STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	?
		MHL092-901	B. WING		08/1	3/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEURO	RESTORATIVE - WIND	DEMERE	DEMERE PL , NC 27604	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000 INITIAL COMMENTS		V 000				
	on August 13, 2025 This facility is licens category: 10A NCA Living for Adults wit This facility is licens	w up survey was completed . Deficiencies were cited. sed for the following service C 27G .5600C Supervised h Developmental Disability. sed for 6 and has a current urvey sample consisted of				
V 118		ication Requirements	V 118			
	REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for a (D) date and time th	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of red to each client must be kept administered shall be ely after administration. The				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
				71. 501251110.			₹
		MHLOS	92-901	B. WING			3/2025
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEURO	RESTORATIVE - WIN	DEMERE		DEMERE PL , NC 27604	ACE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	Continued From particles (5) Client requests checks shall be recipile followed up by a with a physician. This Rule is not me Based on record refacility failed to ensure administered by an a registered nurse legally qualified per and administer meaudited staff (#1, #The findings are: Reviews on 8/12/20 record revealed: -Admission date of -Diagnoses of Intraconsciousness of Loiabetes, Essential Hyperlipidemia, Os and Benign Neoplathyperlipidemia, Os a	for medication of the corded and known appointment of the corded and known appointment of the corded and corde	ced by: terviews, the ons were person trained by acist or other ileged to prepare ecting four of six ogram Manager). To of client #1's with loss of uration, Type II on, Mixed f knee, Rosacea ate. for the following ag) (Heart Health), sterol), one tablet by Tract), four	V 118	DEFICIENCY		
	Levetiracetam 1000 tablet twice daily						

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
					R	
		MHL092-901	B. WING		08/1	3/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEURO I	RESTORATIVE - WINI	DEMERE	DEMERE PL , NC 27604	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Levothyroxine 50 m (Hypothyroidism), Cosartan Potassium tablet daily Metformin Extender (Diabetes), one tab Metformin 500 mg, Metronidazole 0.75 apply thin layer to fa Sertraline HCL 50 mbedtime Silodosin 4 mg (Enlat breakfast Trospium Chloride one tablet twice dai Vitamin D3 50 mcg the morning Glipizide 10 mg (Dimorning Gabapentin 300 mg times daily Review on 8/13/25 revealed: -August, July and Jand staff #3's initial administered the at Reviews on 8/12/25 record revealed: -Admission date of	nicrograms (mcg) one tablet in the morning on 50 mg (Hypertension), one d Relief (ER) 500 mg let one hour before dinner 2 tablets after breakfast % cream (Skin Conditions), ace twice daily ong (Depression), 1.5 tablets at larged Prostate), one capsule 20 mg (Overactive Bladder), ly (Bone Health), one capsule in abetes), one tablet in the g (Pain), one capsule three of MARs for client #1 une 2025-Staff #1, staff #2 s were listed to indicate they ove medications. 5 and 8/13/25 of client #2's 5/31/23.	V 118	DEFICIENCY)		
	-Admission date of 5/31/23Diagnoses of Diffuse Traumatic Brain Injury (TBI), Conversion Disorder with seizures and convulsions, Hypothyroidism, Gastroesophageal Reflux Disorder (GERD) and Benign Prostatic HyperplasiaPhysician's order dated 7/5/25 for the following medications: Atorvastatin 80 mg (High Cholesterol), one tablet					

