Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078082	A. BUILDING: ______ B. WING ______	R 02/26/2019

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

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D 000	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted a follow up survey and compliant investigations on February 21, 22, 25, and 26, 2019. A complaint investigation was initiated by the Robeson County Department of Social Services on January 17, 2019.	D 000		
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 observations, interviews, and record review, the facility failed to assure supervision was provided for a resident (Resident #4) with a known behavior of smoking in the facility. The findings are: Review of Resident #4's current FL-2 dated 11/14/18 revealed: -Diagnoses included anxiety unspecified, asthma unspecified, and aftercare following surgery muscular. -Resident #4 was ambulatory with assistance of a	D 270		

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walker.

Observation of Resident #4's bedroom door on 02/21/19 at 8:45am revealed:
-The resident's room door was closed.
-There was a posted sign on the outside of the door which read "Caution No Smoking Oxygen in Use".

Observation of the hallway outside Resident #4's bedroom on 02/21/19 at 9:40am revealed:
-There was a smell of cigarette smoke in the air.
-There were No Smoking signs posted above the door casings of the entrance and exits doors.

Observation inside Resident #4's bedroom on 02/21/19 at 9:40am revealed:
-There was a heavy smell of cigarette smoke in the air when the door was opened.
-Resident #4 was awake and sitting in an upright position on her bed.
-There was a closed metal box with a key in the key lock on the bed beside the resident.
-There was a nebulizer machine that was off, next to the metal box on the bed.
-There was no oxygen equipment seen in Resident #4's room.

Interview with Resident #4 on 02/21/19 at 9:40am revealed she had just taken a puff of a cigarette in the bathroom.

Observation of the Medication Aide/Supervisor (MA/S) on 02/21/19 at 9:41am revealed:
-The MA/S entered Resident #4's bedroom.
-The MA/S asked Resident #4 had she been smoking in the bathroom.
-The MA/S informed the resident the smell of smoke was in the room and was not in the room earlier when she (MA/S) had been in the room to

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clean in the bathroom.
-Resident #4 told the MA/S she had one cigarette in the seat basket of her walker.

Observation of the Administrator on 02/21/19 at 9:43am revealed he entered Resident #4's room, raised the seat to her walker, and removed a half cigarette that had been burned.

Second interview with Resident #4 on 02/21/19 at 9:43am revealed:
-She had put the cigarette ashes from the half burned cigarette in the bathroom commode when she smoked it.
-She did not usually smoke inside the facility.
-Her legs were hurting and she did not feel like walking outside to smoke.
-She was allowed to have cigarettes.
-She had her own lighter inside the seat of her walker.
-Staff tried to keep her from smoking in the facility.

Interview with the Administrator on 02/21/19 at 9:50am revealed:
-Staff had monitored Resident #4 with the resident's bedroom door opened in the past when the staff had smelt cigarette smoke inside the facility.
-The facility had a smoking policy.
-All residents knew there was no smoking inside the facility.

Interview with the MA/S on 02/21/19 at 9:55am revealed:
-Resident #4 did not normally smoke in her room.
-Resident #4 normally went outside to smoke.
-She thought Resident #4 was caught smoking in the facility one day last weekend and had been placed on a seven day restriction, of not being

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allowed to keep her cigarettes and lighter, because she was smoking in her room.
-The seven day restriction ended 02/18/19.
-According to the facility smoking policy, there were specific areas where smoking was allowed.
-For a resident who smoked in the facility, there was a $5.00 fine for a first offense.
-The Administrator had recently updated the smoking policy because he was getting ready to make the facility a smoke free facility in 2020.
-All the residents were read the updated smoking policy and had signed a copy.
-She did not know the exact date for when the updated smoking policy had been read to the residents.
-She had given Resident #4 a cigarette yesterday afternoon and gave her one this morning after breakfast.
-Resident #4 went to her room and laid down after breakfast.
-The MA/S was thinking Resident #4 was going to go outside with the cigarette.
-She had not been given any specific directions on the supervision of Resident #4 from the Administrator or Supervisor since the last time Resident #4 had been caught smoking in the facility.
-Today was the second time Resident #4 had been caught smoking in her room that she (MA/S) was aware of.

Interview with a second MA/S on 02/26/19 at 12:10pm revealed:
-About 1-2 weeks ago, there was a strong smell of cigarette smoke in the hall near Resident #4's room.
-When she went into Resident #4's room, the resident was coming out of the bathroom and she (MA) could see smoke in the bathroom.
-She (MA) notified the Resident Care Coordinator

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(RCC) of what she had seen and the RCC handled it from there.
-The RCC held a meeting last week with all the residents about no smoking in the facility.

