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	FCL092206	A. BUILDING: _____ B. WING _____	R 05/19/2026

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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 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 05/19/26.	C 000		
C 206	10A NCAC 13G .0702 (e) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following: (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status including orders for therapeutic diets; (4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;	C 206		

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C 206	Continued From page 1 (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. 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 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 09/18/25 revealed: -Diagnoses included schizophrenia, dyskinesia, chronic kidney disease, and hypertension. -There was a checkmark next to the section listed for diet. -There was no diet order written on the current FL-2. Review of Resident #1's Resident Register revealed an admission date on 08/29/16. Review of Resident #1's record revealed there was no documentation of the resident's diet.	C 206		

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C 206	Continued From page 2 Refer to interview with a medication aide (MA) on 05/19/26 at 9:20am and 11:40am. Refer to interview with the Administrator 05/19/26 at 9:45pm and 11:45am. Observation in the kitchen on 05/19/26 at 9:11am revealed: -There was diet list posted on the wall in the kitchen. -Resident #1 was listed as a regular diet. 2. Review of Resident #2's current FL-2 dated 09/07/25 revealed: -Diagnoses included schizophrenia, hypertension, type 1 diabetes, and autism. -There was no diet order written on the current FL-2. Review of Resident #2's Resident Register revealed an admission date on 01/20/25. Review of Resident #2's record revealed there was no documentation of the resident's diet. Refer to interview with a medication aide (MA) on 05/19/26 at 9:20am and 11:40am. Refer to interview with the Administrator 05/19/26 at 9:45pm and 11:45am. Observation in the kitchen on 05/19/26 at 9:11am revealed: -There was diet list posted on the wall in the kitchen. -Resident #2 was listed as a regular diet with low sugar. 3. Review of Resident #3's current FL-2 dated	C 206		

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C 206	Continued From page 3 08/28/25 revealed: -Diagnoses included schizophrenia, hypertension, and bipolar disorder. -There was no diet order written on the current FL-2. Review of Resident #3's Resident Register revealed an admission date on 08/29/24. Review of Resident #2's record revealed there was no documentation of the resident's diet. Refer to interview with a medication aide (MA) on 05/19/26 at 9:20am and 11:40am. Refer to interview with the Administrator 05/19/26 at 9:45pm and 11:45am. Observation in the kitchen on 05/19/26 at 9:11am revealed: -There was diet list posted on the wall in the kitchen. -Resident #3 was listed as a low sodium diet. _____ Interview with a medication aide (MA) on 05/19/26 at 9:20am and 11:40am revealed: -The Administrator placed the resident diet order sheet in the kitchen. -He followed the diet order list posted in the kitchen when making melas. Interview with the Administrator 05/19/26 at 9:45pm and 11:45am revealed: -The diet order should have been on the residents' FL2. -She was responsible for making sure diet orders were in the residents' records. -Most of the residents were on a regular diet. -She got the resident diets, that was posted on the wall in the kitchen, from the residents' primary	C 206		

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C 206	Continued From page 4 care provider (PCP). -She did not have any documentation that the PCP ordered diets for the residents. -She would get documented diet orders from the PCP.	C 206		
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 all food items stored by the facility were protected from contamination related to improper storage of food items in the refrigerator.	C 257		

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C 257	Continued From page 5 The findings are: Observation of the kitchen counter on 05/19/26 at 9:00am revealed: -There was a whole fish placed on top of a container on butter. -There were six pieces of cooked chicken in a butter container. Observation of the kitchen refrigerator on 05/19/26 at 9:10am revealed: -There were five bags of salad that were brown and all had expiration dates that had passed. -There was a bag of expired brussel sprouts. -There was a container of expired strawberries. -There was a bag with cut watermelon wrapped in a plastic grocery bag with no label. -There was a styrofoam container with a yellow liquid substance uncovered and not labeled. Interview with the medication aide (MA) on 05/19/26 at 9:20am revealed: -The fish left on the counter was his lunch he planned on cooking. -The chicken that was left on the counter was cooked that morning for the residents. -He checked the refrigerator daily to make sure there were no expired foods. -He only checked the expiration dates on the foods he planned on cooking that day. -He should have gone through all the food in the refrigerator and thrown away the expired foods. -He was responsible for the expired foods in the refrigerator. Interview with the Administrator on 05/19/26 at 11:00am revealed: -The MA should not have fish out on the counter not in a proper container. -The MA should not have had chicken on the	C 257		

