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	HAL078082	A. BUILDING: _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROMARTIE SPRING VILLAGE REST HOME	508 WORTH STREET SAINT PAULS, NC 28384

(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
D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual survey on December 1-3, 2015.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes 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 facilities. This Rule is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain the home in a clean, orderly manner and free of hazards as evidenced by: cleaning supplies not securely stored; buckled floor covering in the facility dayroom; missing tile in the community bathroom; broken toilet paper dispenser in the community bathroom; floors soiled with urine in the bathrooms; and walls and door posts soiled with scratches, fingerprints, and grime. The findings are: 1. Observation of the facility dayroom during the initial facility tour on 12/01/15 at 10:30am revealed: -There were several large wrinkles in the sheet linoleum flooring in the Day Room of the facility, creating a trip/fall hazard.	D 079		

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D 079	Continued From page 1 -Walls and doors showed evidence of fingerprints, handprints, scratches, and dirty marks. Observation of 4 residents in the room revealed they were watching TV, looking out the windows, and conversing with each other. Interview with Resident #3 at 10:30am revealed: -He was alert and oriented. -He had no complaints about the condition of the floor, walls, or clutter in the dayroom or in his room. -He stated the linoleum floor of the dayroom had been wrinkled for "a couple of months at the most." He had not seen or heard of anyone tripping or falling on the linoleum floor. -The facility staff tidy up as best they can every day, they are usually busy with residents' personal care, medication administration, and cooking. He had no complaints about the cleanliness of the facility. Interview with the Owner/Administrator (O/A) on 12/01/15 at 11:25am revealed: -The wrinkled flooring in the dayroom had been like that for "a month or so." -He was "not that concerned" about the flooring in the dayroom even though the facility had residents with walkers and gait problems because no resident had fallen as a result of the wrinkled flooring in the dayroom. He sis not see it as trip hazard. -No family members had complained to him about the flooring or dirty walls in the dayroom. Interview with the Resident Care Coordinator (RCC) on 12/3/15 at 9:00am confirmed the information revealed by the O/A on 12/01/15 at 11:25am.	D 079		

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D 079	Continued From page 2 Further interview with the O/A on 12/3/15 at 9:18am revealed he was in the facility every day and was responsible for ensuring maintenance and repairs are completed as needed. 2. Observation of the community bathroom during the initial facility tour on 12/01/15 at 10:30am revealed: -There was a 1 X 2 inch chip in the bathtub enamel. -There was one missing tile square on the wall near the floor adjacent to the toilet, grout/plaster was crumbling on the wall where the tile was missing. -The wall of the community bathroom with the missing tile was discolored with light brown stains. -The call bell cord located beside the community bathroom toilet had a rusty clip. -Portions of the grout and caulk around the tub, shower, and tile flooring had brown stains. -In the community bathroom, the hardware to the toilet tissue holder was not secured to the wall on the left side, resulting in the toilet tissue holder being loose. Therefore the toilet tissue holder was not operational. The toilet paper holder spindle was missing. The metal framework used to hold the spindle was dirty and decomposing. -The safety bar railing around the toilet in the community bathroom contained rust. Interview with a female resident on 12/01/15 at 11:50 am revealed: -The community bathroom was "dirty." -She does not use the community bathroom because it was "nasty." -Facility staff cleaned the community bathroom but "men pee on the floor."	D 079		

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D 079	Continued From page 3 Interview with four male residents on 12/02/15 at 11:15 am revealed: -None of the four residents had complaints about the community bathroom. -Staff cleaned the community bathroom every day. Interview with the RCC on 12/03/15 at 9:00am revealed: The RCC had not received any complaints from residents or family members about the community bathroom. -The community bathroom was cleaned twice daily in the morning and evening. -All facility staff were responsible for maintaining the cleanliness of the community bathroom and all other areas inside of the facility. -The RCC did not know how long the tile square had been missing in the community bathroom. -The RCC did not know how long the brown stains had been on the caulk and grout in the community bathroom. -The RCC did not know when the last time any work was done to the caulking in the community bathroom. -It was facility procedure for the RCC to verbally report any maintenance or repair issues to the O/A. -The O/A was responsible for coordinating all facility maintenance and repairs. Interview with the O/A on 12/03/15 at 9:18 am revealed: -Some of the caulk and all of the grout in the community bathroom was gray in color which is why it looked "dingy." -The tile square had been missing for "3 weeks." -The missing tile square had been repaired twice; one repair was completed by the O/A and one repair was completed by the "tile man."	D 079		

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D 079	Continued From page 4 -The last time the tile was repaired was "6 weeks ago." -The missing tile square was the result of "normal wear and tear" because residents hit the wall with their wheelchairs. -The O/A acknowledged that some of the grout and caulk near the toilet in the community had stains. -The grout and tile was to "maintain the water seal" which was why it was stained. -The "tile man" had last worked on the caulking in the community bathroom "a season or two ago." -The toilet tissue holder in the community bathroom was loose on the left side because residents grabbed it to help them get up. -The O/A had made plans to have the toilet tissue holder securely affixed to the wall and additional grab bars installed in the community bathroom at the toileting area "within the next 5 days." -The O/A removed the rusty piece from the call bell in the community bathroom. -The O/A was responsible for ensuring maintenance and repairs are completed as needed. Random observations on 12/3/13 from 3:00 - 5:00pm revealed: -A "tile man" was in the community bathroom performing repairs. Interview with the "tile man" at 4:10pm on 12/3/15 revealed: -The O/A had contacted him earlier this week about performing repairs in the bathrooms of the facility. -He was asked to repair grout, replace missing tiles, and make the bathrooms functional and look good. -He stated he specialized in tile work, and has worked for the O/A in the past.	D 079		