Interview with the RCC on 02/26/19 at 11:00am revealed:
-She had taken Resident #4 to the store to buy cigarettes in the past.
-She had not bought Resident #4 any cigarettes.
-She did not know how Resident #4 got the cigarettes and lighter found in her room on 02/21/19.
-She had issued the smoking addendum to Resident #4 about one week before the resident was placed on a seven day restriction for smoking in her bathroom.
-Staff were supposed to give Resident #4 a cigarette and the resident would go outside to smoke.
-She was able to tell if the resident went outside by looking at the monitor from the computer on the medication cart located in the dining room area.
-Staff were supposed to light Resident #4's cigarette if there was no one else outside to light it.
-She, or whoever was working, would just have to go outside with Resident #4 to smoke.

Interview with the Administrator on 02/21/19 at 10:32am revealed:
-Staff normally kept Resident #4's cigarettes.
-Resident #4 was given a cigarette before and after each meal and after the 10:00am and 3:00pm snacks.
-The facility staff had come to the conclusion that resident cigarettes could not be handled and the whole smoking program was an infringement on their rights, and the campus was going to be a

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smoke free campus.
-There had been a similar incident about 10 days ago with Resident #4 when staff thought smoking had occurred in the facility. There was a "stench" of cigarette smoke in the air.
-The facility went on with a policy to manage Resident #4's cigarettes.
-He told staff Resident #4 was not supposed to have cigarettes or a lighter in her possession.
-Everyone knew there was no smoking in the building.
-A smoking policy addendum was signed by everybody about eight days ago.
-Handling of cigarettes and smoking in the building was a serious issue.
-Resident #4 had disrespected smoke free policies in other places.
-When Resident #4 went places, staff had to tell her she could not smoke in those places.
-Smoking inside the building was a dangerous thing and was not proper etiquette.

Review of the facility's Smoking Policy/Procedure with Resident #4's initials dated 08-22-15 revealed:
-The facility's intent was to provide an environment to allow residents who wished to smoke, the opportunity to do so in a safe environment.
-The policy applied to all residents, staff, and volunteers.
-Smoking was prohibited in rooms, including resident rooms and restrooms.
-Smoking was allowed in designated areas only.
-Staff would conduct a smoking assessment upon admission to establish frequency guidelines, of each resident wishing to smoke.
-Any restrictions would be noted in the resident's record.
-Smoking privileges would be addressed in the

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care plan.

Review of an undated Smoking Policy Addendum with Resident #4's undated signature revealed:
-Smoking was allowed only in specified areas at designated times.
-Consequences for residents not abiding by the smoking policy would include fines, restriction of smoking privileges, and possible discharge.

Review of a Resident Smoking Assessment for Resident #4 dated 01/12/15 revealed:
-The resident was oriented to person, place, and time.
-The resident accepted the responsibility to refrain from smoking in bed.
-The resident was able to store smoking materials to prevent access by other residents.
-The resident was able to verbalize the request for smoking materials.
-The resident could verbalize the location of designated smoking areas.
-The resident's smoking regimen was not included in the care plan.

Further record review revealed there were no additional Resident Smoking Assessments completed for Resident #4.

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The facility failed to implement and provide increased supervision to Resident #4 who was known to smoke inside the facility, resulting in Resident #4's continued behavior of smoking in the bathroom inside her room, which was a fire hazard. The facility's failure was detrimental to the health, safety, and welfare of all the residents in the facility and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G. S. 131D-34 on 02/21/19 for

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D 270	Continued From page 7 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2019.	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 assure an inhaler used to treat respiratory disorders was administered as ordered for 1 of 2 sampled residents (Resident #5) who had a history of chronic obstructive pulmonary disease (COPD). The findings are: Review of Resident #5's current FL-2 dated	D 358		

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11/24/18 revealed:
-Diagnoses included diabetes mellitus type 2, bipolar disorder, schizophrenia, hypercholesterolemia, and chronic obstructive pulmonary disease (COPD).
-There was a medication order for Spiriva (used to treat respiratory disorders such as COPD) 18 micrograms (mcg) inhale one capsule once daily.
-There was a medication order for Pro-Air (used to treat respiratory disorders) inhale one puff four times a day as needed.

