STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-144			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING			R 10/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PASSION	ATE CARE HOME #1			DRIVE		
			N, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual and follo on 1/10/25. Deficier	w up survey was completed ncies were cited.				
		sed for the following service C 27G .5600A Supervised h Mental Illness.				
	census of 2. The su	sed for 4 and has a current urvey sample consisted of clients and 1 former client.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, inclusion administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the distance of a person sector of the sector of the	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications liministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
м		MHL051-144	B. WING			R 10/2025
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	1 •	
PASSION	IATE CARE HOME #1		NUT CREEK D N, NC 27520	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	ge 1	V 118			
	checks shall be rec	or medication changes or orded and kept with the MAR ppointment or consultation				
	failed to administer order of a physician	et as evidenced by: view and interview the facility medications on the written and failed to keep MARs ents (#2). The findings are:				
	 Admission date Diagnoses: Bip Disc Disease, Hype Prostatic Hyperplas Physician's order hydrochloride (hcl) tablet by mouth dail Physician's order "multivitamin" take of (supplement) Physician's disconsistency 	olar Disorder, Degenerative rlipidemia, Insomnia, Benign ia, Nicotine Dependence er dated 4/25/24 for cetirizine 10 mg (milligram) take one				
	the morning before Review on 1/8/25 of 10/1/24-12/31/24 re - No staff initials administration for m 12/31/24 - No staff initials	breakfast (reflux) f client #2's MARs from				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-144			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
						_
		MHL051-144				R 01/10/2025
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PASSION	ATE CARE HOME #1		.NUT CREEK D N, NC 27520	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 118	Continued From page	ge 2	V 118			
	- Staff initials that documented administration for omeprazole from 11/23/24-12/31/24					
	Interview on 1/8/25	client #2 reported: at the facility for a year and 2				
	months					
		medication daily es with receiving medication				
	Interview on 1/8/25 staff #1 reported: - Client #2 went to the local veterans hospital					
	for all medical needs and his sister attended the					
	appointments with him - The veterans hospital sent client #2's					
	medication directly to the facility via mail					
	- The facility had difficulty getting information from client #2's sister regarding any medication					
	updates or changes	but often called the				
		erans hospital for clarification the facility used printed client				
	#2's MARs for the fa	acility monthly but had not				
	added cetirizine hcl	to client #2's MARs eceived cetirizine hcl daily				
		ordered but it was not				
	documented on the November 2024	MARs for October 2024 and				
	- Was not sure w	hy the multivitamin wasn't				
	initialed from 12/20/	24-12/31/24 n was administered daily				
		ordered on 11/22/24				
		ospital had continued to send omeprazole so she continued				
	to administer it desp	•	4			
	discontinued order of	0				
	Interviews on 1/8/25 Administrator report	5 and 1/10/25 the Facility				
	- Client #2 knew	his medication regimen and				
	took his medication	r took him to the veterans				

STATE FORM

		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL051-144	B. WING		R 01/10/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, ST	ATE, ZIP CODE		
	NATE CARE HOME #1	105 WALN	IUT CREEK D	RIVE		
FA33101	ATE CARE HOME #1	CLAYTON	, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	ge 3	V 118			
	attended the appoin - She was respon and MARs including matched the MARs, medication was disp there was daily door administration - "I take this as a administrator, I have have been and have - Moving forward medication when it pharmacy and the v would be checking r ensure accuracy - If a medication would ensure it was herself - She had contact	nsible for reviewing medication g ensuring physicians' orders discontinued and expired bosed of appropriately, and umentation of medication hit on myself because as the en't been here like I should en't been on top of my staff " , she would be checking in was delivered from the reterans hospital and staff #2 medication in with her to had been discontinued, she removed from the MARs ted the facility nurse and tration training would be				
	medication administ determined if the cli ordered by the phys					
		been cited 3 times since the /21 and must be corrected				
V 736	27G .0303(c) Facilit	y and Grounds Maintenance	V 736			
	maintained in a safe					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 01/10/2025	
		MHL051-144	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PASSION	IATE CARE HOME #1		NUT CREEK D	RIVE		
			I, NC 27520		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From pa	ge 4	V 736			
	odor.					
		on and interview, the facility in a safe, clean, attractive				
	Observation on 1/8/25 at approximately 10:25am revealed: - A single high-pitched chirp every 60 seconds which originated from a smoke detector in the dining room					
	light were not worki - The front of 1 c the kitchen	abinet drawer was missing in				
	#2's bathroom was substance in approx area	d the front of the toilet in client stained with a brown kimately a 4 inch by 1 inch				
	covered in a layer o - The door which	he return air filter vent were f dust lead to client #2's bedroom imately 10 inches by 5 inches				
	that were smudged - The inside of th client #1's bedroom	with a black substance e door frame which lead to had an area approximately was smudged with a black				
	time	ector had chirped for a short				
	repaired recently bu again	etectors had been tested and it that one had started chirping				
		e maintenance person on ke detector was chirping again				
	Interview on 1/8/25	the Facility Administrator				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-144		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER.	A. BUILDING:	BUILDING:		COMPLETED	
		B. WING			R 10/2025		
AME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
ASSION	ATE CARE HOME #1		IUT CREEK D	RIVE			
		CLAYTON	, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
V 736	Continued From pa	ige 5	V 736				
	the dining room ear - Not sure why the chirping again but set - Would ensure the mopped and cleaned brown stain around	he smoke detector was she would get that repaired that client #2's bathroom was ed very well to eliminate the I the toilet stitutes a re-cited deficiency					