

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
---	---	--	--

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 a follow-up survey on August 17, 2016 through August 18, 2016.	{C 000}		
C 259	10A NCAC 13G .0904(a)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a 3 day supply of perishable food for a census of 5 residents. The findings are: The facility on 8/17/16 had a census of five residents. Confidential interview with a resident revealed: -"We have a little bit of food." -No milk was served yesterday nor today. -Workers from sister facilities on the property are calling other houses for food and borrowing from each other. -Residents have not gone without meals. -"It's not the employees' fault," "they are making do" and "being creative." Confidential interview with a second resident revealed enough food was served and they had	C 259		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 259	Continued From page 1 snacks and meals. Observation on 8/17/16 at 10:05AM of the food inventory in the refrigerator/freezer in the kitchen revealed: -A one gallon milk jug with a printed manufacturer's use-by date of 8/8/16 and approximately 2 cups of milk at the bottom of the jug. -4 dozen eggs with a printed manufacturer's best use-by date of 8/16/16. -4 single eggs in a carton with a printed manufacturer's best use-by date of 8/26/16. -3 slices of bologna in an opened package, wrapped in a plastic bag (manufacturer's date could not be found on the original packaging). -2 pints of blueberries. -An opened box of pancake mix. -One opened bag of flour in the produce drawer. -6 containers of concentrated apple and orange juice (when reconstituted, each container made 48 ounces of juice). -An approximately 1 pound labeled package of frozen sausage wrapped in butcher's paper. -2 frozen pops. -1 prepared frozen single serving entrée. -An opened package with 11 individually sliced and wrapped American cheese with a manufacturer's use-by date of 8/16/16. -An open block of cream cheese with a printed manufacturer's use by date of 3/11/16. -An open package of sliced ham with a printed manufacturer's use-by date of 6/24/16. -Various bottled condiments. Interview on 8/17/16 at 10:05AM with Staff A, Supervisor-in-Charge (SIC) revealed: -She was off the previous weekend through Tuesday (8/16/16). -She could not remember the last time milk was	C 259		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 259	Continued From page 2 delivered to the facility. -The facility had been "running out of milk." -The SIC from a sister facility on the property needed to borrow a loaf of bread. Observation on 8/17/16 at 10:10AM of the deep freezer revealed: -No frozen milk. -1 loaf of white bread with a printed manufacturer's best-by date of 8/9/16. -1 loaf of wheat bread with a printed manufacturer's best-by date of 8/1/16. -A box of 30 sausage patties. -A bag with 11 bagel thins. -7 packages labeled bacon, each wrapped in butcher's paper and weighing approximately a pound. -4 packages labeled pork chops, each wrapped in butcher's paper and weighing approximately 2 pounds. -2 packages of ground beef in plastic packaging and each weighing approximately 1 pound. -1 package of chicken leg quarters, wrapped in butcher's paper and weighing approximately 2 pounds. -1 package of ground sausage weighing approximately 1 pound. -1 opened package of a prepared breaded fish product with a few pieces in the bottom of the box. -2 pre-shaped meat patties. Interview on 8/17/16 at 1:45PM with Staff A, SIC revealed: -One of the two Supervisors (Staff C and Staff D) over the facility and sister facilities on the property delivered food supplies. -"I think tomorrow [Thursday] is shopping day." -Milk and bread were purchased on Thursdays. -The "food [supply] gets real low."	C 259		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 259	Continued From page 3 -When she works her shifts the food never runs out. -She had not reported to the Supervisors or Administrator recently of needing any food. -If food supplies did get low, she would "borrow" food from a sister facility on the property. -She was down to 2 ½ loaves of bread. Interview on 8/17/16 at 2:26PM with Staff C, Supervisor revealed: -Perishable food items were purchased by the Administrator from a vendor monthly. -The Administrator was going to go grocery shopping today. -The Administrator may have told the other Supervisor to get fresh fruits and vegetables this week. -Eggs were probably purchased a few weeks prior. Telephone interview on 8/18/16 at 9:25AM with the Administrator revealed: -She purchased milk, bread and eggs weekly. -Each of the facilities on the property received the same food items according the menu, "I just purchase it [food]." -She had received no reports from staff regarding having no milk. -Eggs not being used before their use-by date were "being wasted." -Her leadership staff should have been monitoring food needs.	C 259		
