

PRINTED: 07/09/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL018040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2025
NAME OF PROVIDER OR SUPPLIER SERENITY FAMILY CARE HOME		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 07/08/25.	C 000	Deficiency: C 230 – Resident Assessment	
C 230	10A NCAC 13G .0801 (a) (b) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal	C 230	The facility failed to complete annual assessments for three sampled residents (#1, #2, and #3) as required under 10A NCAC 13G .0801(a)(b). - Immediately audited all resident records to identify overdue assessments and care plans. - Scheduled assessments using the DMA-3050R instrument provided by DHSR to ensure compliance with required elements. - Designated a qualified staff member, trained per Rule .0508, to conduct and complete all outstanding Care Plans within 10 business days. - Obtained PCP signatures where applicable and ensured forms are fully completed with dates and assessor credentials.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Tamara Phillips**Administrator**8/5/25*

STATE FORM

6899

FYFW11

If continuation sheet 1 of 17

Reviewed and acknowledged 8/8/25 RP

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SERENITY FAMILY CARE HOME

**2415 - B SOUTH CENTER STREET
HICKORY, NC 28602**

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C 230	Continued From page 1 hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicare/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf. at no cost. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure care plans were updated annually for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/25/25 revealed diagnoses included neuro cognitive, vascular dementia, brain tumor, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hyperlipidemia, depression and	C 230	<u>Prevention Plan</u> - Developed a digital tracking log with reminders 30 days post-admission and annually for each resident. - Staff training on proper completion and documentation of assessments to be conducted monthly for three months, then quarterly. - Assessment procedures and expectations added to Serenity Family Care Home's official policy manual. <u>Responsible Party</u> - Facility Administrator, Tamara Phillips, will oversee completion and compliance. - Lead Medication Aide will verify assessment records during weekly care review meetings. <u>Monitoring Process</u> - Weekly chart audits for 90 days to confirm timely completion of all assessments and care plans. - Ongoing monthly audits thereafter, documented and reviewed by the Administrator. <u>Completion Date</u> All corrective actions, including training and audits, will be completed by August 15, 2	8/5/25

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C 230	Continued From page 2 asthma. Review of Resident #1's Resident Register revealed an admission date of 09/22/10. Review of Resident #1's record revealed one completed care plan dated 04/06/23 and there were no other care plans. Refer to the interview with the medication aide (MA) on 07/08/25 at 11:40am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. 2. Review of Resident #2's current FL2 dated 06/01/25 revealed diagnoses included vascular dementia and seizures. Review of Resident #2's Resident Register revealed an admission date of 09/05/24. Review of Resident #2's record revealed there was one incomplete care plan without a date, assessor's signature, and without the Primary Care Provider's (PCP) signature. Refer to the interview with the MA on 07/08/25 at 11:40am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. 3. Review of Resident #3's current FL2 dated 06/01/25 revealed diagnoses included obesity and schizophrenia. Review of Resident #3's Resident Register revealed an admission dated of 08/02/23.	C 230		

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C 230	Continued From page 3 Review of Resident #3's record revealed there was one completed care plan dated 08/01/23 and there were no other care plans. Refer to the interview with the MA on 07/08/25 at 11:40am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. Interview with the MA on 07/08/25 at 11:40am revealed: -She knew the residents' required care plans. -The Administrator was responsible for the care plans. -She knew to ask the Administrator if she had questions about the care of the residents. Interview with the Administrator on 07/08/25 at 11:10am revealed: -She was responsible for ensuring the care plans for the residents were completed. -She was responsible for instructing staff on the care of the residents. -She had a system in place to ensure the care plans were completed in a timely manner, but she missed them.	C 230	<u>Deficiency: C 339 – Medication Administration</u> Medications were not administered within the required time frame (one hour before or after scheduled time) for Residents #1, #2, and #3 on July 8, 2025, per 10A NCAC 13G .1004(g). <u>Corrective Measures</u> • Updated Medication schedules with the Pharmacy & Nurse Practitioner to ensure morning medication distribution times begin at 9 am and evening medication distribution times begin at 9 pm. • Revised the Medication Management Policy to include clarification of the "1-hour window" rule with emergency exceptions only. • In-service training conducted for all medication administration staff by the Administrator, with emphasis on timing accuracy, documentation, and escalation protocols when delays occur. • Daily reminder alerts implemented in the eMAR system to prompt staff at scheduled med pass times.	
C 339	10A NCAC 13G .1004 (g) Medication Administration 10A NCAC 13G .1004 Medication Administration (g) The facility shall ensure that medications are administered within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.	C 339		

