STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092228	A. BUILDING: _____ B. WING _____	R 09/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES II	6704 SHANGHI DRIVE WILLOW SPRINGS, NC 27592

(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 and follow-up survey on September 21-22, 2017 with an exit conference via telephone on September 26, 2017.	C 000		
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 interviews and record review, the facility failed to assure 1 of 3 residents sampled (#2) was administered Velphoro, used to reduce the amount of phosphorus in the blood in patients with chronic kidney disease who are on dialysis, as ordered by the licensed prescribing practitioner. The findings are: Review of Resident #2's current FL-2 dated 07/11/17 revealed the resident's diagnoses included end stage renal disease with dialysis 3 times a week, diabetes mellitus, anemia of chronic disease, and obesity. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 12/08/16.	C 330		

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C 330	Continued From page 1 Review of a physician's order dated 7/27/17 for Resident #2 revealed: -There was an order from the Dialysis provider for Velphoro 500 mg tablet chewable, take one tablet by mouth three times a day with meals. Review of Resident #2's July 2017 MAR revealed: -There was a hand written entry (not dated) for Velphoro 500 mg chewable. Chew one tablet and swallow three times daily with meals. -It was documented staff administered Velphoro 500 mg three times a day for three days (7/29-7/31/17). Review of Resident #2's August 2017 MAR revealed: -There was a hand written entry (not dated)for Velphoro 500 mg chewable. Chew one tablet and swallow three times daily with meals. -It was documented staff administered Velphoro 500 mg three times a day for thirty-one days (8/1-8/31/17). Review of Resident #2's September 2017 MAR revealed: -There was a computer generated entry for Velphoro 500 mg chewable. Chew one tablet and swallow three times daily with meals. -It was documented staff administered Velphoro 500 mg three times a day for twenty-one days (9/1-9/21/17), and one dose on 9/22/17 at 8:00 a.m. Review of Resident #2's medications on hand on 9/22/17 at 1:00 p.m. revealed Velphoro 500 mg chewable was not available. Interview with the Supervisor-in-Charge (SIC) on 9/22/17 at 1:45 p.m. revealed: -The SIC gave the 8:00 a.m. dose of Velphoro	C 330		

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C 330	Continued From page 2	C 330		

500 mg on 9/22/17, but she "could not give the 2:00 p.m. dose for 9/22/17 because the medication was out".
-The SIC called the pharmacy the morning of 9/22/17 to get it refilled.
-The Pharmacy told the SIC that the insurance company was calling the dialysis unit because the medication was not covered by insurance.

Review of Consultant Pharmacist progress note dated 8/31/17 for Resident #2 revealed:
-"The cart was missing Velphoro."
-There was a recommendation by the Pharmacist to "please check on the medication".

Interview with the Pharmacist on 9/22/17 at 2:00 p.m. revealed:
-Velphoro 500 mg was initially filled on 7/27/17 with 90 doses (30 day supply).
-Insurance covered the initial 30 day supply only.
-The concern with the resident not receiving the Velphoro 500 mg three times a day was the resident's phosphorus levels being maintained in normal range.
-The dialysis unit would be monitoring the phosphorus levels.
-There were other medication substitutions for Velphoro available but not ordered.
-The pharmacy sent the facility Primary Care Provider (PCP) the Velphoro rejection letter on 8/28/17, but has not received a response from the PCP.
-The pharmacy did not list the available Velphoro substitutions on the rejection letter.
-The pharmacy attempted to process the medication again on the morning of 9/22/17 but it was rejected as "non-formulary".

Interview with the SIC on 9/22/17 at 3:20 p.m. revealed:

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C 330	Continued From page 3 -The SIC stated (Resident #2) "did not miss a dose of Velphoro". -The resident came with "a bottle of Velphoro" from her dialysis appointment when it was first prescribed on 7/27/17. -The SIC did not know how many doses were in the bottle. -When all of the doses had been administered to the resident, the SIC disposed of the bottle in the garbage. -The bottle with label was not available. Interview with the Administrator on 9/22/17 at 3:50 p.m. revealed: -She spoke with the Registered Nurse (RN) at the dialysis center on 9/22/17. -The RN told her there are times when the dialysis provider may send home samples of medication with the residents. -The RN told her that she would check to see if the resident (#2) received any. Interview with the dialysis RN on 9/22/17 at 3:55 p.m. revealed: -She spoke with the resident's (#2) dialysis provider on 9/22/2017, who said she did give samples of Velphoro to the resident. -The dialysis provider was out of the office and would send her progress notes reflecting what was given to the resident once she was back in the office on 9/25/17. -She does not have access to the dialysis provider's progress notes. Attempted interview with the resident on 9/22/17 at 4:00 p.m. was unsuccessful. The resident was out of the facility. Review of lab results for Resident #2 revealed: -On 6/24/17 the phosphorus level was 4.8 mg/dL	C 330		