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D 079	Continued From page 5 3. Observation of the bathroom shared by Resident Rooms #2 and #3 on 12/1/15 at 11:00am revealed: -The green linoleum flooring squares underneath and around the toilet in the bathroom between Room #2 and Room #3 were discolored. -The flooring around the toilet in the bathroom between Room #2 and Room #3 was wet with an unknown substance. -There was urine in the toilet of the bathroom between Room #2 and Room #3; the bathroom had a strong odor of urine. -There was no toilet tissue holder in the bathroom between Room #2 and Room #3; the toilet tissue was sitting on the sink in front of the toilet. Interview with Resident #3 on 12/01/15 at 10:30am revealed: -He resided in Room #2. -He had no complaints about the cleanliness of his room, his bathroom, or the facility. Observation of the O/A on 12/01/15 at 11:16am revealed: -The O/A checked the bathroom between Rooms #2 and #3. -The O/A flushed the toilet. -The toilet was sluggish when flushed so the O/A used a plunger on the toilet. -The O/A mopped the wet floor around the toilet. Interview with the O/A on 12/01/15 at 11:25 am revealed: -The flooring in the bathroom between Room #2 and Room #3 had been like that "for a while." -The flooring had become discolored because the male residents' who resided in the two rooms unintentionally urinated on the floor. -The smell of urine in the bathroom had been	D 079		

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D 079	Continued From page 6	D 079		

coming from the urine on the floor and in the toilet bowl.
-There was usually a mat placed on the floor in front of the toilet in that bathroom to prevent the residents from urinating on the floor.
-The O/A had purchased some "sheet vinyl" to replace the flooring in the bathroom between Room #2 and Room #3 and had made plans to have it installed "today or tomorrow."

Observation on 12/01/15 at 3:10pm revealed;
-The bathroom between Room #2 and Room #3 was clean and had no smell of urine.
-The floor was dry.
-There was a gray mat on the floor in front of the toilet.

Interview with the RCC on 12/03/15 at 9:00am revealed:
-All facility staff were responsible for maintaining the cleanliness of all areas inside of the facility.
-It was facility procedure for the RCC to verbally report any maintenance or repair issues to the O/A.
-The O/A was responsible for coordinating all facility maintenance and repairs.

Interview with the O/A on 12/03/15 at 9:18 am revealed:
-The toilet between Room #2 and Room #3 had been clogged on 12/01/15 and had been repaired; "somebody put towels in it."

4. Observation of the Maintenance/Janitor's closet located on the same side of the hallway as the kitchen and dining room on 12/1/15 at 10:00am revealed:
- The door was left unlocked and wide open.
- The closet was approximately 3 feet wide, and contained a metal laundry sink.

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D 079	Continued From page 7 - Several used, dirty, damp cleaning cloths were draped over the side of the sink. - Three 1-quart spray bottles of grout scrubber were hanging off the side of the sink by the sprayer nozzles. Precautions for use included the following: "Do not eat, drink, or smoke when using. Wear eye protection, gloves, clothing protection." - Another spray bottle of disinfectant was hanging on the sink. This chemical was labeled as causing moderate eye irritation, and advised to wear protective clothing, gloves, and eye protection. - A 1-gallon container of chute and dumpster cleaner was on the floor. This chemical was labeled as causing eye irritation if direct contact is made. It may cause skin irritation with prolonged exposure. Continued observation of the facility main hallway for the next hour and 45 minutes revealed: - The door to the janitor's closet was not closed and locked until 11:45am by the RCC. - No residents closed the door to the closet. - No chemicals were removed from the closet by staff or residents. Interview with the RCC at 11:45am on 12/1/15 revealed: -He did not believe that any of the facility residents would try to use the chemicals. -Residents did not perform cleaning tasks, they knew staff performed cleaning and maintenance. -The smells and vapors of the chemicals were mildly irritating, enough to keep them away. Interview with the O/A at 2:30pm on 12/1/15 revealed he preferred to keep the closet shut tight, but did not believe residents would purposefully seek out cleaning products.	D 079		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to provide supervision for 1 of 6 residents sampled (Resident #2) who acknowledged she was smoking in her room and 1 of 6 residents (#2) who physically assaulted two residents (#4, #5) resulting in the risk for serious harm. The findings are: 1. Observation during the initial facility tour on 12/01/15 revealed there were multiple residents sitting on the front porch of the facility smoking cigarettes. Review of the facility "Smoking Policy/Procedure" revealed: -"Smoking will be allowed in designated areas only." -"Smoking in resident rooms, common rooms, treatment rooms, ...restrooms, break room, and kitchen areas is strictly prohibited. SMOKING IN BED IS STRICTLY PROHIBITED. " -"The staff will conduct an assessment upon admission to establish frequency and guidelines for each resident who wishes to smoke."	D 270		