C 265	10A NCAC 13G .0904(c)(2) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (2) Menus shall be maintained in the kitchen and	C 265		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235			STREET ADDRESS, CITY, STATE, ZIP CODE 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 265	Continued From page 4 identified as to the current menu day and cycle for any given day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow a menu for meal preparation. The findings are: Confidential interview with a resident revealed " I don't know if there is a menu" and residents did not know what was for a meal until it was served at the table. Observation on 8/17/16 at 11:43AM of the kitchen cabinet revealed: -A plastic page protector affixed to the cabinet door to the right of the refrigerator. -The visible top sheet in the protector was a menu labeled January/February/March, week #2. -Underneath this menu were menus for October/November/December, weeks #1 through #4. Review of a substitution list, posted on the refrigerator, revealed the most current entry dated 3/7/16. Review of a menu, provided by a Supervisor over the facility and all sister facilities on the property, revealed: -A title of July/August/September. -Confirmation that the facility was on week #3 of	C 265			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 265	Continued From page 5 this menu. -The lunch meal on this menu for Wednesday (8/17/16) was a peanut butter and jelly sandwich, celery stick, carrot stick, plums, brownie for dessert and a beverage. Observation on 8/17/16 at 10:05AM of the food inventory in the refrigerator/freezer in the kitchen revealed no celery, carrots or plums. Observation on 8/17/16 at 10:15AM of the kitchen food cabinets revealed an empty jar of peanut butter. Observation on 8/17/16 at 11:46AM of the kitchen revealed: -On the stove top was a pan of cooked spaghetti and a pan of meat sauce. -On the counter next to the stove top were cans of fruit cocktail in fruit juice. -Staff A, SIC was present in the kitchen. Interview on 8/17/16 at 11:46AM of Staff A, SIC revealed she did not have a current menu. Observation on 8/17/16 at 12:05PM of residents dining at lunch revealed: -A meal of spaghetti with meat sauce and fruit cocktail. -No complaints from residents. Interview on 8/17/16 at 1:45PM with Staff A, SIC revealed: -She prepared meals based on "what's in refrigerator." -The facility sometimes did not have the food items required for meals on the menu. -"They [the residents] got to eat something." -Meals were prepared based on what food items the facility had in stock.	C 265		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 265	Continued From page 6 Interview on 8/17/16 at 2:26PM with Staff C, Supervisor revealed: -Every one of the facilities on the property was to have a book of menus to address different seasons and different months. -She had not been at the facility to know if they were following the right menu. -Staff had been trained to follow the menu and how to make substitutions. -She believed the Administrator was going to "re-vamp" the menus. Telephone interview on 8/18/16 at 9:25AM with the Administrator revealed: -She did the food purchases according to the menu. -She did not know why the facility did not have a posted menu. Telephone interview on 8/18/16 with Staff B, SIC, revealed he did not know where the menu book was located in the facility.	C 265		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination.	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 7 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide and have an adequate supply of milk for a census of 5 residents. The findings are: Confidential interview with a resident revealed: -No milk was served yesterday nor today. -Workers from sister facilities on the property were calling each other for food and borrowing from each other. -The last meal with milk was lunch or dinner on Monday (8/15/16). -She liked milk and drank it with her meals. -The lack of milk made "other people stress over it which makes me stressed" and "it makes me mad." Confidential interview with a second resident revealed: -There had been no milk the "last couple of days, like with a snack." -She last had milk "a few days ago" but could not remember the exact date. -Enough food was served and they had snacks and meals. Confidential interview with a third resident revealed: -There was no milk served with breakfast. -She drank milk "a little bit." Observation on 8/17/16 at 10:05AM of the refrigerator/freezer in the kitchen revealed: -A one gallon milk jug with a printed manufacturer's use-by date of 8/8/16. -There were approximately 2 cups of milk at the bottom of the jug.	