

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL018034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/16/2021
NAME OF PROVIDER OR SUPPLIER SERENITY FAMILY CARE # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 - B SOUTH CENTER STREET HICKORY, NC 28602		
(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 03/16/21.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the Medication Administration Records for 1 of 3 sampled residents (Resident #2). The findings are:	C 342		

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

TITLE

(X6) DATE

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C 342	Continued From page 1 Review of Resident #2's current FL-2 dated 03/16/21 revealed: -Diagnoses included neurocognitive disorder, hypothyroidism, tremors, and Alzheimer's dementia. -A physician's order for albuterol 2.5mg/3ml (to treat asthma) one vial via nebulizer every four hours as needed for shortness of breath. Review of Resident #2's December 2020 medication administration record (MAR) revealed: -There was an entry for albuterol 2.5mg/3ml one vial via nebulizer every four hours as needed for shortness of breath. -There was documentation albuterol 2.5mg/3ml was administered daily 12/01/20-12/31/21. Review of Resident #2's January 2021 MAR revealed there was no entry for albuterol 2.5mg/3ml one vial via nebulizer every four hours as needed for shortness of breath. Review of Resident #2's February 2021 MAR revealed there was no entry for albuterol 2.5mg/3ml one vial via nebulizer every four hours as needed for shortness of breath. Review of Resident #2's March 2021 MAR revealed there was no entry for albuterol 2.5mg/3ml one vial via nebulizer every four hours as needed for shortness of breath. Observation of Resident #2's medication on hand on 03/16/21 at 10:30am revealed: -A box of albuterol 2.5mg/3ml vials was dispensed on 02/16/21; the box contained 9 foil packets and each packet contained 5 vials. -There were 45 of 60 vials available for administration.	C 342		

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C 342	Continued From page 2 Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/16/21 at 12:50pm revealed: -The pharmacy received an order for Resident #2's albuterol 2.5/3ml on 07/08/20. -The pharmacy entered Resident #2's order for albuterol onto the MAR until January 2021. -When the physician orders were reviewed by the pharmacy, Resident #2's order for albuterol was accidentally excluded in the MAR system by the pharmacy. -Resident #2's albuterol 2.4mg/3ml was not discontinued by the physician. -Resident #2's albuterol 2.5mg/3ml was not on a monthly refill schedule. -The facility requested a refill on 11/25/20 and 02/16/21 for 60 vials of albuterol 2.5mg/3ml. -The facility could write Resident #2's order for the albuterol onto the MAR and contact the pharmacy to correct the MAR. -She did not see a communication from the facility to correct Resident #2's MAR. Interview with the supervisor in charge (SIC) on 03/16/21 at 11:00am revealed: -She administered Resident #2's albuterol 2.5mg/3ml when Resident #2 needed it. -The last time she documented Resident #2's albuterol 2.5gm/3ml on the MAR was 12/31/21. -She knew Resident #2 had the albuterol 2.5ml/3ml vials available because they were reordered when they ran out. -She routinely pulled Resident #2's medications from the medication cart and administered them according to MAR. -After she administered all of Resident #2's medications she returned to document them on the MAR. -She did not realize she did not document Resident #2's albuterol 2.5mg/ml since 12/31/20.	C 342		

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C 342	Continued From page 3 Interview with the Administrator on 03/16/21 at 11:30 revealed: -She expected the SICs to administer Resident #2's medications according the physicians orders and the MAR. -She tried to review the MARs at least monthly with the previous month's MAR and physician orders. -She must have overlooked Resident #2's albuterol order and it was left off the MAR since December 2020. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	C 342		