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D 270	Continued From page 9 Review of the facility's "Smoking Policy Addendum 1" revealed: -"Any resident found smoking in the bed or the building can be immediately evicted from the resthome (sic)." -"The first violation will result in verbal warning ...The second violation will result in immediate eviction from the resthome (sic). No other notice will be provided." -"Blatant disregard of this policy will also be grounds for immediate eviction from the resthome (sic). " Review of Resident #4's current FL-2 dated 09/01/15 revealed diagnoses included bi-polar disorder, seizure disorder, anemia, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Resident Registry revealed Resident #4 was admitted to the facility on 04/12/12. Review of Resident #4's medical record revealed Resident #4 received ongoing evaluation and treatment from a mental health provider. Observation and interview with Resident #4 on 12/01/15 at 2:24pm revealed: -Resident #4 was alert and oriented, neatly groomed, and dressed for the season. -A surveillance camera was installed in Room #1 because Resident #2 had been smoking in the bed and bathroom. -The last time Resident #4 observed Resident #2 smoking in Room #1 was "about a week ago." -Resident #4 observed Resident #2 go in the bathroom with her walker (where she kept her cigarettes and lighter). -Resident #4 "could smell it" [the cigarette smoke]	D 270		

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and observed a "cigarette butt" in the toilet after Resident #2 came out of the bathroom a week ago.
-Resident #4 observed a third shift staff member come into Room #1 to ask Resident #2 if she was smoking; Resident #2 admitted she was smoking in her bed.
-"I can't tell you the date. A couple weeks ago maybe."
-"The Administrator has caught her" [Resident #2] smoking inside the facility.
-The Resident Care Coordinator (RCC) had caught Resident #2 smoking inside the facility.

Additional interview with Resident #4 on 12/02/15 at 1:46pm revealed:
-Resident #2 had admitted she had been smoking in her bed to a third shift staff member.
-Resident #4 did not know how often staff checked on residents at night: "I sleep soundly at night and it doesn't wake me up" (when staff complete resident checks).

Review of Resident #5's current FL-2 dated 04/15/15 revealed diagnoses included alcoholic liver disease with cirrhosis, anemia, uncontrolled diabetes mellitus, and noncompliance with medical treatment.

Observation and interview with Resident #5 on 12/01/15 at 10:56 am revealed:
-Resident #5 was alert and oriented.
-Resident #5 was ambulating in the common hallway walking towards Room #1.
-Resident #5 resided in Room #1.
-One of Resident #5's roommates (Resident #2) had been caught smoking in their room multiple times.

Interview with Resident #5 on 12/02/15 at

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D 270	Continued From page 11 10:10am revealed: -Resident #5 "caught her [Resident #2] smoking in bed three times. I ratted her out" to the O/A. -The last time Resident #5 had observed Resident #2 smoking in bed was "last month." -Resident #2 went into the bathroom to smoke now. -"I can smell the smoke." -"I can see her ashes." -Resident #5 had not observed any other residents smoking in the facility. -It was facility policy that smoking was only allowed outside of the building on the porches. -All residents signed the facility's smoking policy. Review of Resident #2's current FL-2 dated 01/02/15 revealed diagnoses included aftercare following surgery of the musculoskeletal system, irritable bowel syndrome (IBS), anxiety state unspecified, insomnia unspecified, asthma unspecified, and unspecified neuralgia. Review of Resident #2's medical record revealed: -A "Resident Smoking Assessment" completed for Resident #2 by the RCC was signed and dated 01/12/15. -The Smoking Assessment completed for Resident #2 included the following documentation: -Resident #2 was oriented to person, place, and time. Resident #2 accepted responsibility to refrain from smoking in bed. -Resident #2 could verbalize the location of designated smoking areas. A "Smoking Contract" was signed by Resident #2 and dated 01/12/15. -The "Smoking Contract" signed by Resident #2 included the following documentation: "I agree to	D 270		

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stipulate to refrain from smoking in my bedroom or in the building at any time; ..."I agree to adhere to the smoking policies, and understand if I violate this agreement, I will lose the privilege of carrying my cigarettes and lighter and that serious violations may also result in eviction from the facility.
-A "Smoking Policy Addendum One" was signed by Resident #2 and dated 08/24/15.

-Documentaion dated 07/02/15 revealed Resident #2 was evaluated by a mental health provider with recommended follow up in 2 weeks.
-The mental health provider documented "mood stable" and recommended 1 month follow up on 07/30/15.
-The mental health provider documented diagnoses including "anxiety, panic attacks", with referral to psychiatrist and psychology on 08/14/15.
-Documentation in the "Nurses Notes" dated 10/21/15 revealed Resident #2 refused a scheduled appointment with the psychiatrist.

Review of the Resident Registry for Resident #2 revealed that Resident #2 was admitted to the facility on 01/14/15.
-Documentation dated 07/17/15 signed by the Owner/Administrator (O/A) under section G "Discharge/Transfer Information" revealed the Administrator initiated paperwork for discharge/transfer for Resident #2 due to her smoking in the facility.

Observation and interview with Resident #2 on 12/01/15 at 11:05am revealed:
-Resident #2 was lying in bed in Room #1.
-Resident #2 was alert and oriented.
-The O/A of the facility had installed a surveillance camera in Room #1 "because of my smoking."

