Division of Health Service Rec	ulation			FOR	WAPPROVI
STATEMENT OF DEFICIENCIES WID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
		A. BUILDING:		COMP	TETED
	MHL011-452	B. WING		06/	20/2025
IAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	ULD BE COMPLETE DATE	20/2020
WANGER HOME		SHEL LANE			
Old the Column of the Column o		ANDA, NC 28778			7
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETE
V 000 INITIAL COMMENT	S	V 000			
An annual survey was deficiency was cited.	as completed on 6/20/25. A				07/10/2025
This facility is license category: 10A NCAC Living for Alternative	ed for the following service 27G .5600F Supervised Family Living.				
The facility is license census of 2. The sur audits of 2 current cli	d for 3 and has a current vey sample consisted of ents.				
V 118 27G .0209 (C) Medic	ation Requirements	V 118		a a	×
10A NCAC 27G .020	9 MEDICATION				
REQUIREMENTS					
(c) Medication admini	istration: n-prescription drugs shall				
only be administered	to a client on the written			1	
order of a person auti	norized by law to prescribe				
drugs.				1	
clients only when auth	be self-administered by norized in writing by the				
(3) Medications, include	ding injections, shall be				
administered only by I	icensed persons, or by		0.00		
unlicensed persons tra	ained by a registered nurse,				
privileged to proper ie	gally qualified person and				
(4) A Medication Admi	and administer medications. inistration Record (MAR) of				
all drugs administered	to each client must be kept		RECE	INFD	
current. Medications a	dministered shall be		1 1	1 2005	
recorded immediately	after administration. The		11 1	4 2023	
MAR is to include the	following:			4	at.
(A) client's name; (B) name, strength, an	d quantity of the days		DHSR-MH Li	censure de	Ot-
(C) instructions for adn	ninistering the drug;		Diloiting		
(D) date and time the o	drug is administered; and				
(E) name or initials of p	person administering the				
drug.					
of Health Service Regulation					
ST. BINEOTOR S OR PROVIDER/SL	IPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	CXC	DATE
(10)	V de la VII nu)	KC1)	()1	271	in Lana.

Division o	f Health Service Regu	lation	T	2 CALIFORNIA TION	(X3) DATE SU	PVEV
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLET	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING:			
	- 50.00201-00.00	MHL011-452	B. WING		06/20	/2025
	OVERED OR SHEED IED	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER	17 HERSH		12.7		
SWANGER	RHOME		IOA, NC 28778			
			T	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETE DATE
V 118	Continued From pag	e 1	V 118			
					1	07/10/2025
	(5) Client requests to	or medication changes or rded and kept with the MAR				
	checks shall be reco	ppointment or consultation				
	with a physician.	Spontation of contourse.				
	mar a prijaraian.		1		1	
				w	1	
			1			
						
	This Rule is not me	t as evidenced by:				
	Rased on record rev	views and interviews, the		i		
	facility failed to ensu	re medications were			1	
	administered on the	written order of a physician				
	and failed to keep th	ne MAR current affecting 2 of				
	2 clients (#1, #2). T	he findings are:			i	
1	Daview on 6/16/25	of Client #1's record revealed:				
1	-Date of admission:				-4-4	
	-Diagnoses: Schizo	affective Disorder, Severe		Signed physician orders are upda	ateo	
	Intellectual Develop	mental Disability (IDD),		and present in MAR.		
1	Seizure Disorder, H	lypothyroidism,				
	Hyperlipidemia, Typ	oe 1 Diabetes with Diabetic				
		ease, Urinary Incontinence,				
	Hydrocephalus.	appointment summary dated	1			
	-Unsigned medical	appointment summary dated				
	instructions to inject	t 32 International units/milliliter				
	(iu/ml) subcutaneou	usly at the same time daily and				
	increase up to 50iu	daily as directed for target	1			
	fasting blood glucos	se (BG) of 100-140.				
	-No physician's ord					
		5.00				
	Review on 6/17/25	of Client #1's physician's		Client #1 physican orders have	e been	
1	orders provided by	the Director of Operations and Director of Operations revealed:		obtained and placed in MAR		
	Did not have Clien	of #1's physician's orders prior				
	to the arrival on 6/1	16/25 of the Division of Health				
		(DHSR) surveyor.				

