STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011318	A. BUILDING: _____ B. WING _____	R 02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HEART FAMILY CARE HOME # 233	233 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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 Buncombe County DSS and the Adult Care Licensure Section conducted an on-site annual and follow-up survey on 2/4/15.	C 000		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure a staff member was available at all times and the residents were not left alone.	C 186		

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C 186	Continued From page 1 The findings are: Confidential interview with 4 residents on 2/4/15 revealed: -During the past few weeks and recently, there were times for up to 1 hour when a staff member was not accessible nor available and residents did not know where staff member was. -Residents knocked on staff member door with no response. -On some occasions, residents needed prn (as needed) medications or wanted some ice in the kitchen. -One resident paced when the staff member was not available and was very anxious. -Two residents were not aware there was a telephone available for use when the Supervisor-in-Chaarge (SIC) was not available and did not know what to do in an emergency. -One resident said, "It doesn't bother me." -Staff reported that one SIC, Staff A, did not tell them when she left the facility or was on break. Interview with Staff A on 2/4/15 at 12:25pm revealed: -She and another SIC work at this facility. -She worked three or four days, off three or four days, then back on again. -The SIC on duty gets up at 7:00am to turn off the door alarms and turns them on at 10:00pm. -From 7:00am to 10:00pm, the SIC on duty is allowed 7 breaks for a total of 5 hours. -Staff A takes the breaks by sitting in her car in front of the facility, by visiting another facility next door on their porch in sight of this facilty, by staying in the SIC bedroom with the door closed. -Staff A said she had never left the residents by themselves. -"Maybe they did not know I was in my room." -The residents had never asked her where she	C 186		

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C 186	Continued From page 2 had been when she came from her room or came in from being outside. -She did not always tell the residents where she was when taking her break but they" should know" I am here in case of an emergency. Interview with the Administrator on 2/4/15 at 1:00pm revealed: -She paid the SICs for 10 hours during the 15 hour work-day from 7:00am to 10:00pm. -A total of 5 hours break time is scheduled for the 15 hour work day. -A Lead Staff person supposed to come to the facility daily to allow Staff A to take a 2 hour break. -There are four facilities where the Lead Staff was responsible for going daily (Monday through Friday) and give each SIC a 2 hour break. -There is a posted schedule for the on duty SICs. -There was no relief staff available on Saturday and Sunday. -They currently have a census of 6 residents. -Staff know if the resident needs something or there is an emergency they should not take the scheduled break. -Staff should let each resident know if the are on break and where they will be during the break. Review of the posted SIC work schedule revealed breaks were scheduled as follows: -8:45am to 9:15am (30 minutes) -10:30am to 11:15am (45 minutes -12:30pm-1:00pm (30 minutes) -2:30pm-3:30pm (1 hour) -4:00pm-4:45pm (45 minutes) -5:30pm-5:45pm ((15 minutes) -6:15pm-8:00pm (1 hour 45 minutes)	C 186		

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C 186	Continued From page 3 Interview with the Lead SIC on 2/4/15 at 1:15pm revealed: -Some days she could not be in the facilities to allow SIC breaks because she does some transportation, some grocery shopping, and some 8 hour day relief staff in one of the sister facilities. -There was no relief staff available on Saturday and Sunday. Interview with Staff A on 2/4/15 at 1:10pm revealed: -She could not remember a time when the Lead SIC came to give her a break and allowed her to leave the property. -She did have to be "on duty from 7:00am to 10:00pm and only got paid for 10 hours and had to be available at night if the resident needed anything." Review of records and interviews related to the six residents who resided in the facilty revealed: A. Review of Resident #1's FL2 dated, 9/15/14, revealed diagnoses which included schizophrenia, Hepatitis C, HIV positive, and asthma. Interview with professional staff who provide mental health services for Resident #1 on 2/4/15 at 1:05pm revealed: -They would be "very concerned" if Resident #1 was left alone -Resident #1 was at "high risk" for leaving the facilty. Interview with Resident #1 on 2/4/15 at 9:15am revealed: -She was oriented to person place and time. -She responded appropriately to questions but was slow in responding.	C 186		

