STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/10/24 and 09/11/24.	C 000		
C 204	10A NCAC 13G .0702 (c) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident's FL2 was updated no more than 90 days prior to admission for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 11/21/23 revealed diagnosis included Schizophrenia. Review of Resident #2's Resident Register revealed he was admitted on 08/29/24. Review of Resident #2's record on 09/10/24 revealed there was not an updated FL2 completed since 11/21/23. Interview with Resident #3's Guardian on	C 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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C 204	Continued From page 1 09/10/24 at 10:30am revealed: -Resident #3 was admitted on 08/29/24. -The facility was informed that Resident #3 would arrive on 08/29/24. -She emailed the FL2 that she had, dated 11/21/23, to the facility on 08/30/24 after the Administrator informed her that the FL2 was not with the other paperwork that the resident brought with him. Interview with the medication aide (MA) on 09/11/24 at 2:50pm revealed: -She was a relief MA and not permanent staff. -She had not worked in the facility since the current MA started approximately 2 months ago. -The Administrator was responsible for getting the FL2 completed. -She assisted the Administrator with the FL2 only by typing the form out for the Administrator after it had been completed by the Administrator. Interview with the Administrator on 09/10/24 at 4:23pm revealed: -She was aware Resident #3's FL2 had not been updated since 11/21/23. -She was responsible for ensuring the residents' FL2s were completed upon admission. -She requested an updated FL2 from Resident #3's Guardian and received the FL2 dated 11/21/23. -An updated FL2 was usually sent with the resident from the previous facility, hospital or primary care provider (PCP). -She never accepted a resident without an updated FL2. -Resident #3 was dropped off by a driver on 8/29/24 without an updated FL2. -She did not know who the current PCP was, so she had to schedule Resident #3 an appointment with a new PCP to get the FL2 completed.	C 204		

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C 204	Continued From page 2 -Resident #3 had a PCP appointment scheduled for 09/17/24. -She was informed in August 2024 that Resident #3 would be admitted to her facility on 08/29/24. -She usually required an FL2 prior to admission but Resident #3 was a previous resident from years ago so she thought his paperwork would be updated. [Refer to Tag 342, 10A NCAC 13G .1004(j) Medication Administration].	C 204		
C 207	10A NCAC 13G .0702 (f) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination and Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the residents' FL-2 was complete to include diet orders for 2 of 3 sampled residents (#1, and #2). The findings are: 1. Review of Resident #1's current FL-2 dated	C 207		

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C 207	Continued From page 3 02/25/24 revealed: -Diagnoses included essential hypertension, congestive heart failure, end stage renal disease, major depressive disorder, iron deficiency anemia unspecified, diabetes mellitus with ketoacidosis, obstructive sleep apnea, and history of non-compliance with medication and treatment. -There was an admission date of 07/22/22. -There was a checkmark next to the section listed for diet. -There was no specified diet order written on the current FL-2. Review of Resident #1's record revealed there was not a subsequent diet order provided. Observation in the kitchen on 09/10/24 at 9:11am revealed there was no diet list posted. Interview with the personal care aide/medication aide (PCA/MA) on 09/10/24 at 9:35am revealed: -He tried to follow the posted menus when he served residents their meals. -All the residents were on regular diets. Interview with the Administrator on 09/10/24 at 2:17pm revealed: -The diet order for Resident #1 should be listed on the current FL-2. -She did not have another diet order for Resident #1. Second interview with the Administrator on 09/10/24 at 2:58pm revealed: -There was an updated FL-2 for Resident #1. -She did not know if the updated FL-2 was at her home office. -When she received a new FL-2, she was responsible to ensure the FL-2 included a diet order.	C 207		