Division of Health Service Regulation

Divisio	on of Health Service Regu	ulation				FOF	RM APPROVE
	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		(V2) DATE	SURVEY
ANDPO	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG:	- 1		PLETED
					-		,
		MHL011-452	B. WNG_		- 1		laataaan
NAME O	F PROVIDER OR SUPPLIER	STREET A	חחחרבה מודע	CTATE TO		06	/20/2025
			SHEL LANE	STATE, ZIP CODE			
SWANG	GER HOME		ANOA, NC 28	2770			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX	(EACH DÉFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	CORRECTION	=	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIA	TE	DATE
				DEFICIEN	CY)		
V 11	8 Continued From page	2	V 118	553300000 10 MANAGEMENT SAC (17 500 - 10 50 -			
	-Obtained copies of C	lient #1's physician's orders					07/10/2025
	on 6/17/25 from the di	spensing pharmacy #2					
	-Physician's orders inc	cluded:					
	-Levothyroxine 15	60 micrograms (mcg)			-		
	(thyroid) - 1 tablet (tab) daily ordered 4/21/25. No					
	prior order was availab	ole. lligrams (mg) (allergies) - 1					
	tab daily ordered 4/21/	25 No prior order was					1
	available.	20. No prior order was		1			
	-Spironolactone 1	00mg (blood pressure) - 1		1			
	tab daily ordered 3/11/	25.		1			
	-Atorvastatin 10mg	g (cholesterol) - 1 tab daily					
	ordered 3/11/25,						
	-Omeprazole 20m (cap) daily ordered 3/1	g (antacid) - 1 capsule					
	-Amindinine 5mg/	1/25. blood pressure) -1 tab daily				- 1	- 1
	ordered 3/11/25.	blood pressure) -1 lab daily				- 1	- 1
	-Trazodone 100mg	(sleep) - 3 tabs daily				- 1	- 1
	ordered 2/20/25.						I
	-Clozapine 100mg	(seizures) - 2 tabs daily				- 1	
	ordered 2/20/25.	00mg (schizophrenia) - 1		1		- 1	
	tab in the morning and	2 tabs in the evening daily					- 1
	ordered 8/6/24.	tabs in the evening daily					1
	-Levetiracetam 500	mg (seizures) - 1 tab					- 1
	twice daily ordered 2/20	/25.				1	
1	-Guanfacine 1mg E	R (extended release)				- 1	
	(behavior) - 2 tabs twice	daily ordered 2/20/25.				- 1	
	daily ordered 2/20/25.	(seizures) - 1 tab twice					
1	-Lantus Solos 100 i	u/ml (diabetes) - inject					
- 1	15iu subcutaneously eve	ery morning, HS (hour of					- 1
ł	sleep) based on: if BG>	(greater than) 220.					1
- 1	administer 15iu; if BG 18	31-219, administer 12iu: if					- 1
- 1	BG 150-180, administer	8iu: if BG < (less than)					
- 1	depending an anti-	e can be changed +/- 2iu	p 14	ŀ		1	
	depending on eating, illn ordered 4/21/25.	ess, activity, or behaviors					- 1
ł		00iu/ml (diabetes) - inject				1	
-	5-9iu subcutaneously bel	fore meals and RG		400			1
sion of Heal	h Senice Population			4			1

	Health Service Regu	lation	(X2) MULTIPLE C	CONSTRUCTION	3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	,	COMPLETED
AND PLAN O	CORRECTION		A BOILDING.		
			B. WING		06/20/2025
		MHL011-452	B. WING		UUI AUI AU
NAME OF PE	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE	
NAME OF TH	OVIDENTIA	17 HERSI	HEL LANE		
SWANGER	HOME	SWANNA	NOA, NC 28778		
	SUMMARYS	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
(X4) ID PREFIX	YEACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1 1/45	DEFICIENCY)	
			1		
V 118	Continued From pag	e 3	V 118		07/10/2025
	competion of a mayir	num of 30iu daily ordered			0171412424
	4/24/25 No prior or	ler was made available.			
	4/2 1/25. 140 phor ore				
	Review on 6/17/25 of	of Client #1's undated			
	Novolog sliding scal	e administration directions		2	
	revealed:				1 1
	-Blood Sugar 200-2	50-sliding scale 2 units.			
	-Blood Sugar 251-3	00-sliding scale 4 units.	1	An updated signed sliding scale completed and placed in MAR	
	-Blood Sugar 301-3	50-sliding scale 6 units.		completed and placed in WAR	
	-Blood Sugar 351-4	00-sliding scale 8 units. 50-sliding scale 10 units.			
1	-Blood Sugar 401-4	igher-sliding scale 12 units,			
	recheck 1 hour, folk	ow scale again.	1		
	Stiding scale did no	ot match order dated 4/21/25.			
	-				1 1
1	Review on 6/16/25	of Client #1's MARs for period			
1	4/1/25-6/16/25 reve	aled:			
	-April MAR			Updated signed med order	
	-Levothyroxine	was documented as		placed in MAR	
		1/25-4/20/25 without an order.	1		
	(20 days)	as documented as administered	1	1	
	on 4/1/25-4/20/25	without an order. (20 days)		1	{
	-Lantus was n	ot documented as administered			1
	on 4/1/25-4/30/25.	(30 days)			
	-Novolog was	documented as administered 4			
1	times daily on 4/1/2	25-4/20/25 without an order.			
1	(20 days)				
	-May MAR			AFL has been placed on strict	
	-Levotnyroxing	e was documented as no separate entries on 5/1/25-		supervision, registered nurse r	eviews
	5/31/25. (31 days)			orders and MAR multiple times	per
	-Novolog was	not documented as		week. Until this occurred, QP v	vas not
1	administered on 5	1/25-5/31/25. (31 days)		aware AFL was dyslexic, QP h	as color
1	"June MAR			coded MAR to aid in understar	nding.
	-The following med	dications were not documented	1		
1	as administered or	n 6/1/25-6/16/25 (16 days):			
	-Levothyroxin	е.			
	-Loratadine.			1	
1	-Spironolacto	ne.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
001011	or correction	IDENTIFICATION NUMBER:	A. BUILDING	·	COMP	LETED
		MHL011-452	B. WNG		06/	20/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
SWANGER	HOME	17 HERS	SHEL LANE			
JIIANOE!	THOME	SWANN	ANOA, NC 287	78		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From page	4	V 118	AFL has been placed on intensi		
				supervision for a period of 3 mor	ve	07/40/000
- 1	-Atorvastatin.			This will consist of wealth wisite	itns.	07/10/2025
	 Omeprazole. 			This will consist of weekly visits.		
	-Amlodipine.			Audits will be in all areas however	er,	
	-Trazodone.		1	medications will be top priority. T	hese	
1	 Clozapine. 		1	will be unannounced visits. After	3	
	 Chlorpromazine. 			months of successful completion	s this	
- 1	 Levetiracetam. 			will go to 2 times per month (this	will	
	-Guanfacine.			be for a 3-month period as well).		
- 1	 Divalproex. 		1	Medication Administration class	was	
- 1	-Novolog.		1	held- this was completed instruct	ion	
- 1	-Lantus.	0 BACKWOO TO 2 400 TON		covering aspects of medication,	i	
	-Neither Lantus nor No	ovolog were documented	i	reviewing MD orders, reviewing t	he 6	
- 1	with the actual numbe	r of units of each	1	rights of medication, reviewing th	e	
		administered on each MAR		importance of insulin and couma	din.	
-	reviewed.			and ensuring MAR documentatio	n is	
				correct. AFL demonstrated	10070	1
		Client #1's BG logs for		proficiency in administering	1	
	period 4/1/25-6/16/25			medication through observed pra	etice	
	-Levels documented a	t 8am, 12pm, 4pm and	1	in her home by		
	8pm daily, with the cor	responding number of		QP. This medication training		
1	Novolog units administ	tered revealed:		encompassed patient safety throu	iah	
1	On 4/1/25 at 8am BG	level 247; 2 units.		knowledge base, skill developme	nt	
	-Un 4/1/25 at 12pm BC	3 level 360; 4 units (8 units		and learning. An in-depth	,	
		ninistered according to the	1	conversation was had with Fran		
	sliding scale).	I 1 000 0 7-		regarding the importance of askin	a	- 1
	On 4/4/25 at 8am BG			questions/assistance if something	اف	- 1
	On 4/11/25 at 4pm BC			not understood. Fran verbalized	13	- 1
	On 4/12/25 at 8am BC			understanding and the great		- 1
1.	On 4/15/25 at 12pm B	G level 240; 2 units.		importance of this- attached is a		- 1
	On 4/16/25 at 8am BG		1 1	of her medication administration	ору	- 1
1.	On 5/7/25 at 8am BG	level 220; 2 units.		training Clients sharman back		- 1
	On 5/15/25 at 8am BG	e level 270; 2 units.	1 1	training. Clients pharmacy has be switched to a local pharmacy,	en	
	All other dates/times n			Prescription Pad of Marion.		1
	evels were between 42 ndicate a need for Nov	2-196 which did not volog to be administered.		rescription rad of Marion.	-	- 1
		6/16/25 with Client #1 was				
11	insuccessful as Client	#1 did not reenand			1	
	rerbally to questions as				1	1