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C 339	Continued From page 4 This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled administration time for 3 of 3 sampled residents (#1, #2, and #3). The findings are: Review of the facility's undated Medication Management Policy and Procedure revealed residents' medications should be administered at the right time (one hour before or after the prescribed time). Observation of the facility on 07/08/25 at 8:45am revealed there was a census of 4 residents and 1 personal care aide (PCA) in the facility. Observation of the facility on 07/08/25 at 10:10am revealed the medication aide (MA) was administering medications to residents. 1. Review of Resident #1's current FL2 dated 06/25/25 revealed: -Diagnoses included neuro cognitive, vascular dementia, brain tumor, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hyperlipidemia, depression and asthma. -There were medication orders for acetaminophen (treats pain) 500mg three times daily and diclofenac 1% gel (treats pain) 1 gram three times daily. Review of Resident #1's eMAR on 07/08/25 at 10:00am revealed there were entries for acetaminophen 500mg three times daily at 8:00am, 2:00pm and 8:00pm, diclofenac 1% gel 1 gram three times daily at 8:00am, 2:00pm and	C 339	<u>Prevention Plan</u> - Developed a Medication Administration Compliance Checklist to be completed after each med pass. - Implemented a Medication Time Review Log to flag any delays and document corrective follow-up, reviewed weekly by the Administrator. - Established a contingency protocol for residents who may be asleep or unavailable during scheduled med pass times, including physician approval and written documentation. <u>Responsible Party</u> - Facility Administrator, Tamara Phillips, will ensure oversight of medication administration schedules, audits, and staff performance. - Medication Aide Lead will maintain compliance logs and communicate any deviations to the Administrator immediately.	

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C 339	Continued From page 5 8:00pm, and documented they were administered on 07/08/25 at 8:00am. Refer to the interview with the MA on 07/08/25 at 9:55am. Refer to the interview with the Administrator on 07/08/25 at 10:10am. Refer to the interview with the Primary Care Provider (PCP) on 07/08/25 at 10:23am. 2. Review of Resident #2's current FL2 dated 06/01/25 revealed: -Diagnoses included vascular dementia and seizures. -There were medication orders for carvedilol (treats high blood pressure) 6.25mg twice daily, guanfacine (treats high blood pressure) 1mg twice daily, and lansoprazole (treats stomach acid) 30mg daily. Review of Resident #2's eMAR for 07/08/25 revealed there were entries for carvedilol 6.25mg and lansoprazole 30mg daily at 8:00am, and guanfacine 1mg twice daily at 8:00am and 8:00pm and no documentation they were administered on 07/08/25 at 8:00am. Refer to the interview with the MA on 07/08/25 at 9:55am. Refer to the interview with the Administrator on 07/08/25 at 10:10am. Refer to the interview with the PCP on 07/08/25 at 10:23am. 3. Review of Resident #3's current FL2 dated 06/01/25 revealed:	C 339	Monitoring Process - Daily audits for 30 days to track administration timing and staff adherence. - Weekly review of Medication Time Review Logs for 60 days. - Continued monthly performance evaluations with staff reinforcement and retraining as needed. Completion Date All corrective actions will be completed by August 10, 2025.	8/5/25