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 8 -There was no frozen milk in the freezer compartment. Interview on 8/17/16 at 10:05AM with Staff A, Supervisor-in-Charge revealed: -She was off the previous weekend through Tuesday (8/16/16). -She could not remember the last time milk was delivered to the facility. -The facility had been "running out of milk." Observation on 8/17/16 at 10:10AM of the deep freezer off of the kitchen revealed no frozen milk. Interview on 8/17/16 at 1:45PM with Staff A, SIC revealed: -One of the two Supervisors (C and D) over the facility and sister facilities on the property delivered food supplies. -"I think tomorrow [Thursday] is shopping day." -Milk and bread were purchased on Thursdays. -She had not reported to the Supervisors recently of needing any food. -Milk was delivered to the facility 4 gallon jugs at a time and lasted "about a week." -Sometimes milk was served with cereal and sometimes residents asked for it during the day. -If milk was drank "constantly" then it would not last a week. -If residents asked her for milk she gave it to them. Interview on 8/17/16 at 2:26PM with Staff C, Supervisor revealed: -Milk was purchased usually on Thursdays. -Milk was last purchased for the facility the previous Thursday (8/11/16). -Each of the facilities on the property received a case of milk, each case contained 4 1-gallon jugs.	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 9 -If residents drank a little more milk, extra milk would be purchased. -"SICs should never have to tell us [they need milk], it comes every week." -If the facility was running low of milk, the Supervisors should be told and we could get more milk from another sister facility or purchase some more. -She did not know that the facility was out of milk. Telephone interview on 8/18/16 at 9:25AM with the Administrator revealed: -She purchased milk, bread and eggs were purchased weekly. -Each of the facilities on the property received the same food items according the menu, " I just purchase it [food]. " -She had received no reports from staff regarding having no milk. -Her leadership staff should have been monitoring food needs. Telephone interview on 8/18/16 with Staff B, SIC, revealed: -Sometimes the milk supply would be low because milk stored frozen and the expanding milk would burst in the freezer, wasting the milk. -If milk was low, he sometimes borrowed some from other facilities on the property.	C 273		
{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.	{C 912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 912}	Continued From page 10 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to insure adequate supervisory staffing, resulting in three residents having to be temporarily and involuntarily moved to a sister facility for a period of three nights. The findings are: Confidential interview with a resident revealed: -There were not enough workers to care for the facility the previous weekend. -Residents had to pack up clothing and toiletries for three days. -She was moved to a sister facility on the property. -She had her own room and the men were nice, but "the point was that we had to move." -This was the first time the resident had to move since her admission. -"I felt betrayed." -Another one of the residents seemed "upset" over the move based on her facial expressions, asking an SIC from another sister facility on the property "over and over" why she had to leave. Confidential interview with a second resident revealed she went to another facility because "nobody [a supervisor] was here [at the facility]." Confidential interview with a third resident revealed: -She had to move to another facility for three nights (starting Friday, 8/12/16) and returned at 2:00PM on Monday, 8/15/16. -Moving was "very hard for me." -Six weeks prior to the weekend move, she had	{C 912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 912}	Continued From page 11 to move for five nights but could remember the exact dates. -There was not enough staff to cover the house. -She went to a specific sister facility on the property and felt safe, but "it was inconvenient," "it was harder for me than most people" and she just had a few things she brought with her. -The move made her feel "overwhelmed" and it provoked "anxiety," but she did not need any additional medication to that already scheduled for her. Interview on 8/17/16 at 1:45PM with Staff A, SIC revealed: -There had been times when there was a shortage of SICs and a facility on the property would have to be shut down and the residents moved to another facility. -She thought that "last