STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl043037	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE FAMILY CARE II	431 JUNNY ROAD ANGIER, NC 27501

(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 conducted an annual survey on 08/06/26.	C 000		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (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 residents' food was free from contamination as evidenced by the facility staff delivering uncovered meals from the kitchen to residents' room. The findings are:	C 257		

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C 257	Continued From page 1 Observation of the lunch meal on 08/06/26 between 12:22pm and 12:32pm revealed: -The cook plated the residents' food in the kitchen and placed the plates on the counter. -There were 3 residents who were eating their meal in their rooms. -The personal care aide (PCA) placed the plates with food, beverages, and fruit in a bowl on a tray. -The PCA did not cover the plates, beverages or bowls with fruit. -The PCA took the trays to the 3 residents' rooms. -One of the residents was not ready to eat and the PCA came back down the hallway with the residents' tray with uncovered food and beverages. Interview with the PCA on 08/06/26 at 12:39pm revealed: -He had been working in the facility for about a week. -He had never seen the food covered when it was delivered to residents in their rooms. -He was trained to deliver the food, beverages and fruit in a bowl uncovered. Interview with the Administrator on 08/06/26 at 1:00pm revealed: -He was responsible for ensuring meals were served properly to the residents. -The residents who ate meals in their rooms should be served at their door from the food cart. -The facility staff were not to deliver meals uncovered to residents in their rooms to prevent contamination.	C 257		
C 280	10A NCAC 13G .0904(d)(4) Nutrition and Food Service	C 280		

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C 280	Continued From page 2 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident during the lunch meal. The findings are: Observation of the lunch meal on 08/06/26 between 12:22pm and 12:32pm revealed: -There were 2 residents eating in the dining room. -There were 3 residents eating in their rooms. -There was no water served to the residents in the dining room or the residents in their rooms. -No staff asked the residents if they wanted water at the time the meal was served. Interview with the personal care aide (PCA) on 08/06/26 at 12:30pm revealed: -He had been working in the facility for about a week. -He was trained to serve tea and other beverages to the residents. -He had not given any residents water or observed any staff give residents water during a meal. Interview with the Administrator on 08/06/26 at 1:00pm revealed he expected water to be served at every meal to the residents in the facility.	C 280		

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C 330	Continued From page 3	C 330		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to 1 of 3 sampled residents (#3) including medications used to treat hypotension (low blood pressure). The findings are: Review of Resident #1's current FL-2 dated 05/07/26 revealed diagnoses included anxiety, hypotension, hypokalemia, hypomagnesemia, hearing loss, and history of left femur fracture. Review of Resident #1's physician's order dated 05/07/26 revealed an order for Midodrine HCL 10mg, take 1 tablet twice per day. Hold if systolic blood pressure is greater than 110. (Midodrine is used to treat hypotension). Review of Resident #1's June 2026 electronic medication administration records (eMAR) revealed: -There was an entry for Midodrine HCL 10mg, take 1 tablet twice per day. Hold if systolic blood	C 330		

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C 330	Continued From page 4 pressure is greater than 110. -On 06/05/26 at 8:00am the systolic blood pressure reading was 111; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 111. -On 06/06/26 at 8:00am the systolic blood pressure reading was 118; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 118. -On 06/06/26 at 8:00pm the systolic blood pressure reading was 113; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 113. -On 06/07/26 at 8:00am the systolic blood pressure reading was 114; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 114. -On 06/10/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 06/10/26 at 8:00pm the systolic blood pressure reading was 120; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 120. -On 06/11/26 at 8:00am the systolic blood pressure reading was 114; Midodrine was documented as administered.	C 330		

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C 330	Continued From page 5 -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 114. -On 06/13/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 06/14/26 at 8:00am the systolic blood pressure reading was 124; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 124. -On 06/14/26 at 8:00pm the systolic blood pressure reading was 122; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 122. -On 06/15/26 at 8:00am the systolic blood pressure reading was 115; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 115. -On 06/16/26 at 8:00pm the systolic blood pressure reading was 115; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 115. -On 06/18/26 at 8:00pm the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 06/21/26 at 8:00am the systolic blood	C 330		

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C 330	Continued From page 6	C 330		

pressure reading was 115; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 115.
-On 06/25/26 at 8:00am the systolic blood pressure reading was 123; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 123.
-On 06/30/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112.
-On 06/30/26 at 8:00pm the systolic blood pressure reading was 133; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 133.
-Midodrine was documented as administered 17 times when it should have been held.

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for Midodrine HCL 10mg, take 1 tablet twice per day. Hold if systolic blood pressure is greater than 110.
-On 07/05/26 at 8:00pm the systolic blood pressure reading was 112; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112.
-On 07/06/26 at 8:00pm the systolic blood pressure reading was 122; Midodrine was documented as administered.

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C 330	Continued From page 7 -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 122. -On 07/08/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 07/09/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 07/13/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 07/14/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 07/19/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -On 07/20/26 at 8:00pm the systolic blood pressure reading was 117; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 117. -On 07/21/26 at 8:00am the systolic blood	C 330		

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C 330	Continued From page 8	C 330		

pressure reading was 118; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 118.
-On 07/23/26 at 8:00pm the systolic blood pressure reading was 111; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 111.
-On 07/24/26 at 8:00pm the systolic blood pressure reading was 124; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 124.
-On 07/20/26 at 8:00am the systolic blood pressure reading was 120; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 120.
-Midodrine was documented as administered 12 times when it should have been held.

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for Midodrine HCL 10mg, take 1 tablet twice per day. Hold if systolic blood pressure is greater than 110.
-On 08/01/26 at 8:00am the systolic blood pressure reading was 117; Midodrine was documented as administered.
-According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 117.
-On 08/02/26 at 8:00pm the systolic blood pressure reading was 111; Midodrine was documented as administered.

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C 330	Continued From page 9 -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 111. -On 08/05/26 at 8:00am the systolic blood pressure reading was 112; Midodrine was documented as administered. -According to the parameter to hold the Midodrine, it should not have been administered for a systolic blood pressure reading of 112. -Midodrine was documented as administered 3 times when it should have been held. Interview with a medication aide (MA) on 08/06/26 at 2:56pm revealed: -She administered medications to Resident #1. -She thought Resident #1's systolic blood pressure hold was 110. Interview with the Administrator on 08/06/26 on 3:22pm revealed he expected the MAs to administer the medications according to the order from the PCP. Telephone interview with a representative from Resident #1's primary care provider (PCP) on 08/06/26 revealed: -He was an on-call PCP. -Midodrine was used to raise blood pressure for residents with hypotension. -If Resident #1 had an elevated blood pressure that was too high and was administered the Midodrine it could cause a stroke. -The current systolic blood pressure readings for Resident #1 were not high enough to cause an injury, if the Midodrine was administered when it should have been held. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	C 330		

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