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C 207	Continued From page 4 Interview with Resident #1 on 09/10/24 at 4:27pm revealed: -He was not on a special diet that he knew of. -He ate meals in the dining room and was fed the same food as the other residents. Third interview with the Administrator on 09/10/24 at 4:42pm revealed: -There was no specified diet order listed on Resident #1's current FL-2. -She had not found an updated FL-2 for Resident #1. Interview with another PCA/MA on 09/11/24 at 3:00pm revealed: -She prepared toast with jelly, eggs and cheese sandwich, bacon, banana, and coffee for the resident's breakfast on 09/11/24. -It was "usually" specified on the resident FL-2 if the resident was on a special diet. -If there was no specific diet written on the resident's FL-2 she assumed the resident was to be served a regular diet. Telephone interviews with the Primary Care Provider on 09/11/24 at 10:08am and 1:30pm were unsuccessful. No specific diet order for Resident #1 was provided for review. 2. Review of Resident #2's current FL-2 dated 12/07/23 revealed: -Diagnoses included history of cerebrovascular accident (CVA), left spastic hemiparesis, coronary artery disease, hypertension and hyperlipidemia. -There was no diet order written on the current FL-2.	C 207		

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	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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C 207	Continued From page 5 Review of Resident #2's record revealed there was no documentation of the resident's diet. Observation in the kitchen on 09/10/24 at 4:55pm revealed there was no diet list posted. Interview with the Administrator 09/10/24 at 2:26pm and 4:22pm revealed: -The diet order should have been on the FL2. -She was responsible for making sure diet orders were in the residents' records. -There was no diet order for Resident #2. -Most of the residents were on a regular diet. -She did not know why there was no diet order in Resident #2's record. -Resident #2's diet order not being in the record was an oversight. -The primary care provider (PCP) provided the diet orders. -She would get the diet order from Resident #2's PCP tomorrow. Interview with Resident #2 on 09/10/24 at 4:55pm revealed: -He did not know if he had a special diet. -He ate what everyone else ate. Interview with a medication aide (MA) on 09/11/24 revealed: -She knew what to serve the residents because the diet was listed on the FL2. -If there was no diet listed on the FL2, she knew the resident was to be served a regular diet. -If the resident was on a special diet, the diet would have been written on the FL2 or other staff members would have told her. Attempted telephone interview with the PCP on 09/11/24 at 1:24pm was unsuccessful.	C 207		

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	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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C 288	Continued From page 6	C 288		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 8:30am revealed: -The facility had a current census of 5 residents. -One resident went to a medical appointment, a second resident signed out to walk in the community to the store, and the remaining three residents were at the facility. Review of the September 2024 activity calendar posted in the facility on 09/10/24 at 10:45am revealed: -There was an entry for day program 9am - 4pm every day except 09/01/24, 09/07/24, 09/08/24, 09/09/24, 09/15/24, 09/21/24, 09/22/24, 09/23/24, and 09/29/24, which included scheduled day program on 09/14/24 (Saturday) and 09/28/24 (Saturday). -On 09/10/24. A board game was scheduled for 5-6:30pm. Interview with the Administrator on 09/10/24 at 10:50am revealed: -None of the residents currently living at the	C 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 288	Continued From page 7	C 288		

facility attended a day program.
-The residents refused to go to the day program.
-There had been residents who used to live at the facility that attended a day program.
-The September 2024 activity calendar listed day program as an activity because previous residents living at the facility used to attend a day program from 9:00am - 4:00pm.
-She did not know who she would have as a resident in the future that would go to the day program.
-Sometimes the residents played cards.
-She completed the activity coordinator/director class.

Observation of a resident on 09/10/24 at intervals between 8:40am - 5:30pm revealed:
-At 8:40am, the resident was seated in the common area watching television.
-At 10:45am - 12:00pm, the resident laid on the sofa in the common area and watched television.
-No activities were offered to the resident that promoted active involvement with the other residents living at the facility.

Interview with the resident on 09/10/24 at 8:40am revealed:
-He stayed at the facility all the time.
-He did not do anything at the facility.

Observation of a second resident on 09/10/24 between 8:51am - 5:30pm revealed:
-At 8:51am, the resident walked through the common area and exited the facility through a door that led to an uncovered porch area in the back of the facility.
-At 9:05am, the resident was laying on his bed facing the wall.
-Throughout the day the resident was observed to walk from his bedroom to the porch on the back

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C 288	Continued From page 8 of the facility. -No activities were offered to the resident that promoted active involvement with the other residents living at the facility. Interview with a third resident on 09/10/24 at 4:27pm revealed: -He did not do "much of nothing" for activities. -He liked to help clean. -There were games at the facility but very seldom were games played. -The facility took the residents to a local department store "probably about one time a month". Observations of the facility at intervals on 09/10/24 between 8:30am and 6:45pm and 09/11/24 between 8:30am and 11:30am revealed there were no activities conducted.	C 288		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews and interviews, the	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

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C 341	Continued From page 9	C 341		

facility failed to ensure medications administered were documented on the Medication Administration Record (MAR) by the medication aide (MA) upon administration for 1 of 3 residents sampled (#1).