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D 270	Continued From page 13 -"I smoked in here sometimes." -The facility had a policy that smoking was only allowed on the porches. -Resident #2 did not smoke inside the facility anymore; "it's been over a month since I did." -Two different third shift staff members had caught her [Resident #2] smoking inside the facility in Room #1. -When the third shift staff members caught her smoking in Room #1, "I admitted it." -Resident #2 had read and signed the facility's smoking policy. -Staff checked on residents "every little bit" and answered if she rang her call bell. A second interview with Resident #2 on 12/03/15 at 3:42pm revealed: -Resident #2 "smoked some in my room about a month ago." -A relative of Resident #2's family member had died; "I was real upset and not thinking straight so that's probably why I was up smoking in the room." -Resident #2 had observed another resident smoking inside the facility in Room #1 "two weeks ago" but did not report the incident to facility staff "because they would think it was me." Observation and interview with a second resident on 12/01/15 at 10:45 am revealed: -The resident was alert and oriented, and neatly groomed. -The resident was sitting in the Day Room of the facility. -There was no smoking allowed inside the facility. -Residents could smoke on the front or back porch of the facility. -The resident had not observed any resident smoking inside the facility.	D 270		

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	HAL078082	A. BUILDING: _____ B. WING _____	12/03/2015

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D 270	Continued From page 14 Interview with a third resident on 12/2/15 at 2:10pm revealed: -Staff came around and checks on residents during the day and night. -Staff opened the room doors to check when completing resident checks. Interview with a fourth resident on 12/2/15 at 2:20pm revealed: -He had not observed anyone smoking in the building. -He has not heard anyone say anybody was smoking in the building. -He goes to bed early after he takes his medicine. -He noticed staff comes around to check on him. -He does not know how often staff comes around because he is sleep. -Staff stays all night at the facility. Observation of the facility's documentation for resident checks revealed: -Staff initialed resident checks were completed on all residents on the dates 11/23/15 through 12/2/15 in 30 minute increments. -No other documented checks were provided by the facility. Interview with a Medication Aide (MA) on 12/02/15 at 3:00 pm revealed: -The facility's smoking policy allowed smoking "only in designated areas." -No smoking was allowed inside of the building. -The MA thought the camera had been installed in Room #1 "to catch residents smoking in there." -The MA had not observed any resident smoking inside the facility. -The MA had "often" smelled smoke "upon entering the room of the females" [Room #1]. -The MA last smelled smoke in Room #1 "a month ago."	D 270		

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D 270	Continued From page 15 -The MA had observed Resident #2 and Resident #4 "accusing one another of smoking in the room." Interview with another MA on 12/03/15 at 2:20pm revealed: -Resident #2 had admitted to smoking inside the facility. -There had been instances when the O/A had taken Resident #2's cigarettes and lighter in order to prevent her from smoking in the building. -The MA had no knowledge of any other resident smoking inside the facility. Telephone interview with a third shift MA on 12/03/15 at 9:26 am revealed: -The MA had observed Resident #2 sitting on the side of her bed with a lit cigarette "multiple times." -The MA had "suspected" resident #2 was smoking in Room #1 "multiple times." -The MA had "caught" Resident #2 coming out of the smoke filled bathroom and had seen cigarette butts in the toilet. -The last time the MA observed Resident #2 smoking in Room #1 was "one month ago." -The MA was in the office monitoring the video feed from the surveillance camera in Room #1 when she [the MA] observed Resident #2 sit up in her bed and light a cigarette. -The MA went into Room #1 and questioned Resident #2 about smoking in bed. -Resident #2 told the MA she did not know why she was smoking in her bed. -The MA confiscated Resident #2's cigarettes and lighter and notified the O/A. -It was facility policy to complete an incident report when a resident was caught smoking inside the facility: "We fill out the report and hang it in the office."	D 270		

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-The staff who observed the smoking was responsible for completing the incident report.
-The MA did not complete an incident report the last time ("a month ago") she observed Resident #2 smoking in Room #1 because "we had updated the smoking policy, [Resident #2] said she didn't realize what she was doing, and he [the O/A] told me not to."
-The MA had written an incident report on the previous occasions when Resident #2 was caught smoking inside the facility.
-The MA thought the other third shift MA had observed Resident #2 smoking inside Room #1.
-The MA had last completed an incident report related to Resident #2 smoking in the facility "maybe in October, I think."

Review of the facility Incident Reports revealed:
-An incident report dated 06/22/15 signed by a third shift MA with documentation including "I smelled smoke in the office. I then checked Room 1 and seen (sic) [Resident #1] leaving the bathroom with a cigarette being in the toilet."
-An incident report dated 06/10/15 signed by another third shift MA with documentation including "found cigarette butt in commode and she [Resident #2] confessed it was hers. Told Administrator."
-There were no other incidents reports located in regards to Resident #2 smoking inside the facility.

A second third shift MA was unavailable for telephone interview during the time of the survey.

Interview with the RCC on 12/01/15 at 3:00pm revealed:
-The RCC had not directly observed Resident #2 smoking inside the facility.
-There had been instances when the RCC saw smoke and smelled smoke after Resident #2

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exited the bathroom.
-The RCC was aware Resident #2 had admitted to smoking inside the facility.
-Resident #4 and Resident #5 had "complained" to the RCC that Resident #2 was smoking in their room.
-The RCC had not seen any other resident smoke inside the facility.
-The RCC had no knowledge of other residents smoking inside the facility.
-The RCC had implemented interventions such as telling the residents to ring the buzzer when they observed or suspected smoking in the room and providing smoking cessation materials to the residents to include videos and printed handouts.
-Residents are checked on by facility staff every two hours or as needed.

