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SERENITY LIVING #4	2127 MCCRAW ROAD MOORESBORO, NC 28114

(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 Cleveland County DSS completed an annual survey on 05/05/21 - 05/07/21.	C 000		
C 034	10A NCAC 13G .0302(n) Design and Construction 10A NCAC 13G .0302 Design and Construction (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was a current fire inspection report available for review. The findings are: Review of the county Fire Marshal inspection report dated 07/19/19 revealed an inspection was completed on 07/19/19 and there were no violations to the Fire Code of the State of North Carolina was documented. Telephone interview with the Administrator on 05/04/21 at 12:06pm revealed: -He was responsible for making sure the inspections were completed. -The last fire inspection was completed on 07/19/19 before he became the Administrator in September 2019. -He was responsible for notifying the fire marshal by 07/19/20, but he did not because of COVID-19 and he did not think the fire marshal was completing inspections at that time.	C 034		

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C 034	Continued From page 1 -He did not notify the fire marshal's office to inquire if or when the inspections would be completed. Telephone interview with the County Fire Marshal on 05/05/21 at 8:33am revealed: -The Inspector was last at the facility on 07/19/19. -There were no concerns documented on the inspection report -There should be annual fire and safety inspections done for the facility. -The facility was responsible to contact the Fire Marshal's office regarding scheduling an annual fire inspection. -There was no documentation regarding the facility contacting the office for a fire and safety inspection for 2020 or 2021. Review of the facility's Fire Drills revealed: -A fire evacuation drill was documented on 03/19/21 at 4:37pm for one staff and three residents. -Evacuation time was documented to begin at 4:37pm and ended 37 seconds later.	C 034		
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.	C 078		

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C 078	Continued From page 2 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. The findings are: Observation of the metal railing on the side ramp and steps on 05/05/21 at 1:19pm revealed: -There was an 8' section where the metal railing was rusted at the bottom that the bottom part of the railing was missing, exposing sharp rusted metal. -The railing had rusted areas on the top, bottom and individual posts. -The vertical posts were rusted away and could not support the weight of a person requiring weight bearing support of a hand rail. Telephone interview with the County Fire Marshal on 05/05/21 at 8:33am revealed: -The Inspector was last at the facility on 07/19/19. -The rusted out metal on the railing could pose a safety issue if someone were to fall. It could cause a severe laceration and tetanus. Interview with the Administrator on 05/04/21 at 2:31pm revealed: -The railings at the front door were rusted since 08/15/19. -He reported them to the owners on 01/10/20 and was told they were "grand-fathered in" and they did not need to be replaced. -It was the responsibility of the owners to replace. Interview with a Supervisor-in-Charge (SIC) on 05/04/21 at 10:35am revealed: -The railing was rusted since August 2019.	C 078		

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C 078	Continued From page 3 -The Administrator told her the owners were responsible for replacing the railing. -There had not been anyone come out and give the Administrator or the owners a quote to fix the railing. Interview with a resident on 05/05/21 at 1:00pm revealed: -The railing on the side of the home and in the front of the home were rusted for a long time. -He used the side entrance most of the time. -The Administrator told him to stay away from the railing but that was hard to do since it was at the entrance he used. -The railing would not hold him if he used them or if he fell into them. -The railing was so sharp they could "rip" his arm or leg off if he fell near them or on them. Observation of the resident common bathroom on 05/05/21 at 1:05pm revealed: -The toilet was loose at the base and shifted to the left or right when sitting down. -The cabinet under the sink contained a powder cleaning agent with bleach. -The cabinet under the sink contained 3 used rusted disposable razors. -There were broken tiles on the floor, at the left side of the bath tub. Interview with the Administrator on 05/05/21 at 1:10pm revealed: -The owners were responsible for fixing the bathroom tiles, and toilet. -They were broken when he took over in August of 2019. -The owners were aware but did not fix them. Interview with the owner on 05/05/21 at 1:15pm revealed:	C 078		

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C 078	Continued From page 4 -She was responsible for the "structure" of the facility, meaning the structure of the house outside. -The Administrator was responsible for the "inside stuff" like the toilet, ceiling, filters and vents.	C 078		
C 097	10A NCAC 13G .0316 (b) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (b) The building shall be provided with smoke detectors as required by the North Carolina State Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure a working fire alarm system was always maintained as evidenced by failing to change the batteries in one smoke detector and replacing the second smoke detector in the dining room after it fell from the ceiling. The findings are: Observation on 05/05/21 from 11:45am-12:00pm and revealed: -There was a chirping/beeping sound heard every few seconds coming from one smoke detector located in the hallway near a resident's bedroom and the staff medication room.	C 097		

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C 097	Continued From page 5 -The smoke detector located in the dining room was missing. Interview with a medication aide (MA) on 05/05/21 at 12:11pm revealed: -The smoke detector in the hallway had been beeping since this morning. -On 05/05/21, he notified the Administrator the smoke detector was beeping, and he needed batteries for it. -He was not able to locate batteries in the facility to use in the smoke detector. -The batteries were changed every 6 months to a year. -He did not know what happened to the smoke detector in the dining room. -The smoke detector was in the dining room last December 2020. -The Administrator or the Supervisor-in-Charge (SIC) was responsible for changing the batteries in the smoke detectors. Observation of the kitchen drawer on 05/05/21 at 12:30pm revealed: -The Administrator pulled out batteries for the hall way smoke detector from the kitchen drawer. -In the kitchen drawer was the missing smoke detector from the dining room. -The smoke detector in the drawer from the dining room did not contain batteries. Interview with the Administrator on 05/05/21 at 12:30pm revealed: -The MA did not notify him about the smoke detector beeping in the facility. -There were batteries in the kitchen drawer. -He thought the smoke detector fell from the ceiling in the dining room in December 2020. -He did not get a new one because he forgot about it.	C 097		

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C 097	Continued From page 6 Interview with a resident on 05/05/21 at 1:00pm revealed: -He noticed the smoke detector beeping the "other day". -He said, "it beeped a lot so he thought that meant it worked".	C 097		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was tested upon hire for tuberculosis (TB) disease. The findings are: Review of the facility's personnel records on 05/07/21 revealed: -Staff B, was a medication aide (MA), personal care aide (PCA) and did not have a personnel record.	C 140		

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C 140	Continued From page 7 -Staff B was hired in 2016. -Staff B received a TB skin test on 06/15/16. -Staff B did not have documentation for a second TB skin test result. Observation on 05/07/21 at 11:45am revealed Staff B was working in the medication room. Telephone interview with Staff B on 05/07/21 at 3:30pm revealed: -He had been working at the facility since 2016. -He did not have the documentation of his TB skin tests in his personnel file at the facility. -He received his TB tests from the college he attended years ago but they would not give him the results because he was not a student there any more. -He checked with his primary care physician and the local health department and they did not have a record of his TB skin tests. -He had documentation of one TB skin test in his staff record, dated 06/15/16 that was negative. Telephone interview with the Administrator on 05/07/21 at 1:50pm and 4:37pm revealed: -Staff B was the Administrator's family member. -Staff B had TB skin test results somewhere in the facility, but he did not know where. -Staff B's 2nd TB skin was required within 2 weeks of the hire date. -He was responsible for maintaining staff records and ensuring TB skin tests were completed on all staff upon hire and available for review. -Staff B's records were difficult to locate due to the fact that he typically worked at a different house and had not worked much recently due to being at college.	C 140		

