STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	FCL011340		R 05/27/2015

NAME OF PROVIDER OR SUPPLIER
SERENITY HEART FAMILY CARE HOME UNIT I

STREET ADDRESS, CITY, STATE, ZIP CODE
19 ELLA LANE
ALEXANDER, NC 28701

(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 a follow-up survey on May 27, 2015.	{C 000}		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the facility was maintained in a clean orderly manner, and free of obstructions and hazards in 3 of 3 common resident bathrooms. The findings are: Observation of the second common men's bathroom on the right side of the hallway on 5/27/15 at 9:15am revealed: -The floor of the walk in shower was yellow with soap scum. -There were multiple pieces of black debris in the bottom of the shower. -There were multiple splatters and a smear of a black substance on the shower wall and soap holder. -The sink bowl was covered with a plastic bag with a sign posted stating the sink was out of order. -One floor tile in front of the shower had a four	C 078		

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C 078	Continued From page 1 inch triangular section missing exposing the uneven subfloor underneath. Observation of the first common men's bathroom on the right side of the hallway on 5/27/15 at 9:49am revealed: -Four floor tiles at the base of the toilet were stained orange. -The bathroom had a strong odor of urine. -Dried, yellow splatters were visible on the rim of the toilet bowl. -A thick gray ring was visible on the sides of the bathtub. Observation of the women's common bathroom on the left side of the hallway on 5/27/15 at 9:50am revealed: -Three floor tiles at the base of the toilet were stained orange. -There was dried yellow splatters on the toilet base and on the rim of the toilet. Confidential interviews with four residents revealed: -"I would love to see the bathrooms cleaner." -"Its really disgusting in [the second common men's bathroom]..." -"That sinks been sitting like that for 3 months now. Its broke....We need a seal for the sink drain..." -"That sinks been broken since I've been here." -Staff "can't stay on [the cleaning] when people mess it up." -"The bathrooms are frigging disgusting....There's been [feces] in the toilet for 3 days" in that bathroom. -There's one resident everytime he goes to the bathroom he misses the toilet and it goes in the floor.	C 078		

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C 078	Continued From page 2 Interview with the Administrator on 5/27/15 at 10:00am revealed: -She had been made aware by the Supervisor-In-Charge (SIC) the sink the second common men's bathroom on the rights sink was broken. -"It's been awhile" since she had been told about the sink needing repair. -"They told me about it, but that just dropped off my radar" and she had forgotten to get the sink repaired. -"[The SIC] has not gotten to the bathrooms [to clean them] yet this morning." Observation of the SIC on 5/27/15 at 10:15am revealed he had finished mopping the kitchen and began to clean the common resident bathrooms. Interview with the SIC on 5/27/15 at 2:06pm revealed: -"I clean the bathrooms at least daily." -He stated he was willing to clean up the bathrooms anytime, but he needed the residents to communicate with him when they found cleanliness problems in the bathrooms.	C 078		
{C 292}	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each	{C 292}		

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{C 292}	Continued From page 3	{C 292}		

resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide a minimum of 14 hours of planned group activities per week.

The findings are:

Review of the posted activity calendar revealed:
-It was dated April 2015/Spring at the top of the calendar.
-There were no activities planned for 21 out of the 30 days on the calendar.
-There were no start or end times listed for the activities that were on the calendar.
-Some of the activities included bingo, cards, board games, and chess.

Observations in the facility on 5/27/15 from 8:45am until 11:50am and from 1:00pm until 3:30pm revealed no planned activities were offered to the residents.

Confidential interviews with six residents revealed the following comments:
-6 of 6 residents agreed that there were not 14 hours of activites being offered in the facility.
-5 out of 6 residents agreed the Activity Director routinely offered to take the residents to shop at a local discount store.
-The Activity Director had recently used the facility van to take a group of residents bowling.
-"I wish we had poker chips" so we could play

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{C 292}	Continued From page 4 poker. -"I would like to play spades" card game as an activity. -"We can do whatever we want to. Most of the time we don't want to do what's offered." -"TV is the only thing I know [offered as an activity]." -One resident stated he would like to go hiking. Interview with the Supervisor-In-Charge (SIC) on 5/27/15 at 2:06pm revealed: -There was a site Activity Director for the facility. -The Activity Director was responsible for creating and updating the activities calendar. -When he had been responsible for the activity calendar, he had made sure the activities had start and end times posted. -The Activity Director routinely took residents for outings. -There were playing cards and board games available in the facility for the residents use. -He frequently offered movie time in the evenings allowing the residents to make selections from his personal DVD collection. -He and the SIC from the house across the street had discussed getting a basketball goal so the residents from both houses could participate as a group. -The facility had bean bag toss game. -Supplies had been obtained for one of the residents who made a rock garden in front of the facility.	{C 292}		
{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,	{C 330}		

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{C 330}	Continued From page 5	{C 330}		

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:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

Based on observation, interview and record review, the facility failed to assure Vitamin D3 was discontinued and Clobetasol cream was administered as prescribed for 2 of 3 sampled residents (Resident #1 and #3).