Interview with the O/A on 12/01/15 at 11:30am revealed:
-The surveillance camera had been installed by the O/A in Room 1 "three weeks ago...because the ladies were accusing one another of smoking."
-Resident #4 and Resident #5 told the O/A Resident #2 smoked in their room.
-Resident #2 had told staff she was smoking inside the facility.
-Resident #2 was "very remorseful" about smoking inside the facility.
-Prior to the installation of the surveillance camera in Room #1, the facility interventions to prevent smoking in Room #1 included monitoring residents every two hours and more closely as needed and instructing the residents to ring the call bell to alert staff.
-The O/A had discussions with the three residents in Room #1 "on and off" about the "behaviors, bickering, smoking, and accusing one another."
-He [the O/A] could not move any of the three

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D 270	Continued From page 18 residents in Room #1 to another room because the facility was full and there were no more female rooms available. A second interview with the O/A on 12/01/15 at 2:45 pm revealed: -The O/A had given the County AHS Resident #2's FL-2 form to initiate moving her to another facility. -"Nobody will take her [Resident #2] because of her history." -"We cannot put somebody in there [Room #1] 24/7 " (twenty four hours daily/7 days per week). Interview with the O/A on 12/03/15 at 9:20am revealed: -The O/A had never observed Resident #2 smoking in Room #1. -The O/A received reports of "alleged smoking" from "several staff." -Resident #2 had told the O/A that Resident #4 smokes in Room #1. -Residents #4 and Resident #5 told the O/A Resident #2 smokes in Room #1. -Some residents only smoked part of their cigarette and "put it out and then smoke the rest of it later" which created the smell of smoke inside the facility. -All residents had read and signed the smoking policy and addendum to the smoking policy. A second interview with the O/A on 12/03/15 at 1:30pm revealed: -The County Department of Social Services (DSS) had issued a Corrective Action Report (CAR) regarding smoking in the facility in "July or August" 2015. -The camera "was put there [Room #1] to verify if smoking was going on in the room ...It's a danger ...Anything can happen with smoking in there."	D 270		

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D 270	Continued From page 19 -"What else can you try [to prevent smoking in the room]?" -All of the residents in Room #1 had reported there was smoking going on in the room "over the last 90 days." -The O/A was aware of the incident a month ago when the third shift MA observed Resident #2 on camera smoking in her bed. -"I think I told her [the third shift MA] I would be responsible for making the incident report." -"I did not want to report it because we are trying to discharge her [Resident #2]." 2. Interview with Resident #4 on 12/01/15 at 2:24pm revealed: -"She [Resident #2] hit me and [the O/A] called the Sheriff, a week and a half ago." -Resident #2 and Resident #4 had been in conflict "for a while" but there had not been any physical altercation until the incident "a week and a half ago." -Resident #4 was awakened from sleep at about 11:30pm as Resident #2 got up to go to the bathroom. -Resident #4 sat up in her bed; "I told her not to get my cigarettes." -When Resident #2 came out of the bathroom "she hit me on the right side of my face." -Twice "last week" Resident #2 got out of bed and came towards Resident #4; "[the O/A witnessed it; he had to get in between us." -"I want her to hit me ...so I can get a bruise and I can swear out a warrant on her." -The O/A told Resident #4 he could not relocate her to another room in the facility because the facility was "full." -The O/A was attempting to relocate Resident #2 to another facility "but nobody will take her." -Resident #4 did not feel safe in the facility "at the moment."	D 270		

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D 270	Continued From page 20 Interview with Resident #4 on 12/02/15 at 1:46pm revealed: -Resident #2 had "bumped" into her [Resident #4] bed and woke her up as she was going into the bathroom. -Resident #2 had "slapped" Resident #4's upper shoulder when she was exiting the bathroom. -Resident #4 and Resident #2 had two additional "really bad" altercations within the last week. -The O/A was "holding" Resident #2 "back." -The Sheriff came the next day. -The O/A "wrote [Resident #2] up" for both of the altercations. -Resident #4 felt safer with the camera in Room #1. -Resident #4 started having conflict with Resident #2 "ever since she [Resident #2] got here." -The O/A was aware of the issues with Resident #2, but "it does not make a difference." -Resident #4 did not know how often staff checked on residents at night: "I sleep soundly at night and it doesn't wake me up" (when staff completes checks). Interview with Resident #2 on 12/01/15 at 2:50pm revealed: -"There are two sides to the story." -"She [Resident #4] claimed I slapped her. I shoved her in the back because she said I stole her cigarettes." -The Sheriff had come to the facility and talked to her and Resident #4. Interview with Resident #2 on 12/03/15 at 3:42pm revealed: -Resident #2 did not "get along" with [Resident #4]. -Resident #2 and Resident #4 had been "arguing since the day I got here."	D 270		