Division of	f Health Service Requ	lation	T Management		NO DATE CIT	DIEV
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SUI	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		00	
					1	- 1
			B MING		06/20	12025
		MHL011-452	B. WING		06/20	12023
	AND AND CUMPULED	STREET AS	DRESS, CITY, STAT	E, ZIP CODE	*	1
NAME OF P	ROVIDER OR SUPPLIER		HEL LANE			i
SWANGE	HOME					- 1
ONANGE	· Howe	SWANNA	NOA, NC 28778			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X6) COMPLETE
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	DIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
			1		-	
V 118	Continued From page	e 5	V 118			- 1
1 110						07/10/2025
		f Client #2's record revealed:	1		1	
1	-Date of admission: 5	5/7/24.	1		1	
	-Diagnoses: Autistic	Disorder, Severe IDD,			1	1
	Seizure Disorder, Blo				1	
	-No physician's orde		1 1		1	
	-No priyations orde	a present.			- 1	- 1
	Deview on GIAZINE o	f Client #2's physician's	1 1			1
1	Review on 6/1/125 0	ne Director of Operations and		Updated signed med order	heaela	- 1
1	orders provided by the	de Dilector or Oberations and			placeu	
1	interview with the Di	rector of Operations revealed:	1 1	in MAR	- 1	
1	-Did not have Client	#2's physician's orders prior	1		1	
1	to the arrival on 6/16	1/25 of the DHSR surveyor.	1		1	
1	-Obtained copies of	Client #2's physician's orders]	- 1
1	on 6/17/25 from the	dispensing pharmacy #2.			1	
1	-Physician's orders i	ncluded:			1	
1	-Cetirizine 10mg	g (allergies) - 1 tab daily				
1	ordered 5/7/25. No	prior order was available.	1		1	
1	-Vitamin D3 25r	ncg (supplement) - 1 cap			-	
	daily ordered 2/11/2		1.			
1	Clanaranam O	.5mg (seizures) - 1 tab daily				
1	-Cionazepani o	orior order was available.				
1	Codered b/5/25. NO	e 300mg ER (seizures) - 2	1			
1	-Carbamazepin	end 2 cons event evening	1			
1		and 3 caps every evening				
1	ordered 2/10/25.	of seed 9350 (seestinglise)			3	
1	-Polyethylene (Slycol 3350 (constipation) -	1		1	
	dissolve 17 grams in	4-8 ounces of water/juice	1			
	daily ordered 8/20/2	4.	1			
1		Omg (acne) - 1 cap twice daily				
1	ordered 5/20/25.		1			
	-Warfarin 1mg	(blood clots) - take as directed	1	1		
1	per protocol ordered	7/17/24.				
	-Warfarin 6mg	take as directed per protocol				
	ordered 5/6/25. No	prior order was available.		Marforin orders have been si	aned	
1	-Warfarin 10mg	- 1 tab daily ordered 4/2/25.		Warfarin orders have been si	yrieu	
	- Constant Torns	,		and placed in MAR- clients le		
1	Peview on 6/16/25	of Client #2's Warfarin		are checked often and Warfa	rin	
1	administration prote	ocol provided by the Warfarin		doseage may change-	9	
		our provided by the Transam		BSN,QP reviews new MD od	ers	
	clinic revealed:	ational Normalized Ratio)	1	after visit and reviews with A	FL	
1		audital Normalized Ratio)	1	AND THE PROPERTY AND THE PROPERTY AND THE PROPERTY OF THE PROP		1
1	2.5-3.5"		- 1	I.		
1	-4/1/25: INR 4.3 - 8	administer: Sunday 10mg,	1			1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			PLETED
		MHL011-452	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	1 06	/20/2025
			HEL LANE	IE, ZIP CODE		
SWANGE	RHOME		ANOA, NC 28778	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	6	V 118			
- 1	Monday 7mg, Tuesda Thursday 7mg, Friday return 1 week. -4/8/25: INR 2.3 - adr Monday 7mg, Tuesda Thursday 10mg, Frida return 2 weeks. -4/23/25: INR 2.5 - ad Monday 7mg, Tuesday Thursday 10mg, Frida return 1 week. -4/30/25: INR 2.8 - ad Monday 7mg, Tuesday Thursday 10mg, Frida return 4 weeks. -5/28/25: INR 2.7 - ad Monday 7mg, Tuesday	y 5mg, Wednesday 10mg, 10mg, Saturday 10mg, ninister: Sunday 10mg, y 10mg, Wednesday 7mg, y 7mg, Saturday 10mg, lminister: Sunday 10mg, y 10mg, Wednesday 7mg, y 7mg, Saturday 10mg, y 10mg, Wednesday 7mg, y 10mg, Wednesday 7mg, y 7mg, Saturday 10mg, minister: Sunday 10mg, y 10mg, Wednesday 7mg, y 7mg, Saturday 10mg, y 10mg, Wednesday 7mg, y 10mg, Wednesday 7mg, y 10mg, Wednesday 7mg, y 7mg, Saturday 10mg,				07/10/202
	4/1/25-6/15/25 reveale -April MAR -Cetirizine was do- on 4/1/25-4/30/25 withVitamin D3 was d administered on 4/1/25 (30 days) -Clonazepam was administered on 4/1/25 (30 days) -Polyethylene Glyc administered from 4/1/2 -Warfarin 1mg was administered on 4/1/25 dosage identified. (30 d -Warfarin 6mg was	cumented as administered out an order. (30 days) ocumented as -4/30/25 without an order. documented as -4/30/25 without an order. ol was not documented as 25-4/30/25. (30 days) documented as 4/30/25 without the days)		Updated signed med orde in MAR	er placed	