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C 339	Continued From page 6 -Diagnoses included obesity and schizophrenia. -There were medication orders for fluvoxamine (treats depression) 50mg daily, meloxicam (treats pain) 15mg daily, omeprazole (treats stomach acid) 20mg daily, fish oil (supplement) 1000mg daily, senna (treats constipation) 8.6mg daily, and vitamin D3 (supplement) 25mcg daily. Review of Resident #3's eMAR for 07/08/25 revealed there were entries for fluvoxamine 50mg, meloxicam 15mg, omeprazole 20mg, fish oil 1000mg, senna 8.6mg, and vitamin D3 25mcg daily at 8:00am and no documentation they were administered on 07/08/25 at 8:00am. Refer to the interview with the MA on 07/08/25 at 9:55am. Refer to the interview with the Administrator on 07/08/25 at 10:10am. Refer to the interview with the PCP on 07/08/25 at 10:23am. Interview with the MA on 07/08/25 at 9:55am revealed: -She had not administered the medications for 8:00am yet. -She knew the medication schedule was 8:00am but she did not start work until 9:00am. -She thought she had until 10:00am to administer the medications. Interview with the Administrator on 07/08/25 at 10:10am revealed: -She knew medications should be administered within 1 hour before or after the scheduled time. -Sometimes the residents were still asleep at 8:00am and they tried to accommodate the residents.	C 339		

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C 339	Continued From page 7 -She reached out to the Primary Care Provider (PCP) to get the times for the morning medications changed but it had not happened yet. Telephone interview with the PCP on 07/08/25 at 10:23am revealed staff should administer the medications to the residents at the scheduled time.	C 339		
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, interviews, and record reviews, the facility failed to ensure the electronic	C 342		

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C 342	Continued From page 8 medication administration records (eMAR) were accurate for 3 of 3 residents (#1, #2, and #3) related to medications used to treat pain, depression, anxiety, inflammation, over active bladder, cholesterol, migraine headaches, sinus headaches, asthma, shortness of breath, coughing, hemorrhoids, low potassium, involuntary movements and chronic obstructive pulmonary disease (#1), high blood pressure, anxiety, stomach acid, seizures, psychosis (#2), and constipation, supplements, stomach acid, pain, depression, and psychosis (#3). The findings are: Review of the facility's undated Management of Medications Policy and Procedure revealed staff would document on the eMAR after administration of medications and before proceeding to the next resident. 1. Review of Resident #1's current FL2 dated 06/25/25 revealed: -Diagnoses included neuro cognitive, vascular dementia, brain tumor, chronic obstructive pulmonary disease, gastroesophageal reflux disease, hyperlipidemia, depression and asthma. -There were medication orders for acetaminophen (treats pain) 500mg three times daily, amitriptyline hcl (treats major depression) 25mg one time daily at bedtime, clonazepam (treats anxiety) 0.5mg one time daily as needed, clonazepam (treats anxiety) 1mg one time daily at bedtime, diclofenac (treats pain and inflammation) 50mg three times daily, diclofenac 1% gel (treats pain) 1 gram three times daily, duloxetine (treats depression and anxiety) 60mg two capsules daily, fluoxetine (treats depression) 20mg one time daily at 12pm, myrbetriq (treats over active bladder) 50mg one time daily at	C 342	Deficiency: C 342 – Medication Administration Record (MAR) Accuracy (Resident #3) For the week of July 1–7, 2025, Serenity Family Care Home failed to document medication administration—or provide justification for omissions—for Resident #3's prescribed treatment regimen. Multiple entries in the eMAR lacked required fields per 10A NCAC 13G .1004(j), including time, initials, and reason for missed or refused doses. Corrective Measures (Resident #3 Focus) - Conducted a line-by-line review of Resident #3's medication regimen to verify what was administered and reconcile discrepancies. - Medications (including clozapine, fluvoxamine, lurasidone, meloxicam, omeprazole, fish oil, senna, and vitamin D3) were confirmed to be in stock, correctly labeled, and available for scheduled administration. - Identified staffing shortages and inconsistent documentation as root causes. - Immediately re-trained involved staff on the eight required MAR elements, including documenting refused doses and PRNs with effects.	