Review of Resident #5's February 2019 electronic medication administration records (e-mar) revealed:
-There was a computer generated entry for Spiriva 18 mcg handihaler inhale contents of one capsule (two inhalations) once daily for COPD with administration time scheduled at 8:00am.
-There were no staff initials indicating documentation for administration of the Spiriva inhaler on 02/13/19 and 02/14/19.
-There was a computer generated entry for Pro-Air 90 mcg inhaler inhale one puff four times daily as needed for shortness of breath.
-There was documentation for administration of the Pro-Air inhaler on 02/01/19 at 6:52pm and again on 02/11/19 at 6:53pm, with documented effective results.

Review of the Medication Notes for Resident #5's February 2019 e-mars revealed:
-On 02/01/19 at 6:52pm, the medication aide (MA) documented the Pro-Air was administered for "shortness of air".
-On 02/11/19 at 6:53pm, the MA documented the Pro-Air was administered for "shortness of air".
-On 02/13/19 and 02/14/19 at 8:00am, the MA documented the Spiriva 18 mcg inhaler was "out of stock".

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Interview with the Administrator on 02/21/19 at 9:10am revealed:
-Resident #5 was admitted to the hospital last week.
-The resident was admitted for fatigue and congestion.
-The resident was said to have the flu.
-The hospital was doing evaluations.
-The resident did not give the facility staff any indication of how she was feeling prior to the hospital admission.

Review of progress notes for Resident #5 dated 02/14/19 revealed:
-The resident was not acting like herself on 02/14/19.
-The resident was "little confuse[d], talking out her head".
-The resident was sent out to the hospital for evaluation prior to the hospital admission.

Observation of Resident #5's mdications on hand 02/25/19 at 12:13pm revealed:
-There was a box of Spiriva dispensed on 01/07/19 with thirty capsules documanted as having been opened on 01/09/19.
-There were 9 tablets remaining in the Spiriva box.
-There was a second unopened box of Spiriva dispensed on 02/12/19 with thirty capsules.

Interviews with the MA on 02/25/19 between 2:30pm and 3:10pm revealed:
-The night shift MA was responsible for administering 8:00am medications and would have been responsible for administring Resident #5's Spiriva scheduled at 8:00am on 02/13/19and 02/14/19.
-She worked 7am to 2pm on 02/14/19 when

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Resident #5 was sent to the hospital.
-She had left a note in a staff notebook for the Supervisor that Resident #5's Spiriva was ordered on 02/04/19.
-She remembered Resident #5 being asleep at the table during lunch on 02/14/19.
-She asked Resident #5 if she was okay and the resident asked the MA "can you get these batteries out my mouth?" The MA told the resident she did not have batteries in her mouth and that she had Brussel sprouts for lunch.
-The resident went back to her room for a few minutes after lunch, then went to the front porch.
-The resident's family member came to visit her, and told the MA the resident was not herself and wanted the resident sent out to the hospital for evaluation.
-The MA checked the resident's vital signs and the resident's temperature was 101.4 degrees Fahrenheit.
-The Administrator called 911 for Emergency Medical Services (EMS).
-When there were five doses of a medication left, she reordered.
-It was the responsibility of all the MAs to reorder medications.
-She was not working on 02/13/19 when Resident #5 was not given her Spiriva at 8am.
-She did not know of any medication running out.
-She had always known Resident #5 to have a cough.
-She had never seen any episodes of Resident #5 not being able to catch her breath.
-Resident #5 had complained of her eyes hurting and they were "puffy" about a week before she was transported to the hospital.

Review of progress notes for Resident #5 dated 02/25/19 revealed Resident #5 was still in the hospital.

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D 358	Continued From page 11 Review of an EMS report for Resident #5 dated 02/14/19 revealed: -The chief complaint was altered mental status for one hour. -Resident #5 was asleep in bed upon EMS arrival. -The resident was alert and confused. -The resident's oxygen saturation was 96% at 2:16pm. -The resident was administered oxygen at 2 liters per minute via nasal prongs at 2:22pm. -The resident's oxygen saturation was 97%. At 2:31pm and 2:44pm. -Resident #5 was transported to the local hospital. Review of hospital emergency room rocrd for Resident #5 revealed: -Resident #5 was admitted to the hospital with altered mental status. -The resident was initially at 70% oxygen saturation on room air upon arrival, but increased to 94% on 6 liters of oxygen. -The resident was in respiratory distress. -The resident's diagnoses included acute respiratory failure with hypoxia and hypercapnia, altered mental status unspecified type, sepsis due to unspecified organism, pneumonia of right lung due to infectious organism unspecified part of lung. Interview with a second MA on 02/25/19 at 8:00pm revealed: -She was supposed to administer Spiriva to Resident #5 at 8:00am on 02/13/19 and 02/14/19. -She did not administer the Spiriva because the box was empty. -She discarded the Spiriva box dated 01/09/19 in the garbage bag on the medication cart.	D 358		