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D 270	Continued From page 21 -Resident #2 and Resident #4 argue "a lot" over the volume of the televisions in their room. -Resident #2 and Resident #4 argue because "she [Resident #4] takes BC's and was staggering all around. I told them [staff] where she kept them in the drawer. She got pissed off." -"I ran into her bed and she started accusing me of stealing her stuff." -"I shoved her on the back and told her to shut up." -The O/A "knows all about it." -Resident #2 acknowledged "I grabbed [Resident #5] by the throat" after resident #5 had called her " a c----." Interview with Resident #5 on 12/02/15 at 10:10am revealed: -"[Resident #2] hit me once and grabbed me by my neck months back." -"She [Resident #2] apologized but I told her if she did it again I would kick her a--." -Resident #2 and Resident #4 had verbal altercations "all the time " -Resident #4 had told Resident #5 "she was afraid for her life." -Staff was aware of the conflict between Resident #2 and Resident #4, and the O/A and RCC had talked with both residents multiple times. Interview with the RCC on 12/01/15 at 3:00pm revealed: -Resident #2 and Resident #4 had "love/hate relationship." -Resident #2 and Resident #4 "bicker about the TV volume." -Resident #2 turned up the volume on her TV because she was hard of hearing. -The RCC had observed Resident #2 and Resident #4 yelling at each other "several times." -The RCC had never observed any physical	D 270		

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D 270	Continued From page 22 confrontation between Resident #2 and Resident #4. -The verbal conflict between Resident #2 and Resident #4 had been going on for "months." -The RCC had not received any complaints from other residents or family members about the verbal conflict between Resident #2 and Resident #4. -The RCC had "tried getting a headphone set" to decrease the conflict about the TV volume but the TVs were not compatible with the headphones. -The RCC thought Resident #2 being reported for smoking caused a ripple effect and contributed to Resident #2 and Resident #4 to arguing. -Both Resident #2 and Resident #4 had mental health diagnoses. -Resident #2 had refused appointments with her mental health provider. -Resident #4 was seen by a mental health provider. -The contracted primary care provider for the facility who is an Adult Nurse Practitioner (ANP) was aware Resident #2 refused mental health appointments. -The RCC had attempted to help relocate Resident #2 to another facility but Resident #2 refused his assistance. -Resident #2 had previously resided in "several homes and has not always left on good terms." Interview with the O/A on 12/01/15 at 11:30am revealed: -The surveillance camera had been installed to monitor Room 1 "because the ladies were squabbling ... " -The conflict between Resident #2 and Resident #4 had been "ongoing for months." -The O/A had discussions with the three residents in Room #1 "on and off" about the "behaviors, bickering, smoking, and accusing one another."	D 270		

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D 270	Continued From page 23 -The three residents in Room #1 could not be moved to another room in the facility because the facility was full and there were no more female rooms available. -"[Resident #4] said [Resident #2] struck her." -The O/A "called the Sheriff to talk some sense into them." -The O/A had been trying to find another facility for placement of both Resident #2 and Resident #4. -Resident #4 "had some issues. From time to time she'll go home and we believe she has problems with substance abuse." -The O/A had notified the County AHS regarding relocation of Resident #2 and Resident #4. Refer to the interview with the O/A on 12/01/15 at 2:45pm. Interview with the O/A on 12/03/15 at 1:30pm revealed: -There had been one incident when he got in between Resident #2 and Resident #4 to prevent a physical altercation. -He contacted the police to come to the facility about the conflict between Resident #2 and Resident #4 on 11/07/15, "I think " -The police did not file a report. -The facility policy on resident to resident abuse was to "talk to the residents and find out what is going on." -"These people have mental illnesses and we sometimes can't accommodate their needs." -"We try to do a check (on each resident) every 2 hours." -"What else are you gonna (sic) do?" -"I'm in a helpless position." _____	D 270		

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D 270	Continued From page 24 The facility provided the following Plan of Protection on 12/3/15: The facility will take the following immediate action to abate the B Violation: -Facility Owner/Administrator and staff will reach out to all residents weekly or daily to find out resident personal care and supervision needs, and if these needs are being met. Facility plans to ensure residents are protected from further risk or additional harm include: -Facility staff will continue to make 30 minute to one hour checks on residents during the day and two-hour checks at night. -Facility staff will be prepared to increase the number of resident checks to provide increased supervision to residents, as needed. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED 01/17/16.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to maintain the privacy of 3 of 6 (#2, #4, and #5) residents sampled, as evidenced by the installation and use of video surveillance equipment in a private	D 338		

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D 338	Continued From page 25 resident room without the resident's consent. The findings are: Observation on 12/01/15 at 10:50am revealed: -There was a black colored surveillance type camera mounted on the ceiling in Room #1 between two closet doors. -The camera was stationary. -There were no colored lights lit on the camera. Observation and interview with Resident #5 on 12/01/15 at 10:56 am revealed: -Resident #5 was alert and oriented. -Resident #5 was ambulating in the common hallway walking towards Room #1. -Resident #5 resided in Room #1. -Two other female residents (Resident #2 and Resident #4) resided in Room #1 with Resident #5. -One of Resident #5's roommates had been caught smoking in their room multiple times. -There was a camera in Room #1 because Resident #2 smoked in the room. Review of Resident #5's current FL-2 dated 04/15/15 revealed diagnoses included alcoholic liver disease with cirrhosis, anemia, uncontrolled diabetes mellitus, and noncompliance with medical treatment. Review of Resident #5's record revealed there was no documentation of consent for the installation or utilization of video surveillance equipment in Resident #5's private bedroom. Observation and interview with Resident #2 on 12/01/15 at 11:05am revealed: -Resident #2 was lying in bed in Room #1. -Resident #2 was alert and oriented.	D 338		

