Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011320	A. BUILDING: _____ B. WING _____	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HEART FAMILY CARE HOME # 235	235 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 survey on January 14, 2016.	C 000		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews and record review, the facility failed to provide supervision for 1 of 1 sampled resident (Resident #1) who had a history of smoking inside the facility. The findings are: Tour of the facility on 1/14/16 beginning at 9:35am revealed: -The smell of cigarette smoke in the hallway leading to the resident rooms. -The smell of cigarette smoke was stronger outside resident room #1 (Resident #1's room). -When Resident #1 opened the door to her room, the smell of cigarette smoke was much stronger inside the room. Interview with Resident #1 on 1/14/16 at 9:37am revealed: -She had been smoking in her room -It was "too cold to go outside and smoke." -This was the first time she had smoked in her	C 243	Resident Continues to be monitored during all Cigarette smoke activities. She is not allowed to have any Smoking Materials in her possession or unsupervised. She also has a one on one Worker with her daily to ensure Secured Safety of the resident & her House mates	2/29/16

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 2/22/16

STATE FORM 6899 — 8RS711 — If continuation sheet 1 of 6

Reviewed & accepted
3/2/16

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C 243	Continued From page 1 room. -She did not have any other cigarettes in her room. -The resident reported staff gave her 2 packs of cigarettes daily but could confirm when she last received cigarettes from the staff. -She had smoked her last cigarette that morning. -She knew she was not supposed to smoke indoors. Observation of Resident #1's room on 1/14/16 at 9:40am revealed: -A small trash can (without a liner) setting beside the resident's bed. -The trash can contained one cigarette butt, one paper tissue, one empty cigarette pack, several paper gum wrappers and one plastic baggie. -The bottom of the trash can was covered with several cigarette ashes. -No other cigarette butts or ashes were observed in the resident's room. Review of Resident #1's current FL2 dated 12/11/15 revealed: -Diagnoses included schizophrenia, asthma, hypertension, diabetes and hyperlipidemia. -The resident was documented as ambulatory. -There was no documentation regarding the residents orientation status Review of Resident #1's record on 1/14/16 revealed: -The resident had been admitted to the facility on 12/11/15. -A Progress Note dated 1/11/16 at 11:00am as: "SIC caught [named resident] Resident #1 smoking cigs. (cigarettes) in her room." -The Progress Note was signed by Staff B, the SIC for this facility. -A section tab labeled "Safe Smoking Evaluation"	C 243		

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C 243	Continued From page 2 revealed this section to be empty of any documentation. Review of Resident #1's Care Plan dated 1/11/16 revealed no concerns noted related to the resident's orientation or need for increased supervision. Interview with Staff A, Supervisor-in-Charge (SIC), on 1/14/16 at 10:00am revealed: -She was just "filling in today for the SIC (Staff B) who was responsible for the facility. -She had not smelled the cigarette smoke. -She was unsure if Resident #1 had been caught smoking in the facility prior to today. Observation while sitting in the dining room on 1/14/16 at 10:30am revealed: -A second staff (Staff C), identified by Staff A as "a one-on-one for Resident #1", entered the facility. -Staff C went into Resident #1's room and sat with the resident. -When Resident #1 came into the living room, Staff C came with the resident and sat with the resident. Interview with Staff C, Personal Care Assistant (PCA), on 1/14/16 at 12:30pm revealed: -She had not been assigned to Resident #1 before. -She had been instructed to sit with Resident #1, "one-on-one today." -She did not know why she was sitting with Resident #1. -She was unaware the resident had been smoking in her room that morning was not to have cigarettes. -She did not know the resident was to be supervised when she smoked.	C 243		

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C 243	Continued From page 3 -The resident had just asked her for cigarettes and she had given her a pack. Observation on 1/14/16 at 12:35pm revealed: -Staff C informed Staff A that Resident #1 had been given a pack of cigarettes. -Staff A retrieved the cigarettes from Resident #1. Review of the facility Tobacco Policy signed by Resident #1's guardian and dated 12/11/15 revealed: -The resident may only smoke outdoors. -If a resident fails to abide by the smoking policy, the facility has the right to confiscate all smoking and tobacco products. -For the first offense, these products will remain with staff for a period of three months and the resident supervised when smoking. -For the second offense, confiscation will be for six months and supervised smoking continued. -For the third offense, a 30-Day Discharge Notice will be given. -An immediate discharge may be issued if the resident continues to smoke inside the facility. Confidential interviews with three residents revealed: -No one had observed or suspected Resident #1 of smoking inside the facility. -They had not been told by the staff not to give Resident #1 cigarettes. -One resident reported they had given Resident #1 a cigarette that morning. Telephone interview with Staff B, SIC, on 1/14/16 at 12:15pm revealed: -He had been hired on 8/18/15. -He had found Resident #1 smoking one time in the facility (1/11/16) since her admission. -He had smelled cigarette smoke coming from	C 243		

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C 243	Continued From page 4 the resident's room. -He found 3-4 cigarette butts in the trash can and one of the cigarette butts was still smoking. -He contacted the Administrator and was told to document the incident. -He had not been given any further instructions. -He did not document this contact with the Administrator or the incident. -He did not retrieve the smoking materials from the resident but "just kept a good eye on her" after the incident. -He was not familiar with the facility's Tobacco Policy. Interview with the Administrator on 1/14/16 at 2:30pm revealed: -She had not been contacted by Staff B regarding Resident #1 smoking in her room on 1/11/16. -She would have expected staff to call her and staff would have been instructed to retrieve all smoking materials from the resident and place the resident on supervised smoking. -Staff C was part of "wrap around" services provided by Resident #1's guardian as part of their behavioral health contract when agreeing to take this resident back into the facility. A Plan of Protection provided by the facility on January 14, 2016 included the following: -The facility will immediately confiscate the resident's smoking materials. -The resident will be required to request smoking materials from the staff and be supervised while smoking. -All residents and relief staff will be instructed not to give Resident #1 any cigarettes or smoking materials. -All staff will be given an in-service on the Smoking Policy and Procedures to assure the facility guidelines are followed.	C 243		

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C 243	Continued From page 5 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 29, 2016.	C 243		
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 observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to supervision. The findings are: Based on observation, interviews and record review, the facility failed to provide supervision for 1 of 1 sampled resident (Resident #1) who had a history of smoking inside the facility. [Refer to Tag 243, 10A NCAC 13G .0901(b) (Type B Violation)].	C 912	The administrator a designee will continue to monitor the accused resident w documented progress by staff to ensure ~~that~~ that all residents ~~are~~ are safe	2/29/16