STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011312	A. BUILDING: _____ B. WING _____	R 08/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HEART FAMILY CARE HOMES #232	232 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 The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey, and complaint investigation on August 10, 2015 and August 12, 2015.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 2 of 3 sampled residents (#1 and #2) related to finger stick blood sugars and blood pressures. The findings are: A. Review of Resident #2's record revealed he was admitted to the facility on 11/12/14. 1. Review of Resident #2's current FL2 dated 3/25/15 revealed: -Diagnoses included: anxiety, coronary artery disease, gout, hepatitis C, pre-diabetes, history of opioid abuse, hyperlipidemia, hypertension and lower extremity edema. -Blood pressure checks twice per day. -Furosemide 20mg, 1 tablet on Tuesday, Thursday, Saturday and Sunday (furosemide is used to treat high blood pressure). -Furosemide 20mg, 2 tablets on Monday,	C 246		

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C 246	Continued From page 1	C 246		

Wednesday and Friday.
-Benazepril 20mg every morning (benazepril is used to treat high blood pressure).
-Amlodipine 10mg every morning (amlodipine is used to treat high blood pressure).

Review of a physician's order dated 4/14/15 revealed:
-Stop benazepril 20mg every morning.
-Start benazepril 40mg every morning.

Review of Resident #2's record revealed a report of services form from the facility to Resident #2's primary care physician (PCP) dated 6/1/15 that stated to "please discontinue blood pressures (BP), [Resident #2] refuses to do it".

Review of a physician's order for Resident #2 dated 6/2/15 revealed "check BP's two times a week".

Review of June 2015 Medication Administration Record (MAR) revealed:
-BP's were recorded 9 times from 6/4/25 to 6/29/15.
-BP's ranged from 126/99 to 180/84.
-Furosemide, benazepril and amlodipine were documented as administered as ordered.

Review of July 2015 MAR revealed:
-BP's were not recorded for the entire month.
-Furosemide, benazepril and amlodipine were documented as administered as ordered for the entire month.

Review of August 2015 MAR revealed:
-BP's were not recorded from 8/1/15 to 8/11/15.
-Furosemide, benazepril and amlodipine were documented as administered as ordered through 8/12/15.

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C 246	Continued From page 2 Interview with Resident #2 on 8/10/15 at 2:30pm revealed: -He was refusing BP's. -"I don't need to, don't want to"due to the physical discomfort is causes him. -He had not had any complications related to BP that he recalled. Interview with the Supervisor in Charge (SIC) on 8/10/15 at 1:25pm revealed: -He had not notified Resident #2's PCP. -"I didn't know I was supposed to ever since [Resident #2] wrote the note on 5/31/15." Interview with the Administrator on 8/10/15 at 1:30pm revealed: -She was not aware of Resident #2 refusing his BP's. -She would expect the SIC to inform the PCP. -She would expect the SIC to inform her. Interview with staff from Resident #2's PCP revealed: -The PCP had not been notified of Resident #2's BP refusals. -The PCP would expect the facility to notify him. -The facility had been good about keeping the PCP informed of Resident #2's health issues. -"It is a concern and could potentially be detrimental" to Resident #2 due to his diagnoses and the resident has a history of being non-compliant. -The facility "should have" notified the PCP. Interview with the Administrator on 8/12/15 at 10:00am revealed the SIC had notified Resident #2's PCP. 2. Review of Resident #2's current FL2 dated	C 246		