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-She did not find any more Spiriva for Resident #5 in the medication cart or in the cabinet where the overflow medication was kept.
-She did not remember any other time that Resident #5's Spiriva was out of stock.
-Medications were reordered, by the MA on duty, eight days prior to running out.
-The MA that was working received medications when they arrived from the pharmacy.
-She saw the Spiriva box that was dated 01/09/19 in the medication cart on 02/25/19 and it had seven tablets of Spiriva in the box.
-She did not know where the box came from because that was the box she had placed in the garbage.
-When a new box of Spiriva was opened, the MA would initial and date it for the day it was opened.
-The facility policy was to initial the medication box and date it for the day the medication was opened.
-Resident #5 was breathing "normally" and in no respiratory distress on 02/14/19.
-Resident #5 was a smoker and always had a cough.
-The MA told Resident #5 the Spiriva was out of stock on 02/13/19
and 02/14/19.

Telephone interview with a Pharmacist from the facility's primary pharmacy on 02/26/19 at 11:13am revealed:
-Spiriva was a medication used to dry up mucus secretions and relax the muscles in the airways and lungs..
- Spiriva was not a fast acting medication and should not be used as a rescue inhaler.

Interview with the Resident Care Coordinator (RCC) on 02/25/19 at 12:05pm revealed:
-No resident should run out of medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13	D 358		

-The reorder policy for the facility was to reorder medication when there were only seven doses remaining.
- Any of the MAs could reorder medications by electronically clicking the reorder button on the e-MAR.
-The MA was to leave a note, on the notebook at the medication cart, the medication had been reordered.

Second interview with the RCC on 02/26/19 at 9:00am revealed:
- The RCC had noticed on occasion that Resident #5's Spiriva would not be in the box in the medication cart but laying in the drawer.
-She had found other medications such as inhalers and creams misplaced in a different drawer two times during the month.
-She had straightened up the medication drawers and put medications back in their proper drawer, and had to do this about two times a month.
-She made the Administrator aware that some of the medications were out of place.
-It was the responsibility of all the MAs to inventory the medications.
-A delivery ticket was received when reordered medications arrived at the facility.

Telephone interview with a family member of Resident #5 on 2/25/19 at 3:05 pm revealed:
-She arrived at the facility on 02/14/19 and Resident #5 was sitting on the front porch, but Resident #5 did not come to the car to greet her like she usually did.
-She called Resident #5's name and the resident walked over to the car and talked to her, but was a little quieter than usual.
-Resident #5 "staggered a little" when walking toward the car.
-She walked inside the facility with Resident #5,

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078082	A. BUILDING: ____ B. WING ____	R 02/26/2019

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CROMARTIE SPRING VILLAGE REST HOME	**508 WORTH STREET SAINT PAULS, NC 28384**

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D 358	Continued From page 14 and stopped to talk with the other residents while Resident #5 went to her bedroom. -She informed staff she thought Resident #5's sugar level may be low because Resident #5 "just didn't seem like herself." -Staff checked Resident #5's "sugar" and blood pressure. - Resident #5's "sugar" and blood pressure were fine so she put her hand on Resident #5's forehead and it was warm. -Staff checked Resident #5's temperature and it was 100.8. -She told the staff to send Resident #5 to the hospital because she felt like something was wrong with Resident #5, and staff called 911. -She followed the ambulance to the hospital. -Resident #5's condition worsened in route to the hospital. -She did not know anything about Resident #5's medication. Interview with the Administrator on 02/25/19 at 4:25pm revealed: -The RCC had brought the missed doses of Spiriva for Resident #5 to his attention on 02/25/19. -He expected all medications to be administered according to the e-MAR. Attempted interview with the provider on 02/25/19 at 2:47pm was unsuccessful.	D 358		
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	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 15 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure each resident received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews, and record review, the facility failed to assure supervision was provided for a resident (Resident #4) with known behavior of smoking in the facility. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		