The findings are:

Review of Resident #1's current FL-2 dated 02/25/24 revealed diagnoses included essential hypertension, congestive heart failure, end stage renal disease, major depressive disorder, iron deficiency anemia unspecified, diabetes mellitus with ketoacidosis, obstructive sleep apnea, and history of non-compliance with medication and treatment.

Review of physician orders for Resident #1 revealed:
-There was a physician order dated 06/24/24 for Cyclosporine 0.05% eye drops (used to treat dry eyes) apply one drop in each eye twice daily.
-There was a physician order dated 06/24/24 for Sevelamer Carbonate 800mg tablet (used to control high levels of phosphorus in people with chronic kidney disease who are on dialysis and should be taken with meals) take one tablet three times a day with meals.
-There was a physician order dated 06/27/24 for Probiotic 10 billion cell capsule (used to treat diarrhea and other stomach/intestinal problems) delayed release two times a day.

Review of Resident #1's September 2024 medication administration records (MAR) revealed:
-There was a printed entry for Cyclosporine 0.05% eye drops apply one drop in each eye twice daily scheduled for administration at 8:00am and 8:00pm daily.

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	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

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C 341	Continued From page 10 -There was no documentation of administration for the 8:00pm scheduled dose of Cyclosporine 0.05% eye drops for September 1, 2024 through September 9, 2024. -There was a printed entry for Sevelamer Carbonate 800mg tablet take one tablet three times daily with meals scheduled for administration at 8:00am, 12:00pm, and 6:00pm. -There was no documentation of administration for the 12:00pm and 6:00pm scheduled doses of Sevelamer Carbonate 800mg tablet for September 1, 2024 through September 9, 2024. -There was a printed entry for Probiotic Formula Capsule take one capsule two times a day scheduled for administration at 8:00am and 8:00pm daily. -There was no documentation of administration for the 8:00pm scheduled dose of Probiotic Formula Capsule for September 1, 2024 through September 9, 2024. -There were printed entries for a total of six medications to be administered at 8:00pm including the Cyclosporine eye drops and the Probiotic capsule. Interview with the medication aide (MA) on 09/10/24 at 3:10pm revealed: -He administered medications to Resident #1 according to what was printed on the MARs. -As soon as he administered Resident #1 medications, he documented the administration on the resident's MARs. -He administered the Cyclosporine eye drops in the morning and at night. -He administered the Probiotic capsule in the am and pm. -He administered the Sevelamer three times a day. -He did not know why he missed documenting the administration of all doses of the Cyclosporine	C 341		

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	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

(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 341	Continued From page 11 eye drops, Probiotic capsule, and Sevelamer tablet. Interview with the Administrator on 09/10/24 at 3:50-m revealed: -The MA was supposed to administer medication and document the administration of the medication when the medication was administered. -To ensure accurate documentation on the MARs, she reviewed the MARs monthly and sometimes mid-month. Interview with Resident #1 on 09/10/24 at 4:27pm revealed: -The MA administered medications to the resident in the morning, after lunch, and at dinner. -He took a pill after lunch and at dinner because he was on dialysis. -He could not pronounce the names of all the medications he was administered. -He counted his pills at night, and he thought he got six pills at night. -He had not missed any of his pills but thought he had missed his eye drops at night sometimes. -He denied any burning or dryness of the eyes.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

(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 342	Continued From page 12 or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records (MAR) were complete and accurate for 1 of 3 sampled residents (#3) related to resident's name and instructions for administering the medication. The findings are: Review of Resident #3's most recent FL-2 dated 11/21/23 revealed: -Diagnosis included Schizophrenia. -There was an order for Amlodipine 10mg oral every morning. (Amlodipine is used to treat high blood pressure.) -There was an order for Aspirin 81 mg oral every morning. (Aspirin is used to treat pain, inflammation and arthritis.) -There was an order for Atorvastatin 10mg oral nightly. (Atorvastatin is used to treat high cholesterol.) -There was an order for Chlorpromazine 100mg oral twice daily. (Chlorpromazine is used to treat schizophrenia.) -There was an order for Cholecalciferol 2,000	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES	1101 LOXLEY PLACE RALEIGH, NC 27610