The findings are:

A. Review of Resident #1's FL2 dated 2/27/15 revealed diagnoses including:
-Chronic schizoaffective disorder
-Chronic Obstructive Pulmonary Disease
-Type 2 Diabetes
-No physician's order for Vitamin D3

Review of Resident #1's record revealed:
-A physician's order for Vitamin D3 (used as a nutritional supplement) prescribed on 5/22/14 with 3 refills.
-Continued review revealed no subsequent order for Vitamin D3.

Review of Resident #1's April 2015 Medication Administration Record (MAR) revealed:
-A computer generated entry for Vitamin D3 5000 units daily scheduled for 8am.
-"D/C" was handwritten out beside the entry.

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{C 330}	Continued From page 6 -No documented administrations of the medication Review of Resident #1's May 2015 MAR revealed: -A computer generated entry for Vitamin D3 5000 units daily scheduled for 8am. -The medication was documented as administered for 26 occurrences out of 27 opportunities from 5/1/15 to 5/27/15. Observation of Resident #1's medications on hand in the facility on 5/27/15 at 1:00pm revealed a bottle of Vitamin D3 5000 unit tablets was stored with the resident's other medications. Interview with Resident #1 on 5/27/15 at 9:30am revealed: -He had no complaints concerning how staff administered his medications to him. -He received his medications on time. -He never ran out of his medications. Telephone interview with the facility pharmacy on 5/27/15 at 1:40pm revealed: -The last order in their system for Vitamin D3 for Resident #1 was dated 5/22/14 with 3 refills. -There was "no new script for it." -They had not received a copy of the resident's new FL2 dated 2/27/15 discontinuing the Vitamin D3 for the resident. -The Vitamin D3 was last dispensed to the facility for Resident #1 on 5/9/15. Telephone interview with Resident #1's primary care physician's (PCP) office nurse on 5/27/15 at 2:00pm revealed: -The Vitamin D3 had been prescribed for Resident #1 on 5/22/14 after the resident's blood work had shown a vitamin D deficiency.	{C 330}		

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{C 330}	Continued From page 7 -The Vitamin D3 was to be discontinued after the 3 refills on the prescription had been completed. -He could not see anywhere in the residents care notes where the PCP had ever reordered the Vitamin D3. -The nurse stated he would ask the resident's primary care physician to see if the PCP would want to obtain a repeat vitamin D level for the resident. -He would contact the facility to communicate any new physician orders to the facility. Interview with the Supervisor-In-Charge (SIC) on 5/27/15 at 2:06pm revealed: -He had been the SIC in the facility since 1/29/15. -He had been administering the Vitamin D3 to Resident #1 daily "this past month" as the MAR indicated. -The Vitamin D3 had come from the facility pharmacy. -The Administrator or Lead SIC were responsible for faxing new FL2's to the facility pharmacy. -He was responsible for making sure the MARs were correct each month for all the residents. B. Review of Resident #3's current FL2 dated 2/16/15 revealed: -Diagnoses included vascular dementia with frontal lobe disinhibition, chronic obstructive pulmonary disease, diabetes, and osteoarthritis. -A physician's order for Clobetasol (used to treat redness and itching) topical 0.05% apply to hands twice a day. Review of Resident #3's March, April, and May 2015 MAR's revealed: -There were no entries, either computer generated or handwritten, for Clobetasol topical on the residents' MARs. -There were no documented occurrences of this	{C 330}		

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{C 330}	Continued From page 8 medication for Resident #1 for these three months. Interview with the SIC on 5/27/15 at 11:20am revealed: -He applied the Clobetasol cream to Resident #3 "after his bath on his dry spots." -The resident was bathed twice a week. -He applied the Clobetasol cream to "dry spots" on the resident's "back, butt, and arms." -The Licensed Health Professional Support nurse had told him he could use the cream on any "dry spots." Observation of Resident #1's medications on hand in the facility on 5/27/15 at 1:15pm revealed there was no Clobetasol cream on hand for Resident #3. A second interview with the SIC on 5/27/15 at 1:15pm revealed he had just reordered the Clobetasol from the facility pharmacy and the medication should be delivered from the pharmacy "today." Interview with Resident #3 on 5/27/15 at 1:37pm revealed: -"My hands are about cured up." -The circular patches on his hands were caused "by gripping my walker." -He stated the Clobetasol cream was kept in the medication cart. -The cream had "been out for a couple weeks back." Telephone interview with the facility pharmacy on 5/27/15 at 1:40pm revealed: -They had not received a copy of Resident #3's current FL2 dated 2/16/15 with the physician's order for Clobetasol cream.	{C 330}		