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C 145	Continued From page 8	C 145		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 3 sampled staff (Staff B) had been checked on the North Carolina Health Care Personnel Registry (HCPR) prior hire. The findings are: Review of the facility's personnel records on 05/06/21 and 05/07/21 revealed: -Staff B was hired in 2016. -Staff B, was a medication aide, personal care aide and did not have a personnel record. -There was no documentation of a HCPR check being completed for Staff B. Observation on 05/07/21 at 11:45am revealed Staff B was working in the medication room. Telephone interview with Staff B on 05/07/21 at 3:30pm revealed: -He had been working at the facility since 2016. -He could not recall if they performed a HCPR on him when he was hired. Telephone interview with the Administrator on 05/07/21 at 1:50pm revealed: -Staff B was the Administrator's family member.	C 145		

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C 145	Continued From page 9 -Staff B was hired in 2016 and worked at his other facility. -He ran Staff B's HCPR when he was hired but he could not locate the original copy. -He was responsible for maintaining staff records and ensuring the HCPR was completed on all staff upon hire and available for review. Review of staff B's HCPR check on 05/06/21 revealed there were no findings.	C 145		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician notification to meet the routine and acute health care needs of 1 of 3 residents (Resident #3) related to wound care, laboratory orders and a no sugar diet. The findings are: Review of Resident #3's current FL2 dated 09/24/20 revealed diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism. a. Review of Resident #3's physician order dated 04/12/21 revealed: -An order for a referral to a surgeon.	C 246		

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C 246	Continued From page 10 -An order to keep the wound covered. -An order to perform good handwashing. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -Resident #3 had a history of diabetes. -On 04/12/21, Resident #3 was seen in the office for a lab draw and complained about a red, painful swollen bump located on his left lower back. -The boil was an 11cm area located on the lumbar spine with the center draining foul smelling, purulent (thick yellow pus) drainage. -She cultured the wound on 04/12/21 and the swab showed Methicillin-Resistant Staphylococcus Aureus (MRSA is a gram-positive bacteria responsible for several difficult to treat infections). -Since the abscess was greater than 5cm, she wanted him to see the surgeon. -MRSA could be spread to other residents or other parts of Resident #3's body very easily by transferring the bacteria by touch or exposing the area to clothing, or other objects if left uncovered. -On 04/12/21, she ordered for the wound to be kept covered and dressing changes every day and as needed in case of soiling and a medication to treat the infection. -On 04/12/21, she ordered for the resident and staff to use good hand washing to prevent the spread of MRSA. -Keeping the area covered and good handwashing was "a must" to prevent the spread of MRSA. -MRSA lived on the skin and it was very contagious. -When the abscess showed increased signs of infection such as with Resident #3, she would refer them to the surgeon.	C 246		

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C 246	Continued From page 11 -It was her experience with abscess like this to start off with dressing changes and medications, refer them to the surgeon and allow the surgeon treat with dressing changes and evaluate the need for surgical intervention. -She educated him on how MRSA was spread and the seriousness of getting the infection under control to prevent the spread of the infection which could cause Resident #3 to become septic, which could be life threatening. Review of Resident #3's physician's order dated 04/20/21 revealed: -An order to keep lesion on back covered with Neosporin and a Band-Aid. -An order to change the Band-Aid and apply Neosporin daily after shower. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -On 04/20/21, Resident #3 was seen in the office and Resident #3 had not seen the surgeon yet, so she ordered more of the antibiotic to treat the infection and to keep the lesion on the back covered with Neosporin and a Band-Aid. -The dressing was to be changed daily after a shower. -On 04/20/21, there was no dressing on Resident #3's wound and when she inquired about it. -Resident #3 reported to her, he "was told to keep it open to air" by someone at the facility. -Resident #3 was due to see the surgeon on 04/29/21. Review of Resident #3's physician's order dated 04/29/21 revealed to pack the left lower back abscess with 1/4-inch Nu Gauze (special sterile wicking gauze strips) packing daily.	C 246		

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C 246	Continued From page 12 Telephone interview with Resident #3's Surgical office representative on 05/06/21 at 8:09am revealed: -Resident #3 was referred to the office by Resident #3's primary care physician (PCP) on 04/12/21. -Resident #3 was first seen on 04/29/21 for a surgical consult related to Resident #3's lower back abscess. -The abscess had "spontaneously decompressed" a couple of days ago. -The abscess did not appear to be draining any further. -The abscess was approximately 3cm deep. -The wound was cleaned and irrigated with saline. -The wound was packed with ¼-inch Nu Gauze, a special sterile gauze soaked in saline. -On 04/29/21, he wrote an order to pack the wound daily with the ¼ inch Nu Gauze soaked in saline by the facility staff. -It was the surgeon's expectation the wound be packed as ordered on a daily basis because the wound could not heal from the inside out as allowed by the packing. -Without the packing the wound could heal over superficially and allow the abscess under the skin to fester. -If he had been informed by the facility staff they could not perform the daily packing with the ¼ inch Nu Gauze, then he would have referred Resident #3 to the wound clinic for the daily wound care. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -Resident #3 was seen last in her office on 05/04/21 for an injection and Resident #3 reported to her the wound was "healed".	C 246		

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-She did not look at the wound because she thought the surgeon had already seen Resident #3 and the abscess was taken care of.
-Resident #3 had several issues that affected his wound healing, including his diabetes as evidence by an elevated Hgb A1C of 10.3 (a Hgb A1C is a blood test that shows a 3 month average of blood glucose levels, a normal level is below 5.7) and had MRSA which with the combination increased Resident #3's risk for sepsis.
-She expected the facility to follow the orders written for Resident #3's wound care and notify her or the surgeon with any concerns.
-She was surprised to find out that the facility was to pack the wound with ¼ inch Nu Gauze daily because it was her understanding the facility staff could not pack wounds.
-She expected Resident #3 to go to the wound clinic which was where she sent residents if home health could not come in to do the packing.
-There were no notifications to her related to wound care in Resident #3's record.