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C 342	Continued From page 13	C 342		

units oral daily. (Cholecalciferol is used to treat vitamin D deficiency.)
-There was an order for Lidocaine 3 patches transdermal daily. (Lidocaine patches are used to treat pain.)
-There was an order for Diclofenac Sodium gel 2g topical twice daily. (Diclofenac Sodium gel is used to treat pain.)
-There was an order for Divalproex ER 1500mg oral daily. (Divalproex ER is used as a mood stabilizer.)
-There was an order for Paliperidone 234mg (Invega Sustenna) intramuscular every 28 days. (Paliperidone is used to treat schizophrenia.)
-There was an entry for Risperidone 2mg oral twice daily. (Risperidone is used to treat schizophrenia.)
-There was an order for Tamsulosin 0.4mg oral every morning. (Tamsulosin is used to treat enlarged prostate.)
-There was an order for Trazodone 100mg oral nightly. (Trazodone is used to treat depression.)
-There was no order for Melatonin 3mg 2 tablets at bedtime. (Melatonin is used to improve sleep conditions.)
-There was no order for Benztropine Mesylate 1mg twice daily. (Benztropine Mesylate is used to treat involuntary movements due to the side effects of certain psychiatric drugs.)
-There was no order for Gabapentin 100mg 2 capsules 3 times daily. (Gabapentin is used to treat nerve pain.)
-There was no order for Olmesartan Medoxomil 40mg 1 tablet daily. (Olmesartan Medoxomil is used to treat high blood pressure.)

Review of Resident #3's Resident Register revealed he was admitted on 08/29/24.

Telephone interview with the pharmacist at the

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	FCL092206	A. BUILDING: _____ B. WING _____	09/11/2024

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C 342	Continued From page 14 facility's contracted pharmacy on 09/10/24 at 3:50pm revealed: -There was an order dated 11/21/23 and 06/20/24 for Amlodipine 10mg once daily, last dispensed today. -There was an order dated 11/21/23 and 06/20/24 for Atorvastatin 10mg at bedtime, last dispensed today. -There was an order dated 12/29/23 and 08/12/24 for Benztropine 1mg twice daily, last dispensed today. -There was an order dated 12/29/23 and 08/12/24 for Chlorpromazine 100mg twice daily, last dispensed today. -There was an order dated 11/21/23 for Diclofenac Sodium but the medication had been on back order and was not readily available. -There was an order dated 11/21/23 and 08/12/24 for Divalproex ER 500mg 3 at bedtime, last dispensed today. -There was an order dated 11/21/23 for Gabapentin 100mg, 2 capsules 3 times daily, last dispensed today. -There was an order dated 11/21/23 and 08/12/24 for Paliperidone 234mg every 28 days that was last filled by their pharmacy on 11/24/23; the ACT team started filling the prescription. -There was an order dated 11/21/23 for Lidocaine 4% 3 patches every 12 hours over the counter but because the resident could not afford the medication, it had not been utilized since late November 2023. -There was an order dated 11/21/23 and 08/12/23 for Melatonin 3mg 2 at bedtime, last dispensed today. -There was an order dated 12/13/23 and 06/20/24 for Olmesartan Medoxomil 40mg 1 daily, last dispensed today. -There was an order dated 03/25/24 and 08/12/24 for Risperidone 1mg in the morning, last	C 342		

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C 342	Continued From page 15 dispensed today. -There was an order for Risperidone 2mg at bedtime from 11/21/23 and 08/12/24. -There was no order for Aspirin, Cholecalciferol, Tamsulosin or Trazodone. Review of Resident #3's September 2024 MAR revealed: -All entries were handwritten. -Resident #3's name was not listed. -There was an entry for Amlodipine Besylate 10mg with no instructions for administering the medication. -There was an entry for Benztropine Mesylate 1mg with no instructions for administering the medication. -There was an entry for Chlorpromazine 100mg with no instructions for administering the medication. -There was an entry for "Olmesartan Medoxomil 40" with no instructions for administering the medication. -There was an entry for Gabapentin 100mg with no instructions for administering the medication. -There was an entry for Risperidone 1mg with no instructions for administering the medication. -There was an entry for Atorvastatin Calcium 10mg with no instructions for administering the medication. -There was an entry for Divalproex Sodium ER 500mg with no instructions for administering the medication. -There was an entry for Melatonin 3mg with no instructions for administering the medication. -There was no entry for Aspirin 81 mg oral every morning. -There was no entry for Cholecalciferol 2,000 units oral daily. -There was no entry for Lidocaine 3 patches transdermal daily.	C 342		