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C 342	Continued From page 9 12:00pm, quetiapine fumarate (treats depression) 25mg twice daily, quetiapine fumarate (treats depression) 50mg one time daily at bedtime, rosuvastatin (treats cholesterol, plaque buildup in arteries and lower risks of stroke and heart attacks) 10mg one time daily at bedtime, topiramate (treats migraine headaches) 25mg one time every other night at bedtime, trazadone (treats depression) 100mg one time daily at bedtime, vitamin b-12 (promotes brain and nervous system health) 1000mg one time daily, austedo xr (treats involuntary movements) 12mg one time daily, buspirone (treats anxiety) 10mg three times daily, acetaminophen 8 hour pain relief (treats pain) 650mg three times daily, mirtazapine (treats depression) 7.5mg one time daily at bedtime, mucus relief er (treats cough) 600mg twice daily, potassium chloride (treats low potassium) 20meq one time daily. Review of Resident #1's eMAR for 07/01/25 - 07/07/25 revealed: -There was an entry for acetaminophen 500mg three times daily at 8:00am, 2:00pm and 8:00pm and no documentation it was administered or reason why for 13 of 21 doses. -There was an entry for amitriptyline hcl 25mg one time daily at 8:00pm and no documentation it was administered or reason why for 3 of 7 doses. -There was an entry for clonazepam 1mg one time daily at 5:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for diclofenac 50mg three times daily 9:00am, 2:00pm and 8:00pm and no documentation it was administered or reason why for 13 of 21 doses. -There was an entry for diclofenac 1% gel 1 gram three times daily 8:00am, 2:00pm and 8:00pm and no documentation it was administered or reason why for 13 of 21 doses.	C 342	Prevention Plan (Facility-Wide Reinforcement) - Introduced "No Skip" MAR Protocol: staff must document administered meds before moving to the next resident. - Added staffing support during peak med pass times to reduce documentation lapses due to workload strain. - Mandated Daily MAR Completion Checks by Administrator or delegated reviewer to catch and correct omissions before end of shift. - Policy revised to include clear expectations on documentation, with accountability measures for repeated lapses. Responsible Party - Facility Administrator, [Name], will oversee all corrective efforts and ensure staff adherence to MAR protocols. - Backup Medication Aide designated to assist during staff shortages, with direct documentation responsibilities clarified.	

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C 342	Continued From page 10 -There was an entry for duloxetine 60mg two capsules daily at 12:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for fluoxetine 20mg one time daily at 12:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for myrbetriq 50mg one time daily at 12:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for quetiapine fumarate 25mg twice daily 9:00am and 8:00pm and no documentation it was administered for 8 of 14 doses. -There was an entry for quetiapine fumarate 50mg one time daily at 8:00pm and no documentation it was administered or reason why for 3 of 7 doses. -There was an entry for rosuvastatin 10mg one time daily at 8:00pm and no documentation it was administered or reason why for 3 of 7 doses. -There was an entry for trazadone 100mg one time daily at 8:00pm and no documentation it was administered or reason why for 3 of 7 doses. -There was an entry for vitamin b-12 1000mg one time daily at 12:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for austedo xr 12mg one time daily at 9:00am and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for buspirone 10mg three times daily at 6:00am, 12:00pm and 6:00pm and no documentation it was administered or reason why for 15 of 21 doses. -There was an entry for acetaminophen 8 hour pain relief 650mg three times daily at 6:00am, 2:00pm and 10:00pm and no documentation it was administered or reason why for 15 of 21 doses. -There was an entry for mirtazapine 7.5mg one	C 342	Monitoring Process • Daily MAR audits on Resident #3's entries for 60 days. • Weekly review of all shift coverage and staff assignments to address gaps in med administration and documentation. • Quarterly performance reviews to assess staff compliance with MAR policies. Completion Date All corrective actions specific to Resident #3 and corresponding policy changes will be fully implemented by August 24, 2025	8/5/25

