/30/25. -A line was drawn across the MAR for 04/01/25-04/03/25. -There were no exceptions documented. Review of Resident #2's May 2025 MAR from 05/01/25-05/14/25 revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 05/01/25-05/13/25 and on 05/14/25 at 8:00am. -There were no exceptions documented. Observation of Resident #2's medications on hand on 05/14/25 revealed: -There was a bottle of flonase that was 90% full. -The label showed the medication was dispensed on 02/17/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed:	C 330		

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C 330	Continued From page 23 -Resident #2's flonase was dispensed on 02/17/25 for a 30-day supply based on the order to use 2 sprays in each nostril twice daily. -If Resident #2's flonase was not administered as ordered, her allergy symptoms would not be resolved. -There were no other dispensing for Resident #2's flonase. Interview with Resident #2 on 05/14/25 at 12:34pm revealed: -She was sneezing "a little while ago". -She sneezed a lot; she had been sneezing every day. -The flonase nasal spray helped when she "got it". -She did not get her nasal spray every day; it depended on who was working. -She did not get her nasal spray when a [named] MA was working. Interview with the [named] MA on 05/14/25 at 3:46pm revealed: -He administered medications by reading the MAR and matching the medications. -Resident #2 did not have a nasal spray. -He did not know Resident #2 was supposed to use a nasal spray twice a day. Telephone interview with another MA on 05/14/25 at 4:16pm revealed: -She administered Resident #2's nasal spray twice a day when she worked. -She had worked at the facility for approximately 9 days in a 3-week period. Interview with the Administrator on 05/14/25 at 2:49pm revealed he was not aware Resident #2's flonase had not been administered as ordered.	C 330		

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C 330	Continued From page 24 Attempted telephone interview with Resident #2's PCP on 05/14/25 at 1:17pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 03/02/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema lung disease, and panlobular emphysema. -There was an order for a trelegy ellipta inhaler (a combination inhaler used to treat moderate to severe COPD and asthma) 200-62.5-25, inhale one puff once daily. Review of Resident #1's March 2025 medication administration record (MAR) revealed: -There was an entry for trelegy ellipta 200-62.5-25, inhale one puff once daily scheduled at 8:00am. -Trelegy was documented as administered at 8:00am from 03/01/25-03/31/25. Review of Resident #1's April 2025 MAR revealed: -There was an entry for trelegy ellipta 200-62.5-25, inhale one puff once daily scheduled at 8:00am. -Trelegy was documented as administered at 8:00am from 04/01/25-04/30/25. Review of Resident #1's May 2025 MAR from 05/01/25-05/14/25 revealed: -There was an entry for trelegy ellipta 200-62.5-25, inhale one puff once daily scheduled at 8:00am. -Trelegy was documented as administered at 8:00am from 05/01/25-05/14/25. Observation of Resident #1's medications on hand on 05/14/25 at 9:21am and 12:44pm revealed:	C 330		

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C 330	Continued From page 25 -There was a box labeled as trelegy ellipta inhaler dispensed on 02/27/25. -There were 2 inhalers in the box, both showing 24 doses remaining in the inhaler out of 30. -There was a second box labeled as trelegy ellipta inhaler dispensed on 03/26/25; the inhaler had not been opened. -There was a third box labeled as a trelegy ellipta inhaler dispensed on 04/28/25; the inhaler had not been opened. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #1's trelegy ellipta inhalers were dispensed on 02/27/25, 03/26/25, and 04/28/25; each dispensing was a 30-day supply. -The trelegy ellipta inhalers started with a dose count of 30, and each time the medication was administered, the dose counter would count down to zero. -If Resident #1's trelegy ellipta inhaler was not administered as ordered, the resident would be at risk for exacerbation of his COPD, which was "not a good outcome". Interview with Resident #1 on 05/14/25 at 9:53am and 2:04pm revealed: -He used his trelegy inhaler every day. -The medication aide (MA) handed him the inhaler; he would pull the cover back and inhale the medication. -He did not know if he pulled the cover back until he heard a click. -He did not look at the dose counter on the inhaler before or after he used it. Interview with a MA on 05/14/25 at 2:14pm revealed: -Resident #1 only used his trelegy ellipta inhaler	C 330		