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C 246	Continued From page 3 3/25/15 revealed: -Diagnoses included: anxiety, coronary artery disease, gout, hepatitis C, pre-diabetes, history of opioid abuse, hyperlipidemia, hypertension and lower extremity edema. -No concentrated sugars (NCS) diet. -An order for metformin 500mg twice a day. Review of Resident #2's record revealed: -A physician order dated 2/28/15 for finger stick blood sugar (FSBS) before meals and at bedtime. -A signed, hand-written statement by Resident #2 dated 5/31/15 stating "I [Resident #2] am not going to do anything more with my diabetic things. If I ate candy and drank sodas or consumed sugar I would worry about it". -A report of services form from the facility to Resident #2's PCP dated 6/1/15 that stated to "please discontinue blood sugars, [Resident #2] refuses to do it". Review of a physician's order for Resident #2 dated 6/2/15 revealed "check CBG's two times a week". Review of June 2015 MAR revealed: -FSBS's were recorded 9 times from 6/4/25 to 6/29/15. -Metformin was documented as administered as ordered for the entire month. Review of July 2015 MAR revealed: -FSBS's were recorded 4 times, on 7/7/15, 7/11/15, 7/17/15 and 7/20/15. -Metformin was documented as administered as ordered for the entire month. Review of August 2015 MAR revealed: -FSBS's were recorded once on 8/7/15 and three times on 8/8/15.	C 246		

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C 246	Continued From page 4 -Metformin was documented as administered as ordered from 8/1/15 through 8/12/15. Interview with Resident #2 on 8/10/15 at 2:30pm revealed: -He was refusing FSBS's. -"I don't need to, don't want to" due to the physical discomfort is causes him. -He had not had any complications related to FSBS that he recalled. Interview with the SIC on 8/10/15 at 1:25pm revealed: -He had not notified Resident #2's PCP. -"I didn't know I was supposed to ever since [Resident #2] wrote the note on 5/31/15." Interview with the Administrator on 8/10/15 at 1:30pm revealed: -She was not aware of Resident #2 refusing his FSBS. -She would expect the SIC to inform the PCP. -She would expect the SIC to inform her. Interview with staff from Resident #2's PCP revealed: -The PCP had not been notified of Resident #2's FSBS refusals. -The PCP would expect the facility to notify him. -The facility had been good about keeping the PCP informed of Resident #2's health issues. -"It is a concern and could be potentially detrimental" to Resident #2 due to his diagnoses and the resident has a history of being non-compliant. -The facility "should have" notified the PCP. Interview with the Administrator on 8/12/15 at 10:00am revealed the SIC had notified Resident #2's PCP this morning.	C 246		

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C 246	Continued From page 5 B. Review of Resident #1's record revealed he was admitted to the facility on 1/16/15. 1. Review of Resident #1's current FL2 dated 1/15/15 revealed: -Diagnoses of bipolar disorder, polysubstance abuse, hypertension and diabetes. -An order for Humulin R 100 units/ml (short acting insulin) 35 units before breakfast, 28 units before lunch and 38 units before supper. -An order for FSBS before meals and at bedtime. Review of a physician's order dated 5/8/15 revealed Humulin R 500 units/ml, 13 units before breakfast, 8 units before lunch and 13 units before supper. Review of the July 2015 MAR revealed: -The Humulin and FSBS's were documented administered as ordered before breakfast and supper. -Review of the Humulin and FSBS entries for the before lunch dose revealed the Humulin and FSBS's were not documented as administered 24 out of 31 opportunities. Review of the documented blood sugar ranges for July 2015 revealed: -6:30am range as 71 to 133. -4:30pm range as 94 to 200. Review of the August 2015 MAR from 8/1/15 through 8/9/15 revealed: -The Humulin and FSBS's were documented administered as ordered before breakfast and supper. -Review of the Humulin and FSBS entries for the before lunch dose revealed the Humulin and FSBS's were not documented as administered 5	C 246		

