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 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES II	6704 SHANGHI DRIVE WILLOW SPRING, 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 09/12/24.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (Resident #1, Resident#2, and Resident #3) had assessment sand care plans updated annually. The findings are:	C 231		

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C 231	Continued From page 1	C 231		

1. Review of Resident #1's FL-2 dated 07/03/24 revealed:
- Diagnoses included malignant neuroleptic syndrome, paranoid schizophrenia, major depressive disorder, and multiple sclerosis.
- Resident #1's recommended level of care was assisted living.

Review of Resident #1's Resident Register revealed an admission date of 10/15/20.

Review of Resident #1's record on 09/12/24 revealed:
-Resident #1's Primary Care Provider (PCP) signed the care plan on 08/22/22.
-There were no additional documented care plans.

2. Review of Resident #2's FL-2 dated 07/31/24 revealed:
- Diagnoses included carbuncle, schizophrenia, hypertension, and lacunar infraction.
- Resident #2's recommended level of care was assisted living.

Review of Resident #2's Resident Register revealed an admission date of 02/06/23.

Review of Resident #1's record on 09/12/24 revealed:
-Resident #2's Primary Care Provider (PCP) signed the care plan on 02/06/23.
-There were no additional documented care plans.

3. Review of Resident #3's FL-2 dated 12/11/23 revealed:
- Diagnoses included chronic obstructive pulmonary disorder, schizophrenia, diabetes mellitus, and hypertension.

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C 231	Continued From page 2 - Resident #3's recommended level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 11/16/16. Review of Resident #3's record on 09/12/24 revealed: -Resident #3's Primary Care Provider (PCP) signed the care plan on 02/02/23. -There were no additional documented care plans. Interview with a medication aide (MA) on 09/12/24 at 10:00pm revealed: -She did not know why the resident care plans were not updated. -The Administrator was responsible for ensuring the resident records are completed. -The Administrator was responsible for ensuring the resident care plans were updated annually. Interview with the Administrator on 09/12/24 at 11:30am revealed: -She was responsible for the resident records. -She was aware residents required updated care plans annually. -She was aware Resident #1's, Resident #2's, and Resident #3's care plans needed to be updated. -She should have gotten the residents care plans updated but she had not gotten around to doing it.	C 231		
C 317	10A NCAC 13G .1002 (c) Medication Orders 10A NCAC 13G .1002 Medication Orders c) The medication orders shall be complete and include the following:	C 317		

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C 317	Continued From page 3 (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) route of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to obtain a clarification of order for as needed (PRN)medications for 1 of 3 residents (Resident#1). The findings are: Review of Resident #1's FL-2 dated 07/03/24 revealed diagnoses included malignant neuroleptic syndrome, paranoid schizophrenia, major depressive disorder, and multiple sclerosis. Review of Resident #1's Resident Register revealed an admission date of 10/15/20. Review of physician orders dated 09/6/23 revealed: -Melatonin 3mg tablet take 1 tablet by mouth at bedtime as needed, used to treat insomnia. -Ondansetron 20mg take 1 tablet by mouth as needed, used to treat nausea and vomiting. Review of Resident #1's July 2024 medication administration record (MAR) revealed: -There was an entry for melatonin 3mg at bedtime as needed. -Melatonin was not documented as administered	C 317		

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C 317	Continued From page 4 from 07/01/24- 07/31/24. -There was an entry for ondansetron 20mg every 8 hours as needed. -Ondansetron was documented as administered daily from 07/01/24- 07/31/24. Review of Resident #1's August 2024 MAR revealed: -There was an entry for melatonin 3mg at bedtime as needed. -Melatonin was not documented as administered from 08/01/24- 08/31/24. -There was an entry for ondansetron 20mg every 8 hours as needed. -Ondansetron was documented as administered daily from 08/01/24- 08/31/24. Review of Resident #1's September 2024 MAR revealed: -There was an entry for melatonin 3mg at bedtime as needed. -Melatonin was not documented as administered from 07/01/24- 07/30/24. -There was an entry for ondansetron 20mg every 8 hours as needed. -Ondansetron was documented as administered daily from 07/01/24- 07/30/24. Interview with a medication aide (MA) on 09/12/24 at 9:20am revealed: -She was responsible for passing medications to residents in the facility. -She was aware that Resident #1 had an as needed (PRN) medication for melatonin 3mg that was given for sleep. -She was aware that Resident #1 had a PRN medication for ondansetron 20mg that was given for vomiting. -She was not aware that the medications needed clarification of symptoms in order to administer.	C 317		

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C 317	Continued From page 5 Interview with the Administrator on 09/12/24 revealed: -She was not aware that Resident #1 had as needed (PRN) medications that had incomplete orders. -She was aware that PRN medications needed clarification of symptoms in order to administer. -She was responsible for ensuring medication orders were complete. Telephone interview with the facility Pharmacy on 09/12/24 at 11:50am revealed: -She was not aware that the melatonin 3mg and ondansetron 20mg did not have clarifications of symptoms in order to administer. -The pharmacy was responsible for ensuring clarifications for as needed medications were on the MAR. -Clarifications for as needed medications are important so that staff know when they should administer the medication. Attempted telephone interview with the Primary Care Provider (PCP) on 09/12/24 at 12:15pm was unsuccessful.	C 317		