	of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
		WHL011-462	B. WING		06/20	/2025
NAME OF ST	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP GODE		
NAME OF PE	TOVIDER OR SUPPLIER		HEL LANE	190 7900		
SWANGER	RHOME		NOA, NC 2877			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	(28 days) -May MAR -Cetirizine was on 5/1/25-5/6/25 with -Vitamin D3 was administered on 5/1/ (5 days) -Clonazepam w administered on 5/1/ (31 days) -Minocycline was administered on 5/2/ -No documentat from 5/1/25-5/11/25Warfarin 10mg documented as adm 5/13/25, 5/15/25, 5/5/26/25-5/31/25. (2-June MAR -Clonazepam w administered on 6/1 (4 days) -Carbamazepin administered on 6/1 entries. (9 days) -Minocycline w administered from 6/1 entries. (9 days) -Warfarin 10mg documented as administered from 6/6/25, 6/8/25, 6/10 (8 days) Attempted interview unsuccessful as Cliverbally to question	documented as administered nout an order. (6 days) a documented as 25-5/5/25 without an order. as documented as 25-5/31/25 without an order. as not documented as 2/25-5/31/25. (12 days) at the daily was not not of Warfarin administration (11 days) 1 tab daily was not not stered on 5/1/25-5/11/25, 1/1/25, 5/19/25, 5/23/25, 2 days) 1 tab daily was not not not stered as 1/25-6/4/25 without an order. The was documented as 1/25-6/9/25 on two separate as not documented as 1/25-6/9/25 on two separate not	V 118	AFL has been placed on intensis supervision for a period of 3 more This will consist of weekly visits will be in all areas however, medications will be top priority. Will be unannounced visits. After months of successful completion will go to 2 times per month (this for a 3-month period as well). Medication Administration class held- this was completed instruct covering aspects of medication, reviewing MD orders, reviewing rights of medication, reviewing importance of insulin and coum and ensuring MAR documentatic correct. AFL demonstrated profin administering medication through conversation in her home. Dobson BSN, QP. This medication through knowledge base, skill development, and learning. An conversation was had with regarding the importance of ast questions/assistance if someth understood. The province of this attached is a copy of hem medication administration train Clients pharmacy has been swallocal pharmacy, Prescription Marion.	nths. Audits These r 3 ns this s will be was ction the 6 the adin, ion is ficiency bugh by April tion afety in-depth king is not apportance or ing.	07/10/2025
	-Packaged medical	tions in dispill packs.				