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C 246	Continued From page 6 out of 9 opportunities. Review of the documented blood sugar ranges for August 2015 revealed: -6:30am range as 88 to 201. -4:30pm range as 68 to 220. Interview with Resident #1 on 8/10/15 at 8:45am revealed: -He goes off site to a day program Monday through Friday from 9:30am to 3:00pm. -He is not allowed to take his insulin or glucometer with him to the day program. -Prior to moving to this facility in January 2015 he was at another facility which allowed him to take the insulin and glucometer with him. -He had not had any negative reactions or problems with his blood sugars as a result of not receiving the before lunch dose of insulin. -He would like to be able to take his lunch dose of insulin. Interview with the SIC on 8/10/15 at 10:40am revealed: -He started working at the facility in April 2015. -The previous staff were not allowing the resident to take the insulin or glucometer with him while attending the day program so he was following the same protocol. -He had not contacted the resident's physician concerning the lunch time insulin due to following the same protocol. -The resident had not complained to him about not receiving the lunch time insulin dose or any health problems related to not receiving the insulin. Interview with the administrator on 8/10/15 at 1:45pm revealed: -She was not aware Resident #1 was not	C 246		

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C 246	Continued From page 7 receiving his lunch dose of insulin. -Staff A had not notified her related to the resident's insulin. -She and the Lead SIC were responsible for checking the MAR's and they had "just overlooked the insulin." -She would contact Resident #1's physician today to notify of the missed insulin and FSBS's. Review of a physician order dated 8/10/15 for Humulin R 500/ml revealed: -Administer 13 units of Humulin before breakfast and supper. -Complete FSBS's before three times daily at breakfast, supper and bedtime. Telephone message left with Resident #1's physician on 8/10/15 at 2:50pm was not returned by time of exit. A plan of protection was received from the facility on 8/12/15 and included the following: -Facility administrator contacted all PCP ' s regarding missing medication doses and refusals of ordered protocols. -Communications with PCP's involved getting clarifications and modified orders. -Facility administrator or designee will do weekly documented checks on all resident health care and follow-ups to ensure that resident care and orders are being followed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2015.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care	C 249		

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C 249	Continued From page 8 (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (Resident #1) with orders for blood pressure checks were implemented as ordered. The findings are: Review of Resident #1's current FL2 dated 1/15/15 revealed diagnoses of bipolar disorder, polysubstance abuse, hypertension and diabetes. Review of Resident #1's record revealed: -The resident was admitted to the facility on 1/16/15. -A subsequent order dated 7/2/15 for daily pulse and blood pressure (BP) checks. -A subsequent medication order for Lisinopril 20mg, once daily (Lisinopril is used to treat hypertension). Review of the July 2015 Medication Administration Record (MAR) documented BP checks revealed: -BP's documented beginning 7/3/15 through 7/9/15. -BP range was documented as 90/70 to 139/97. -There were no documented BP's beginning 7/10/15 through 7/31/15. Review of the August 2015 MAR documented BP	C 249		

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C 249	Continued From page 9 checks revealed: -BP's were documented as ordered daily. -BP range from 8/1/15 through 8/9/15 were documented as 120/54 to 136/91. Interview with the Supervisor-In-Charge (SIC) on 8/10/15 at 2:40pm revealed: -The BP monitoring device was broken in July 2015 and was replaced the beginning of August 2015. -BP's for resident were not taken 7/10/15 through 7/31/15. Interview with the administrator on 8/10/15 at 3:00pm revealed: -She thought the batteries needed to be replaced in the BP monitor but thought staff had taken care of that in July. -She was not aware the BP's for Resident #1 were not being completed. Interview with Resident #1 on 8/12/15 at 8:50pm revealed: -He was aware his BP's were not taken in July for several weeks. -He did not have any complications related to BP that he recalled. Telephone message left with Resident #1's physician on 8/10/15 at 2:50pm was not returned by time of exit.	C 249		
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.	C 288		