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C 330	Continued From page 26 when the resident asked for it. -He did not recall the last time the resident used the trelegy ellipta inhaler. Interview with a second MA on 05/14/25 at 2:20pm revealed: -He handed Resident #1 his trelegy ellipta inhaler and let the resident administer the medication himself. -Resident #1 opened the medication himself, and when the resident breathed in, the medication was automatically dispensed. -He did not know why the dose counter read as 24 on the two opened trelegy ellipta inhalers. -He could not say what other MAs did, but he knew he administered the trelegy ellipta when he worked. Interview with the Administrator on 05/14/25 at 2:49pm revealed: -Resident #1 had an order for trelegy ellipta inhaler every day. -When he administered Resident #1's trelegy ellipta inhaler, he handed the resident the inhaler, watched him take the medication, and then documented on the MAR. -The dose counter on the front indicated the inhaler had been used. Interview with a MA on 05/14/25 at 3:44pm revealed a line drawn across the MAR where a medication would be initialed as administered meant the resident was out of the facility. Interview with the Administrator on 05/14/25 at 3:44pm revealed: -Resident #1 was in the hospital for "almost" the entire month of January 2025. -He was not sure the date Resident #1 went into the hospital or when the resident returned to the	C 330		

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C 330	Continued From page 27 facility. -Resident #1's medications continued to be filled even though the resident was in the hospital and that was why there were extra boxes of the trelegy inhaler. Review of the trelegy ellipta inhaler instructions on how to use the inhaler revealed: -Slide the cover down to expose the mouthpiece until you hear a "click". -The counter would count down by one number. -If the counter did not count down when you heard the click, the inhaler would not deliver the medication. -Call your pharmacist or healthcare provider if this happened. Request for Resident #1's January 2025 MAR was made on 04/15/25 at 3:44pm was not provided by the survey exit date. Attempted telephone interview with Resident #1's primary care provider (PCP) on 05/14/25 at 1:17pm was unsuccessful. The facility failed to administer medications as ordered, including a resident who had a medication with parameters to be held if her BP was less than 110/70 and her BP had not been taken prior to administering the medication. The resident complained of being dizzy, had reported falls from being dizzy, and was noted to have a BP of 81/52 on 05/14/25 (#2); and a resident who had COPD and emphysema, and was not being administered his inhaler correctly, which put the resident at risk of an exacerbation of his COPD. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	C 330	All staff will pay close attention to all medication orders, ensuring the safety of the resident. As the administrator, I will pay close attention to this requirement, all staff will be re-trained to compliance.	5/28/25

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C 330	Continued From page 28 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 28, 2025.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff immediately documented the administration of medications for 3 of 3 sampled residents (#1, #2, and #3). The findings are: Review of the facility's Medication Administration Policy (undated) revealed the medication aide (MA) will ensure the medication administration was documented correctly on the medication administration record (MAR) after the resident	C 341	Staff will receive Re-training ensuring complete compliance with all medications dispensing rules&guidelines. AS the administrator, I will continue to monitor the staff ensuring compliance 5/28/25	

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C 341	Continued From page 29 had been observed taking the medication, but prior to another resident being administered medication. 1. Review of Resident #1's current FL-2 dated 03/02/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema lung disease, and panlobular emphysema. -There was an order for divalproex (used to manage mood disorders) 500mg take two tablets twice daily. -There was an order for ingrezza (used to treat involuntary movement) 40mg once daily. -There was an order for melatonin (used for sleep) 10mg at night. -There was an order for oxybutynin (used to treat an overactive bladder) 5mg tale two tablets daily. -There was an order for paliperidone (used to treat schizophrenia) extended release (ER) 6mg twice daily. -There was an order for paroxetine (used to treat depression) 40mg once daily. -There was an order for prazosin (used to treat high blood pressure) 1mg once daily. -There was an order for trelegy ellipta (a combination inhaler used to treat moderate to severe COPD and asthma) 200-62.5-25 inhale one puff into the lungs once daily. Review of Resident #1's May 2025 medication administration record (MAR) from 05/13/25-05/14/25 revealed: -The medication aide (MA) failed to document the administration of divalproex 500mg, melatonin 10mg, oxybutynin 5mg, paliperidone 6mg, and prazosin 1mg on 05/13/25 at 8:00pm. -The MA failed to document the administration of the resident's ingrezza 40mg, paliperidone 6mg, paroxetine 40mg, and trelegy ellipta inhaler on	C 341		

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C 341	Continued From page 30 05/14/25 at 8:00am. Refer to the interview with the MA on 05/14/25 at 8:48am. Refer to the interview with the Administrator on 05/14/25 at 2:49pm. 2. Review of Resident #2's FL-2 dated 04/03/25 revealed diagnoses included acute asthma exacerbation, acute bronchitis, depression/anxiety, and hypokalemia. -There was an order for divalproex (used to manage mood disorders) 500mg twice daily. -There was an order for duloxetine (used to treat depression) delayed release (DR) 60mg once daily. Review of Resident #1's May 2025 medication administration record (MAR) from 05/13/25-05/14/25 revealed: -The medication aide (MA) failed to document the administration of the resident's divalproex 500mg and duloxetine 60mg on 05/13/25 at 8:00pm. -The MA failed to document divalproex 500mg on 05/14/25 at 8:00am. Refer to the interview with the MA on 05/14/25 at 8:48am. Refer to the interview with the Administrator on 05/14/25 at 2:49pm. 3. Review of Resident #3's current FL-2 dated 09/10/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), edema, schizophrenia, and arthritis. -There was an order for furosemide (used to treat fluid retention) 20mg once daily.	C 341		