Telephone interview with Resident #3's guardian from the local Department of Social Services on 05/06/21 at 11:15am revealed:
-She last spoke to Resident #3 on 03/01/21.
-The last contact with the facility was in April 2021 related to a peer support program and there was no mention of Resident #3 going to a physician related to an abscess.
-She was not aware of the abscess on 04/12/21.
-She was not notified about the referral to the surgeon's office on 04/29/21.
-She was not notified of the daily dressing changes from the 04/29/21 order.
-It was her understanding the facility staff could not perform "wound packing" like was ordered.
-She would have authorized Resident #3 to see the wound clinic to pack the wound if she had

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C 246	Continued From page 14 known about it. -She had concerns about the wound getting the care required to prevent further infection. Telephone interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 1:53pm revealed: -She was aware of the wound packing order dated 04/29/21 only after a medication aide (MA) informed her that there was only one MA Resident #3 would allow to let the wound be packed. -She was on leave at the time and she was notified. -She was told by a MA at the facility, on 05/06/21 during this telephone conversation after she called the MA and put the MA on speaker, the MA "packed" the wound with the "1/4 Nu Gauze" but did not document it because there was no place to document it. Telephone interview with a medication aide (MA) on 05/06/21 at 1:47pm revealed: -The MA was not aware that Resident #3 had an order to pack his wound daily. -If the MA saw the order then she would have packed the wound daily with gauze. -The MA reported the facility had Nu Gauze on hand. Telephone interview with a second MA on 05/06/21 at 2:05pm revealed she new what Nu Gauze was and packed Resident #3's wound daily. Observation of gauze on hand on 05/07/21 at 9:20am revealed: -A box of individually wrapped 2 inch x 2 inch gauze pads. -Nu Gauze was not in the facility.	C 246		

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C 246	Continued From page 15 An interview with the second MA on 05/07/21 at 9:30am revealed: -She did not know what Nu Gauze was. -The packing she used was 4x4's that she thought was Nu Gauze and could not explain how she packed the wound with 4x4's. Review of the Licensed Health Professional Support (LHPS) revealed: -The skill of wound dressing was marked, "non-applicable". -The form was signed by the MAs, a Registered Nurse and the SIC. Interview with the SIC on 05/07/21 at 12:40pm revealed: -She was with Resident #3 on 04/12/21, at the appointment to receive his monthly injection of a medication. -Resident #3 told her about a bump on his back the night before so she informed the PCP about it. -The PCP looked at it and cultured it. -She was told that it looked like MRSA and was greater than 5cm so Resident #3 needed to see the surgeon and started him on an antibiotic. -She was informed by the PCP the abscess was contagious, so keep it covered and use good handwashing. -There was not any ¼ inch Nu Gauze located in the facility. -She was not aware the MAs were not permitted to pack wounds per the Licensed Health Profession Support (LHPS) as this type of dressing required a skilled Registered Nurse. -The MAs were responsible for notifying her and the physician related to Resident #3's wound order.	C 246		

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C 246	Continued From page 16 Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed: -He was not aware of the orders dated 04/20/21 for Resident #3 and expected the staff to follow all orders written by a physician. -He expected the staff to notify the physician regarding the packing order since MAs were not allowed to pack wounds. -He expected the staff to notify the physician regarding a referral for home health to assist with the packing order. Refer to telephone interview with the Administrator on 05/07/21 at 4:30pm. b. Review of Resident #3's laboratory values dated 04/12/21 revealed a hemoglobin A1c (blood test that measures the average blood sugar levels over the last 3 months) of 10.3% (well controlled diabetics have a A1c less than 7%). Review of Resident #3's physician order dated 04/20/21 revealed an order to avoid sugar. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -Resident #3 was diagnosed with pre-diabetes on 02/25/20 with a Hemoglobin Hgb A1C of 6.4 (normal was 4.8-5.5) and placed on a regular diet. -On 04/12/21, Resident #3's Hgb A1C was 10.3. -According to her "communication with the facility note" dated 04/15/21, her assistant notified the facility on 04/15/21 with the new order for Resident #3 to "avoid sugar" and "no white foods". -The white foods were potatoes, rice and bread which were considered "carbohydrates" because they increase blood sugars.	C 246		

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-Refined sugars can suppress the function of the immune system by reducing the amount of white blood cells (WBCs) produced to fight infection.
-Resident #3 was diagnosed with Methicillin-resistant Staphylococcus Aureus (MRSA is a gram-positive bacteria responsible for several difficult to treat infections) on 04/12/21.
-Resident #3 required no sugar, sodas and white foods not only to decrease his high Hgb A1C but for productive wound healing as well.
-Without this diet Resident #3's blood sugar could continue to increase putting Resident #3 at a greater risk of complications related to uncontrolled diabetes including, wound healing, neuropathy (weakness, numbness and pain from nerve damage related to diabetes), retinopathy (damage to the retina which can lead to blindness), nephropathy (damage to the kidney resulting in kidney failure), and cardiovascular disease (including heart attack and stroke).
-Resident #3 was at a greater risk for a heart attack, stroke or nephropathy because Resident #1 was also diagnosed with high blood pressure and high cholesterol and with the triglycerides levels of 733 (normal 0-149) on 04/12/21, she increased Resident #1's medication to treat his high cholesterol and a medication to help control Resident #1's blood sugar along with the diet change on 04/20/21.
-She expected the facility staff to give Resident #1 a no sugar diet and to avoid white food to lower Resident #3's Hgb A1c to prevent the complications of diabetes.

Interview with Supervisor in Charge (SIC) on 05/07/21 at 1:05pm revealed:
-She was on leave when Resident #3 received an order for a therapeutic diet.
-The facility did not accept residents on therapeutic diets due to it was difficult for the

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facility to meet their dietary needs.
-If a resident was started on a therapeutic diet the SIC would send a 30-day letter to their guardian for the resident to be placed in another facility.

Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed he was not aware of the orders dated 04/20/21 for Resident #3 and if had been aware of the special diet he would have issued Resident #3 a 30 day notice discharge because they could not make special meals for every resident, because of the time and cost.

Refer to telephone interview with the Administrator on 05/07/21 at 4:30pm.

c. Review of Resident #3's physician order dated 09/15/20 revealed an order for Resident #3 to be fasting for the next office visit.

Telephone interview with Resident #3's PCP on 05/07/21 at 9:28:am revealed:
-Resident #3 was to have a Basic Metabolic Panel (BMP is a test that reveals information about the body's fluid balance, electrolytes and kidney function), Hgb A1c and a lipid panel (a blood test that measures total and different types of cholesterol) completed on 09/24/20.
-Resident #3 did not come to the appointment.
-There was no communication recorded in his record as to why.
-Resident #3's labs were not drawn until 04/12/21.
-She wanted the labs drawn in order to check Resident #3's Hgb A1c because the last Hgb A1c was on 02/25/20 and it was 6.4 (normal was 4.8-5.5), and to check the triglycerides which were 138 (normal was 0-149).
-Resident #3 had a history of diabetes, high blood pressure and high cholesterol.

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-Because Resident #3 did not have that lab draw on 09/24/21, there was a delay of treatment from 09/24/21 to 04/12/21.
-Resident #3's Hgb A1c on 04/12/21 was 10.3 and the triglycerides were 733.
-If she had known the values of the Hgb A1c and the triglycerides in 09/24/20, she could have adjusted his medications and could have prevented those values from getting too high which increased Resident #3's risk of complications related to uncontrolled diabetes including, wound healing, neuropathy (weakness, numbness and pain from nerve damage related to diabetes), retinopathy (damage to the retina which can lead to blindness), nephropathy (damage to the kidney resulting in kidney failure), and cardiovascular disease (including heart attack and stroke).