	of Health Service Reg	ulation			FOR	MAPPROVE
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	(X3) DATE	SURVEY
AND I DAY	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		MHL011-452	B. WING		ne	20/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE 7/0 0005	1 00	2012025
			HEL LANE	WE, ZP CODE		
SWANGE	RHOME		ANOA, NC 28778	D		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES				-
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XS) COMPLETE DATE
V 118	Continued From page	9 8	V 118			
- 1	-Warfarin was packed	in bottles due to possible				
	changes in administrative week basis. "Importative (Warfarin) clinic." -"Coumadin (Warfarin adjust carefullyther	ation dosing on a week to ant to follow instructions from a) clinic monitors dose to apeutic level is 2.5too		Signed Coumadin orders are by QP and rewrith		07/10/202
	much Warfarin would make INR go up; not enough, INR would go down." Interview on 6/19/25 with the Pharmacist from					
1	dispensing pharmacy	with the Pharmacist from				
	-Received transferred	physicians' orders for	1 1			
	Client #1 and Client #	2 on 8/17/25 from				
	dispensing pharmacy					
1.	" Without Insulin for	Type 1 diabetic, well, his	1			
1	(Client #1's) sugar is n	poing to be offcould lead	1 1			
14	to serious complication	ns, depending specifically	1 1		1	
- 1	on him and how his bo	dv uses the insulin	1 1		1	
	pancreas is being at	lacked so the body is not			1	
l r	producing insulin at all	have to put (administer)	1 1		1	
li	nsulin inwhat the bo	ody should be producing	1 1		-	
r	naturallyshould be a	base level of insulin given	1		1	
(administered)with To	ype 1 (diabetes), they will			1	- 1
0	check sugar (blood glu	cose) before eating and	1		1	
n	nay not need a dose (of insulin) if not highnot	1 1		1	- 1
a	all insulins are the sam	e, as all diabetics are not			}	- 1
	he same"		1			- 1
-	He did not understand	the physician's orders for	1 1			- 1
10	lient #2's Warfarin. "	haven't processed this	1 1	Clients prescriptions have be	en	. 1
p	articular order so I doi	n't have the answer	1	moved to local pharmacy.		- 1
(6	explanation of orders)	l can't speak for	l i	Prescription Pad of Marion		- 1
le	dispensing pharmacy a	#1]patient (Client #2)			- 1	- 1
s	hould receive Warfarin	based on INR testing and				- 1
P	rotocolswe would re	each out (to Client #2's				- 1
P	hysician) to get (Warfa	arin) protocols"				
-V	The goal is to lease INF	R to prevent blood clots.			. 1	
10	INC goal is to keep INF	R in a therapeutic range		N/		
IN	IR increases the fi	isk of blood clotshigh				- 1
111	want enoting the acid!	eedinggot to find the				
	weet spot in the middle Service Regulation	9"				

Division of	f Health Service Regu	lation			LOW DATE SI	100.00
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		l	1			
		MHL011-452	B. WING		06/20)/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		1
		17 HERSI	HEL LANE			1
SWANGER	RHOME	SWANNA	NOA, NC 28778			
	SIMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
V 118	Continued From pag	e 9	V 118	*		
1 110				*		07/10/2025
		ocol is confusing, even to the				
	trained person."					
		5 and 6/17/25 with the	-			
	Alternative Family Li	ving (AFL) provider revealed:				
	-Client #1 had lived i	n the facility for 12 years.	1			1
	-Client #2 moved to	the facility in April 2024.	l l			
	-Client #1 "is two hai	ndfuls (of work to provide				
	care for)spilled dri	ink all over the table, ruined		1		
		Rjust picked up new one	1			
	(MAR) on Saturday	(6/14/25)."				
	-Administered the pi	Il packs dispensed by by #1 to Client #1. "don't	1			
i .	know what units (of	inculin) Lagra				
	(now what units (or	rmacist just said, 'mark the				
	MAR with initials' (at	for medication				
	administration) sol	metimes I don't give any		1		
1	(Navalog) Novolog	g is on sliding scaleLantus,	1			
1	Laive 15iu in the mo	orning and 5-9iu at night, if	1			
	needed"			Ì		
1	-Procedure to check	Client #1's blood glucose				
	levels was to " wa	sh hands, put on gloves, wipe				
1	skin with alcohol pa	d, stick finger, take strip test]
1	in unit, put in sharps	s box"				
	-Client #1 allowed h	er to check his blood glucose				
	levels 4 times daily.	She would then record the	1			1
	reading on a separa	ate sheet from the MAR.				
	-"Give orange juice	(to Client #1) If blood sugar				
	dropsI can tell so	methings (Client #1) is not		į		
1	right if he looks dizz	ry, staggerswill check blood				
		n't had to recheck sugar in				
1	months."	hus in language potics and				
1		tus is longer acting and				
	Novolog is short ac	torad) before mosts as slidica				1
1	- Novoiog (adminis	tered) before meals on sliding				
	scales5-9 units b					1
	- Novolog always a	sliding scaleLantus sliding scalePrior to April,				1
	Lantus was given /	administered) 32 units every				1
1	night Novolog 5-9	units based on sugar level."	1			