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C 186	Continued From page 4 -She recently signed out of the facility for the day and did not return to the facility for several days when she went to Charlotte and visited family. B. Review of FL2 for Resident #4, dated 12/18/14 revealed diagnoses which included: -Schizoaffective disorder -Anxiety disorder -Intermittent explosive disorder -Obsessive compulsive disorder/attention deficit hyperactivity disorder -Borderline personality disorder. Review of FL2 for Resident #4, dated 12/18/14 revealed no information on behavior. C. Review of Resident #2's FL2 dated 10/1/14 revealed diagnoses which included: -Diabetes -Mood disorder -Bipolar -Post traumatic stress disorder Review of Resident #2's FL2, dated 10/1/14, revealed the resident had been injurious to self in the past. Review of Resident #2's current Care Plan, dated 11/16/14 revealed resident "can become verbally aggressive toward others and self." Review of Resident #2's record revealed a psychiatric hospitalization before admission to this facility on 10/1/14. Telephone interview with Resident #2's guardian on 2/4/15 revealed: -The guardian stated she would be "very concerned" if a supervisor was not always "readily available" in the facility.	C 186		

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C 186	Continued From page 5 -The guardian reiterated the psychiatric hospitalization Resident #2 had before admission to this facility. D. Review of Resident #6's FL2, dated 2/2/15, revealed: -Diagnoses of severe adaptive mental retardation and paranoid schizophrenia -"Wanderer" checked under behavior. -"Intermittently disoriented" checked under orientation. Interview with Resident #6's guardian on 2/4/15 at 1:45pm revealed he did not have concerns that Resident #6 would wander away from the facility. E. Review of Resident # 5's FL2 dated 1/20/15 revealed diagnosis of mild mental retardation. Review of Resident #5's Care Plan, dated 12/22/14, revealed no documented issues related to need for increased supervision. Interview with Resident #5 on 2/4/15 at 9:45am revealed she had rather not discuss whether the SIC was always available. F. Review of Resident #6's FL2, dated 11/7/14, revealed: -Diagnoses which included schizophrenia, paranoid type -No information under behavior. Review of Resident #6's current care plan, dated 12/17/14, revealed "can become verbally aggressive toward others and self." _____ The Plan of Correction submitted by the facilty revealed:	C 186		

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C 186	Continued From page 6 -The Administrator will instruct staff to assure the residents that there is a staff member present during scheduled break times and that if they need anything he/she is available should an emergency or matter arise. -Staff will be required to leave the staff door open during business hours to allow accessibility to residents and guest. -The Administrator will continue to randomly check/call to the facilty to assure that staff are in the building. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED March 25, 2015.	C 186		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure therapeutic menus were available for the guidance of food service staff for 2 of 2 residents (#1 and #2) with therapeutic diet orders (one 1800 calorie and one No Concentrated Sweets). The findings are: Observation of the noon meal on 2/4/15 at 12:30pm revealed:	C 270		

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-All residents were served a cheese sandwich, a bowl of vegetable beef soup, and iced tea.
-Resident #1 was served sugar free cookies for dessert and Resident #2 was served a cinnamon roll.
-Resident #1 and #2 were served unsweetened tea.

Review of the facilty menus revealed:
-The only menus available was 2010 "week at a glance" regular menus.
-There were no matching therapeutic menus available.

A. Review of Resident #2's FL2 dated 10/1/14 revealed:
-Diagnoses which included diabetes and hyperlipidemia
-An order for a 1800 Calorie diet.
-An order for Metformin 500 mg, 1 tablet per day.

A subsequent physician order, dated 1/16/15, revealed an order, dated 1/16/15, for fingerstick blood sugar checks (FSBS) in the morning and "as needed" and to to increase the Metformin 500 mg to 1 tablet twice per day.

On 2/4/15, review of the February 2015 Medication Administration Records (MARs) revealed FSBS:
2/1- 8:00am: 198 5:00pm: 184
2/2- 8:00am: 133 5:00pm: 215
2/3-8:00am: 133 5:00pm: 175
2/4-8:00am: 129

Review of the January 2015 MAR revealed blood sugars ranged from 173 to 521 from 1/23/15 to 1/31/15.