Interview with the SIC on 05/05/21 at 2:20pm revealed:
-She was not able to take Resident #3 to have labs drawn during COVID-19.
-Resident #3 went to the PCP's office monthly and received his medication injection.
-During a visit for an injection on 04/12/21, she inquired about another medical issue Resident #3 was having and was seen by the PCP then.
-She did not think the labs could be done the same way with previous injection visits.

Refer to telephone interview with the Administrator on 05/07/21 at 4:30pm.

_____

Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed:
-When a resident was sent to any appointment, they were sent with a "examination or contact with a doctor" form which was to be filled out by the

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C 246	Continued From page 20 physician with new orders. -The MAs were responsible for receiving a copy from the resident after they returned from the visit. -The MAs were responsible for faxing all orders to the pharmacy, add or change any orders to the MAR and to notify the SIC. -The MAs were also responsible for notifications to the PCP as needed and a notification to the SIC as well. -He expected the staff to follow all orders written by a physician. The facility failed to notify the surgeon about the need for a home health referral or a referral to a wound clinic for a resident's wound care for a resident who had a recent diagnoses of diabetes type 2 and a contagious skin infection of MRSA, which was putting Resident #3 at risk as well as putting the other residents at risk for a contagious skin infection, and with orders to pack the infected wound. The facility also failed to notify the resident's PCP of their inability to initiate a no sugar, no white food diet. This resulted in the resident's risk of diabetic complications and delayed wound healing. This failure resulted in the risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 4, 2021.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care	C 249		

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C 249	Continued From page 21 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Type B Violation Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (Resident #3) with orders for finger stick blood sugar (FSBS) checks. The findings are: Review of Resident #3's current FL2 dated 09/24/20 revealed diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism. Review of physician order on 04/20/21 revealed an order to check blood sugars 2 hours after supper. Review of Resident #3's April 2021 Medication Administration Record (MAR) revealed there was no entry for a FSBS to be checked 2 hours after supper daily. Telephone interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 1:53pm revealed:	C 249		

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C 249	Continued From page 22 -She was not aware of the order dated 04/20/21 for the FSBS to be checked 2 hours after supper because she was out on leave. -The MAs were responsible for receiving orders from the residents after every visit to the physician. -Those orders were to be faxed to the pharmacy and handwritten on the Medication Administration Record (MAR). -The FSBS were to be obtained as ordered and documented on the MAR. -The facility did not have a glucose monitor for Resident #3. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -Resident #3 had a diagnosis of diabetes. -On 02/25/20, Resident #3's Hgb A1C was 6.4 (a Hgb A1C is a blood test that shows a 3 month average of blood glucose levels, a normal level is below 5.7). -On 04/12/21, Resident #3's Hgb A1C was 10.3. -Without Resident #3's blood sugar checks on a daily basis, there was no way to monitor Resident #3's FSBS and this could increase Resident #3's risk of complications related to uncontrolled diabetes including, wound healing, neuropathy (weakness, numbness and pain from nerve damage related to diabetes), retinopathy (damage to the retina which can lead to blindness), nephropathy (damage to the kidney resulting in kidney failure), and cardiovascular disease (including heart attack and stroke). -Resident #3 was at a greater risk for a heart attack, stroke or nephropathy. -She increased Resident #3's medication to treat his blood sugars along with the diet change on 04/20/21. -She expected the facility staff to check Resident	C 249		

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C 249	Continued From page 23 #3's FSBS daily and report them to her on the next visit in order for her to make changes to his diabetic treatment to prevent the complications of diabetes. Telephone interview with a medication aide (MA) on 05/07/21 at 3:30pm revealed: -He worked in the evening and had not checked Resident #3's FSBS. -There was no order in the MAR and there was no glucose monitor for him to use to check the FSBS. Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed he was not aware of the orders dated 04/20/21 for Resident #3 and expected the staff to follow all orders written by a physician. Refer to telephone interview with the Administrator on 05/07/21 at 4:30pm. _____ Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed: -When a resident was sent to any appointment, they were sent with an "examination or contact with a doctor" form which was to be filled out by the physician with new orders. -The MAs were responsible for receiving a copy from the resident after they returned from the visit. -The MAs were responsible for faxing all orders to the pharmacy, add or change any orders to the MAR and notify the SIC. -The MAs were also responsible for notifications to the PCP as needed and a notification to the SIC as well. -He expected the staff to implement all orders written by a physician.	C 249		

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C 249	Continued From page 24 The facility failed to implement orders to obtain FSBS for a resident, 2 hours after supper in a resident with a recent diagnoses of diabetes Type 2, and with a Hgb A1C of 6.4 increased to 10.3 in 14 months (#3), which resulted in a delay of treatment by the PCP for the treatment of his diabetes. This failure was detrimental to the health, safety and well being of the resident which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2021.	C 249		
C 269	10A NCAC 13G .0904 (c-6) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a registered dietitian. The facility shall maintain verification of the registered dietitian's approval of the therapeutic diets which shall include an original signature by the registered dietitian and the registration number of the dietitian. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to provide a therapeutic menu signed by a	C 269		

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dietitian for a therapeutic diet for 1 out of 3 residents (Resident #3).

The findings are:
Observation during tour of the facility on 05/05/21 at 11:45am revealed that there was no menu posted.

Review of Resident #3's current FL2 dated 09/24/20 revealed:
-Diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism.
-Regular diet was ordered.

Review of Resident #3's physician communication notes with the facility on 04/15/21 revealed that Resident #3 should avoid sugar as well as white foods.

Interview with the medication aide (MA) on 05/05/21 at 11:59am revealed:
-Only breakfast was prepared in the facility.
-Lunch and supper were provided by the facility next door.

Interview with MA from the facility that supplied lunch and supper on 05/04/21 at 8:26am revealed:
-Second shift facility employees typically made the menu for the month but that had not been completed.
-There had not been a menu at all posted in the facility in several months.

Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28:am revealed:
-Resident #3 was diagnosed with pre-diabetes on

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02/25/20 with a Hemoglobin (Hgb) A1c (an Hgb A1c is a blood test that shows a 3 month average of blood glucose level, normal level is below 5.7%) of 6.4% and placed on a regular diet.
-On 04/12/21, Resident #3's Hgb A1C was 10.3%.
-According to her "communication with the facility note" dated 04/15/21, her assistant notified the facility on 04/15/21 with the new order for Resident #3 to "avoid sugar" and "no white foods".
-The white foods were, potatoes, rice and bread which were considered "carbohydrates" because they increase blood sugars.
-Resident #3 required no sugar, sodas and white foods not only to decrease his high Hgb A1C but for wound healing as well.
-She expected the facility staff to give Resident #3 a no sugar diet and to avoid white food to lower Resident #3's Hgb A1c to prevent the complications of diabetes and to prevent any delayed wound healing.