Division of Health Service Regulation

4WY011

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL011-452 B. WNG 06/20/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 17 HERSHEL LANE SWANGER HOME SWANNANOA, NC 28778 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 118 Continued From page 10 V 118 -"Had [Client #1] for 12 years and sign (MAR) when I check his sugar ... no one ever told me Medication Administration has been differently." performed with AFL discussion is 07/10/2025 -Acknowledged on 6/17/25 that Client #1's June always had to initial on MAR after a 2025 MAR had no documentation to indicate medication administration as of 6/16/25 at the medication has been given. AFL has start of the DHSR survey. "I completed (initialed been educated with MAR documentation. As mentioned above, to indicate medication administration from 6/1/25-6/16/25) June (2025) MAR yesterday an extensive medication training was conducted to ensure proficiency and (6/16/25, after the start of the DHSR survey) understanding with medications and ...thought I was supposed to finish them (MARs) administration. QP is with AFL multiple ...wanted to make things better." -Received information from Client #1's day times per week to ensure support workers regarding his blood glucose understanding and to answer any levels when Client #1 is away from the facility questions. Documentation continues during the day. "I write down what (day support) to be reviewed weekly, MARs have workers tell me his sugar readings are during the been color coded to facilitate times/ day." understanding, new insulin and -Client #2 was prescribed Minocycline in May coumadin logs created to aid in 2025. "I didn't know it was here ...it was in a understanding. AFL verbalizes separate thing ... I just put It in the (medication) understanding and knows to contact box ... I looked at the dispill pack, but I didn't look QP with any questions. New pharmacy at the bottle ..." has begun filling medication in bottles -Administered the correct dose of Warfarin to versus pill packs. Client #2 and identified " ... if 10mg is needed then I give him a 10mg tab ...7mg, I give one 1mg tab and one 6mg tab." Before receiving the 10mg tablets, "I was giving one 6mg tab and four 1mg tabs ... -"Warfarin was given (administered in early May 2025); I don't know why it was not recorded (documented as administered on the MAR)," -"[Client #2] has been treated for blood clots ...has filters in arteries to keep the clots from getting to his heart ... ' -Client #2 went to see his doctor twice annually, but "had blood draws (INR testing) sometimes weekly, sometimes every 4 weeks, depending on thickness of blood." -"He (Client #2) did get (was administered) the

	f Health Service Regu of DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ELED
		MHL011-452	B. WING		06/2	20/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
SWANGER	HOME	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	HEL LANE			
SWANGER	CHOME	SWANNA	NOA, NC 28778		TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	Miralax (polyethylene- Process for medicat "Open bubble packs time in their (clients') water to make sure y document on the MA document when I giv (medication)." -Client #2's Warfarin but was not added to "Began administration Coumadin (warfarin) unexpectedlyI jus doingI didn't know promise both boys (administered) their -The Quallfied Profe (QP/RN) "visits ever boys' rooms, looks if fire extingulshers, m locked, sometimes I sometimes looks at what she looked at boysmeets client other month." Interviews on 6/18/2 QP/RN revealed: -"Meets with [AFI paperwork, includin ordershaven't ha May (2025) meeting the home (facility)absolutely would (2025) MARrevi issues." -"[AFL provider] has	e 11 e glycol) every day in April." ion administration was to place one or two pills at a mouths, have them drink pills are down (swallowed)I uR at nightI should we (administer) it 10mg was added on 4/2/25, po the April 2025 MAR. on on 4/4/25 based on of clinic resultsmy sister died it wasn't sure what I was who to contact beforeI dients) got (were meds" essional/Registered Nurse y other monthtalks, checks in fridge (refrigerator), checks lakes sure chemicals are looks at medications, MARSDon't really know because I'm busy with the is in the community every 25 and 6/20/25 with the L provider]go through g MARs, any changes, new d June (2025) meeting yet. g was in the community, not in I only take the original MAR not have taken a partial April ewed April MAR and saw no	V 118	AFL has always been aw contact with any questions/conce AFL verbalizes understar and know the point of cor Since this audit AFL and have worked closely in identifying problems, que, or concerns.	erns. nding ntact. QP	07/10/2025
	on a single sheet	(medications) from the doctor " to for (AFL provider to record				
Division of H	lealth Service Regulation	tion (A) Epionael to locala				

