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{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on June 29, 2021 - June 30, 2021.	{C 000}		
{C 022}	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 5 of 5 sampled residents (#1, #2 , #3, #4, #5) who had cognitive impairments and/or physical impairments and required verbal prompting to exit the facility during a fire drill. The findings are: Review of the facility's current provisional license effective 06/08/21 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 5 residents	{C 022}		

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{C 022}	Continued From page 1 resided in the facility on 06/29/21. Interview the Administrator/Owner on 06/29/21 at 8:15am revealed: -She was the only staff working at the facility on 06/29/21. -She currently had one personal care aide/medication aide (PCA/MA) who worked at the facility. -She and the PCA/MA took turns rotating shifts from 7:00am - 11:00pm and 11:00pm - 7:00am. -She had hired a second PCA/MA in May 2021, but she recently resigned a week or so ago. Observations of the facility on 06/29/21 at intervals from 8:15am - 4:45pm revealed: -There were two exit doors accessible to the residents. -The facility's side exit door was located on the right end of the facility. -Staff and residents were observed using the facility's side exit door located on the right end of the facility as the main exit/entrance door. -There was a front door exit door located near the left end of the facility. -There was no sprinkler system in the facility. -There was one main hallway in the facility. -In the hallway, there were 2 steps with a handrail on each side of the steps. -There were 2 resident rooms with 2 residents assigned in each room, located down the hallway (on the left side of the facility) down the two steps with the handrails. Review of the facility's Fire Safety Policy and Procedure with a revised date of 06/28/21 revealed: -To best ensure the safety of residents, staff and property, management had implemented the policy to aid in fire prevention.	{C 022}		

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{C 022}	Continued From page 2 -Staff would assist residents in preparedness for a fire in the facility while taking every possible step to prevent such an occurrence. -There would be a written fire and disaster plan posted in the hallway on the closet door and one in each resident bedroom on the wall beside the door. -The plan was reviewed with each resident following admission and with each employee during orientation. -Unannounced fire drills were conducted monthly at varying times of the month and varying times of the day including normal sleep time. -Additional drills may be conducted if the Supervisor in Charge or the Administrator believed it was necessary. -The location of the fire would change from one drill to the next. -Residents and staff were to treat the fire drills as though it was an actual fire. -Fire drill reports were completed by staff on duty and included the date, time, location of the fire, number of staff and residents in the facility at the time of the fire and time involved in evacuation. -The predestined meeting place was in the front yard of the facility. Review of an Evacuation Plan and Fire Drill Report dated 01/07/20 revealed: -The time of the drill was not documented. -There were 6 residents participating in the drill. -The total evacuation time was documented as 3 minutes and 57 seconds -A PCA/MA signed the report. Review of an Evacuation Plan and Fire Drill Report dated 06/14/21 revealed: -The time of the drill was not documented. -There were 5 residents participating in the drill. -There was a section labeled "time required to	{C 022}		

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{C 022}	Continued From page 3	{C 022}		

evacuate" with documentation of "1 sec" beside each residents' name.
-In the employees participating section of the form, there was documentation "everyone was out of the facility on time for all residents".
-The total evacuation time was not documented.
-A PCA/MA signed the report.

Review of the Evacuation Plan and Fire Drill Reports for the facility revealed there were no additional reports for 2020 or 2021.

Interview with the Administrator/Owner on 06/30/21 at 11:12am revealed:
-During the facility's fire drills none of the residents required verbal or physical assistance to exit the facility.
-She had been performing fire drills with the residents 2-3 times per week since April 2021.
-Documentation for the fire drills performed since April 2021 were not available for review because a PCA/MA who resigned from the facility had taken the fire drill reports with her and did not return the reports to the facility.
-She was not sure why there were no fire drill reports for 2020 because they were filed in the same place.

1. Review of Resident #3's current FL-2 dated 03/16/21 revealed:
-Diagnoses included mental retardation, unspecified psychosis, unspecified mood disorder, incontinence of bowel and bladder and the resident was non-verbal.
-The resident was ambulatory but required total care from staff.
-There was no documentation of his orientation status.

Review of Resident #3's current assessment and

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{C 022}	Continued From page 4	{C 022}		

care plan dated 03/16/21 revealed:
-The resident had developmental disabilities and saw a mental health provider.
-The resident was oriented with significant memory loss and required direction.
-The resident was deaf and non-verbal.
-The resident required extensive assistance with eating, and total assistance with toileting, ambulation, bathing, dressing, grooming and transferring.
-The resident did not move from one place to another unless asked to do so.

Observations of Resident #3 on 06/29/21 at 9:08am revealed:
-The resident sat in a chair in his bedroom.
-He was non-verbal and did not answer questions.
-He made brief eye contact at intervals, nodded his head, occasional gestures with his hands and smiled when spoken to.

Observations of Resident #3 on 06/30/21 at intervals from 8:30am - 4:45pm revealed:
-The resident followed his roommate when the roommate went outside to sit on the patio.
-The roommate was observed adjusting the resident's mask in the hallway.
-The resident had a steady gait and did not use an assistive device.

Interview with Resident #3's roommate on 06/30/21 at 12:00pm revealed:
-When the facility had fire drills, he had instructed Resident #3 to follow him to exit the facility.
-He always "looks out" for Resident #3.