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C 342	Continued From page 16 -There was no entry for Diclofenac sodium 2g topical twice daily. -There was no entry for Tamsulosin 0.4mg oral every morning. -There was no entry for Trazodone 100mg oral nightly. Observation of Resident #1's medications on hand on 09/10/24 at 3:30pm revealed: -There was a supply of multi dose packs that contained Amlodipine 10mg, Benztropine 1mg, Chlorpromazine 100mg, Gabapentin 100mg, Olmesartan Medoxomil 40mg and Risperidone 1mg in 1 pack labeled "Breakfast." -There was a supply of multi dose packs that contained Gabapentin 100mg labeled "Afternoon". There was a supply of multi dose packs that contained Atorvastatin 10mg, Benztropine 1mg, Chlorpromazine 100mg, Divalproex ER 500mg, Gabapentin 100mg and Melatonin 3mg labeled "Bedtime." -There was a supply of multi dose packs that contained Risperidone 2mg labeled "Bedtime." -There was no Aspirin 81mg, Cholecalciferol 2000 units, Lidocaine transdermal, Diclofenac Sodium 2g, Tamsulosin 0.4mg, or Trazodone 100mg. Interview with a medication aide (MA) on 09/11/24 at 11:00am and 2:50pm revealed: -She was a relief MA and not permanent staff. -She had not worked in the facility since the current MA started approximately 2 months ago. -She administered medication to Resident #3 for the first time this morning. -The Administrator was responsible for ensuring the MAR was completed on the residents. -The MA used the MAR to administer the medications. -The MA made sure the medication on the MAR	C 342		

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C 342	Continued From page 17 corresponded with the medication administered to the resident. -The MAR should have the resident's name, date of birth, medication name, strength and dosage of the medication and instructions on how to administer the medication. -Resident #3 was recently admitted so all his medications were prepackaged. -She saw a handwritten MAR that did not have instructions. -A typed MAR was received from the pharmacy yesterday, 09/10/24, so she used that MAR to administer Resident #3's medication. -She did not know why the handwritten MAR did not have Resident #3's name or instructions or how to administer the medication. -She did not know who completed the MAR for Resident #3. Interview with the Administrator on 09/11/24 at 3:10pm revealed: -The Administrator was responsible for ensuring that the MAR was completed. -She completed the MAR for Resident #3. -The MAR should contain the medication name, instructions on how the medication was to be administered and staff initials when the medication was administered. -The Resident #3's name, date of birth and instructions on how to administer the medication was not on the MAR but was supposed to be there. -She did not know why the MAR was incomplete. -The pharmacy usually completed the MAR. -She completed the MAR because she had not received a MAR from the facility's contracted pharmacy and the MA needed a place to document medication administration. -The pharmacy sent a MAR yesterday, 09/10/24, with Resident #3's refilled medications.	C 342		

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C 342	Continued From page 18 Interview with the Assertive Community Treatment (ACT) Medical Doctor (MD) on 09/10/24 at 11:30am revealed: -The ACT team had been working with Resident #3 for over 1 year, providing psychiatric services and peer support. -The ACT team provided all Resident #3's psychiatric medications but tried to make sure the resident received all his medications to include non-psychiatric medications. -Resident #3 had been stable over the past 5 months. -Today was her first visit to the facility since Resident #3 moved in. -The ACT team visited Resident #3 one to two times per week. Interview with Resident #3's previous primary care provider (PCP) on 09/11/24 at 8:21am revealed: -She had a medication list for Resident #3. -Resident #3 may not be currently taking some of the medications on the list she had as she had not prescribed or filled some of the medications. -Tamsulosin and Trazadone were on the medication list, but she did not prescribe these medications. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/11/24 at 9:09am revealed: -Divalproex, Risperidone, Benztropine, Chlorpromazine, Melatonin and Paliperidone were psychiatric medications that were prescribed by the psychiatric provider so, the PCP would not have the accurate dosing information. -The Risperidone order was for 1mg in the morning and 2mg a bedtime.	C 342		