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C 288	Continued From page 10 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure the development of an activity program which promoted active involvement of the residents with each other and the community. The findings are: Observation of the activity calendar on 8/10/15 revealed: -An activity calendar was posted in the dining room on the office door. -The month on the calendar was July 2015. -There were more than 14 hours of scheduled activities weekly. -Examples of the posted activities included bingo, talk time, scrabble, baseball and cards. Interviews with 6 residents in the facility on 8/10/15 and 8/12/15 revealed: -Four of the six residents stated the facility did not follow the activities calendar. -Two of the six residents stated they would not participate in activities even if offered. -Six residents could not recall ever having a meeting to discuss what the residents would like to do for activities. -"Activities are a joke." -"There aren't many activities, there is nothing offered." -One resident said he would participate in what was posted on the activities board if they were offered. -The "activities schedule is just for show". -One resident said "you do get bored around here". -One resident indicated he and another resident will play cards in the evenings.	C 288		

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C 288	Continued From page 11 -One resident said "he wasn't interested in activities". -"If [Staff A] is not busy he might offer cards to play, but not very often." Observation on 8/10/15 between 8:45am and 4:00pm revealed: -No activities were offered. -Four of the residents spent time outside smoking. -One resident went to a day program. -One resident had a medical appointment in the morning and watched TV in the afternoon. -One resident stayed primarily in his room with the exception of mealtimes. Observation of the activity calendar on 8/10/15 revealed "talk time" from 10:00am to 12:00pm was the scheduled activity. Observation on 8/12/15 between 8:30am and 2:30pm revealed: -No activities were offered. -Four of the residents spent time outside smoking. -One resident went to a day program. -One resident watched TV most of the day. -One resident stayed primarily in his room with the exception of mealtimes. Observation of the activity calendar on 8/12/15 revealed "news" was the scheduled activity. Interview with the Supervisor in Charge (SIC) on 8/12/15 at 1:30pm revealed: -Another SIC made the monthly activities calendar. -He is supposed to offer the activity daily and usually does but "no one wants to participate".	C 288		

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C 288	Continued From page 12 Interview with the administrator on 8/12/15 at 1:35pm revealed: -"[SIC name] makes a new activities calendar every month." -She (SIC) made the new calendar but forgot to change the month from July to August, the dates are correct. -It was the SIC's responsibility to conduct an activity.	C 288		
C 294	10A NCAC 13G .0905(f) Activities Program 10A NCAC 13G .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that each resident has the opportunity to participate in at least one outing every other month. The findings are: Interviews with six residents in the facility on 8/10/15 and 8/12/15 revealed: -One resident could not remember the last time an outing was offered. -"The resident across the hall hasn't been off the mountain since last October." -One resident said he "wasn't interested in outings". -One resident said "the facility doesn't take us on outings, they don't take us shopping" and he would go on outings if offered. -One resident said "he has not been on an outing"	C 294		

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C 294	Continued From page 13 since admission. -One resident said the only outing he goes on is to a local health service provider every 21 days. -"No outings away from the facility unless I go with my case manager." -"I would really like to go on an outing." -"I have been here for a while and no outings." -"It would depend on what the outing was if I would participate." -"No one has asked me what I might like to do for an outing." -"Maybe three months since I have been away from the facility." -"We do get bored here and it might be nice to get away for a change." -"I go out with family so that is good for me, but some of the other residents never go off the hill." Observation of the activity calendar on 8/10/15 revealed: -An activity calendar is posted in the dining room on the office door. -The month on the calendar was July 2015. -An "outing" is scheduled for 8/14/15 from 3:00pm to 5:00pm, the type of outing wasn't specified. Interview with the administrator on 8/12/15 at 1:45pm revealed: -The facility did have a van for outings. -She had offered the residents an off campus outing about one month ago and "there were no residents from this facility that went on the outing".	C 294		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of	C 311		

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	FCL011312	A. BUILDING: _____ B. WING _____	R 08/12/2015

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SERENITY HEART FAMILY CARE HOMES #232	232 COUNTRY TIME CIRCLE LEICESTER, NC 28748