Observations of a fire drill conducted by the Administrator/Owner and the personal care

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{C 022}	Continued From page 5	{C 022}		

aide/medication aide (PCA/MA) on 06/29/21 between 5:12pm and 5:15pm revealed:
-The Administrator and the PCA/MA initiated the fire drill by activating the smoke detector located at the end of the hallway on the right side of the facility using an opened flame lighter held under the sensor of the smoke detector.
-The audible alarm of the smoke detector was activated by sounding three beeps followed by the activation of the other smoke detectors in the facility with a five second (approximate) continuous audible alarm heard throughout the facility.
-Resident #3 was in his bedroom located at the end of the hallway, down the two steps with the handrails on the left side of the facility watching television with another resident during the fire drill.
-At 5:15pm, Resident #3 and the other resident did not respond during the drill and was observed sitting in a chair in the bedroom.

Interview with the Administrator/Owner on 06/29/21 at 5:18pm revealed:
-Resident #3 did not respond to the fire drill because the roommate was watching television.
-Resident #3 would have followed his roommate to exit the facility if the roommate had exited during the fire drill.

Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed:
-She recently started activating the smoke detectors audible alarm when fire drills were done (since May 2021).
-She was previously using the bell in the hallway of the facility for the heat alarm when fire drills were performed.

Observation in the hallway of the facility on

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{C 022}	Continued From page 6 06/29/21 at 5:22pm revealed: -The Administrator/Owner activated an audible alarm bell alarm (the audible bell was not a smoke detector, per the Administrator/Owner this was a heat detector alarm and a not part of the smoke alarm) located in the hallway of the facility. -Resident #3 and the roommate exited their bedroom while the roommate told Resident #3 to "come on". -Resident #3 and the roommate proceeded down the hallway toward the right side of the facility. -Resident #3 and the roommate were stopped by the Administrator/Owner who asked the two residents why they were going in that direction. -The Administrator/Owner looked at the roommate and told the roommate that he knew to go out the nearest exit and questioned the roommate why he didn't use the closest exit door (located in a room directly across the hallway from the residents' bedroom). Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed: -Resident #3 was born with intellectual disabilities and was not able to speak. -Resident #3 could hear but was hard of hearing. -Resident #3 was not aware of his own safety and required staff to ensure he made safe decisions. -Resident #3 was not aware of the day, time, month or where he was at. -If there was an emergency such as a fire, she thought the resident would need assistance to ensure he exited the facility. Telephone interview with the Nurse Manager at Resident #3's primary care provider's (PCP's) office on 06/30/21 at 2:15pm revealed she would speak with the resident's PCP regarding the residents diagnoses, orientation and safety/ability of independently evacuating the facility in the	{C 022}		

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{C 022}	Continued From page 7 event of an emergency such as a fire. A second telephone interview with the Nurse Manager with Resident #3's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed: -The PCP had safety concerns for the resident because the resident would not have been able to exit the facility on his own due to his mental limitations in the event of an emergency such as a fire at the facility. -The resident's mental limitations would prevent the resident from understanding there was a danger and would require verbal prompting from staff to exit the facility safely in the event of a fire. -The resident would "not get out" on his own. Telephone interview with Resident #3's mental health provider's nurse on 06/30/21 at 10:33am revealed: -If the resident did not respond in a fire drill there were concerns the facility may not have enough staff in the home to help the resident to get out of the facility in the event of an emergency such as a fire. -The resident had intellectual disabilities which included mental retardation. -There were safety concerns for the resident not being able to exit the facility safely without verbal and or physical assistance from staff. -The resident also had a mood disorder which would be a concern because the resident might not want to move when asked to which also would be a safety concern for the resident. -The resident would need staff assistance in an emergency. Refer to the telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am.	{C 022}		

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{C 022}	Continued From page 8 Refer to the attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. 2. Review of Resident #5's current FL-2 dated 03/02/21 revealed: -Diagnoses included schizophrenia, testicular cancer and incontinence of bowel and bladder. -The resident was ambulatory and had speech limitation and contractures. -The resident was intermittently disoriented. Review of Resident #5's current assessment and care plan dated 03/02/21 revealed: -The resident was oriented and had his memory was adequate. -The resident required limited assistance from staff for grooming, and extensive staff assistance with eating and, toileting, and totally dependent on staff for bathing. Observations of a fire drill conducted by the Administrator/Owner and the personal care aide/mediation aide (PCA/MA) on 06/29/21 between 5:12pm and 5:15pm revealed: -The Administrator and the PCA/MA initiated the fire drill by activating the smoke detector located at the end of the hallway on the right side of the facility using an opened flame lighter held under the sensor of the smoke detector. -The audible alarm of the smoke detector was activated by sounding three beeps followed by the activation of the other smoke detectors in the facility with a five second (approximate) continuous audible alarm heard throughout the facility. -Resident #5 was in his bedroom located at the end of the hallway, down the two steps with the	{C 022}		

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handrails on the left side of the facility watching television with his roommate.
-At 5:15pm, Resident #5 and the roommate did not respond during the drill.
-Resident #5 was observed sitting in a chair looking at the television in the bedroom.

Observation in Resident #5's room on 06/29/21 at 5:18pm revealed:
-The Administrator/Owner asked Resident #5 did he hear the smoke detector's alarm and the resident responded he heard the alarm sound and he knew it was the fire alarm.
-The Administrator/Owner asked Resident #5 why he did not get up and exit the facility and Resident #5 responded to "do it (fire drill) again and I will go out".

Interview with the Administrator/Owner on 06/29/21 at 5:18pm revealed:
-Resident #5 did not respond to the fire drill because he was watching television.
-Resident #5 responded to fire drills in the past but had a habit of ignoring what was going on around him when he watched certain television shows.

Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed:
-She recently started activating the smoke detectors audible alarm when fire drills were done (since May 2021).
-She was previously using the bell in the hallway of the facility for the heat alarm when fire drills were performed.