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D 338	Continued From page 26 -There was a rollator walker sitting at the resident's bedside. -The camera had been in Room #1 "about a month." -The camera was "not on all the time; the camera is on at night." -The camera "bothers" Resident #2. -The O/A had not notified her prior to placing the camera. -"We didn't sign anything about any camera." -Resident #2 had discussed her concerns about the camera with the Owner/Administrator (O/A) at the time the camera was installed. -The O/A told Resident #2 the camera was installed because she [Resident #2] had been smoking in the room and because Resident #4 had been taking BC Powder Medication that she [Resident #4] was not supposed to be taking. -"I thought he [the O/A] was joking at first because you can't just up and do that." -"It's a violation of my privacy." Review of Resident #2 current FL-2 dated 01/02/15 revealed diagnoses including aftercare following surgery of the musculoskeletal system, irritable bowel syndrome (IBS), anxiety state unspecified, insomnia unspecified, asthma unspecified, unspecified neuralgia, neuritis, and radiculitis. Review of the Resident Registry revealed Resident #2 was admitted to the facility on 01/14/15. Review of Resident #2's record revealed there was no documentation of consent for the installation/utilization of video surveillance equipment in the resident's private bedroom. Observation and interview with Resident #4 on	D 338		

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	HAL078082	A. BUILDING: _____ B. WING _____	12/03/2015

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12/01/15 at 2:24pm revealed:
-Resident #4 was alert and oriented.
-Resident #4 was neatly groomed and dressed for the season.
-Resident #4 resided in Room #1 with two roommates.
-The camera had been in Room #1 "3 or 4 weeks."
-The camera was installed in Room #1 because "[Resident #2] smokes in bed and in the bathroom and she hit me and we called the Sheriff."
-The O/A told Resident #4 "he needed to take footage to protect me."
-"[The O/A] wants to put the fear of God in [Resident #2]."
-The O/A discussed the installation of the camera with each resident of Room #1 after the camera was installed.
-She [Resident #4] had given verbal consent for the camera to the O/A after it was installed; "[The O/A] came to me two weeks ago and asked my permission."
-Resident #4 dressed in the bathroom "for privacy."
-Resident #2 "still dresses and undress in there and I don't think she believes it's [the camera] on."
-The O/A had shown Resident #4 footage from the camera in Room #1; "it is camera number 4."
-The camera is "on at night"; "if the camera has a red light on, it is taping."
-The O/A told Resident #4 he was trying to move Resident #2 to another facility but "nobody would take her" because she had problems at the other places she had lived.

Review of Resident #4's current FL-2 dated 09/01/15 revealed diagnoses included bi-polar disorder, seizure disorder, anemia, and Chronic

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D 338	Continued From page 28 Obstructive Pulmonary Disease (COPD). Review of the Resident Registry revealed Resident #4 was admitted to the facility on 04/12/12. Review of a handwritten document in Resident #4's record revealed: -Documentation acknowledging "request for monitoring" by Resident #4 at the discretion of the facility administrator. -The document was signed by Resident #4 and dated 12/01/15. Observation on 12/01/15 at 3:25 pm revealed the O/A brought a black colored camera to the survey team and reported he had just removed the camera from Room #1. Observation on 12/01/15 at 4:15pm revealed there was no camera mounted on the ceiling of Room #1. Observation on 12/02/15 at 09:55am revealed there was no camera in Room #1. Interview with Resident #5 on 12/02/15 at 10:10am revealed: -The camera had been in Room #1 "2 months or a little less." -The O/A told Resident #5 the camera was installed to "catch [Resident #2] smoking." -Resident #4 told Resident #5 "she [Resident #4] was afraid for her life" and the camera was installed "to protect her [Resident #4]." -Resident #5 had not given verbal or written consent for the camera to be installed "in my private room" [Room #1]. -Resident #5 told the O/A the camera was invading her privacy "when I saw it" [the camera]	D 338		

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D 338	Continued From page 29 in the room. -The O/A did not remove the camera after talking to Resident #5; "but there was nothing I could do about it." -"I think it's [the camera] against the law." -The O/A removed the camera from Room #1 "yesterday" (12/01/15) after you guys [the survey team] left." Interview with Resident #4 on 12/02/15 at 1:46pm revealed: -The camera had been removed from Room #1 the previous day (12/01/15). -"I know it [the camera] was an invasion of our privacy." Interview with a Medication Aide (MA) on 12/02/15 at 3:00 pm revealed: -The camera had been in Room #1 "about a month or so." -The MA thought the camera had been installed in Room #1 because of the "arguing and bickering ..." and "to catch residents smoking in there." -The MA had never been shown how to operate the camera in Room #1. -The MA had heard that other MAs working in the facility used the camera. -The camera was on "at night mainly." -The MA had not received any complaints from any of the residents of Room #1 about the camera. Telephone interview with a second MA on 12/03/15 at 9:26 am revealed: -The camera had been in Room #1 "maybe a month." -The MA had not received any complaints from Resident #2 or Resident #4 about the camera in Room #1.	D 338		

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-Resident #5 had complained to the MA about the camera; [Resident #5] "didn't want the camera in the room."
-The MA had not received any complaints from visitors about the camera in Room #1.
-The MA had utilized the camera to monitor Room #1.
-The MA had used the surveillance camera to observe Resident #2 sit up in her bed and light a cigarette "3 or 4 weeks ago."