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at bedtime

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Division	<u>of Health Service Re</u>	egulation					
	IT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				D WING		F	
		MHLO	92-901	B. WING		08/1	3/2025
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEURO	RESTORATIVE - WINI	DEMERE	3601 WIN	DEMERE PL	ACE		
- NEONO			RALEIGH	, NC 27604			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PRE	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3		V 118			
	Bromocriptine Mess tablets twice a day Divalproex Sodium one tablet twice a day Donepezil HCL 23 is bedtime Hydroxyzine 25 mg bedtime Lacosamide 200 m tablet twice daily Levothyroxine 112 is tablet daily Losartan Potassium tablet daily Memantine HCL 28 one capsule at bed Modafinil 100 mg (\$\frac{3}{2}\) Pantoprazole Sodiut two times daily Sudogest 30 mg (\$\frac{3}{2}\) two times daily Loratadine 10 mg (\$\frac{3}{2}\) the morning Quetiapine Fumara tablet at bedtime Miralax 17 grams (\$\frac{3}{2}\) two times daily -Physician's order of 10 mg (Hypertension) Review on 8/13/25 revealed: -August, July and Jand staff #3's initial administered the attention of the page of the p	ylate 2.5 mg 500 mg (Se ay mg (Cogniti (Anxiety), t g (Seizure I mcg (Hypoti n 50 mg (Hy mg (Cogni time Sleep), 2 tab am 40 mg (C lasal Conge Allergy Relic te 100 mg (gm) (Consti lated 7/25/2 on), one tab of MARs fo une 2025-S s were lister ove medica	eizure Disorder), ve), one tablet at hree tablets at Disorder), one hyroidism), one vpertension), one tive Impairment), blets in the morning GERD), one tablet estion), one tablet ef), one tablet in Depression), one pation), give 17 gm est for Amlodipine let daily r client #2 taff #1, staff #2 d to indicate they ations				
	record revealed:	o and 8/13/	25 OI CHENT#3'S				

-Admission date of 9/24/24.

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DIVISION	of Health Service Re	egulation	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	2
		MHL092-901	B. WING		08/13/2025	
					1 00/1	0,2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEURO	NEURO RESTORATIVE - WINDEMERE 3601 WII			ACE		
		RALEIG	H, NC 27604			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
1710		,		DEFICIENCY)		
\/ 110	Continued From no	ngo 4	V 118			
V 118	Continued From pa	ige 4	V 110			
		se TBI and Abnormalities of				
	gait and mobility.					
		dated 7/5/25 for the following				
	medications:					
		ng (Cognition), one capsule				
	twice daily	(Oldin In faction)				
		er (Skin Infection), apply to				
	buttocks twice daily	g (Drooling), one tablet three				
	times daily	g (Droomig), one tablet tillee				
		5 mg (Sleep), two tablets at				
	bedtime	o mg (Gleep), two tablets at				
		CL 5 mg (Attention Deficit				
		der), one tablet twice daily				
		(GERD), one capsule prior to)			
	breakfast	. , ,				
		nstipation), one tablet daily				
		n Deficiency), one tablet daily				
		ng (Cognitive), two tablets at				
	bedtime	(D:) (
	bedtime	g (Pain), two capsules at				
		npoo 2% (Skin Infection),				
		ally in the morning every othe	r			
	day	any in the morning every othe				
	,	(Sleep), one tablet at bedtime	•			
	3	(17)				
		der (Constipation), give one				
	dose two times dail					
		lulose Sodium 0.5% drops				
		vo drops into both eyes two				
	times a day	O man (Caimuna Diagradan)				
	tablet two times dai	O mg (Seizure Disorder), one				
		ily (Cognitive), one tablet twice a				
	day	(Cognitive), one tablet twice a				
	Cetylpyridinium Chl	loride mouthwash				
		30 millileters (ml) orally two				
	times daily	The standard of the standard o				