Observation in the hallway of the facility on 06/29/21 at 5:22pm revealed:
-The Administrator/Owner activated an audible alarm bell alarm (the audible bell was not a

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{C 022}	Continued From page 10	{C 022}		

smoke detector, per the Administrator/Owner this was a heat detector alarm and a not part of the smoke alarm) located in the hallway of the facility.
-Resident #5 told his roommate to "come on" and both residents exited the bedroom.
-Resident #5 and the roommate proceeded down the hallway toward the right side of the facility.
-Resident #5 and the roommate were stopped by the Administrator/Owner who asked the two residents why they were going in that direction.
-The Administrator/Owner looked at Resident #5 and stated that he knew to go out the nearest exit and questioned the resident why he didn't use the closest exit door (located in a room directly across the hallway from the residents' bedroom).

Interview with Resident #5 on 06/30/21 at 12:00pm revealed:
-He was not paying attention when the alarm sounded during the fire drill on 06/29/21 because he was watching television.
-He did not exit out of the facility's front exit door on 06/30/21 because he forgot about that exit door (During the time the Administrator/Owner activated the heat detector's audible bell alarm).

Telephone interview with the Nurse Manager at Resident #5's primary care provider's (PCP's) office on 06/30/21 at 2:15pm revealed she would speak with the resident's PCP regarding the residents diagnoses, orientation and safety of independently evacuating the facility in the event of an emergency such as a fire.

A second telephone interview with the Nurse Manager at Resident #5's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed the resident had intellectual limitations.

Telephone interview with Resident #5's mental

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health provider's nurse on 06/30/21 at 10:33am revealed:
-The resident had mild intellectual disabilities and schizophrenia.
-She thought the resident would understand that fire meant danger.
-If the resident did not exit during the fire drill on 06/29/21 then she thought the resident would require verbal prompting from staff to ensure the resident exited the facility safely in the event of an emergency such as a fire.

Refer to the telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am.

Refer to the attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm.

Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm.

3. Review of Resident #2's current FL-2 dated 03/16/21 revealed:
-Diagnoses included diabetes, hypertension and obsessive-compulsive disease.
-The resident was intermittently disoriented
-The resident was ambulatory.

Review of Resident #2's current assessment and care plan dated 03/08/21 revealed:
-The resident was sometimes disoriented and forgetful, needing reminders.
-The resident required limited staff assistance with ambulation, extensive staff assistance with toileting and dressing, and dependent on staff for bathing and grooming.

Observations of a fire drill conducted by the Administrator/Owner and the personal care aide/mediation aide (PCA/MA) on 06/29/21

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between 5:12pm and 5:15pm revealed:
-The Administrator and the PCA/MA initiated the fire drill by activating the smoke detector located at the end of the hallway on the right side of the facility using an opened flame lighter held under the sensor of the smoke detector.
-The audible alarm of the smoke detector was activated by sounding three beeps followed by the activation of the other smoke detectors in the facility with a five second (approximate) continuous audible alarm heard throughout the facility.
-Resident #2 exited her bedroom located at the end of the hallway, up the two steps with the handrails on the left side of the facility with her roommate and walked toward the facility's side exit door of the facility located in a common living room.
-Resident #2 sat down on the couch in the common living room.
-Resident #2 did not exit the facility during the fire drill.
-The fire drill ended at 5:15pm.

Interview with the Administrator/Owner on 06/29/21 at 5:15pm revealed:
-She could not answer why Resident #2 sat down in the common living room and did not exit during the fire drill.
-Resident #2 exited the facility without verbally prompting her during past fire drills.

Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed:
-She recently started activating the smoke detectors audible alarm when fire drills were done (since May 2021).
-She was previously using the bell in the hallway of the facility for the heat alarm when fire drills were performed.

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{C 022}	Continued From page 13 Observation in the hallway of the facility on 06/29/21 at 5:22pm revealed: -The Administrator/Owner activated an audible alarm bell alarm (the audible bell was not a smoke detector, per the Administrator/Owner this was a heat detector alarm and a not part of the smoke alarm) located in the hallway of the facility. -Resident #2 stood from a seated position from the couch in the common living room and proceeded to the exit door and told her roommate who was standing at the exit door to "come on, you're supposed to get out". -Resident #2 proceeded out the side exit door to a patio and stood at the edge of the front grounds of the facility with three other residents. -The PCA/MA told the three residents to come back into the facility. -Resident #2 came up the steps slowly using the handrail for support and steadiness. -Resident #2 proceeded down the hallway of the facility to her bedroom. -The resident held to both rails going down the two steps in the hallway slowly and as the resident raised her left foot, her left foot moved in a slipping motion to the next level of the step. Interview with Resident #2 on 06/30/21 at 12:10pm revealed: -When there was a fire drill she was supposed to "get up and get out". -She was not sure why she did not get out and why she sat down in the common living room of the facility during the fire drill on 06/29/21. Observations of Resident #2 at intervals on 06/29/21 from 8:15am - 4:45pm revealed the resident was able to engage in conversation answering in short responses, however unable to engage in detailed topics of conversation.	{C 022}		

