STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL023046	A. BUILDING: _____ B. WING _____	04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING FAMILY CARE # 2	113 LESLIE DRIVE SHELBY, NC 28152

(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 survey on April 06, 2016 with an exit conference via telephone on April 08, 2016.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled residents were tested for tuberculosis (TB) upon admission in compliance with the control measures adopted by the Commission for Health Services. (Resident #2). The findings are: Review of Resident #2's Record on 04/06/16 revealed an admission date of 03/02/15. Review of a Local Health Department Tuberculin Skin Test revealed: -A TB test was placed 02/27/15. -The TB test was read 03/02/15 with results of 0 millimeters. -No documentation in the resident's record that a	C 202		

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C 202	Continued From page 1 second TB test had been administered. Interview with the Adminstrator on 04/06/16 at 4:15pm revealed: -TB testing was the first thing the facility did before admitting a resident. -He felt sure two TB tests had been done for Resident #2. -Resident #2 had been admitted from a private residence. -He did not have documentation to verify Resident #2 had a second step TB test.	C 202		
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: TYPE B VIOLATION Based on record observation, record review, and interviews the facility failed to administer medications as ordered for 2 of 3 residents (Resident #1 and #2) regarding divalproex and aspirin. The findings are: A. Review of Resident #1's FL2 dated 03/29/16 revealed:	C 330		

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C 330	Continued From page 2	C 330		

-Diagnoses included schizoaffective disorder, bipolar type.
-Orders for divalproex ER 500mg a day (an anti-seizure medications sometimes used to treat manic episodes related to bipolar disorder).

Review of Resident #1's Medication Administration Record for April 2016 revealed:
-A computer generated entry for divalproex 500mg ER, 1 tablet to be administered at bedtime.
-The divalproex had been documented on April 03, 04, and 05 as not given due to "drug temporarily unavailable."

Observations of Resident #1's medications on 04/06/16 at 1:00pm revealed no divalproex was available for administration.

Interview on 04/06/16 at 11:00am with the Supervisor in Charge (SIC) revealed:
-She was responsible for faxing refill requests to the pharmacy "3-4 days" before a resident ran out of medication.
-Medication refill requests faxed before 2:00pm normally would be at the facility the next day and medications refill requests faxed after 2:00pm would be at the facility in 2 days.
-She had faxed a request to the pharmacy for a refill of Resident #1's divalproex last week on Thursday (03/31) or Friday (04/01), unsure which day.
-She did not have a fax confirmation to verify the request had been sent.
-The last pill had been given Saturday (04/02/16) and she had "just been waiting" for the refill to arrive.
-She "should have called the pharmacy... no excuse".
-Resident #1's had no behavior changes or

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C 330	Continued From page 3	C 330		

problems since being out of the medication.

Telephone interview with the pharmacy staff on 04/07/16 at 10:30am revealed:
-They last filled Resident #1's divalproex with 30 tablets on 03/02/16 and had not received a recent request to refill the divalproex until yesterday, 04/06/16.
-This medication was not on continuous refill but had to be requested every month.

Interview with Resident #1 on 04/06/16 at 9:40am revealed:
-He had been out of Depakote 3 days (brand name for divalproex).
-The resident stated he did not have seizures, did not think he needed any medicines, but took them because his guardian wanted him to.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 04/08/16 at 8:00am revealed:
-Resident #1 had no history of seizures.
-Divalproex was not prescribed by the PCP but by the resident's Mental Health Provider for behaviors.
-The PCP stated if the medication was stopped suddenly there was potential for liver damage.
-Resident #1 had had liver enzymes checked in November, 2015 and they were within normal limits.

Refer to interview with Adminstrator on 04/06/16 at 4:15pm.

B. Review of Resident #2's FL2 dated 03/30/16 revealed:
-Diagnoses included hyperlipidemia.
-An order for aspirin 81mg every day (sometimes used to reduce the risk of a stroke with high

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C 330	Continued From page 4 cholesterol.) Review of Resident #1's Medication Administration Record for April 2016 revealed: -A computer generated entry for aspirin 81mg, 1 tablet to be administered each morning. -The aspirin had been documented on April 02, 03, 04, and 05 as not given due to "drug temporarily unavailable." Observations of Resident #2's medications on 04/06/16 at 2:00pm revealed no aspirin was available for administration. Interview on 04/06/16 at 2:00pm with the Supervisor in Charge (SIC) revealed: -She was responsible for faxing refill request to the pharmacy "3-4 days" before a resident ran out of medication. -Medication refill requests faxed before 2:00pm would normally arrive at the facility the next day and medications refill requests faxed after 2:00pm would arrive at the facility in 2 days. -She faxed a request to the pharmacy for a refill of Resident #2's aspirin last week on Thursday (3/31). -She did not have a fax confirmation from the pharmacy to verify the request had been sent. -The medication should have arrived at the facility the next day (Friday, 04/01) but it did not come in so she thought it would come in the next day or the next and she had not followed up when it did not arrive. -The SIC stated the last pill had been given Friday (04/01/16) and she had "just been waiting" for the refill to arrive. -She had not followed up with the pharmacy to check the refill status of the aspirin. Record review of a Primary Care Provider (PCP)	C 330		

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C 330	Continued From page 5 note dated 03/30/16 revealed "Lipids all WNL (within normal limits), done 03/07/16". Telephone interview with the pharmacy staff on 04/07/16 at 10:30am revealed: -They last filled Resident #2's aspirin with 30 tablets on 02/24/16 and had not received a recent request to refill the aspirin until yesterday, 04/06/16. -This medication was not on continuous refill but had to be requested every month. Interview with Resident #2 on 04/06/16 at 3:45pm revealed the resident got medicines, did did not know the names of the medicines and did not know if she had ever run out. Refer to interveiw with Adminstrator on 04/06/16 at 4:15pm. _____ Interview with the Administrator on 04/06/16 at 4:15pm revealed: -The facility's policy was to fax a refill request for medications once the medications got down to the "blue" section of the card. -If the medications had not arrived at the facility within 2 days of the re-ordering date, staff should call the pharmacy to check the delivery status. -A resident should never run out and there was "no excuse" for running out of medications. _____ The facility provided a Plan of Protection on 04/06/16 that included: -Both residents' medications were called to back-up pharmacy and would be picked up today. -Any medications that are not delivered within 2 days of ordering, staff will call the pharmacy check delivery status.	C 330		

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C 330	Continued From page 6 -If not in delivery status, pharmacy will call back-up for a week supply to assure medications are available.	C 330		
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 review the facility failed to assure residents received care and services which are adequate, appropiate, an in compliance with relevant federal and state laws and rules and regulations related to medication administration for 2 of 3 residents. (Residents #1 and #2). The findings are: Based on record observation, record review, and interviews the facility failed to administer medications as ordered for 2 of 3 residents (Resident #1 and #2) regarding divalproex and aspirin. [Refer to Tag C330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		