Interview with Administrator on 05/04/21 at 11:02am and at 12:00pm revealed:
-The binder of menus was in his car because he was trying to organize the menus and recipes.
-Administrator brought in a stack of menus and recipes from his car.
-The staff did not follow an official cyclic menu planned by a dietitian because the residents would not eat all of the food and most of it was thrown away.
-The Administrator allowed staff to pick out recipes that the residents would eat for each meal.
-He previously told the physician that his facility would not accommodate therapeutic diets since they have to prepare meals for other residents.
-If a resident required a therapeutic diet then a 30

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SERENITY LIVING #4	2127 MCCRAW ROAD MOORESBORO, NC 28114

(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 269	Continued From page 27 day discharge letter would be issued to the resident's guardian to place the resident at an alternate facility. Observation on 05/04/21 at 11:02am revealed that all of the menus and associated recipes were for a regular diet and signed by a dietitian.	C 269		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to provide a therapeutic diet as ordered by the resident's physician for 1 out of 3 residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 09/24/20 revealed: -Diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism. -A regular diet was ordered. Review of Resident #3's physician communication notes with the facility on 04/15/21	C 284		

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C 284	Continued From page 28 revealed that Resident #3 should have taken Metformin 500 2 tablets twice per day (a medication used to lower blood glucose levels) and avoided sugar as well as white foods. Review of Resident #3's physician order on 04/20/21 revealed a sugar free diet order and fasting blood sugar levels 2 hours after eating. Review of Resident #3's laboratory values on 04/12/21 revealed a hemoglobin A1c (blood test that measures the average blood sugar levels over the last 3 months) of 10.3% (well controlled diabetics have a A1c less than 7%). Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28:am revealed: -Resident #3 was diagnosed with pre-diabetes on 02/25/20 with a Hemoglobin (Hgb) A1c (an Hgb Alc is a blood test that shows a 3 month average of blood glucose level, normal level is below 5.7%) of 6.4% and placed on a regular diet. -On 04/12/21, Resident #3's Hgb A1C was 10.3. -She increased medication to help control Resident #3's blood sugar along with the diet change on 04/15/21. -According to her "communication with the facility note" dated 04/15/21, her assistant notified the facility on 04/15/21 with the new order for Resident #3 to "avoid sugar" and "no white foods". -The white foods were, potatoes, rice and bread which were considered "carbohydrates" because they increase blood sugars. -She expected the facility staff to give Resident #3 a no sugar diet and to avoid white food to lower Resident #3's Hgb A1c to prevent the complications of diabetes and delayed wound healing.	C 284		

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C 284	Continued From page 29 Interview with medication aide (MA) on 05/07/21 at 3:30pm revealed: -He was at the facility on 04/20/21, and left by 9:00am, and did not see the order dated 04/20/21 to avoid sugar diet. -He was not aware of the order at all. -When a resident returned from the physician's office, the staff were to fax the orders to the pharmacy, handwrite the orders onto the Medication Administration Record (MAR) and notify the SIC. -The SIC at the time was out on leave. -There was a second SIC the notification should have been made to. Interview with Supervisor in Charge (SIC) on 05/07/21 at 1:05pm revealed: -She was on leave when Resident #3 received an order for a therapeutic diet. -The facility did not accept residents on a therapeutic diet due to it was difficult to meet their dietary needs. -If a client was started on a therapeutic diet the SIC would send a 30 day letter to their guardian for the resident to be placed in another facility. Interview with a second MA on 05/05/21 at 1:30pm revealed: -He was working on 04/20/21, ater 9:00am and verified his signature on the MAR. -He was the only staff working in the facility from 9:00am to 9:00pm on 04/20/21. -He was not aware of the order dated 04/20/21 from Resident #3's PCP. -When Resident #3 returned from the PCP visit, there were no orders. -He did not know where the orders came from in Resident #3's record. -The MA was responsible for receiving the order,	C 284		

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C 284	Continued From page 30 notifying the SIC and hand writing the order on the MAR. -The SIC and the Administrator informed the staff that they were not to cook for special diets, "all regular". Telephone interview with a third MA on 05/05/21 at 4:30pm revealed: -There was only one MA working on 04/20/21 who received the order. -The MA was responsible for notifying the SIC of the order for the diet change. Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed he was not aware of the orders dated 04/20/21 for Resident #3 and if had been aware of the special diet he would have issued Resident #3 a 30 day notice discharge because they could not make special meals for every resident, because of the time and cost. _____ The facility failed to provide a therapeutic diet to help control a resident's blood sugar and aid in the healing of an infection (Resident #3). This failure resulted putting the resident at a greater risk of complications related to uncontrolled diabetes including, wound healing, neuropathy retinopathy, nephropathy and cardiovascular disease, including heart attack and stroke. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/07/21 for this violation. CORRECTION DATE FOR THE TYPE B	C 284		

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C 284	Continued From page 31 VIOLATION SHALL NOT EXCEED JUNE 21, 2021.	C 284		
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, 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: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to administer a medication as ordered by the licensed prescribing practitioner and didn't discuss any policies for 2 of 3 sampled residents (#3) related to an antipsychotic, a medication used to treat high blood sugars (Resident #3) and a cholesterol reducing medication (Resident #2). The findings are: Review of Resident #3's current FL2 dated 09/24/20 revealed diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism. a. Review of a physician order dated 04/20/21 revealed an order to discontinue quetiapine	C 330		

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C 330	Continued From page 32 300mg, two times a day. Review of Resident #3's April 2021 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for quetiapine 300mg, 2 times a day. -The quetiapine 300mg, 2 times a day was documented as administered 04/01/21 to 04/30/21, at 8:00am and 8:00pm. -Resident #3 received the quetiapine 60 out of 60 doses in April 2021. Review of Resident #3's May 2021 MAR revealed there was no entry for quetiapine 300mg 2 times a day. Observations of Resident #3's medications on hand on 05/05/21 at 1:16pm revealed: -There was a bubble card with quetiapine fum 300mg tablets. -The quetiapine was dispensed on 04/14/21 with a quanty of 60 tablets. -There were 29 of 60 tablets left. Telephone interview with Resident #3's contracted pharmacy on 05/05/21 at 4:48pm revealed: -There was a discontinue order for the qutiapine from Resident #3's primary care physician (PCP) dated 04/20/21. -The quetiapine was last filled on 04/14/21 for 60 tablets, a 30-day supply and was delivered to the facility on 04/15/21, ready for administration on 04/16/21 at 8:00am. -When the order was discontinued on 04/20/21, there should have been 51 doses left on the card. -The order was discontinued in their system but because the facility had paper MARs, the facility was responsible for discontinuing it on their paper MARS.	C 330		

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C 330	Continued From page 33 -The entry for quetipine would not be on the next month's MAR. Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed: -On 04/20/21, Resident #3 was seen in the office for an injection and a wound issue. -Resident #3 received quetiapine 300mg 2 times a day to help with sleep. -Based on 04/12/21 labs, Resident #3's Hgb A1c was 10.3 (a Hgb A1C is a blood test that shows a 3 month average of blood glucose levels, a normal level is below 5.7) she discontinued the quetiapine because it could also stimulate his appetite. -Resident #3 had gained a significant amount of weight and with the Hgb A1c 10.3, she was trying to keep the blood sugars under control. -She expected the facility staff to discontinue the quetiapine as ordered to decrease the risk of Resident #3 having the increased appetite, and possibly increasing the blood sugars and weight. Telephone interview with the Administrator on 05/07/21 at 4:37pm revealed: -He was not aware of the 04/20/21 order to discontinue the quetiapine 300mg 2 times a day. -The order came in when the SIC was out on leave. -The MAs were responsible for receiving the orders from the resident after every visit to the PCP. -The MAs were responsible for faxing the ordesr to the pharmacy and updating the current MARs and placing the copy in the record. -The copy was in Resident #3's record. -The MAs and SICs were responsible for monthly audits comparing the old, and new MAR with the orders for accuracy and changes.	C 330		