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C 311	Continued From page 14 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (#1 and #2) were free from verbal disrespect from the Supervisor-In-Charge (Staff A) and failed to assure 1 of 3 sampled residents (#1) received adequate and appropriate care as related to having a lunch packed for him on days he goes off-site to a day program. The findings are: A. Confidential interviews with six residents related to the Supervisor-in-Charge (Staff A's) behavior revealed: -"[Staff A] can't cope well." -"I'm afraid if I talk to you I will get in trouble with [Staff A]." -"He (Staff A) is much meaner now since a call from the Ombudsman." -"Every time I ask for my prn (as needed) meds I am told no." -"One time [Staff A] said, "I'm in charge here [expletive]"." -One resident stated he had confronted Staff A following a disagreement about 2 months ago and have had "no more problems" since then. -"[Staff A] does get upset with [Resident #1] because he is always asking for his prn medications." -"I can tell when staff are upset, so I will wait when staff are not busy, I don't want to be a	C 311		

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C 311	Continued From page 15 bother." -"When residents are nagging staff (staff A) about their prn meds, staff (Staff A) will put them in their place and sometimes will curse at a resident." -"[Staff A] have never cursed me." -"[Staff A] had cursed one resident (Resident #1), because he is always pushing the staff's button's and asking a lot of questions." -"Some residents, especially [Resident #1], do not know their boundaries." -"He (Staff A) loses it when resident's bring a lot of paperwork back from their doctor visits because he does not want to be bothered with it." -No resident stated they had told the administrator about Staff A's behaviors. Observation on 8/12/15 at 8:45am in the dining room revealed: -Staff A was in the office next to the dining room with one resident (Resident #2) administering medications. -A second resident (Resident #1) walked into the office and started talking to Resident #2 about his new shirt. -Staff A stated to Resident #1, "you know the rules only one resident in the med room at one time." -Resident #1 remained in the med room and continued to talk to Resident #2. -Staff A stated a second time, more loudly, "I told you to get out, the rule is only one resident at a time in here and I have told you and told you that." -Resident #1 ignored Staff A's instruction and continued to talk to Resident #2. -Staff A then spoke very loudly, "Get out, get out now and close the door." -Resident #1 was then observed to leave the med room.	C 311		

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C 311	Continued From page 16 Interview with the Administrator on 8/12/15 at 8:50am revealed: -The tone used by Staff A with Resident #1 was inappropriate. -"He could have handled that differently." -"Residents in this house do tend to push staff buttons more than others and I have been trying different ways to address this issue." -"I just spoke with him (Staff A) yesterday concerning how he interacts with residents and that he needed to me more careful with his approach and demeanor." -"Residents are going to push buttons and staff must learn how to address these behaviors appropriately, or find another type of employment, residents rights are first and foremost." -No residents had voiced concerns to her related to Staff A. Interview with Resident #1 on 8/12/15 at 9:15am revealed: -He was not aware of any rules about only one resident being in the med room at one time. -Staff A was always like this with him. -He had observed other residents going into the med room and Staff A had not told them to leave. -Staff A had been "taunting" him after the surveyors left on 8/10/15. -Staff A has "been teasing me, tells me to do whatever I want and to be sure you tell that to the state people or why don't you call the ombudsman. -"[Staff A] has been needling me." -"I don't want to nitpick, it will only get worse with [Staff A]." -"I feel uncomfortable talking to [administrator's name]. I don't know her that well." Interview with the Staff A on 8/12/15 at 1:30pm revealed:	C 311		

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C 311	Continued From page 17	C 311		

-"I do not curse at residents."
-"Sometimes I do get frustrated when residents see I am busy and they come up to me with something frivolous to say."
-"I do not yell at residents, but might raise my voice when they continue talking and knowing I am busy, it does get frustrating at times."
-When asked if he had received any training on resident rights, Staff A responded, "no, not per se, but I have worked in other facilities and know how to treat the residents".