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SERENITY FAMILY CARE HOME

**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 342	Continued From page 11 time daily at 5:00pm and no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for mucus relief 600mg twice daily at 12:00pm and 8:00pm and no documentation it was administered or reason why for 8 of 14 doses. -There was an entry for potassium chloride 20meq one time daily at 9:00am and no documentation it was administered or reason why for 5 of 7 doses. Observation of Resident #1's medications available for administration on 07/08/25 at 12:10pm revealed: -There was one bubble pack labeled acetaminophen 500mg three times daily. -There was one bubble pack labeled amitriptyline hcl 25mg one time daily. -There was one bubble pack labeled clonazepam 1mg one time daily. -There was one bubble pack labeled diclofenac 50mg three times daily. -There was one tube labeled diclofenac 1% gel 1 gram three times daily. -There was one bubble pack labeled duloxetine 60mg two capsules daily -There was one bubble pack labeled fluoxetine 20mg one time daily. -There was one bubble pack labeled myrbetriq 50mg one time daily. -There was one bubble pack labeled quetiapine fumarate 25mg twice daily. -There was one bubble pack labeled quetiapine fumarate 50mg one time daily. -There was one bubble pack labeled rosuvastatin 10mg one time daily. -There was one bubble pack labeled trazadone 100mg one time daily. -There was one bubble pack labeled vitamin b-12 1000mg one time daily.	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL018040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2025
NAME OF PROVIDER OR SUPPLIER SERENITY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 - B SOUTH CENTER STREET HICKORY, NC 28602		
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C 342	Continued From page 12 -There was one bubble pack labeled austedo xr 12mg one time daily. -There was one bubble pack labeled buspirone 10mg three times daily. -There was one bubble pack labeled ft 8 hour pain relief 650mg three times daily. -There was one bubble pack labeled mirtazapine 7.5mg one time daily. -There was one bottle labeled mucus relief 600mg twice daily. -There was one bubble pack labeled potassium chloride 20meq one time daily. Refer to the interview with the medication aide (MA) on 07/08/25 at 10:58am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. Refer to the attempted interview with the second MA on 07/08/25 at 10:35am. 2. Review of Resident #2's current FL2 dated 06/01/25 revealed: -Diagnoses included vascular dementia and seizures. -There were medication orders for carvedilol (treats high blood pressure) 6.25mg twice daily, clonazepam (treats anxiety) 2mg daily at bedtime, guanfacine (treats high blood pressure) 1mg twice daily, lansoprazole (treats stomach acid) 30mg daily, levetiracetam (treats seizures) 1000mg twice daily, and quetiapine (antipsychotic) 50mg two tablets daily at bedtime. Review of Resident #2's eMAR for 07/01/25 - 07/07/25 revealed: -There was an entry for carvedilol 6.25mg twice daily at 8:00am and 8:00pm and no	C 342		