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{C 022}	Continued From page 14 Interview with Resident #2's roommate on 06/30/21 at 10:50am revealed she was not sure why Resident #2 sat down and did not exit during the fire drill on 06/29/21. She told her to come on, but the resident did not move. Interview with the Administrator/Owner on 06/29/21 at 9:21am revealed: -Resident #2 required assistance with bathing and the resident was incontinent of bowel and bladder requiring assistance from staff with incontinent brief changes. -She could not provide an answer regarding the resident's orientation status. Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed she was not aware until recently Resident #2 was diagnosed with dementia. Telephone interview with the Nurse Manager at Resident #2's primary care provider's (PCP's) office on 06/30/21 at 2:15pm revealed she would speak with the resident's PCP regarding the residents diagnoses, orientation and safety of independently evacuating the facility in the event of an emergency such as a fire. A second telephone interview with the Nurse Manager at Resident #2's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed: -The resident had a diagnosis of dementia and the severity of the resident's dementia would vary daily. -The resident "may or may not" exit the facility without verbal or physical prompting from staff in the event of an emergency such as a fire. -The PCP thought the resident would know that fire was dangerous.	{C 022}		

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{C 022}	Continued From page 15 -The resident would be prompted to follow the other residents out of the facility if there was a fire. Telephone interview with Resident #2's mental health provider's nurse on 06/30/21 at 10:33am revealed the resident would "definitely" require verbal and physical prompting from staff to exit the facility safely in the event of an emergency such as a fire. Refer to the telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am. Refer to the attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. 4. Review of Resident #1's current FL-2 dated 03/01/21 revealed: -Diagnoses included bipolar 1 disorder, major neurocognitive disorder and cluster B disorder. -The resident was ambulatory. -There was no documentation of the resident's orientation status. Review of Resident #1's current assessment and care plan dated 03/02/21 revealed: -The resident was receiving mental health services. -The resident resisted care and had disruptive/socially inappropriate behavior. -The resident enjoyed giving and/helping others. -The resident was oriented and had an adequate memory. -The resident was independent with bathing dressing and grooming and required staff supervision with eating.	{C 022}		

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{C 022}	Continued From page 16 Observations of a fire drill conducted by the Administrator/Owner and the personal care aide/medication aide (PCA/MA) on 06/29/21 between 5:12pm and 5:15pm revealed: -The Administrator and the PCA/MA initiated the fire drill by activating the smoke detector located at the end of the hallway on the right side of the facility using an opened flame lighter held under the sensor of the smoke detector. -The audible alarm of the smoke detector was activated by sounding three beeps followed by the activation of the other smoke detectors in the facility with a five second (approximate) continuous audible alarm heard throughout the facility. -Resident #1 exited her bedroom located at the end of the hallway, up the two steps with the handrails on the left side of the facility with her roommate and walked toward the facility's side exit door of the facility located in a common living room. -Resident #1 stopped and stood at the facility's side exit door looking back at staff and her roommate sitting on the couch in the common living room. -Resident #1 did not exit the facility during the fire drill. -The fire drill ended at 5:15pm. Interview with the Administrator/Owner on 06/29/21 at 5:15pm revealed she could not answer why Resident #1 did not exit during the fire drill. Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed: -She recently started activating the smoke detectors audible alarm when fire drills were done (since May 2021).	{C 022}		

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{C 022}	Continued From page 17 -She was previously using the bell in the hallway of the facility for the heat alarm when fire drills were performed. Observation in the hallway of the facility on 06/29/21 at 5:22pm revealed: -The Administrator/Owner activated an audible alarm bell alarm (the audible bell was not a smoke detector, per the Administrator/Owner this was a heat detector alarm and a not part of the smoke alarm) located in the hallway of the facility. -Resident #1 was still standing at the facility's side exit door and was told by her roommate to "come on, you're supposed to get out". -Resident #1 proceeded out the side exit door to a patio and stood at the edge of the front grounds of the facility with three other residents. Interview with Resident #1 on 06/30/21 at 10:50am revealed: -She did not exit the facility during the fire drill because she was waiting on her roommate to exit out the door with her. -She always waited on her roommate to assist her down the steps if needed. -She was not sure why her roommate sat down and did not exit during the fire drill on 06/29/21. She told her to come on, but the resident did not move. Telephone interview with the Nurse Manager at Resident #1's primary care provider's (PCP's) office on 06/30/21 at 2:15pm revealed she would speak with the resident's PCP regarding the residents diagnoses, orientation and safety of independently evacuating the facility in the event of an emergency such as a fire. Telephone interview with the Nurse Manager at Resident #1's primary care provider's (PCP's)	{C 022}		

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{C 022}	Continued From page 18 office on 06/30/21 at 3:56pm revealed: -Resident #1 did not have any limitations that would prevent the resident from independently exiting the facility, however the resident moved slow. -There were concerns for the resident's safety if the resident was trying to help other residents that lived in the facility and did not exit the facility when there was a real emergency such as a fire. Telephone interview with Resident #1's mental health provider on 07/01/21 at 3:35pm revealed he would have safety concerns for the resident when the resident didn't exit the home during the fire drill on 06/29/21. Refer to the telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am. Refer to the attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. 5. Review of Resident #4's current FL-2 dated 03/02/21 revealed: -Diagnoses included schizo-affective schizophrenia, essential hypertension, incontinence of urine and obstructive sleep apnea. -The resident was intermittently disoriented. Review of Resident #4's current assessment and care plan dated 03/02/21 revealed: -The resident was sometimes disoriented and was forgetful and needed reminders. -The resident's mental health and social history included the resident was socially inappropriate and had disruptive behavior.	{C 022}		