Interview with the Administrator on 8/12/15 at 1:35pm revealed:
-She had not received any concerns from residents related to Staff A's behavior or treatment of residents.
-She had not known of any concerns with Staff A's behavior until surveyors brought the issue to her attention on 8/10/15.
-She has been in the facility "a lot lately" and would think residents would mention to her if they had a problem with Staff A.
-She will meet with Staff A and schedule resident rights training for him.

B. Review of Resident #1's current FL2 dated 1/15/15 revealed:
-Diagnoses of bipolar disorder, polysubstance abuse, hypertension and diabetes.
-Admitted to the facility on 1/16/15.
-An order for a no concentrated sugars (NCS) diet.
-An order for Humulin (short acting insulin) at 6:30am, 11:30am, 4:30pm and at bedtime.

Interview with Resident #1 on 8/10/15 at 8:45am revealed:
-He would go off site to a day program Monday through Friday from 9:30am to 3:00pm.

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C 311	Continued From page 18 -The staff pack him a lunch. "It's a good lunch, sandwich, fruit, cookies and water." -He stated on 8/3/15 he went to the day program without a lunch. -"Last week [Staff A] said there was no food and I'm a diabetic." -He did not feel good that day and thought his blood sugar level was low, his "stomach was growling". -He contacted [name of a community partner] and they went to the facility to discuss with the staff. -"I think once the [named community partner] spoke with [Staff A] and he fixed a sandwich and contacted the administrator." -This was the first time that he had left the facility without taking a lunch. Telephone interview with staff at the day program on 8/12/15 at 9:00am revealed: -Resident #1 attended their program Monday through Friday. -Resident #1 did come to the program on 8/3/15 without lunch. -The day program did not provide lunch meals for participants. -Resident #1 had told the day program staff that the worker told him there was no food to prepare lunch for him today. -Resident #1 had been attending the day program for a "very long time" and this had never happened before. Interview with the administrator on 8/10/15 at 12:01pm revealed: -On 8/3/15 she had been buying groceries for the facilities. -She had been in another facility and received a call around "12:00 or 12:30" from [Staff A] on 8/3/15. -Staff A had told her Resident #1 had gone to his	C 311		

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C 311	Continued From page 19 day program without a lunch because he had been picked-up earlier than normal. -"[Staff A] probably would not have called if the ombudsman had not intervened." -"I've instructed [Staff A] to make lunch in the evenings." Interview with Staff A on 8/12/15 at 2:05pm revealed: -Resident #1's ride had come early on 8/3/15 and he had not had the time to prepare his lunch. -He had not told Resident #1 there was no food to prepare lunch. -[A named community partner] arrived at the facility "around 12:15pm" to inquire why the resident had been sent to the day program without his lunch. -He contacted the administrator "around 12:15pm or 12:30pm" about the lunch not being sent with the resident. -When asked why he waited so long to telephone the administrator, Staff A hesitated and then stated, "I really do not have an answer for that." Telephone message left with Resident #1's physician on 8/10/15 at 2:50pm was not returned by time of exit. _____ A plan of protection was received from the facility on 8/12/15 and included the following: -Administrator will conduct her own investigation on resident's and staff interactions. -Current staff will receive technical support from the administrator. -Administrator will initiate a referral to the Health Care Personnel Registry. -Administrator will schedule staff additional resident rights training. -Administrator will conduct weekly checks with residents to ensure they are safe and free from	C 311		

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C 311	Continued From page 20 mental/physical harm. -Administrator will document weekly meetings with residents. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2015.	C 311		
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: Based on interview and record review, the facility failed to assure medication (Humulin R) was administered as ordered by the prescribing physician for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's record revealed the resident was admitted to the facility on 1/16/15. Review of Resident #1's current FL2 dated 1/15/15 revealed: -Diagnoses of bipolar disorder, polysubstance abuse, hypertension and diabetes. -An order for a no concentrated sugars (NCS) diet.	C 330		