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C 330	Continued From page 4 (high). The normal range was 2.6-4.5 mg/dL. -On 7/7/17 the phosphorus level was 3.6 mg/dL. -There were no further lab results available. Interview with the Administrator on 9/25/17 at 11:15 a.m. revealed: -The Administrator received a fax from the dialysis center showing the prescription for Velphoro. -The Administrator called the facility's PCP and left message to either discontinue the Velphoro or substitute the medication. Review of fax received on 9/25/17 at 11:30 a.m. for Resident #2 revealed: -The dialysis center documented "medication history: Velphoro 500 mg chewable, one three times a day with meals. Start date 7/27/17, stopped 8/29/17". Interview with the Administrator on 9/25/17 at 4:18 p.m. revealed: -The Administrator was told by the facility's PCP to contact the dialysis provider regarding the Velphora prescription since that was who ordered the medication. -The Administrator would go to the dialysis center on 9/26/17 to speak with the dialysis provider. -Resident #2 would be at the dialysis center on 9/26/17. Interview with the PCP on 9/25/17 at 4:35 p.m. revealed: -The Velphora rejection letter from the pharmacy dated 8/28/17 was in Resident #2's record at the dialysis center. -She was not notified that the Velphora was denied. -She was not notified that the rejection letter was placed in Resident #2's chart.	C 330		

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C 330	Continued From page 5 -The normal procedure was that the Velphora rejection letter should have been sent to the dialysis provider who initially ordered the medication. -Her last visit with Resident #2 at the facility was on 8/17/17. -She received a response in their automated medication system on 8/27/17 that the Velphora was denied. -She reviewed the prior authorization for the Velphora on 8/28/17 and responded to the pharmacy "please refer to the dialysis center because that was not a medication that was prescribed by her". -She notified the facility on 9/7/17 to contact the dialysis provider to get the Velphora medication either discontinued or replaced with an alternative medication. Review of fax received on 9/26/17 at 9:45 a.m. revealed: -The dialysis provider documented Resident #2 "was given one sample (bottle) of Velphoro in July". -There was no reference regarding how many pills were in the bottle. -The dialysis provider documented "a prescription was sent to the Long Term Care facility with directions to take one tablet with meals". -A copy of the prescription for Velphoro 500 mg tablet chewable take one tablet by mouth threes times a day with meals, 30 day supply was issued on 7/27/17 at 4:02 p.m. -The dialysis provider documented that a prior authorization form was received on 9/26/17 to complete. -The dialysis provider would complete the prior authorization information and would "send the required documentation".	C 330		

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C 350	Continued From page 6	C 350		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 1 of 3 residents sampled (#2) had a self-administration order signed by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record. The findings are: Review of Resident #2's current FL-2 dated	C 350		

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C 350	Continued From page 7 07/11/17 revealed diagnoses included: -end stage renal disease with dialysis 3 times a week -chronic obstructive pulmonary disease -hypertension -diabetes mellitus -anemia of chronic disease -obesity -obstructive sleep apnea Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 12/08/16. Review of a physician's order dated 8/15/17 for Resident #2 revealed: -There was an order for ProAir HFA (albuterol sulfate), used to prevent and treat wheezing and shortness of breath caused by breathing problems, 90 mcg/actuation on HFA aerosol inhaler. Inhale 2 puffs using inhaler every four hours as needed for shortness of breath. -There was no order to self-administer the ProAir HFA (albuterol sulfate) inhaler. Review of Resident #2's August 2017 MAR revealed there was no documentation that the ProAir HFA (albuterol sulfate) inhaler had been administered. Review of Resident #2's medications on hand on 9/22/17 at 1:00 p.m. revealed that the ProAir HFA (albuterol sulfate) inhaler was not available. Review of a consultant pharmacist communication to physician letter dated 8/31/2017 revealed that the pharmacist recommended that the resident may self-administer and keep the inhaler in room. The Physician/Practitioner did not provide a response	C 350		

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C 350	Continued From page 8 or signature. Attempted interview with the resident on 9/22/17 at 4:00 p.m. was unsuccessful. The resident was out of the facility. Interview with the Supervisor-in-Charge (SIC) on 9/22/17 at 4:30 p.m. revealed: -Resident #2 was out of the facility with the inhaler in possession. -She feels that Resident #2 can effectively self administer the ProAir HFA (albuterol sulfate) inhaler. -She was not aware that the Provider/Practitioner did not sign provide a response or signature to the pharmacist's recommendation for self-administration. -She would get a physician's order for the self-administration of the ProAir HFA (albuterol sulfate) inhaler. Interview with the Administrator on 9/22/17 at 4:45 p.m. revealed: -She was not aware that the Provider/Practitioner did not sign provide a response or signature to the pharmacist's recommendation for self-administration. -If the provider did not respond to the pharmacist's recommendations, the normal process would be the SIC would follow-up with the provider. -She would insure that a physician's order for the self-administration of the ProAir HFA (albuterol sulfate) inhaler was obtained.	C 350		