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C 330	Continued From page 34 -He did not know why the order 04/20/21 to discontinue the quetiapine was not processed. Refer to telephone interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 1:53pm. Refer to telephone interview with the Administrator on 05/07/21 at 4:37pm. b. Review of Resident #3's current FL2 dated 09/24/20 revealed an order for metformin 500mg daily with evening meals. Review of Resident #3's April 2021 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for metformin 500mg daily with evening meal. -The metformin 500mg daily with evening meal was documented as administered 04/01/21 to 04/30/21, at 5:00pm. -There was no entry for metformin 500mg 2 tablets, two times a day with meals documented. -There were 30 doses of the metformin 500mg document as administered. Review of Resident #3's May 2021 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for metformin 500mg, 2 tablets, two times a day with food. -The metformin 500mg 2 tablets, two times a day was documented as administered 05/01/21 to 05/05/21, at 8:00am and 8:00pm. -There were 9 doses of the metformin 500mg document as administered. Observations of Resident #3's medications on hand on 05/05/21 at 1:16pm revealed: -There was a bubble card with metformin 500 mg	C 330		

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daily with evening meals.
-The metformin was dispensed on 04/14/21 with a quanty of 30 tablets.
-There were 16 of 30 tablets left.

Review of Resident #3's Hgb A1C dated 04/12/21 revealed a Hgb A1c of 10.3 (a Hgb A1C is a blood test that shows a 3 month average of blood glucose levels, a normal level is below 5.7).

Telephone interview with Resident #3's primary care physician (PCP) on 05/07/21 at 9:28am revealed:
-Based on 04/12/21 labs, Resident #3's Hgb A1c was 10.3, she ordered an increase in Resident #3's metformin 500mg daily to 1000mg two times a day on 04/15/21.
-On 04/15/21, her nurse faxed the new orders to the pharmacy and called the facility staff and gave them a verbal order for metformin 500mg, 2 tablets, two times a day with food.
-Resident #3 had gained a significant amount of weight and with the Hgb A1c 10.3, she was trying to keep the blood sugars under control.
-She expected the facility staff to increase the metformin as ordered in efforts to decrease the risk of Resident #3 blood sugars and putting Resident #1 at a greater risk of complications related to uncontrolled diabetes including, wound healing, neuropathy (weakness, numbness and pain from nerve damage related to diabetes), retinopathy (damage to the retina which can lead to blindness), nephropathy (damage to the kidney resulting in kidney failure), and cardiovascular disease (including heart attack and stroke).

Telephone interview with Resident #3's contracted pharmacy on 05/07/21 at 12:00pm revealed:
-Resident #3's PCP faxed over an order for

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C 330	Continued From page 36 Metformin 500mg 2 tablets two times a day with food on 04/15/21. -The Metformin was not dispensed because the facility had just received Metformin 500mg tablets with evening meals, quanity of 30, dispensed on 04/14/21 and delivered to the facility on 04/15/21. -This required an "order change" sticker on the medication at the facility and to use the remaining doses and reorder when the medication was about out. -The order change would have given Resident #3, 7 days worth of the metformin 500mg, 2 tablets two times a day with food before reordering the medication. -There was no request for a refill from the facility. -It was the facility staff responsibility to notify the pharmacy of a refill need. Refer to telephone interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 1:53pm. Refer to telephone interview with the Administrator on 05/07/21 at 4:37pm. _____ Telephone interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 1:53pm revealed: -She was not aware of the orders dated 04/20/21. -She was on leave at the time. -The medication aides (MAs) were responsible for receiving all orders from the physician visits and faxing them to the pharmacy. -The MAs were responsible for discontinuing the medication on the MAR. -The MAs were responsible for end of the month audits comparing the new pre-printed MAR to the orders and the previous month MARs. -She and the other SIC were responsible for the second check after the MAs performed theirs.	C 330		

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C 330	Continued From page 37 -Since she was out on medical leave, there were some things that were missed. Telephone interview with the Administrator on 05/07/21 at 4:37pm revealed: -He received a call from the Registered Nurse (RN) from Resident #3's PCP office on 04/15/21, with new verbal orders. -He explained to the RN the facility did not take orders over the phone and they needed to be faxed to the pharmacy and the facility. -The reason the orders were to be faxed to the facility was because they would have a copy for the resident's record. -He expected the PCP to fax order to the pharmacy. -The pharmacy would update the MARs and print on the new MAR next month. -The MAs were responsible for updating the current MARs. -The MAs and SICs were responsible for monthly audits comparing the old, and new MAR with the orders for accuracy and changes. -With one of the SICs on leave during April 2021, the audits were missed. -He did not call the nurse back to remind her to fax the order to him. 2. Review of current dated FL2 for Resident #1 revealed: -Diagnoses included schizophrenia, reflux esophagitis, high cholesterol and high triglycerides. -An order for Tricor 145 mg (medication used to treat high cholesterol) taken one time daily. Review of Resident #1's March 2021 MAR revealed: -An entry for Tricor 145 mg once daily scheduled	C 330		

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for 8:00am.
-Tricor 145 mg once daily was documented as administered daily at 8:00am from 03/01/21-03/31/21.
-There was no documentation that the resident refused the medication or that the facility was out of the medication during the month of March 2021.

Review of Resident #1's April 2021 MAR revealed:
-An entry for Tricor 145 mg once daily scheduled for 8:00am.
-Tricor 145 mg once daily was documented as administered daily at 8:00am from 04/01/21-04/30/21.
-There was no documentation that the resident refused the medication or that the facility was out of the medication during the month of April 2021.

Review of Resident #1's May 2021 MAR revealed:
-An entry for Tricor 145 mg once daily scheduled for 8:00am.
-Tricor 145 mg once daily was documented as administered daily at 8:00am from 05/01/21-05/05/21.
-There no documentation that the resident refused the medication or that the facility was out of the medication during the month of May 2021.

Observation of medications on hand revealed that Tricor 145 mg was not available to be dispensed.

Interview with medication aide (MA) on 05/05/21 at 4:00pm revealed:
-His shift started after the morning medications had been administered.
-He called the MA that worked that morning and was told the last dose of Tricor 145 mg was

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administered and a refill was called in to the pharmacy.

Telephone interview with a 3rd MA on 05/07/21 at 11:39am revealed:
-She could not remember the last time she administered Tricor 145 mg to the resident.
-She thought the medication had been "recalled".