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{C 022}	Continued From page 19 -The resident was receiving mental health services, -The resident required limited assistance from staff for grooming and dressing, extensive staff assistance with toileting, and totally dependent on staff for bathing. Observations of a fire drill conducted by the Administrator/Owner and the personal care aide/medication aide (PCA/MA) on 06/29/21 between 5:12pm and 5:15pm revealed: -The Administrator and the PCA/MA initiated the fire drill by activating the smoke detector located at the end of the hallway on the right side of the facility using an opened flame lighter held under the sensor of the smoke detector. -The audible alarm of the smoke detector was activated by sounding three beeps followed by the activation of the other smoke detectors in the facility with a five second (approximate) continuous audible alarm heard throughout the facility. -Resident #4 was in the bathroom when the fire drill was initiated. -Resident #4 did not exit the facility during the fire drill. -The fire drill ended at 5:15pm. Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed: -She recently started activating the smoke detectors audible alarm when fire drills were done (since May 2021). -She was previously using the bell in the hallway of the facility for the heat alarm when fire drills were performed. Observation in the hallway of the facility on 06/29/21 at 5:22pm revealed: -The Administrator/Owner activated an audible	{C 022}		

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{C 022}	Continued From page 20	{C 022}		

alarm bell alarm (the audible bell was not a smoke detector, per the Administrator/Owner this was a heat detector alarm and a not part of the smoke alarm) located in the hallway of the facility.
-Resident #4 proceeded out the side exit door to a patio and stood at the edge of the front grounds of the facility with three other residents.

Interview with Resident #4 on 06/30/21 at 10:56am revealed:
-He was in the bathroom when the fire drill occurred on 06/29/21.
-When he heard the alarm in the bathroom, he was not sure if it was a fire drill alarm and "didn't pay it no mind".
-He was not sure what the alarm was because it made different sounds, sometime the alarm sounds like a bell.
-He later heard the third ringing sound in the hallway, and he went out of the facility.

Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed:
-Resident #4 did not have any limitations to prevent him from exiting the facility in the event of an emergency such as a fire.
-She was not sure why Resident #4's current FL-2 had documentation the resident was intermittently disoriented.
-She was not sure why Resident #4's current assessment and care plan had documentation that the resident was sometimes disoriented.

Telephone interview with the Nurse Manager at Resident #4's primary care provider's (PCP's) office on 06/30/21 at 2:15pm revealed she would speak with the resident's PCP regarding the residents diagnoses, orientation and safety of independently evacuating the facility in the event of an emergency such as a fire

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{C 022}	Continued From page 21 Telephone interview with the Nurse Manager at Resident #4's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed: -The resident had intellectual disabilities. -The resident would need verbal prompting to ensure the resident's safety in the event of a fire such as an emergency. Refer to the telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am. Refer to the attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. _____ Telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am revealed: -It was important to ensure fire drills were conducted with the audible alarms that would be used in a true fire emergency. -If the residents did not respond to the audible alarm on the smoke detector then it was possible the smoke detectors were not used when drills were done, not practiced or because the residents had cognitive or physical limitations that prevented them to react independently to the sounding alarm. -If the residents at the facility did not respond to the smoke detector's audible alarm and there was a real fire in the facility, then the residents would have been "overcome" (overwhelmed by the heat and smoke). -When the audible alarm of the smoke detector was activated, it meant to "get up and get out". -If the residents did not evacuate then they could die in the fire.	{C 022}		

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{C 022}	Continued From page 22 Attempted telephone interview with the PCA/MA on 06/30/21 at 1:58pm was unsuccessful. Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed: -She was licensed for all ambulatory residents but was not aware residents who required physical or verbal prompting from staff to exit the facility were considered non-ambulatory. -She had never been told that before. -She thought about finding other placement for a few of the residents living at the facility but had not done so because she wanted to work with all of the residents to get them accustomed to recognizing the sounds of the audible smoke alarms when fire drills were conducted. The facility failed to ensure the building was equipped and maintained to allow 5 of 5 residents living in the facility who had physical and cognitive deficits to evacuate independently in case of an emergency such as a fire. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. A Plan of Protection was requested in accordance with G.S. 131D-34 on 06/29/21 and 06/30/21. The plan of correction was not received.	{C 022}		
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;	C 078		

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C 078	Continued From page 23 This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations interviews and record reviews, the facility failed to ensure the facility was free of hazards related to the Administrator/Owner routinely smoking in the living quarters of the facility. The findings are: Review of the facility's undated Policy and Procedure on Smoking revealed: -The intent was for the facility to provide a safe and "healthful" work and living environment. -Smoking was prohibited by all employees inside the workplace and on the grounds of the facility. -Smoking was not permitted in the residents' bedrooms or other non-designated areas of the facility. Review of the facility's Fire Safety Policy and Procedure with a revised date of 06/28/21 revealed: -In order to best ensure the safety of residents, staff and property, management had implemented the policy to aid in fire prevention. -The facility's policy set forth on smoking [sic] in the facility would be followed. Observation of the facility at intervals on 06/29/21 from 8:15am - 4:45pm revealed: -There was a closed door on the right side of the residents'' common living room that lead to the	C 078		

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C 078	Continued From page 24 Administrator/Owners living quarters. -The door to the Administrator/Owners living quarters remained closed when observed at intervals. -There was not any no smoking signage posted in the facility. Interview with the Administrator/Owner on 06/29/21 at 11:10am revealed she just returned from taking a break and smoking a cigarette in her living quarters. Observation of the Administrator/Owner of the facility on 06/29/21 at 11:55am revealed the Administrator/Owner walked out of the facility's office and in the living quarters of the facility and stated that she was going to smoke a cigarette. Interview with the personal care aide/medication aide (PCA/MA) on 06/29/21 at 3:05pm revealed: -She did not smoke cigarettes. -The Administrator/Owner smoked in the living quarters of the facility, but she had never seen her smoke in the residents' area of the facility. A second interview with the Administrator/Owner on 06/29/21 at 3:10pm revealed: -She only smoked in her living quarters of the facility. -She smoked on the side of her bed and close to a dehumidifier. -She never smoked cigarettes when she was lying in her bed. -The dehumidifier removed all the odor and smoke from the cigarettes she smoked. -There was no risk of health concerns to the residents that lived in the home when she smoked cigarettes because she did not smoke around them. -She had routinely smoked in the facility for "29	C 078		

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C 078	Continued From page 25	C 078		

years".
-She knew that smoking cigarettes in the home could cause a hazard of an accidental fire and was not safe.
-There were not any "No smoking" signs posted in the home because the signs were taken down while she was painting the facility.

Telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am revealed smoking was a hazard in facilities "just in the nature" of cigarettes being linked to starting house fires.

Interview with a resident on 06/30/21 at 12:00pm revealed:
-The Administrator/Owner smoked cigarettes in her living area of the facility.
-He knew the Administrator/Owner smoked cigarettes in her living area because he had seen her smoking.

Interview with a second resident on 06/30/21 at 10:03pm revealed the Administrator/Owner smoked cigarettes in the facility in her living area but not in the resident's living area.

Telephone interview with a nurse from the facility's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed:
-All the residents' providers were concerned about a staff smoking inside the home which posed a safety hazard for the residents and "should not happen".
-There was a concern for health hazards cigarette smoke could cause for residents along with the combination of other health problems the residents might have.

_____

The facility failed to ensure the facility was free

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C 078	Continued From page 26 from hazards and failed to follow the facility's written smoking policy and procedures related to the Administrator/Owner routinely smoking in the living quarters of the facility. The facility's failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/29/21 for this violation.	C 078		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the overhead smoke detectors used for fire safety were maintained in a safe and operating condition. The findings are: Review of the daily census revealed 5 residents resided in the facility on 06/29/21. Review of the facility's Fire Safety Policy and	C 102		

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C 102	Continued From page 27 Procedure with a revised date of 06/28/21 revealed: -To best ensure the safety of residents, staff and property, management had implemented the policy to aid in fire prevention. -The batteries in fire alarms were changed every six months. Observations at the facility on 06/29/21 at intervals from 8:15am - 5:45pm revealed at least two separate smoke detector alarms in the facility intermittently beeped and continued to beep throughout the day. Interview with the Administrator/Owner of the facility on 06/29/21 at 12:34pm revealed: -The intermittent beeping sound was coming from the smoke detectors in the facility. -The intermittent beeping sound meant the batteries were low in the smoke detectors. -The low battery alert on the smoke detectors started beeping yesterday, (06/28/21). -She changed the batteries in the smoke detectors every 6 months. -There was no documentation completed when the batteries in the smoke detectors were changed. -It was time for her to change the batteries in the smoke detector again. -She had new batteries and would change the batteries today, (06/29/21). Observations at the facility on 06/30/21 at intervals from 8:30am - 4:45pm revealed: -There were intermittent, separate beeping sounds heard from some of the smoke detector alarms in the facility and continued to beep throughout the day. -There was a smoke detector located on the ceiling in the facility's office that made an	C 102		

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C 102	Continued From page 28	C 102		

intermittent beeping sound.
-There were approximately seven smoke detectors located on the ceiling in the common living room, the hallway and the resident rooms.
-There were beeping sounds from a smoke detector located on the right end of the facility.
-There were beeping sounds from a smoke detector located on the left end of the facility.

Interview with a resident on 06/30/21 at 12:03pm revealed:
-He had heard intermittent beeping noises coming from different areas of the facility.
-He was not sure what the intermittent beeping noise was coming from.
-The intermittent beeping noise had been heard for a "long time" (more than one month).

Interview with the Administrator/Owner on 06/30/21 at 12:17pm revealed:
-She had not changed the batteries in the smoke detectors yet.
-A ladder was required to reach the smoke detectors in order to change the batteries.
-She did not feel safe using a ladder due to unsteadiness.
-She would contact someone to come to the facility to change the batteries of the smoke detectors today, (06/30/21).
-The smoke detectors in the facility were wired to the electricity,
-She was aware of the importance of ensuring the smoke detectors were always maintained in a working order.

Telephone interview with the county's Fire Marshall on 06/30/21 at 9:38am revealed:
-There were safety concerns for the residents living in a facility with chirping smoke detectors.
-A chirping smoke detector indicated the batteries

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C 102	Continued From page 29	C 102		

in the smoke detector were dying.
-A dying battery in a smoke detector would eventually stop chirping and the smoke detector would no longer be active and would not sound.
-The facility's smoke detector batteries were the backup to the electrical power in the event the electricity went out.
-The residents' safety would be at risk with a dying battery in a smoke detector if the facility's electricity went out and a fire occurred.

Telephone interview with a nurse from the facility's primary care provider's (PCP's) office on 06/30/21 at 3:56pm revealed:
-All of PCPs' for the 5 residents residing in the facility were concerned if smoke detectors in the facility were intermittently beeping indicating the batteries were low and needed to be changed.
-It was important for the safety of the residents to ensure the smoke detectors were working and operable at all times because the smoke detectors would alert staff and residents of a fire and to safely get out of the facility.

Refer to Tag C 0022, 10A NCAC 13G .0302 Design and Construction.

_____

The facility failed to ensure a smoke detector located on the left end of the facility, the right end of the facility and in the facility's office were maintained in proper working condition at all times which placed the residents' safety at risk in the event of a fire and/or during power outages. The facility's failure was detrimental to the safety, health and welfare of the residents and constitutes a Type B Violation.