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C 341	Continued From page 31 -There was an order for olanzapine (used to treat schizophrenia) 5mg once daily. -There was an order for sertraline (used to treat depression) 25mg once daily. -There was an order for spironolactone (used to treat fluid retention) 50mg once daily. Review of Resident #3's May 2025 medication administration record (MAR) from 05/13/25-05/14/25 revealed: -The medication aide (MA) failed to document the administration of olanzapine 5mg and sertraline 25mg on 05/13/25 at 2:00pm. -The MA failed to document the administration of the resident's furosemide 20mg and spironolactone 50mg on 05/14/25 at 8:00am. Refer to the interview with the MA on 05/14/25 at 8:48am. Refer to the interview with the Administrator on 05/14/25 at 2:49pm. Interview with the MA on 05/14/25 at 8:48am revealed: -He called the residents to the medication room one at a time to administer medications. -He administered all medications and then signed the MARs. -He did not sign the MARs on 05/13/25 because he had a family emergency. -He did administer all the medications on 05/13/25, he just did not sign the MARs. -He knew he was supposed to sign the MARs after each resident was administered their medication. -He could not "justify" why he did not sign the MAR after each medication pass. Interview with the Administrator on 05/14/25 at	C 341		

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C 341	Continued From page 32 2:49pm revealed: -The MA should sign the MARs as soon as the medication was administered. -The MA should make sure the medication was correct and once the resident had taken the medication, the MA should document "right then and there". -He had seen times when the MA had not documented the medication pass immediately after administering the medication and had talked to the MAs about this. -He was concerned the MAs were not following protocol.	C 341		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .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 ensure that action was taken in response to the quarterly pharmaceutical review recommendation for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 09/1024 revealed diagnoses of edema, schizophrenia, alcohol abuse, chronic obstructive pulmonary disease, and arthritis.	C 381		

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C 381	Continued From page 33 Review of Resident #3's pharmacy quarterly review dated 10/10/24 revealed: -Resident #3 was taking 2 diuretics (a medication used to increase urine production, causing the body to release excess fluid and sodium). -The following recommendations by the consultant for a Metabolic Panel (MP is a test that reveals information about the body's fluid balance, electrolytes, and kidney function), -The form was signed by the Pharmacist. -The form had a place for the primary care provider (PCP) to accept or reject the recommendation. -The PCP marked the recommendation as accepted and signed the form on 05/02/25. Review of Resident #3's pharmacy quarterly review dated 01/15/25 revealed: -Resident #3 was taking 2 diuretics (a medication used to increase urine production, causing the body to release excess fluid and sodium). -An MP was not found in the resident record. -To ensure proper monitoring of the diuretics, please consider obtaining the BMP. -The form was signed by the Pharmacist. -The form had a place for the PCP to accept or reject the recommendation. -The PCP marked the recommendation as accepted and signed the form on 05/02/25. Review of Resident #3's pharmacy quarterly review dated 04/29/25 revealed: -Resident #3 was taking 2 diuretics (a medication used to increase urine production, causing the body to release excess fluid and sodium). -An MP was not found in the resident record. -To ensure proper monitoring of the diuretics, please consider obtaining the BMP if not obtained in the last 6 months. -The form was signed by the Pharmacist.	C 381		

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C 381	Continued From page 34 -The form had a place for the PCP to accept or reject the recommendation. -The PCP had not reviewed the recommendations, as evidenced by no response to the recommendation and no signature. Interview with the Administrator on 05/14/25 at 2:49pm revealed: -The pharmacist usually told him if there were any problems noted during the quarterly review. -If there were any recommendations for the PCP, he would leave them in front of the medication administration record (MAR) book because the PCP usually looked at the MARs. -Once the PCP addressed the issues, he would file the quarterly review in the resident's record. -He was taking Resident #3 to have labs drawn on Friday, 05/16/25. Attempted telephone interview with Resident #3's PCP on 05/14/25 at 1:17pm was unsuccessful.	C 381	A book was created for 5/28/25 the PCP to receive ~~a review~~ for all new information that affect every resident in the facility. Staff have been instructed to give this book to the PCP when on site.	