MHL011-452 MHL011	STATEMEN	of Health Service Reg	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SLIBVEY
AMAGER HOME SUMMARY STATEMENT OF DEFICIENCIES (PACH DEPOCEMENT WINTER DEPRECEDED BY FULL PREFIX TAG CO ID PREFIX TAG COntinued From page 12 Client #1's) blood sugars." -Conducted monthly supervision with the AFL provider and "would have made a note (on supervision record) but not aware of any med changes in April (2025)." -"Some of this (medication administration and documentation) is done correctly and members (iclients) are safe." -"I will ensure this (medication administration and documentation) and get it corrected, but she's got the piece (overall care of the (elients) you can't teach" -"I spent 11 hours with the (AFL provider)I think she was just nervous with (OH-ISR) survey and didn't really know what to say." Interview on 6/17/25 with the Director of Operations revealed: -Unable to access previous physician's orders for Client #1 and Client #2 due to a system change in April 2025. -Changed pharmacies on 6/17/25 during the DHSR survey to keep all licensed homes receiving services from one pharmacy; -Will have the dispensing pharmacy #2 dispensa medications in separate bottles rather than dispill packs to more easily manage medication -Was not aware the AFL provider had not Initialed to indicate medication administration on Client #1's June 2025 MAR from 6/1/25-6/16/25 when it was first reviewed by the DHSR surveyor.	AND PLAN	UP GURRECTION	IDENTIFICATION NUMBER:				
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PROPRIES INJURY STATEMENT OF DEFICIENCIES SWANNANDA, NC 28778 SUMMARY STATEMENT OF DEFICIENCIES SWANNANDA, NC 28778 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOCEMENT MUST BE PRECEDED BY FULL TAG CROSS-REFERENCE) TO THE APPROPRIATE CATON SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE CATON SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) V118 Continued From page 12 Client #1's) blood sugars." -Conducted monthly supervision with the AFL provider and "would have made a note (on supervision record) but not aware of any med changes in April (2025)." "Some of this (medication administration and documentation) is done correctly and members (clients) are safe." -Occasionally made "drop in visits" to the facility, but "talks frequently on the phone with [AFL provider]." "I can teach this (medication administration and documentation) and get it corrected, but she's got the piece (overall care of the clients) you can't teach" "I spent 11 hours with her (AFL provider)I think she was just nervous with (DHSR) survey and didn't really know what to say." Interview on 6/17/25 with the Director of Operations revealed: -Unable to access previous physician's orders for Client #1 and Client #2 due to a system change in April 2025. -Changed pharmacies on 6/17/25 during the DHSR survey to keep all licensed homes receiving services from one pharmacy. -We not aware the AFL provider had not initiated to indicate medication administration on Client #1's June 2025 MAR from 6/1/25-6/16/25 when it was first reviewed by the DHSR surveyor.	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE. ZIP CODE	1 00/	LUIZUZU
SWANNANOA, NC 28778 SUMMAP SYMEMBY OF DEFICIENCES PREFX 1AG SUMMAP SYMEMBY OF DEFICIENCES PREFX 1AG CACHER GENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V18 Continued From page 12 Client #1's) blood sugars." -Conducted monthly supervision with the AFL provider and "would have made a note (on supervision record) but not ware of any med changes in April (2025)." -"Some of this (medication administration and documentation) is ofone correctly and members (clients) are safe." -Occasionally made "drop in visits" to the facility, but "falks frequently on the phone with [AFL provider]." -"I can teach this (medication administration and documentation) and get it corrected, but she's got the piece (overall care of the clients) you can't teach" -"I spent 11 hours with her (AFL provider)! think she was just nervous with (DHSR) survey and didn't really know what to say." Interview on 6/17/25 with the Director of Operations revealed: -Unable to access previous physician's orders for Client #1 and Client #2 due to a system change in April 2025. -Changed pharmacies on 6/17/25 during the DHSR survey to keep all licensed homes receiving services from one pharmacy; #2 dispense medications in separate bottles rather than dispill packs to more easily manage medication administration. -Vise not aware the AFL provider had not initialed to indicate medication administration on Client #1's June 2025 MAR from 6/1/25-6/16/25 when it was first reviewed by the DHSR surveyor.							
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#1's June 2025 MAR from 6/1/25-6/16/25 when it was first reviewed by the DHSR surveyor.	1.	vvas not aware the AF	L provider had not initialed				
was first reviewed by the DHSR surveyor.							
-"I will be monitoring the AFL (provider) now."	#	ris June 2025 MAR fr	rom 6/1/25-6/16/25 when it				
- I will be infoliting the AFL (provider) now."	V	vas first reviewed by th	ne DHSK surveyor.				
	-	i will be monitoring th	e Art (provider) now."				
Due to the failure to accurately document			curately document				

5599

Division of	f Health Service Requ	ation	Town AND THE CONSTRUCTION		(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		COMPLETED	
AND PLAN OF CORRECTION			A BUILDING.			
			B. WING		06/20/2025	
		MHL011-452				
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	, ZIP CODE		
		17 HERSH				
SWANGER	R HOME	SWANNA	NOA, NC 28778	AND AND THE AND TO CORDECTION	N (X5)	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	E COMPLETE	
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	NAIC	
V 118	Continued From page 13		V 118		07/10/2025	
	medication administr	ation, it could not be			0// (5//	
	determined if clients	received their medications				
	as ordered by the ph					
	_ ,	file Dien of Protection				
	Review on 6/20/25 of	of the Plan of Protection of and signed by the QP/RN				
	revealed:	and signed by the termina				
	-"What immediate a	ction will the facility take to				
1	ensure the safety of	the consumers in your care?	1 1			
	A remedial medication	on administration class was		9		
1	held 06/19/2025 7:4	5 am-4:45 pm to ensure				
	compliance and und	lerstanding of rules and is comprehensive instruction				
	company policy. Thi	t limited to the following				
	covered but was no	medication review, review of				
	medication orders.	reviewing the 6 rights of				
	medication, reviewil	ng the importance of Insulin				
1	and Coumadin, con	rect MAR documentation, and		*		
	the importance of o	rganization. [AFL provider]				
	demonstrated profit	ciency in administering				
	medication through	observed practice in her nsed registered nurse. This				
	medication training	encompassed patient safety				
	through knowledge	base, skill development, and				
	learning. An in-dep	th conversation was had with		₩.		
1	(AFL provider) rega	rding the importance of asking				
	questions if someth	ning is not understood. All				
	prescriptions have	been moved to local pharmacy				
	[dispensing pharma	acy #2]. All medication will be				
	in bottles verses th	e prepackaged blister packs. A k was given with updated				
1	new WAK notebook	lew Coumadin and Insulin logs				
	were created and	given. [AFL provider] was also				
	made aware to cor	ntact QP (QP/RN) with any		1		
	medication change	es and verbalized		1		
	understanding. The	ere will be no new clients				
	placed in the Swar	nger home (facility) until the	1			
1	home is in full com	pliance and CSB (Clear Sky				
		Licensee) is confident that she				
1	is ready.		1			