_____

Based upon review by management on 07/06/21 it was determined this a Type B Violation. A plan of protection, in accordance with G.S. 131D-34

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C 102	Continued From page 30 was not requested because all residents have been discharged as of 07/06/21. Therefore, the Type B Violation is abated.	C 102		
{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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents sampled (#3) for a medication used to promote sleep. The findings are: Review of Resident #3's current FL-2 dated 03/16/21 revealed: -Diagnoses included mental retardation, unspecified psychosis, unspecified mood disorder, incontinence of bowel and bladder and the resident was non-verbal. -There was an order for Benadryl 50mg, daily at bedtime. (Benadryl is used to treat sleep). Observation of Resident #3's medications on hand on 06/29/21 at 12:15pm revealed Benadryl 25mg take one capsule at bedtime as needed for	{C 330}		

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{C 330}	Continued From page 31	{C 330}		

sleep.

Review of Resident #3's June 2021 medication administration record (MAR) from 06/13/21 - 06/29/21 revealed:
-There was an entry for Benadryl 50mg one at bedtime "as need" for sleep with a scheduled administration time of as needed.
-There was no documentation Benadryl 50 mg one at bedtime had been administered.

Telephone interview with a Pharmacist with the facility's pharmacy provider on 06/29/21 at 4:09pm revealed:
-Resident #3 had a prescription order dated 03/09/21 for Benadryl 25 mg one tablet as needed for sleep.
-There were no prescription orders for Benadryl 50 mg at bedtime for sleep.
-It was important to ensure medications were administered as ordered by the residents' primary care provider.

Interview with the Administrator/Owner on 06/29/21 at 1:45pm revealed:
-Resident #3 had an order for Benadryl at bedtime as needed for sleep.
-Resident #3 did not have an additional order for Benadryl 50mg at bedtime.
-She had not noticed Resident #3's medication order on the current FL-2 dated 03/16/21 was for Benadryl 50mg daily at bedtime and on the resident's June 2021 MAR the medication administration for Benadryl was as needed.

Telephone interview with a nurse at the facility's primary care providers' office (PCP) on 06/30/21 at 3:56pm revealed it was important for the facility to ensure medications were administered as ordered for the safety of the resident's.

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{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents related to medications used as a stool softener (#3) and a medication used for flatulence (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 03/16/21 revealed diagnoses included mental retardation, unspecified psychosis, unspecified	{C 342}		

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{C 342}	Continued From page 33 mood disorder, and was non-verbal. Telephone interview with a pharmacist with the facility's pharmacy provider on 06/29/21 at 4:09pm revealed: -There was a prescription order dated 03/05/21 for Silace Syrup 60mg/15ml, 4 teaspoons (tsp) twice per day with one refill remaining (Silace is used to treat constipation). -Silace 60mg/15ml, 4 teaspoons (tsp) twice per day was dispensed on 03/05/21, 05/17/21 and 06/22/21. (A ml is a unit of volume with 5ml in one teaspoon and 20ml in 4 teaspoons). -There was a second prescription order dated 06/22/21 for Silace 60mg/15ml, 4 tsp twice daily. Observation of Resident #3's medications on hand on 06/29/21 at 12:15pm revealed Silace Syrup 60mg/15ml, take 4 teaspoons twice daily for constipation. Review of Resident #3's June 2021 medication administration record (MAR) from 06/13/21 - 06/29/21 revealed: -There was an entry for Silace Syrup, take "4ml" teaspoon (tsp) twice per day with a scheduled administration time at 8:00am and 8:00pm. -There was documentation Silace had been administered twice daily at 8:00am and 8:00pm from 06/13/21 - 06/28/21. -There was no documentation for the administration of 20ml of Silace Syrup twice daily. Interview with the Administrator/Owner on 06/29/21 at 12:15pm revealed Resident #3 was administered Silace Syrup 4 tsp twice daily. Attempted telephone interview with the personal care aide/medication aide (PCA/MA) on 06/30/21 at 1:58pm was unsuccessful.	{C 342}		

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{C 342}	Continued From page 34 Refer to the telephone interview with a Pharmacist with the facility's pharmacy provider on 06/29/21 at 4:09pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. Refer to the telephone interview with a nurse at the facility's primary care providers' office (PCP) on 06/30/21 at 3:56pm. 2. Review of Resident #1's current FL-2 dated 03/17/21 revealed: -Diagnoses included bipolar 1 disorder, major neurocognitive disorder, and cluster B personality disorder. -There was an order for Simethicone 125mg every 6 hours. (Simethicone is used to treat flatulence). Review of Resident #1's subsequent medication orders dated 05/03/21 revealed an order for Simethicone 125mg Chew, take one tablet every 6 hours as needed. Observation of Resident #1's medications on hand on 06/29/21 at 12:15pm revealed Simethicone 125mg one tablet chew and swallow every 6 hours as needed for flatulence dated 06/03/21. Review of Resident #3's June 2021 medication administration record (MAR) from 06/13/21 - 06/29/21 record revealed: -There was an entry for Simethicone 125mg one tablet chew and swallow every 6 hours as needed for flatulence with a scheduled administration time as needed. -There was documentation Simethicone 125mg	{C 342}		

