STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B 14/11/0		R		
MHL092-735		B. WING		02/09	9/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CI OPA'	S ANGELS HOME	7205 JON	NATHAN DRIN	/E		
CLUKA	S ANGELS HOWE	WENDEL	L, NC 27591			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	An annual and follow up survey was completed on 2/9/24. Deficiencies were cited. This facilty is licensed for the following service					
	category: 10A NCA Living for Alternative	C 27G .5600F Supervised e Family Living.				
This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.						
V 118 27G .0209 (C) Medication Requirements		V 118				
	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the drug.					

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-735		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED R 02/09/2024	
		B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE	•	
CLORA'S	S ANGELS HOME		NATHAN DRIV	E		
OLONA.	ANGLEGITOME	WENDEL	L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure medications were administered as prescribed for 1 of 2 clients (#2). The findings are: Review on 2/7/24 of Client #1's record revealed: - Admitted: 12/1/18 - Diagnoses: Severe IDD, Chromosome Deletion 7Q, Anemia and Seizure Disorder - No doctor orders for: - Risperdal 3 milligrams (mgs), 1 tab daily at 3:30pm (seizures) - Melatonin 3 mgs, 1 tab at bedtime (sleep) - Vitamin D 1000 units softgel, 1 capsule daily (supplement) - Ensure, 1 can 3 times per day					
	MAR revealed: - All above medic MAR and initialed a Observation & Inter approximately 4:35 - The AFL (Alterr					

Division of Health Service Regulation

STATE FORM 6899 W2NS11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL092-735		B. WING		I	R 09/2024	
CLORA'S ANGELS HOME 7205 JONA		ORESS, CITY, S ATHAN DRIV -, NC 27591				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Melatonin, Vitamin The AFL Provide to call the doctor for pharmacist didn't has linterview on 2/9/24 reported: She made sure she didn't check methe facility The AFL Provide doctors' orders in the facility They were ever AFL's to the electron homes which would office to help managen urse' will be able to orders and MARs. Interview on 2/7/24 Living) Provider repensiving doctor orders were correct When new MAR monthly, she check medication She did not alw unless it changed She knew that a order She would start the MARs and med refills came in	e a doctor's order for the D, Ensure or Risperdal ler stated that she would need in the orders since the lave them. The Qualified Professional MARs were complete, but redications when she visited ler was responsible for having the facility intually going to move their nic MARs like their group I make it a lot easier for the ge medications because the orcheck on medications, the AFL (Alternative Family forted: Insible for medication re-fills, as and making sure the MARs. Rs and medications came in the MAR with the lays check the doctor's order all medications had to have an at checking doctor orders with ications monthly when the stitutes a re-cited deficiency.	V 118			
		,				

6899

Division of Health Service Regulation STATE FORM

W2NS11 If continuation sheet 3 of 6

Division	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-735		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 02/09/2024		
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CLORA'S	S ANGELS HOME		IATHAN DRIV L, NC 27591	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 139	Continued From pa	ge 3	V 139			
V 139	27G .0404 (F-L) Operations During Licensed Period		V 139			
	Continued From page 3 27G .0404 (F-L) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (f) DHSR shall conduct inspections of facilities without advance notice. (g) Licenses for facilities that have not served any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of July 1, 2007. (i) Written requests shall be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Construction of a new facility or any renovation of an existing facility; (2) Increase or decrease in capacity by program service type; (3) Change in program service; or (4) Change in location of facility. (j) Written notification must be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Change in ownership including any change in partnership; or (2) Change in name of facility. (k) When a licensee plans to close a facility or discontinue a service, written notice at least 30 days in advance shall be provided to DHSR, to all affected clients, and when applicable, to the legally responsible persons of all affected clients. This notice shall address continuity of services to clients in the facility.					

STATE FORM 6899 W2NS11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
			, soles		R		
		MHL092-735	B. WING		02/09/2024		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CLORA'S	S ANGELS HOME		ATHAN DRI\ _, NC 27591				
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 139	to DHSR the following information: (1) Annual Fee; (2) Description of any changes in the facility since the last written notification was submitted; (3) Local current fire inspection report; (4) Annual sanitation inspection report, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.		V 139				
	This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to submit a written request to the Division of Health Service Regulation (DHSR) a minimum of 30 days prior to any change in decrease in capacity. The findings are: Review on 2/7/24 of the facility's license revealed: - Capacity: 3 Observation on 2/7/24 at approximately 2:00pm revealed: - Bedroom that was previously used for a 3rd client was occupied by a family member - There was no other bedroom or bed available for a 3rd client						
	Interview on 2/9/24 the Qualified Professional (QP) reported: - She would connect the AFL (Alternative						

Division of Health Service Regulation

STATE FORM 6899 W2NS11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
MHL092-735		B. WING			R 09/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CLORA'S	CLORA'S ANGELS HOME 7205 JONATHAN DRIVE WENDELL, NC 27591						
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 139	Family Living) Provinelped clients with I with changing her li Interview on 2/7/24 - She didn't know bedroom available to The last 3rd clie - Her son moved October 2023 and i previously used for She did not plate.	ider with the staff member that icense renewals to assist her cense capacity the AFL Provider revealed: that she needed to keep that for a 3rd client ent she had was in 2021 back in the home around into the bedroom that was	V 139				

6899

Division of Health Service Regulation STATE FORM

W2NS11 If continuation sheet 6 of 6