STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL082025	A. BUILDING: _____ B. WING _____	08/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY FAMILY CARE HOME #2	912 BUCKHORN ROAD HARRELLS, NC 28444

(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 Sampson County Department of Social Services conducted an annual survey and complaint investigation on 07/28/16 and 08/08/18. The complaint investigation was initiated by the Adult Care Licensure Section on 07/28/16.	C 000		
C 220	10A NCAC 13G .0705 (b) Discharge Of Residents 10A NCAC 13G .0705 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1).	C 220		

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C 220	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed assure 1 of 2 residents sampled (#4) was notified of discharge and appeal rights at least 30 days prior to discharge from the facility. The findings are: Review of Resident #4's FL-2 dated 05/26/16 revealed: -Diagnoses included schizoaffective disorder, post-traumatic stress disorder (PTSD), autism spectrum disorder, and alcohol use disorder "mild." -The admission date to the facility was documented as 05/16/16. Review of Resident #4's Resident Register revealed: -In section G, line 1,"Notice of Discharge/Transfer" was documented as 06/05/16. -Section G, line 3 "Date of Discharge/Transfer" was documented as 07/12/16. -Resident #4 had not signed to acknowledge the discharge. -The acknowledgement of discharge was signed by the Administrator of the facility that Resident #4 was being transferred to and also by the current facility's Administrator. Review of the "Notice of Transfer/Discharge" revealed: -The date of the notice was documented as 06/05/16. -The date of transfer/discharge was documented as 07/05/16. -The reason for the notice of discharge was documented as "[Resident #4's name] does not need the services provided by [facility name]."	C 220		

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C 220	Continued From page 2 -Line 4 contained documentation that Resident #4's family member was notified of the discharge. -The Notice of Transfer/Discharge was signed by the Administrator and dated 06/05/16. Interview with Resident #4 on 07/28/16 revealed: -Resident #7 returned from a visit at home with his family on 07/12/16 and his bags were packed. -Staff told him he had been discharged to another facility that day (07/12/16). -Resident #4 was shocked he had been transferred because he had not had any problems with anyone at the facility. -Resident #4 did not sign any papers about being discharged from the facility. -Resident #4 had not been given a discharge notice. -Since he was discharged from the facility, he had been in the hospital. -He liked the new facility alright but liked the other facility better. -Resident #4 notified his family that he was discharged/transferred; the facility did not notify his family about his change of residence. Interview with the Administrator on 08/08/16 at 10:55am revealed: -Since admission into the facility, Resident #4 had been in the hospital a lot "for hearing voices." -Resident #4 was discharged from the facility on 07/12/16. -The Administrator did not know the reason Resident #4 was discharged from the facility; the Administrator did not know if Resident #4 wanted to move or not. -Resident #4 had not had any problems or behaviors while living in the facility; there was no reason for Resident #4 to be immediately discharged or moved. -The Office Manager (OM) told the Administrator	C 220		

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C 220	Continued From page 3 in June 2016 (date unknown by Administrator) that Resident #4 was going to be moved to another local facility in July 2016. -The documentation written on the Resident Register in section G, line 1 did not look like the Administrator's handwriting, but the signature acknowledging the discharge was the Administrator's signature. -Normal procedure was for the responsible party to sign acknowledging discharge. -The Administrator did not why Resident #4 did not sign the Resident Register because he was his own responsible party. -The Administrator did not know why the Administrator of the facility that Resident #4 was moving to would sign acknowledging the discharge. -The Administrator assumed Resident #4 had been notified verbally about the discharge/move by the OM. -The Administrator knew Resident #4 was not given a written notice about his discharge. -The day before Resident #4 went home to visit his family, the OM told the Administrator that Resident #4 would be moving the following Monday or Tuesday, (07/11/16 or 07/12/16). -The OM completed the information on Resident #4's Notice of Transfer/Discharge and the Administrator just signed it. Telephone interview with the OM on 08/08/16 at 11:42am revealed: -Resident #4 had a history of calling 911 but the OM did not know for sure if that was why he was discharged from the facility. -The OM was "pretty sure" the Licensee notified Resident #4 that the facility was discharging him. -Resident #4 had PTSD and it was possible he forgot being notified of the discharge. -The OM did not know anything about Resident	C 220		

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C 220	Continued From page 4 #4's discharge because she did not complete his discharge. -The OM did not have a copy of the Notice of Transfer/Discharge with her at the time of the telephone interview and could not answer any questions about it without having a copy. Telephone interview with the facility Licensee on 08/08/16 at 11:55am revealed: -The Licensee "talked" to Resident #4 to notify him of the discharge 1-2 months before he was discharged from the facility. -The OM was responsible for assuring that residents were discharged from the facility in accordance with the rules. -Resident #4 was discharged on 07/12/16 for financial reasons. -The Licensee spoke with Resident #4 the day after he moved from the facility and he said he was "ok" at the new facility but he just wished his family would have been notified about his move. -The Licensee did not notify Resident #4's family because his family was not his guardian. -The Licensee did not know if Resident #4's belongings were packed without his knowledge. -It was facility procedure for residents to pack their own belongings in preparation of discharge/moving but the day that Resident #4 moved (07/12/16), the Licensee's other facility admitted three new residents; it was busy so staff had to pack Resident #4's belongings for him. -Resident #4 should have signed the Resident Register acknowledging the discharge. -The Licensee did not know why Resident #4 did not sign the Resident Register to acknowledge his discharge; "They messed that up. That was an error." -Resident #4 was in and out of the hospital "every month." -"This is a business. When he is in the hospital,	C 220		

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C 220	Continued From page 5 we cannot bill him and we don't get paid when they are not actually in the facility."	C 220		
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: Based on record reviews and interviews, the facility failed to assure 1 of 3 residents sampled (#2) followed up with their health care provider as directed after an emergency department visit. The findings are: Review of Resident #2's current FL-2 dated 05/03/16 revealed: -Diagnoses included schizophrenia, attention deficit hyperactivity disorder (ADHD), and pervasive developmental disorder. -The admission date in to current facility was documented as 04/26/16. -Resident #2's family member was his guardian. Review of a hospital Emergency Department (ED) notes dated 06/16/16 revealed: -Resident #2 was evaluated in the ED on 06/16/16 and discharged on 06/16/16. -The diagnoses included assault and hypokalemia. -The "Follow up information" recommended a one week follow up appointment with Resident #2's health care provider. Review of Resident #2's record revealed there was no documentation of a one week follow up	C 246		

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C 246	Continued From page 6 appointment with his health care provider. Resident #2 was not available for interview. Resident #2's guardian was not available for telephone interview on 08/08/16. Interview with the Administrator on 08/08/16 at 10:30am revealed: -Resident #2 went to the ED on 06/16/16 after being bitten by another resident. -Resident #2 did not go to a one week follow up appointment with his health care provider. -The Administrator was responsible for making resident appointments. -The Administrator would contact Resident #2's health care provider that day (08/08/16) to schedule an appointment. Telephone interview with a Registered Nurse (RN) at Resident #2's Physician Assistant's (PA) office on 08/08/16 at 11:28am revealed: -Resident #2 had only been seen by the PA one time, which was on 05/03/16. -The PA had not evaluated Resident #2 since the ED visit on 06/16/16. -The facility had not notified the PA office about the ED visit, assault, or diagnosis of hypokalemia. -The PA office expected to be notified of the assault and hypokalemia. -The PA expected Resident #2 to follow-up with an appointment per the ED orders.	C 246		