Division of Health Service Regulation

4WY011

	of Health Service Regi	ulation			FOR	RM APPROVE	
	OF CORRECTION	NCIES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
		MHL011-452	B. WING				
NAME OF F	PROVIDER OR SUPPLIER		22222		1 06	06/20/2025	
WOME OF T	NO VIDEN ON SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
SWANGE	R HOME		SHEL LANE ANOA, NC 28778				
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES					
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION			
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
				DEFICIENCY)			
V 118	Continued From page	14	V 118				
	-Describe your plans to make sure the above					07/10/202	
	happens.					1	
	[AFL provider] will be	placed under intensive				1	
	supervision for a perio	od of 3 months. This will				1	
	consist of unannounce	ed weekly visits.					
	Supervisions will revie	ew and audit for deficiencies				1	
	in all areas with an en	nphasis being on					
	medications. After the	initial 3 months have been				1	
	completed successfully, the intensity will reduce		1 . 1				
1	to 2 times per month and continue for an						
t t v f f	additional 3-month period. Intense supervision will		1 1				
	be terminated upon successfully demonstrating compliance over a period of no less than 6					1	
	months."	idd of the less triain o					
	Review on 6/20/25 of	the amended POP signed					
	and dated 6/20/25 by 1	the QP/RN, Operations of				1	
	Innovations, and the D	Director of Operations					
	revealed:	•	1		1	1	
	"These supervisions w	rill be completed by				1	
	[QP/RN]."						
	Client #1 was diagnose	ed with Schizoaffective					
	Disorder, Severe IDD,	Seizure Disorder.					
	Hypothyroidism, Hyper	flipidemia, Type 1 Diabetes					
	with Diabetic Chronic I	Kidney Disease, Urinary					
	Incontinence, and Hyd	rocephalus. Client #1's					
	medication orders inclu	ided Novolog and Lantus					
	to assist in control of 1	ype 1 Diabetes. Lantus	1		1		
	the morning or evening	s administered for either			1		
	through 6/16/25 for a to	otal of 77 days. Novolog			ļ		
	was documented as ad	Iministered 4 times daily			İ	1	
	from 4/1/25 through 4/3	80/25 for a total of 30 days					
	without the specific num	nber of units administered.					
	There was no physiciar	n's order for Novelog prior			1	- 1	
	o 4/21/25. Novolog wa	as not documented as				1	
	administered 5/1/25 thr	ough 6/16/25 for a total of			1		
	17 days. There was no	documentation of					
		nyroxine and Loratadine			1	1	
n of Healti	h Service Regulation						

Division of	Health Service Regu	ation	Tarman man man	SUCTOLICTION	(X3) DATE SUF	EVEY		
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		COMPLETED			
AND PLAN O	FORRECTION		A. BUILDING:					
	MHL011-452		B. WING		06/20/2025			
			J	TR CODE	10.40			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 17 HERSHEL LANE								
SWANGER	HOME		IOA, NC 28778	(*)		1		
			ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)		
(X4) tD PREFIX	(FACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)				
			1					
V 118	Continued From page	e 15	V 118			07/10/2025		
	from 4/1/25 through	4/20/25 for a total of 20 days.			1			
	There was no docum	entation of any medication			Í			
	administration for Cli	ent #1's medications from			1			
	6/1/25 through 6/16/	25 for a total of 16 days.			1	l		
	Client #2 was diagno	osed with Autistic Disorder,			. 1			
	Severe IDD, Seizure	Disorder, and Blood Clots.						
	The following medica	ations were administered		•				
	without an order. Co	etirizine on 4/1/25-5/6/25 (36						
	days), Warrann omg	on 4/1/25-5/5/25 (35 days), 4/1/25-6/4/25 (65 days).	1		1			
	Based upon the lack	of information documented	1 1					
	on the MARs, it could not be determined if Client							
	#2 was administered	the correct dose of						
	Warfarin. He was a	dministered Warfarin 1mg ly for 7 days in May. He was						
	administered Warfa	nn 6mg daily in April, but only	1					
1	for 8 days in May. T	he administration of Warfarin						
1	did not reflect the de	osing requirements provided						
	by Warfarin clinic.	Client #2 was ordered			1			
	Wartarin 10mg dally	on 4/2/25 which was not ninistered until 5/12/25 which						
	was 40 days later.	In May, Warfarin 10mg daily						
	was documented as	s administered for only 9 days.						
	He was not adminis	tered polyethylene glycol for						
	30 days in April. In	June, polyethylene glycol was						
	while it was only or	ninistered twice for 10 days,						
	Carbamazenine wa	s also documented as						
	administered twice	for 9 days in June.						
	Minocycline was or	dered on 5/20/25 but was not						
	administered 5/21/2	25-6/16/25 (26 days). This						
	denciency constitut	es a Type A1 rule violation for I must be corrected within 23						
	days.	a made do demode a man, de						
	1							