Telephone interview with the pharmacy at facility's contracted pharmacy on 05/05/21 at 4:24pm revealed:
-If a refill was needed the facility would fax a label from the medication card to request the refill.
-The pharmacy had not received any recent requests from the facility for Tricor 145 mg to be refilled.
-Tricor 145 mg had been previously filled on 02/02/21, 01/05/21 and 12/07/21 for 30 tablets each time.
-The 30 tablets of Tricor 145 mg that was filled on 02/02/21 arrived at the facility on 02/03/21.
-The resident would have run out of tablets on 03/04/21 if he was being administered the medication as the physician ordered.
-The resident could have an increase in his cholesterol by not taking Tricor 145 mg as directed which could also lead to heart issues.

Attempted interview with Resident #1's physician on 05/07/21 at 9:45am was unsuccessful.

Telephone interview with the Administrator on 05/07/21 at 4:37pm revealed:
-He would expect staff to contact the pharmacy prior to using the last tablet of the resident's medication.
-If the medication was not on hand then he should have been notified and could have picked up a refill from a secondary pharmacy.

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(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 330	Continued From page 40 -He expected staff to write a note on the back of the MAR when the dose of a medication was missed. _____ The facility failed to ensure the quetiapine was discontinued and metformin was administered as ordered, resulting in Resident #3 continuing to receive quetiapine putting him at risk of experiencing increased appetite and the receiving 14 out of the 69 required doses of metformin which resulted in an increased risk for complications of diabetes and weight gain. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2021.	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	C 342		

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C 342	Continued From page 41 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 interviews and record reviews the facility failed ensure the accuracy of the medication administration records (MAR) related to documenting the administration of a cholesterol reducing medication when it had not been administered (Resident #1) and to ensure the documentation on the MARs included the initials of the medication aide (MA) who administered the medication for three residents. The findings are: a. Review of current dated FL2 for Resident #1 revealed: -Diagnoses of schizophrenia, reflux esophagitis, high cholesterol and high triglycerides. an order for Tricor 145 mg (medication used to treat high cholesterol) taken one time daily. Review of Resident #1's March 2021 MAR revealed: -An entry for Tricor 145 mg once daily scheduled for 8:00am. -Tricor 145 mg once daily was documented as administered daily at 8:00am from 03/01/21-03/31/21. -There was no documentation that the resident	C 342		

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C 342	Continued From page 42	C 342		

refused the medication or that the facility was out of the medication during the month of March 2021.

Review of Resident #1's April 2021 MAR revealed:
-An entry for Tricor 145 mg once daily scheduled for 8:00am.
-Tricor 145 mg once daily was documented as administered daily at 8:00am from 04/01/21-04/30/21.
-There was no documentation that the resident refused the medication or that the facility was out of the medication during the month of April 2021.

Review of Resident #1's May 2021 MAR revealed:
-An entry for Tricor 145 mg once daily scheduled for 8:00am.
-Tricor 145 mg once daily was documented as administered daily at 8:00am from 05/01/21-05/05/21.
-There was no documentation that the resident refused the medication or that the facility was out of the medication during the month of May 2021.

Observation of medications on hand revealed that Tricor 145 mg was not available to be dispensed.

Interview with medication aide (MA) on 05/05/21 at 4:00pm revealed:
-His shift started after morning medications had been administered.
-He called the MA that worked that morning and was told the last dose of Tricor 145 mg was administered and a refill was called in to the pharmacy.

Telephone interview with the pharmacy at facility's contracted pharmacy on 05/05/21 at 4:24pm

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revealed:
-If a refill was needed the facility would fax a label from the medication card to request the refill.
-The pharmacy had not received any recent requests from the facility for Tricor 145 mg to be refilled.
-Tricor 145 mg had been previously filled on 02/02/21, 01/05/21 and 12/07/21 for 30 tablets each time.
-The 30 tablets of Tricor 145 mg that was filled on 02/02/21 arrived at the facility on 02/03/21.
-The resident would have run out of tablets on 03/04/21 if he was being administered the medication as the physician ordered.

Telephone interview with facility's previous Licensed Health Professional Support Registered Nurse (LHPS RN) at 9:50am on 05/07/21 revealed:
-She provided brief education to staff on how to document on the MAR.
-The LHPS RN advised staff to document on the back of the MAR anytime that a resident did not take a medication and why the medication was not administered.

Telephone interview with the Administrator on 05/07/21 at 4:37pm revealed:
-He would expect staff to contact the pharmacy prior to using the last tablet of the resident's medication.
-If the medication was not on hand then he should have been notified and could have picked up a refill from a secondary pharmacy.
-He expected staff to write a note on the back of the MAR when the dose of a medication was missed.
-He expected that staff would not document a medication as given if it was not on hand. Staff would be expected to document the reason the

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medication was not taken and follow the appropriate process for obtaining the medication.
b. Review of three residents' Medication Administration Record (MARs) for April 2021 revealed a medication aide (MA) documented the Supervisor-in Charge's (SIC) initials for administering all the medication instead of his own.

Interview with a resident on 05/05/21 at 12:45pm revealed:
-Medications were administered by a named MA in April and May while the SIC was not there.
-Staff E administered the medications most of the time early in the morning but not every time.

Interview with a second resident on 05/05/21 at 12:45pm revealed:
-Medications were administered by a named MA in April and May while the SIC was not there.
-Staff E administered the medications most of the time early in the morning.

Interview with the SIC on 05/06/21 at 1:53pm revealed:
-She was on leave 04/12/21 to 05/03/21.
-The initials in the April 2021 MARs were her initials but in a named MA's handwriting.
-She did not understand why a named MA signed her initials instead of his.
-The named MA was her son.
-The person who administered the medication was to use their initial's on the MAR after the medication was administered by them.

Telephone interview with the named MA on 05/06/21 at 1:54pm revealed:
-He signed the SIC's initials instead of his own.
-He has his MA certification.
-He did not know why he initiated his mother's

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C 342	Continued From page 45 initials to the MAR. -He knew that the staff administering the medications was to initial their own initials to the MAR. Interview with the Administrator on 05/07/21 at 4:37pm revealed the staff whom administered the medications, initial the MAR.	C 342		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that action was taken in response to the quarterly pharmaceutical review recommendation for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 09/24/20 revealed diagnoses of paranoid schizophrenia, mild intellectual disability disorder, type 2 diabetes mellitus, specified personality disorder and hypothyroidism. Review of Resident #3's pharmacy review dated 11/18/20 revealed: -The following recommendations by the consultant for a Basic Metabolic Panel (BMP is a test that reveals information about the body's fluid	C 381		

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balance, electrolytes and kidney function), because Resident #3 was on Hydrochlorothiazide for his blood pressure, Hgb A1c (a Hgb A1C is a blood test that shows a 3 month average of blood glucose levels, a normal level is below 5.7) for his metformin for diabetes, and a lipid panel for his Lipitor for cholesterol.
-The form was signed by the Pharmacist and the Administrator/SIC.
-The form indicated the report should be forwarded to the physician.
-There was no physician's signature documenting it was reviewed by the physician.