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C 257	Continued From page 6 counter. -The MA was responsible for ensuring all food was put in containers and labeled. -She expected the MA to check the refrigerator daily for expired foods. -She expected the MA to cover and label all food stored in the refrigerator. -She was responsible for making sure that the staff were trained to store food properly.	C 257		
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: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) related to a medication used to treat Type 1 diabetes. The findings are: Request for the facility's medication administration policy on 05/19/26 at 4:00pm revealed the facility did not have a medication administration policy.	C 330		

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C 330	Continued From page 7 Review of Resident #2's current FL-2 dated 10/18/25 revealed diagnoses included schizophrenia, type 1 diabetes mellitus, narcissistic personality disorder, and autism spectrum disorder. Review of Resident #2's Resident Register revealed an admission date of 01/20/25. Review of the endocrinology after visit summary dated 02/13/26 for Resident #2 revealed: -There was an order for Humalog (a rapid acting insulin used to control blood sugars at meals) inject 10 units before breakfast, inject 8 units before lunch, and inject 12 units before dinner. -There was an order for Humalog sliding scale 201-250 add 2 units, 251-300 add 4 units, 301-350 add 6 units, greater that 350 add 8 units. Review of Resident #2's medication administration record (MARs) for March 2026 revealed: -There was an entry for Resident #2's blood glucose was checked four times each day. -There was an entry for Resident #2 was administered Humalog three times daily, inject 10 units before breakfast, inject 8 units before lunch, and inject 12 units before dinner. Review of Resident #2's medication administration record (MARs) for April 2026 revealed: -There was an entry for Resident #2's blood glucose was checked four times each day. -There was an entry for Resident #2 was administered Humalog three times daily, inject 10 units before breakfast, inject 8 units before lunch, and inject 12 units before dinner.	C 330		

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C 330	Continued From page 8 Review of Resident #2's medication administration record (MARs) for May 2026 revealed: -There was an entry for Resident #2's blood glucose was checked four times each day. -There was an entry for Resident #2 was administered Humalog three times daily, inject 10 units before breakfast, inject 8 units before lunch, and inject 12 units before dinner. Review of Resident #2's blood glucose measurement results sheet for March 2026 revealed: -There were instructions for Humalog sliding scale 201-250 add 2 units, 251-300 add 4 units, 301-350 add 6 units, greater than 350 add 8 units. -On 03/01/26 there was a documented blood glucose of 264 before lunch, 2 additional units of Humalog were documented as administered when 4 units should have been administered. -On 03/08/26 there was a documented blood glucose of 457 before lunch, 4 additional units of Humalog were documented as administered when 8 units should have been administered. -On 03/10/26 there was a documented blood glucose of 315 before lunch, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 03/12/26 there was a documented blood glucose of 202 before dinner, no additional units of Humalog were documented as administered when 2 units should have been administered. -On 03/18/26 there was a documented blood glucose of 264 before breakfast, 2 additional units of Humalog were documented as administered when 4 units should have been administered. -On 03/19/26 there was a documented blood glucose of 310 before breakfast, 4 additional	C 330		

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C 330	Continued From page 9 units of Humalog were documented as administered when 6 units should have been administered. -On 03/21/26 there was a documented blood glucose of 306 before dinner, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 03/26/26 there was a documented blood glucose of 302 before lunch, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 03/30/26 there was a documented blood glucose of 227 before lunch, 4 additional units of Humalog were documented as administered when 2 units should have been administered. Review of Resident #2's blood glucose measurement results sheet for April 2026 revealed: -There were instructions for Humalog sliding scale 201-250 add 2 units, 251-300 add 4 units, 301-350 add 6 units, greater than 350 add 8 units. -On 04/04/26 there was a documented blood glucose of 354 before lunch, 4 additional units of Humalog were documented as administered when 8 units should have been administered. -On 04/08/26 there was a documented blood glucose of 306 before breakfast, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 04/08/26 there was a documented blood glucose of 325 before dinner, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 04/12/26 there was a documented blood glucose of 258 before lunch, 2 additional units of Humalog were documented as administered when 4 units should have been administered.	C 330		

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C 330	Continued From page 10 -On 04/14/26 there was a documented blood glucose of 256 before breakfast, 2 additional units of Humalog were documented as administered when 4 units should have been administered. -On 04/15/26 there was a documented blood glucose of 259 before lunch, 2 additional units of Humalog were documented as administered when 4 units should have been administered. -On 04/17/26 there was a documented blood glucose of 230 before lunch, no additional units of Humalog were documented as administered when 2 units should have been administered. -On 04/21/26 there was a documented blood glucose of 305 before dinner, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 04/28/26 there was a documented blood glucose of 267 before lunch, 2 additional units of Humalog were documented as administered when 4 units should have been administered. Review of Resident #2's blood glucose measurement results sheet for May 2026 revealed: -There were instructions for Humalog sliding scale 201-250 add 2 units, 251-300 add 4 units, 301-350 add 6 units, greater than 350 add 8 units. -On 05/03/26 there was a documented blood glucose of 316 before lunch, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 05/05/26 there was a documented blood glucose of 325 before lunch, 2 additional units of Humalog were documented as administered when 6 units should have been administered. -On 05/08/26 there was a documented blood glucose of 259 before lunch, 2 additional units of Humalog were documented as administered	C 330		