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C 330	Continued From page 21 -An order for Humulin R 100 units/ml (short acting insulin) 35 units before breakfast, 28 units before lunch and 38 units before supper. Review of a subsequent medication order dated 5/8/15 revealed Humulin R 500 units, 13 units before breakfast, 8 units before lunch and 13 units before supper. Review of the July 2015 Medication Administration Record (MAR) revealed: -The Humulin was documented administered as ordered before breakfast and supper. -Review of the Humulin entry for the before lunch dose revealed the Humulin was not documented as administered 24 out of 31 opportunities. Review of the documented blood sugar ranges for July 2015 revealed: -6:30am range as 71 to 133. -11:30am range when resident was in facility as 93 to 165. -4:30pm range as 94-200. -8:30pm range as 84 to 183. Review of the August 2015 MAR from 8/1/15 through 8/9/15 revealed: -The Humulin was documented administered as ordered before breakfast and supper. -Review of the Humulin entry for the before lunch dose revealed the Humulin was not documented as administered 5 out of 9 opportunities. Review of the documented August 2015 blood sugar ranges revealed: -6:30am range as 88 to 201. -11:30am range when resident was in facility as 84 to 121. -4:30pm range as 68-220. -8:30pm range as 78 to 120.	C 330		

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C 330	Continued From page 22 Interview with Resident #1 on 8/10/15 at 8:45am revealed: -He goes off site to a day program Monday through Friday from 9:30am to 3:00pm. -He is not allowed to take his insulin with him to the day program. -Prior to moving to this facility in January 2015 he was at another facility which allowed him to take the insulin with him. -He had not had any negative reactions or problems with his blood sugars as a result of not receiving the before lunch dose of insulin. -He would like to be able to take his lunch dose of insulin. Interview with the Supervisor-In-Charge (SIC) on 8/10/15 at 10:40am revealed: -He started working at the facility in April 2015. -The previous staff were not allowing the resident to take the insulin with him while attending the day program so he was following the same protocol. -He had not contacted the resident's physician concerning the lunch time insulin. -The resident had not complained to him about not receiving the lunch time insulin dose or any health problems related to not receiving the insulin. Interview with the Administrator on 8/10/15 at 1:45pm revealed: -She had not been aware of Resident #1 was not receiving his lunch dose of insulin. -The SIC had not notified her related to the resident's insulin. -She and the Lead SIC were responsible for checking the MAR's and they had "just overlooked the insulin". -She would contact Resident #1's physician today	C 330		

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C 330	Continued From page 23 to notify of the missed insulin. Review of a physician order dated 8/10/15 for Humulin R 500 revealed administer 13 units of Humulin before breakfast and supper. Telephone interview with staff at the day program on 8/12/15 at 9:00am revealed: -Resident #1 attends their program Monday through Friday. -They had not been contacted by the facility regarding Resident #1's insulin until 8/10/15. -The facility did call on 8/10/15 to inquire if the day program could accommodate storage of the insulin for Resident #1. -She had sent paperwork to the physician to discuss what the requirements for the insulin were so she could discuss with her manager if this was a possibility. Telephone message left with Resident #1's physician on 8/10/15 at 2:50pm was not returned by time of exit.	C 330		
C 911	G.S 131D 21(1) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that every resident be treated with respect, consideration and dignity as related to staff's verbal interactions with residents.	C 911		

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C 911	Continued From page 24 The findings are: Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (#1 and #2) were free from verbal disrespect from the Supervisor in Charge (Staff A), and assure 1 of 3 sampled residents (#1) had a lunch packed for him on days he goes off-site to a day program [Refer to Tag 311, 10A NCAC 13G .0909 Resident's Rights (Type B Violation)].	C 911		
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 observation, interview and record review, the facility failed to assure that every resident receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations. The findings are: Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 2 of 3 sampled residents (#1 and #2) related to finger stick blood sugars and blood pressures [Refer to Tag 246, 10A NCAC 13G	C 912		

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C 912	Continued From page 25 .0902(b) Health Care (Type B Violation)].	C 912		