Review of Resident #3's pharmacy review dated 02/12/21 revealed:
-The following recommendations by the consultant for a BMP because Resident #3 was on Hydrochlorothiazide for his blood pressure, Hgb A1c for his metformin for diabetes, and a lipid panel for his Lipitor for cholesterol.
-The form was signed by the Pharmacist and the Administrator/SIC.
-The form indicated the report should be forwarded to the physician.
-There was no physician's signature documenting it was reviewed by the physician.

Telephone interview with Resident #3's PCP on 05/07/21 at 9:28:am revealed:
-Resident #3 was to have a BMP, Hgb A1c and a lipid panel completed on 09/24/20.
-Resident #3 did not show up for the appointment.
-There was no communication from the facility staff related to the pharmacy review recommendations.
-She expected the pharmacy recommendations be forwarded to her when the pharmacists requested.

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C 381	Continued From page 47 -Resident #3's labs were not drawn until 04/12/21. -She wanted the labs drawn in order to check Resident #3's Hgb A1c because the last Hgb A1c was on 02/25/20 and it was 6.4 (normal was 4.8-5.5), and to check the triglycerides which were 138 (normal was 0-149). -Resident #3 had a history of diabetes, high blood pressure and high cholesterol. -Because Resident #3 did not have that lab draw on 09/24/21, there was a delay of treatment from 09/24/21 to 04/12/21. -Resident #3's Hgb A1c on 04/12/21 was 10.3 and the triglycerides were 733. -If she had known the values of the Hgb A1c and the triglycerides in 09/24/20 or 11/20/20, she could have adjusted his medications and could have prevented those values from getting too high which increased Resident #3's risk of complications related to uncontrolled diabetes including, wound healing, neuropathy (weakness, numbness and pain from nerve damage related to diabetes), retinopathy (damage to the retina which can lead to blindness), nephropathy (damage to the kidney resulting in kidney failure), and cardiovascular disease (including heart attack and stroke). -Resident #3 was at a higher risk of stroke and heart attack because of his history and the labs were significantly higher on 04/12/21 compared to 02/25/20. Interview with the SIC on 05/05/21 at 2:20pm revealed: -She and the other SIC were responsible for taking the Pharmacist Quarterly Drug Regimen Report to the physician for them to see and give orders. -She was not able to take Resident #3 to have labs drawn during COVID-19.	C 381		

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C 381	Continued From page 48 -Resident #3 went to the PCP's office monthly and receive him medication injection. -She did not think the labs could be done the same day as the injection visits. Telephone interview with the Administrator on 05/07/21 at 4:30pm revealed: -He did not know Resident #3 did not have a BMP, Hgb A1c or lipid level drawn per the recommendations from the 11/18/21 and the 02/12/21 Pharmacist Quarterly Drug Regimen Report. -He did not know Resident #3 did not have the 09/24/20 lab visit. -The 2 SICs were responsible for taking the Pharmacist Quarterly Drug Regimen Report to the physician for them to review. -He did not think labs could be drawn during COVID-19.	C 381		
C 443	10A NCAC 13G .1212 Record of Staff Qualifications 10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS A family care home shall maintain records of staff qulaifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by:	C 443		

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C 443	Continued From page 49 Based on observations and interviews, the facility failed to ensure records of staff qualifications were maintained in the facility for 1 of 3 sampled staff (Staff B). The findings are: Review of the facility's personnel records on 05/06/21 and 05/07/21 revealed: -Staff B was hired in 2016. -Staff B, was a medication aide, personal care aide and did not have a personnel record. Telephone interview with Staff B on 05/07/21 at 3:30pm revealed: -He had been working at the facility since 2016. -He worked at any of the four facility's the Administrator owned. Telephone interview with the Administrator on 05/07/21 at 1:50pm revealed: -Staff B was the Administrator's family member. -Staff B was hired in 2016 and worked at his other facility. -He was responsible for maintaining staff records and ensuring the record was completed on all staff upon hire and available for review. Interview with the Supervisor-in-Charge on 05/07/21 at 1:41pm revealed: -Staff B worked full-time for four family care homes the Administrator owned. -She could not locate a full employee record for Staff B. -The staff records were kept at the main family care home located at a seperate building. -She called another one of their facilities and Staff B's employee records were there. -The medication aide (MA) at the main facility would fax over what they had.	C 443		

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C 443	Continued From page 50 -The MA was not able to fax the complete records for Staff B.	C 443		
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. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care, medication administration and nutrition and food services. The findings: 1. Based on observations, interviews, and record reviews, the facility failed to ensure physician notification to meet the routine and acute health care needs of 1 of 3 residents (Resident #3) related to wound care, laboratory orders and a no sugar diet. [Refer to Tag C0246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (Resident #3) with orders for finger stick blood sugar (FSBS) checks. [Refer to Tag C0249, 10A NCAC 13G .0902(c)(3-4) Health Care (Type B Violation)].	C 912		

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C 912	Continued From page 51 3. Based on record reviews and interviews the facility failed to provide a therapeutic diet as ordered by the resident's physician for 1 out of 3 residents (Resident #3). [Refer to Tag C0284, 10A NCAC 13G .0904(e)(4) Nutrition and Food Services (Type B Violation)]. 4. Based on interviews, and record reviews, the facility failed to administer a medication as ordered by the licensed prescribing practitioner and didn't discuss any policies for 2 of 3 sampled residents (#3) related to an antipsychotic, a medication used to treat high blood sugars (Resident #3) and a cholesterol reducing medication (Resident #2). [Refer to Tag C0330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	C935		

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C935	Continued From page 52 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications to residents had completed the 5, 10, or 15-hour state approved medication administration training course as required. The findings are: Review of Staff B's personnel record on 05/06/21 and 05/07/21 revealed: -Staff B was hired as a personal care aide (PCA) in 2016. -There was no documentation Staff B had completed the 5, 10, or 15-hour state approved medication administration training course.	C935		

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C935	Continued From page 53 -Staff B had completed the competency validated medication clinical skills checklist 06/01/20. -Staff B had successfully passed the state medication aide (MA) exam on 07/29/20. Review of a resident's April 2021 Medication Administration Record (MAR) revealed Staff B had documented medications were administered to the residents. Interview with a resident on 05/05/21 at 1:00pm revealed Staff B had administered medications to him recently. Telephone interview with Staff B on 05/07/21 at 3:30pm revealed: -He had been working at the facility since 2016. -He administered medications on a daily basis. -He took the medication aide training once after he was hired in 2016 and again in 2020 but he could not remember the dates. Telephone interview with the previous LHPS nurse (RN) on 05/07/21 at 9:50am revealed: -She completed Staff B's "Skills Competency Evaluation" checklist on 06/01/20 and provided study material for the MA exam. -Some of the tasks on the checklist were not covered since the facility did not have residents with those needs. -When special needs arose, such as the use of a particular inhaler, the LHPS RN would Facetime with staff to teach them how to use it; however, the LHPS RN did not have documentation of the Facetime education. -She was not asked to return to the facility for additional staff inservices or trainings after completion of the "Skills Competency Evaluation" checklist.	C935		