Interview with the Resident Care Coordinator (RCC) on 12/01/15 at 3:00pm revealed:
-The camera had been in Room #1 a "couple weeks."
-The RCC went to work one day and "it [the camera] was here."
-The camera was installed because the residents in the room did not get along and [Residents #4 and #5] complained [Resident #2] smoked in the room.
-The RCC was "unsure" if verbal or written consent had been obtained from the residents in Room #1 regarding installation and utilization of the surveillance camera.
-Prior to the installation of the camera in Room #1, video surveillance equipment had only been utilized in the common areas of the facility.
-The RCC was "aware" Resident #2 and Resident #5 "did not like the camera."
-Resident #2 told the RCC she had been in contact with facilities in another county about placement but refused assistance from the RCC.

Interview with the O/A on 12/01/15 between 11:16 am and 11:40 am revealed:
-The surveillance camera was installed in Room 1 "because the ladies were squabbling and accusing one another of smoking."
-The camera was installed "three weeks" ago.

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D 338	Continued From page 31 -The O/A installed the camera. -The surveillance camera had capabilities for motion detection and recording. -The three residents who resided in Room #1 had not given any type verbal or written consent before the camera was installed. -The O/A had spoken to each of the three residents who resided in Room #1 individually and "also together around the 3rd or 4th of the month" (November) about the installation of the camera after it was installed. -The O/A did not have any documentation of discussing the installation and utilization of the camera with any of the three residents. -The facility contract did not contain any documentation about the use of surveillance/camera equipment in private residents' rooms. -There was a sign posted on the entrance door to the facility acknowledging surveillance equipment is used only in the common areas of the facility. -The O/A acknowledged "two residents don't want the camera; one resident wants the camera." -Resident #2 had "voiced concerns" to the O/A "the other day ...that it [the camera] was violating her privacy." -Resident #5 had told the O/A she "wanted it [the camera] taken down." -The camera in Room #1 was focused on Resident #4 "because she wants it [the camera]." -Prior to the installation of the surveillance camera, the facility interventions to prevent smoking and conflict in Room #1 included monitoring residents every two hours and more closely as needed and instructing the residents to ring the call bell if there were any problems. -The camera was turned on at random times "during conflict" or "any indication of anyone trying to smoke." -The camera is used "mostly for intimidation."	D 338		

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D 338	Continued From page 32 -The County Adult Home Specialist (AHS) had discussed the use of the surveillance camera in Room #1 with him "at length" during her monthly monitoring visit on 11/30/15. -The O/A called the Adult Care Licensure Section on 11/30/15 after talking with the county AHS and was told "if the residents' did not want [the camera] in their room we couldn't use it." A second interview with the O/A on 12/01/15 at 2:45 pm revealed: -The O/A acknowledged the residents' rights had been "usurped"; "I wouldn't say violated." -We cannot put somebody in there [Room #1] 24/7 (twenty four hours daily/7 days per week). Interview with the O/A on 12/03/15 at 1:30pm revealed: -The County Department of Social Services (DSS) had issued a Corrective Action Report (CAR) regarding smoking in the facility in "July or August" 2015. -The camera "was put there [Room #1] to verify if smoking was going on in the room ...It's a danger ...Anything can happen with smoking in there." -"What else can you try [to prevent smoking in the room]? " -All of the residents of Room #1 had reported there was smoking going on in the room " over the last 90 days " -Staff had reported "potential smoking" in Room #1 within the last 30 days. -"At any time they [the residents] said they did not want the camera, then I should have removed it. It was not in my authority to put it up because it was not in the contract." _____ The facility provided the following Plan of	D 338		

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D 338	Continued From page 33 Protection on 12/02/15: Immediate action taken by the facility to immediately abate the A2 Violation included: -Facility Owner/Administrator removed surveillance equipment from Room #1 on 12/01/15 to re-establish and maintain residents' privacy. Plans to ensure residents are protected from further risk or additional harm include: -Facility staff will continue to make visual checks on residents every 30 to 60 minutes during the day and every two hours during hours of sleep . -Facility staff will increase the number of visual resident checks to protect residents from risk of harm and to provide increased supervision to residents. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 2, 2016.	D 338		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 residents received care and services which were adequate, appropriate, and in compliance with relevant	D912		

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D912	Continued From page 34 federal and state laws and rules and regulations regarding personal care and supervision, and residents' rights. The findings are: A. Based on record reviews and interviews, the facility failed to provide supervision for 1 of 6 residents sampled (Resident #2) who acknowledged she was smoking in her room and 1 of 6 residents (Resident #2) who physically assaulted two residents (#4, #5) resulting in the risk for serious harm. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (B Violation).] B. Based on observations, record reviews, and interviews, the facility failed to maintain the privacy of 3 of 6 (#2, #4, and #5) residents sampled as evidenced by the installation and use of video surveillance equipment in a private resident room without the resident's consent. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (A2 Violation).]	D912		