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NAME OF PROVIDER OR SUPPLIER SERENITY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 - B SOUTH CENTER STREET HICKORY, NC 28602		
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C 342	Continued From page 13 documentation it was administered or reason why for 7 of 14 doses. -There was an entry for clonazepam 2mg daily at 8:00pm and no documentation it was administered or reason why for 7 of 7 doses. -There was an entry for guanfacine 1mg twice daily at 8:00am and 8:00pm and no documentation it was administered or reason why for 7 of 14 doses. -There was an entry for lansoprazole 30mg daily at 8:00am and no documentation it was administered or reason why for 4 of 7 doses. -There was an entry for levetiracetam 1000mg twice daily at 9:00am and 8:00pm and no documentation it was administered or reason why for 7 of 14 doses. -There was an entry for quetiapine 50mg two tablets daily at 8:00pm and no documentation it was administered or reason why for 3 of 7 doses. Observation of Resident #2's medications available for administration on 07/08/25 at 11:00am revealed: -There was one bubble pack labeled carvedilol 6.25mg twice daily. -There was one bubble pack labeled clonazepam 2mg daily. -There was one bubble pack labeled guanfacine 1mg twice daily. -There was one bubble pack labeled lansoprazole 30mg daily. -There was one bubble pack labeled levetiracetam 1000mg twice daily. -There was one bubble pack labeled quetiapine 50mg two tablets daily. Interview with Resident #2 on 07/08/25 at 8:50am revealed staff administered all his medications. Refer to the interview with the MA on 07/08/25 at	C 342		

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C 342	Continued From page 14 10:58am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. Refer to the attempted interview with the second MA on 07/08/25 at 10:35am. 3. Review of Resident #3's current FL2 dated 06/01/25 revealed: -Diagnoses included obesity and schizophrenia. -There were medication orders for clozapine (antipsychotic) 100mg give 2 and ½ tablets daily at bedtime, fluvoxamine (treats depression) 50mg daily, lurasidone (antipsychotic) 80mg daily, meloxicam (treats pain) 15mg daily, omeprazole (treats stomach acid) 20mg daily, fish oil (supplement) 1000mg daily, senna (treats constipation) 8.6mg daily, and vitamin D3 (supplement) 25mcg daily. Review of Resident #3's eMAR for 07/01/25 - 07/07/25 revealed: -There was an entry for clozapine 100mg take 2 and ½ tablets daily at bedtime and there was no documentation it was administered or reason why for 3 of 7 doses. -There was an entry for fluvoxamine 50mg daily at 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for lurasidone 80mg daily at 5:00pm and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for meloxicam 15mg daily at 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for omeprazole 20mg daily at 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for fish oil 1000mg daily at	C 342		

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C 342	Continued From page 15 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for senna 8.6mg daily at 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. -There was an entry for vitamin D3 25mcg daily at 8:00am and there was no documentation it was administered or reason why for 5 of 7 doses. Observation of Resident #3's medications available for administration on 07/08/25 at 11:05am revealed: -There was one bubble pack labeled vitamin D3 25mcg daily. -There was one bubble pack labeled senna 8.6mg daily. -There was one bubble pack labeled fish oil 1000mg daily. -There was one bubble pack labeled clozapine 100mg 2 and ½ tablets daily. -There was one bubble pack labeled fluvoxamine 50mg daily. -There was one bubble pack labeled lurasidone 80mg daily. -There was one bubble pack labeled meloxicam 15mg daily. -There was one bubble pack labeled omeprazole 20mg daily. Attempted interview with Resident #3 on 07/08/25 at 9:00am was unsuccessful. Refer to the interview with the medication aide (MA) on 07/08/25 at 10:58am. Refer to the interview with the Administrator on 07/08/25 at 11:10am. Refer to the attempted telephone interview with the second MA on 07/08/25 at 10:35am	C 342		

PRINTED: 07/09/2025
FORM APPROVED

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SERENITY FAMILY CARE HOME

**2415 - B SOUTH CENTER STREET
HICKORY, NC 28602**

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C 342	Continued From page 16 Interview with the medication aide (MA) on 07/08/25 at 10:58am revealed: -She did not know why staff was not documenting they administered medications. -She always documented on the eMAR after she administered medications to the residents. Interview with the Administrator on 07/08/25 at 11:10am revealed: -There were times when the facility was short of staff and she or a second MA would administer the medications to the residents. -They just did not document after they administered the medications and she did not know why. Attempted telephone interview with the second MA on 07/08/25 at 10:35am was unsuccessful.	C 342		