Interview with Resident #2 on 2/4/15 at 9:15 am

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C 270	Continued From page 8	C 270		

revealed:
-She knew she was supposed to be on a 1800 calorie diet but did not think she had been receiving a 1800 calorie menu.
-She did not think the facilty had the 1800 calorie menu available.
-She was usually served what everyone else was served.

Interview with the SIC on duty on 2/4/15 at 12:15pm revealed:
-She knew Resident #2 was on a diabetic diet.
-She used the regular menus for all residents, but served the diabetic residents sugar free beverages and sugar free desserts and did not fry any foods.
-She was not aware of any 1800 calorie menu.
-She served Resident #2 a cinnamon roll for lunch today because her FSBS was "low this morning."

Refer to interview with the Administrator on 2/4/15 at 2:00pm.

B. Review of Resident #1's FL2 dated, 9/15/14, revealed:
-Diagnoses which included Hepatitis C and HIV positive.
-An order for Metformin 500 mg, 2 tablets daily.
-An order for a No Concentrated Sweets diet.

Review of physician order, dated 1/9/15, revealed orders to check fingerstick blood sugars twice daily.

Review of 1/10/15 through 1/31/15 Medication Administration Records (MARs) revealed FSBS ranged from 116 to 367.

Interview with Resident #1 on 2/4/15 at 9:25am

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C 270	Continued From page 9 revealed: -She knew she was supposed to receive a diabetic diet. -The facilty did serve some sugar free snacks and desserts. Interview with the SIC on duty on 2/4/15 at 12:15pm revealed: -She knew Resident #1 was on a diabetic diet. -She used the regular menus for all residents, but served the diabetic residents sugar free beverages and sugar free desserts and did not fry any foods. -She was not aware of a No Concentrated Sweets menu. Refer to interview with the Administrator on 2/4/15 at 2:00pm. _____ Interview with the Administrator on 2/4/15 at 2:00pm revealed: -The SIC on duty had used the wrong menus. -She had a new set of menus delivered to all her facilities and she did not know why this facilty did not have them. -She would make sure a set of the new menus would be available -She had been buying groceries based on the new menus.	C 270		
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:	C 342		

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C 342	Continued From page 10 (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 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 observation, interview, and record review, the facilty failed to assure the effectiveness of a prn medication (Oxycodone) was documented for 1 of 1 resident (#1). The findings are: Review of Resident #1's FL2 dated, 9/15/14, revealed diagnoses which included: -Hepatitis C -HIV positive -Asthma. Review of a physician order, dated 1/9/15, revealed Oxycodone 5 mg, one tablet three times per day as needed for hand pain. Review of the January 2015 Medication Administration Record (MAR) revealed: -Documentation of the administration of	C 342		

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C 342	Continued From page 11 Oxycodone 5 mg 20 times from 1/9/15 through 1/29/15. -Documentation on back of the MAR for administration of Oxycodone for 5 days for "hand pain," but no documentation for the effectiveness. -No documentation of the effectiveness of the Oxycodone for the other 15 doses administered during the month. Interview with the SIC on duty, (Staff A) on 2/4/15 at 1:20pm revealed: -The other SIC had administered most of the Oxycodone to Resident #1. -Staff A said she always tried to remember to document the back of the MAR for effectiveness. On 2/4/15 at 11:25am, telephone interview with the other SIC (Staff B), who works in this facilty revealed she must have forgotten to document on the back of the MAR but knew she should. Interview with Resident #1 on 2/4/15 at 1:45am revealed she did ask for Oxycodone in the evenings and it usually relieved her pain.	C 342		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate and in	C 912		

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C 912	Continued From page 12 compliance with relevant federal and state laws and rules and regulations related to management and other staff. The findings are: Based on interview and record review, the facility failed to assure a staff member was available at all times and the residents were not left alone. [Refer to Tag 186 10A NCAC 13G .0601 Management and Other Staff (Type B Violation).]	C 912		