year" residents had to leave the facility for another facility on the property "I think" due to "no supervisor." - "It [a resident move] had not occurred recently." -Residents did not handle this very well as they wanted to remain in their facility to "watch their stuff." -Residents could only bring a couple changes of clothes and were placed in empty rooms at other facilities on the property. -She was not aware since she had been off work that residents had to move from the facility. - "We could use more help" as every facility on the property required an SIC. -A "lot of people have quit" which was why the facility was "short staff." Interview on 8/17/16 at 2:26PM with Staff C, Supervisor revealed: -Residents had to move to another facility on the property the previous weekend because of a "staff issue."	{C 912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235			STREET ADDRESS, CITY, STATE, ZIP CODE 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 912}	Continued From page 12 -Three residents in the facility at the time went to other facilities on the property, two residents to one facility and one resident to another, and the facility was shut down. -She was unable to personally provide SIC coverage for personal reasons and the other Supervisor (Staff C) was already covering another facility on the property. -If staff were available to pull they would have been pulled. -Regarding closing a facility, residents "never like it" and "it puts them out." -They tailored the resident's moves for their comfort and to prevent no more anxiety. -She could not recall if a resident move had occurred recently other than this past weekend. -She thought the Administrator could not provide coverage herself due to personal reasons, but was working on getting "someone." Combined interview on 8/18/16 at 8:30AM with Staff E, SIC and Staff F, SIC revealed: -Staff E was an SIC at a sister facility on the property and Staff F provided relief SIC coverage to all the facilities on the property. -The facility had to be shut down on Friday (8/12/16) as there was no staff coverage and they assisted moving the residents to other facilities. -Two SICs who work at the facilities on the property were off at the same time (Staff B, SIC who was assigned to the facility in question and Staff E, SIC). -Staff B and Staff E were unable to work that weekend so Staff C, Supervisor told them to close the facility. -Staff F "took a deep breath" knowing residents wanted to remain in their facility. -One of the residents was "uncomfortable" and had "just this look" with the move, wringing her hands and wanting to talk to Supervisor C and	{C 912}			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235		STREET ADDRESS, CITY, STATE, ZIP CODE 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 912}	Continued From page 13 the Administrator. -Facilities on the property had closed down before, in the past, but neither Staff E of Staff F could remember actual dates. -A couple of months prior, three relief SICs had quit in one week and Staff B was out of the state, otherwise the facility would not have had to close. -Staff B was back to work at the facility tomorrow. -For the facilities on the property there was a need for two more relief SICs. -Supervisors C and D were responsible for staff schedules. Telephone interview on 8/18/16 at 9:25AM with the Administrator revealed: -She was having a series of staff shortages. -The decision to move residents was "always a last resort." -She had reached out to on-call and current staff but could not identify available staff. -"I made the decision to move them" and there were "no other options at my disposal." -She would normally have worked but was unable to. Telephone interview on 8/18/16 with Staff B, SIC, revealed: -He could not work the period of 8/12/16 through 8/15/16 as it was his scheduled time off and he was out of the state. -Staff leaving employment did affect overall staffing. -There was one other time (he could not remember the exact date) when no SIC was available and the residents had to stay in another facility on the property. A Plan of Protection was obtained from the Supervisor on 8/18/16 and included: -Adequate staffing would be in place at all times.	{C 912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/18/2016
NAME OF PROVIDER OR SUPPLIER SERENITY HEART FAMILY CARE HOME # 235			STREET ADDRESS, CITY, STATE, ZIP CODE 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 912}	Continued From page 14 -Hiring of qualified staff and back-up staff was in progress. -Supervisors would be on call if necessary to cover staff shortages. -Residents would not be moved due to staff shortages. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 2, 2016.	{C 912}			