MiraLax 17 gm (Constipation), give twice daily

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.		,	R	
		MHL092-901		B. WING			13/2025	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
NEURO	RESTORATIVE - WINI)FMFKF		DEMERE PL , NC 27604	ACE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 5		V 118				
	please add two pactors of twice daily Melatonin 3 mg (Sleaview on 8/13/25 revealed:	(Seizure Disorder), one eep), one tablet at bedtin	tablet ne					
		une 2025-Staff #1, staff as were listed to indicate to ove medications						
	Review on 8/13/25 records revealed th	of the facility's personnel e following:	l					
	Nurse Case Manag -Date of hire was 4/ -She was a License							
	Staff #1: -Date of hire was 8/30/23Hired as a Life Skills TrainerMedication Administration training was completed on 2/19/25 by the Nurse Case Manager.							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			₹
		MHL092-901	B. WING			13/2025
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
NEURO	RESTORATIVE - WIN	DEMERE	INDEMERE PL 6H, NC 27604	ACE		
(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 AC CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	completed on 2/19/Manager. Interview on 8/12/2 -He administered in his shiftThe Nurse Case in administration train ago. Interview on 8/12/2 Manager revealed: -She was a LPNThey had a Nurse medication administration administ	istration training was /25 by the Nurse Case /25 with staff #1 revealed: nedication to the clients during Manager did the medication ning for them a few months /25 with the Nurse Case Practioner who did the stration training originally for the medication administration ar ago. cation training with staff. she could not do the stration training for staff. ere was no documentation of stration training for staff #1, 3 and the Program Manager I, pharmacist or other legally /25 with the Program Manager on administration training with				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		SURVEY LETED		
		MHL092-901	B. WING		F 08/1	R 3/2025
			1		1 00/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S IDEMERE PLA			
NEURO	RESTORATIVE - WINI	DEMERE	I, NC 27604	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 7	V 118			
	revealed: -The Nurse Case M Manager made him that a LPN can't do training for staff"We were never in surveys." -He confirmed there medication adminis staff #2 and staff #3	5 with the Program Director lanager and Program aware yesterday (8/12/25), the medication administration formed of that during previous was no documentation of tration training for staff #1, 3 and the Program Manager , pharmacist or other legally				
V 121	10A NCAC 27G .02 REQUIREMENTS (f) Medication revie (1) If the client rece governing body or of for obtaining a revie regimen at least eve shall be to be perfo physician. The on-st the client's physicia the review when me (2) The findings of the	w: ives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or ite manager shall assure that n is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with	V 121			
		et as evidenced by: views and interviews, the ain drug regimen reviews every	,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			R
		MHL092-901	B. WING		I	13/2025
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
NEURO	RESTORATIVE - WINI	NEMEDE	WINDEMERE PL IGH, NC 27604	ACE		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 121	Continued From pa	age 8	V 121			
	six months for three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are:		t			
	record revealed: -Admission date of -Diagnoses of Intra consciousness of u Diabetes, Essential Hyperlipidemia, Os and Benign Neopla -Physician's order of 50 mg (Depression Gabapentin 300 mg times dailyThere was no door review completed v Review on 8/13/25	cranial injury with loss of unspecified duration, Type II I Hypertension, Mixed teoarthritis of knee, Rosace ism of Prostate. dated 7/5/25 for Sertraline Hill, 1.5 tablets at bedtime and g (Pain), one capsule three umentation of a drug regime within the last six months.	ICL d			
		ord (MAR) revealed: client #1 was administered on 8/1 thru 8/12.	the			
	record revealed: -Admission date of -Diagnoses of Diffu (TBI), Conversion I convulsions, Hypot Reflux Disorder (Gi HyperplasiaPhysician's order of medications: Divalproex Sodium one tablet twice a of Hydroxyzine 25 mg bedtime	ise Traumatic Brain Injury Disorder with seizures and hyroidism, Gastroesophage ERD) and Benign Prostatic dated 7/5/25 for the following 500 mg (Seizure Disorder), day (Anxiety), three tablets at B mg (Cognitive Impairment)	9			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
					F	₹
		MHL092-901	B. WING		08/1	3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEURO RESTORATIVE - WINDEMERE			DEMERE PL , NC 27604	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 9	V 121			
V 121	Quetiapine Fumara tablet at bedtime -A a drug regimen r 5/23/24There was no docreview completed w Review on 8/13/25 revealed: -Staff documented above medication of the control of the	te 100 mg (Depression), one review was completed on umentation of a drug regimen within the last six months. of the August 2025 MAR client #2 was administered the on 8/1 thru 8/12.	V 121			
	day Divalproex 500 mg	(Cognitive), one tablet twice a (Seizure Disorder), one tablet				
		umentation of a drug regimen vithin the last six months.				
	revealed:	of the August 2025 MAR client #3 was administered the on 8/1 thru 8/12.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING			₹
		MHL092-901	B. WING			3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
NEURO RESTORATIVE - WINDEMERE			IDEMERE PL I, NC 27604	ACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 121	Continued From pa	ige 10	V 121			
	Interview on 8/13/2 Manager revealed: -The Medical Directoreviews for clientsThe Medical Directoreview for clients in She was not sure and the drug regimen review and #3 within the late of the drug regimen review and within the late of the dru	5 with the Nurse Case tor did the drug regimen tor did the last drug regimen May 2024. why the Medical Director had egimen reviews for clients. re was no documentation of a w completed for clients #1, #2 ast six months. 5 with the Program Director umentation of a drug regimen or clients #1, #2 and #3 within				

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