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{C 330}	Continued From page 9 -According to their records, the last time they had filled Clobetasol cream for Resident #3 was on 11/7/13. A third interview with the SIC on 5/27/15 at 2:06pm revealed: -He had been working as the SIC in the facility since 1/29/15. -"I just ran out" of the Clobetasol cream for Resident #3. -He had been using the "same tube" of Clobetasol cream for Resident #3 since he had started working in facility and began administering medications. -The facility's Licensed Health Professional Support nurse had "told me to put the cream on any dry places, especially his bottom."	{C 330}		
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	C 342		

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C 342	Continued From page 10 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 observation, interview, and record review the facility failed to assure medication administration records were accurate and complete for 1 of 3 sampled residents (Resident #3). The findings are: A. Review of Resident #3's current FL2 dated 2/16/15 revealed: -Diagnoses included vascular dementia with frontal lobe disinhibition, chronic obstructive pulmonary disease, diabetes, and osteoarthritis. -A physician's order for ProAir HFA (used to treat shortness of breath) 90mcg 1 puff 4 times a day while awake. -A physician's order for Clobetasol (used to treat redness and itching) topical 0.05% apply to hands twice a day. 1. Review of a physician's order for Resident #3 dated 4/28/15 revealed ProAir HFA 90mcg 2 puffs 4 times a day. Review of Resident #3's April 2015 Medication Administration Record (MAR) revealed: -A computer generated entry for ProAir HFA 90mcg inhale 1 puff every four hours while awake at 8am, 12pm, 4pm, and 8pm. -The ProAir HFA 90mcg 1 puff every four hours was documented as administered to the resident from 4/1/15 to 4/31/15 for 124 occurrences out of 124 opportunities.	C 342		

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C 342	Continued From page 11 Review of Resident #3's May 2015 MAR revealed: -A computer generated entry for ProAir HFA 90mcg inhale 1 puff every four hours while awake at 8am, 12pm, 4pm, and 8pm. -The ProAir HFA 90mcg 1 puff every four hours was documented as administered to the resident from 5/1/15 to 5/27/15 for 104 occurrences out of 105 opportunities. Interview with the Supervisor-In-Charge (SIC) on 5/27/15 at 11:21am and 2:06pm revealed: -He administered 2 puffs of the ProAir inhaler to Resident #3. -He had just signed the administration without correcting the number of puffs on the ProAir entry on the MAR. -It was his responsibility to check the preprinted MARs each month when they came in from the pharmacy and to make sure they were accurate. -He would immediately get the ProAir HFA entry corrected on the MARs for Resident #3 to indicate the correct order of 2 puffs for each scheduled dose. Interview with Resident #3 on 5/27/15 at 1:37pm revealed he received 2 puffs from his ProAir inhaler when staff administered it to him. 2. Review of Resident #3's March, April, and May 2015 MARs revealed: -There was no entry for Clobetasol topical 0.05% on the MAR. -There were no documented administrations of Clobetasol on the MAR. Interview with the SIC on 5/27/15 at 11:20am, 1:15pm, and 2:06pm revealed: -He applied the Clobetasol cream to Resident #3 "after his bath on his dry spots."	C 342		

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C 342	Continued From page 12 -The resident was bathed twice a week. -He applied the Clobetasol cream to "dry spots" on the resident's "back, butt, and arms." -The Licensed Health Professional Support nurse had told him he could use the cream on any "dry spots." -He had "just ran out" of the cream, but he had ordered the medication from the pharmacy and it "should be in today" from the pharmacy. Interview with Resident #3 on 5/27/15 at 8:45am and 1:37pm revealed: -He was getting his medications on time from facility staff. -He felt he was getting the correct medications. -He never ran out of his medications. -The Clobetasol cream was prescribed to treat the circular patches on the palms of his hands which were caused "by gripping my walker." -"My hands are about cured up." -He stated the Clobetasol cream was kept in the medication cart. -The cream had "Been out for a couple weeks back." Interview with the Supervisor-In-Charge (SIC) on 5/27/15 at 2:06pm revealed: -It was his responsibility to check the preprinted MARs each month when they came in from the pharmacy and to make sure they were accurate. -He had "missed" getting an entry on the MAR for the Clobetasol cream, so administrations of the medication could be documented.	C 342		