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C 330	Continued From page 11 when 4 units should have been administered. -On 05/09/26 there was a documented blood glucose of 401 before breakfast, 6 additional units of Humalog were documented as administered when 8 units should have been administered. -On 05/09/26 there was a documented blood glucose of 351 before lunch, 4 additional units of Humalog were documented as administered when 8 units should have been administered. -On 05/10/26 there was a documented blood glucose of 436 before lunch, 6 additional units of Humalog were documented as administered when 8 units should have been administered. -On 05/11/26 there was a documented blood glucose of 422 before lunch, 6 additional units of Humalog were documented as administered when 8 units should have been administered. -On 05/11/26 there was a documented blood glucose of 315 before dinner, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 05/13/26 there was a documented blood glucose of 336 before breakfast, 4 additional units of Humalog were documented as administered when 6 units should have been administered. -On 05/13/26 there was a documented blood glucose of 414 before lunch, 6 additional units of Humalog were documented as administered when 8 units should have been administered. -On 05/17/26 there was a documented blood glucose of 252 before breakfast, 2 additional units of Humalog were documented as administered when 4 units should have been administered. -On 05/17/26 there was a documented blood glucose of 377 before lunch, 6 additional units of Humalog were documented as administered when 8 units should have been administered.	C 330		

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C 330	Continued From page 12 Observation of Resident #2's medications on hand on 05/19/26 at 2:05pm revealed Resident #2 had a Humalog insulin pen with an open date of 05/12/26. Interviews with the medication aide (MA) on 05/19/26 at 11:00am and 2:05pm revealed: -Resident #2 had type 1 diabetes and was administered insulin dosages daily on a sliding scale. -He added two additional units of insulin for each 50 milligrams in which Resident #'2's blood sugar level was over 200. -When Resident #2 had a blood glucose level of 351 on 05/09/26 he should have administered eight additional units of insulin, but he administered Resident #2 four additional units of insulin on 05/09/26. -He administered Resident #2 the wrong units of insulin on multiple occasions. -He referred to the sliding scale chart when he administered insulin to Resident #2. -He believed that he was reading the sliding scale chart incorrectly. Interview with the Administrator on 05/19/26 at 11:10am revealed: -Resident #2 had type 1 diabetes and was administered insulin dosages daily on a sliding scale. -The MA was not administering Resident #2 his sliding scale insulin correctly. -She expected the MA to follow the sliding scale insulin chart in order to administer the proper amount of insulin to Resident #2. -The Administrator and the House Manager should have checked the blood glucose measurement sheets to ensure that the MA was administering the sliding scale insulin correctly.	C 330		

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C 330	Continued From page 13 -The Administrator and the House Manager had not checked the blood glucose measurement sheets because she believed the MA was doing them properly. -She had serious concerns that staff administering Resident #2's insulin incorrectly could cause health problems. Telephone interview with Resident #2's primary care provider (PCP) on 05/19/26 at 1:00pm revealed: -Resident #2's endocrinologist provided the facility with sliding scale parameters for the MA to follow to properly administer his insulin. -Resident #2's Humalog sliding scale was 201-250 add 2 units, 251-300 add 4 units, 301-350 add 6 units, greater than 350 add 8 units. -He expected staff members at the facility to follow the sliding scale chart when administering insulin to Resident #2. -The outcome of Resident #2 being administered insulin incorrectly depended on the level of errors that occurred, two units of insulin administered incorrectly would probably not have any significant effect. -He was more concerned about Resident #2's blood glucose levels being low. -The errors that were done when administering Resident #2 his sliding scale insulin were mildly consequential. Attempted telephone interview with Resident #2's endocrinologist on 05/19/26 at 9:37am was unsuccessful. Based on observations, interviews, and record reviews it was determined that Resident #2 was uninterviewable.	C 330		

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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 330	Continued From page 14 The facility failed to ensure Resident #2 diagnosed with type 1 diabetes was administered sliding scale insulin as ordered. The medication aide incorrectly administered an incorrect dose of Humalog insulin to Resident #2 on 30 occasions from 03/01/26 to 05/19/26, during this time Resident #2's blood sugars ranged from 43 to 457. This failure was detrimental to the health, safety, and welfare of the Resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/19/26 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED July 3, 2026.	C 330		