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C 342	Continued From page 19 Review of the Prescription Profile (signed by the pharmacist and dated 09/11/24) received from the ACT team licensed practical nurse (LPN) on 09/11/24 revealed: -There was an order for Invega Sustenna (Paliperidone) 234mg, Inject 1.5ml intramuscular once a month. -There was an order for Risperidone 1mg, take 1 tablet by mouth every day. -There was an order for Risperidone 2mg, take 1 tablet by mouth at bedtime. -There was an order for melatonin 3mg, take 2 tablets by mouth at bedtime. -There was an order for Benztropine MES 1mg, take one tablet by mouth twice a day. -There was an order for Chlorpromazine HCL 1mg, take one tablet by mouth twice a day. -There was an order for Divalproex SOD ER 500mg, take 3 tablets by mouth at bedtime. -There was an order for Diclofenac Sodium 1% gel, apply 2 grams to the affected area twice daily. -There was an order for Gabapentin 100 milligram, take two capsules by mouth three times a day. -There was an order for Lidocaine pain relief, apply 3 patches on skin daily for 12 hours and then remove for 12 hours. -There was an order for Olmesartan Medoxomil 40mg, take one tablet by mouth every day. -There was an order for Amlodipine Besylate 10mg, take one tablet by mouth everyday -There was an order for Atorvastatin 10mg, take one tablet by mouth every day. Telephone interview with the ACT team LPN on 09/11/24 at 2:20pm revealed: -She managed Resident #3's psychiatric medications.	C 342		

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C 342	Continued From page 20 -She administered Resident #3's Paliperidone monthly and the medication was not kept at the facility. -Diclofenac Sodium had been on back order. -Resident #3 had not used the Lidocaine pain patches for quite some time due to lack of pain and inability to afford the medication. Attempted interview with the current MA on 09/11/24 at 10:10am was unsuccessful.	C 342		
C 443	10A NCAC 13G .1212 Record of Staff Qualifications 10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS A family care home shall maintain records of staff qulaifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure records of staff qualifications were maintained in the facility for 2 of 3 staff (Staff A, Staff B). The findings are: 1. Interview with Staff A, personal care aide (PCA) upon entering the facility on 09/10/24 at	C 443		

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C 443	Continued From page 21 8:30am revealed: -The Administrator was not present in the facility and he would call her. -He was "in charge" of the facility in the absence of the Administrator. -He administered medications to the residents. -He was the only staff working at the facility. -He had been employed at the facility for three months. Observations of the facility on 09/10/24 at 9:29am revealed the Administrator arrived onsite. Interview with the Administrator on 09/10/24 between 3:56pm to 4:15pm revealed: -There were no staff records at the facility available for review. -Personnel records were kept in her home office. -It would take her an hour to retrieve the personnel records from her home office. -She knew records of staff qualifications were to be accessible at the facility. Second interview with the Administrator on 09/10/2024 at 5:25pm revealed: -Staff A was a live-in staff. -Staff A was the only staff working at the facility. The Administrator provided a personnel record for Staff A on 09/11/24 at 8:58am upon arrival at the facility. Review of Staff A's personnel record revealed required documentation was present in the record. 2. Interview with Staff B, Administrator, on 09/11/24 at 4:00pm revealed: -Staff records were not kept at the facility. -Staff records were kept in her home office.	C 443		

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C 443	Continued From page 22 -It would take her an hour to get the staff records from her home office. -She knew records of staff qualifications were to be kept at the facility. -She did not keep staff records at the facility because she had an issue in the past with records being stolen. -She would provide her personnel file by 9:00am on 09/12/24. The Administrator provided a personnel record for Staff B, Administrator, on 09/11/24 between 3:37pm and 8:45pm via text messages. Review of the personnel record for Staff B, Administrator, between 09/11/24, 3:45pm and 09/12/24, 12:00pm revealed all required documentation was present in the record.	C 443		