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{C 342}	Continued From page 35 was administered twice daily from 06/13/21 - 06/20/21 with no documentation of the time administered, reason given and results of effective or ineffective. -There was documentation Simethicone 125mg was administered once daily on 06/23/21, 06/24/21 and 06/28/21 with no documentation of the time administered, reason given and results of effective or ineffective. Attempted telephone interview with the personal care aide/medication aide (PCA/MA) on 06/30/21 at 1:58pm was unsuccessful. Refer to the telephone interview with a Pharmacist with the facility's pharmacy provider on 06/29/21 at 4:09pm. Refer to the interview with the Administrator/Owner on 06/30/21 at 3:18pm. Refer to the telephone interview with a nurse at the facility's primary care providers' office (PCP) on 06/30/21 at 3:56pm. _____ Telephone interview with a Pharmacist with the facility's pharmacy provider on 06/29/21 at 4:09pm revealed: -The pharmacy did not provide the residents' medication administration records (MARs) for the facility. -The facility was responsible for creating the residents' MARS. -It was important to ensure medications were documented accurately and as ordered to prevent medication errors. Interview with the Administrator/Owner on 06/30/21 at 3:18pm revealed: -She created the residents' MARs from her	{C 342}		

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{C 342}	Continued From page 36 computer. -She reviewed the residents' MARS every month and when a residents' medication changed. Telephone interview with a nurse at the facility's primary care providers' office (PCP) on 06/30/21 at 3:56pm revealed it was important for the facility to ensure the safety of medication administration by accurately documenting medications administered to the residents.	{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 #2) related to a medication for anxiety. The findings are: Review of Resident #2's current FL-2 dated 03/16/21 revealed: -Diagnoses included diabetes, hypertension and obsessive-compulsive disorder. -The resident was intermittently disoriented. -The resident was ambulatory. -There were handwritten medication orders on page 1 of the FL-2. -There were typed medication orders on page 2	{C 381}		

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{C 381}	Continued From page 37	{C 381}		

of the FL-2.
-There was a medication order for Ativan 0.5mg every hour of sleep. (Ativan is a medication used for anxiety).
-There was a medication order for Ativan 0.5mg every 6 hours.

Review of Resident #2's quarterly pharmacy review dated 05/31/21 revealed there was documentation Ativan was not in stock and should be obtained and administered as ordered or a discontinuation order obtained for the resident's record.

Review of Resident #2's previous quarterly pharmacy reviews revealed:
-On 02/24/21 there was documentation that Ativan should be obtained and administered as ordered by the primary care provider (PCP).
-On 11/27/20 there was documentation Ativan was not in stock and should be obtained and administered as ordered or a discontinuation order obtained for the resident's record.
-On 08/21/20 there was documentation Ativan was not on hand.
-On 02/25/20, there was documentation Ativan was out of stock and should be replaced for resident use.

Observation of Resident #2's medications on hand on 06/29/21 at 11:59am revealed Ativan was not available for administration.

Telephone interview with a pharmacist at the facility's pharmacy provider on 06/29/21 at 4:09pm revealed:
-Resident #2 did not have a current order for Ativan 0.5mg every 6 hours or Ativan 0.5mg every hour of sleep.
-There were no prescriptions received from any

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{C 381}	Continued From page 38 of Resident #2's providers for Ativan in the last 2 years. -Resident #2's last prescription for Ativan was dated 08/02/18. -Resident #2 had an electronic prescription for Ativan 0.5 mg every hour of sleep and Ativan 0.5mg, may take every 6 hours as needed for anxiety that was denied dated 03/06/19 with documentation from the provider the resident was no longer on this medication. Interview with the Administrator on 06/30/21 at 11:24am revealed: -She completed the resident's FL-2's including the current medication orders and the residents' PCP signed the FL-2's. -She had contacted Resident #2's PCP and the resident's mental health provider in the past (no date provided) regarding Resident #2's Ativan order. -Resident #2's providers informed her at that time they were not the prescribing provider for the resident's Ativan order. -She could not receive a discontinuation order for Resident #2's Ativan order because the resident's current PCP and mental health provider had told her in the past they were not the ordering provider for the medication. -Resident #2's Ativan had been recently filled from the pharmacy provider and the medication was administered within the last 2 months to the resident. -She could not provide an answer why Resident #2 did not have Ativan every hour of sleep or Ativan 0.5mg every 6 hours on hand. -Resident #2 had not received any prescription refills from any other pharmacy providers. -She received the quarterly pharmacy reviews from the contracted nurse approximately 3-4 weeks after the reviews were completed.	{C 381}		

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{C 381}	Continued From page 39 -She forwarded the residents' quarterly pharmacy reviews to the residents PCP for signature once received. -She had not contacted Resident #2's PCP regarding Resident #2's Ativan order from the quarterly pharmacy review dated 05/31/21. -She had not attempted to send a written request to Resident #2's PCP or mental health provider to have the resident's Ativan orders discontinued. -There were no additional processes/policies in place to ensure action was taken as needed in response to the medication review. Telephone interview with Resident #2's PCP's nurse on 06/30/21 at 3:56pm revealed the facility would have been responsible to ensure any pharmacy recommendations were followed up on.	{C 381}		
{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 reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to design and construction, housekeeping and furnishings and building service equipment. The findings are: 1. Based on observations interviews and record	{C 912}		

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{C 912}	Continued From page 40 reviews, the facility failed to ensure the facility was free of hazards related to the Administrator/Owner routinely smoking in the living quarters of the facility. [Refer to Tag C0078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings(Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 5 of 5 sampled residents (#1, #2 , #3, #4, #5) who had cognitive impairments and/or physical impairments and required verbal prompting to exit the facility during a fire drill. [Refer to Tag C0022, 10A NCAC .0302(b) Design and Construction (Unabated Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure the overhead smoke detectors used for fire safety were maintained in a safe and operating condition. [Refer to Tag C0102, 10A NCAC 13G 10A NCAC 13G .0317(a) Building Service Equipment (Type B Violation)].	{C 912}		