STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-658	A. BUILDING: _____ B. WING _____	R 01/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROL'S DDA GROUP HOME	334 MOORE STREET FAYETTEVILLE, NC 28301

(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
V 000	INITIAL COMMENTS An annual and follow up survey was completed on January 18, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108		

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide training to meet client needs and to have at least one staff in the facility when a client is present who is trained in first aid, seizure management, cardiopulmonary resuscitation (CPR), and the Heimlich maneuver, or other first aid techniques equivalent to training provided by Red Cross or the American Heart Association, affecting 2 of 3 staff audited (Staff #2, #3). The findings are: Review on 1/18/19 of client #5's record revealed: -36 year old male admitted 5/3/01. -Diagnoses included mild mental retardation, major depression, glaucoma, Hirschsprung disease and a colostomy. Review on 1/17/19 of Staff #2's Personnel record revealed: -Hire date was 7/16/18. -Position, Paraprofessional, direct care staff. -On line training for CPR dated 7/11/18. No skills training or validation equivalent to Red Cross, or the American Heart Association. -No documentation of training in first aid or seizure management. -No documentation of training in colostomy care. Review on 1/18/19 of Staff #3's Personnel record revealed: -Hire date was 3/11/15, -Position, Paraprofessional, direct care staff. -No documentation of training in colostomy care.	V 108		

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V 108	Continued From page 2 Interview on 1/18/19 Staff #3 stated: -She worked evenings and overnight "sleep" shifts, and occasionally week ends if needed. -Client #5 needed a lot of help with his colostomy. He would have leakage from his bag. -She had not had any training by the facility on colostomy care. -She had received training about 9 years prior because she had a daughter with a colostomy. Interview on 1/18/19 the Licensee stated: -Client #5 required help with his colostomy care. -She thought the staff had been trained by the registered nurse on colostomy care. -She did not realize Staff #2 did not have the required training in CPR and First Aid. -Staff #2 had been working as the only staff on duty. She would work evenings and overnights. -Staff #2 was scheduled to work the evening of 1/18/19. -She would find coverage and not allow Staff #2 to work as the only staff on duty until she was certified in CPR and First Aid as required.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted	V 114		

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V 114	Continued From page 3 under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to hold fire and disaster drills at least quarterly on each shift. The findings are: Interview on 1/17/19 the Licensee stated: -The facility shifts were as follows: -Monday - Friday 5 pm - 1 am. -Monday 9am - Saturday 1 am. -Saturday 1 am - Monday 9 am -There were no staff in the home from 9 am - 5 pm during the week days because clients were either at work, school, or their day program. -If for some reason a client was in the home between 9 am and 5 pm she or another staff would be in the home with the client. -The overnight staff were sleep staff. One staff worked from Saturday 1 am through Monday 9 am. Review of fire and disaster drills from 1/1/18 - 12/31/18 revealed: -Quarter 1/1/18 - 3/31/18: Disaster drills were documented for Friday, 1/19/18 at 8 pm, and Thursday, 2/15/18. There was no time documented for the drill on 2/15/18; therefore, the shift could not be determined. No disaster drills were documented during the week end shift. -Quarter 4/1/18 - 6/30/18: -No fire drills documented on the 5 pm - 1 am shifts. -One disaster drill was documented for Tuesday, 4/17/18, but no time documented;	V 114		

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V 114	Continued From page 4 therefore, the shift could not be determined. No disaster drills documented during the week end shift. -Quarter 7/1/18 -9/30/18: No disaster drills documented for either of the Monday - Friday shifts. -Quarter 10/1/18 -12/31/18: No disaster drills documented during the week end shift. Interview on 1/17/18 client #6 stated: -Fire and disaster drills were done. -He could not say how often these were done. -He remembered practicing tornado drills. They would go to an area in the home where there were no windows, like the bathroom, and keep their head down. -For fire drills they would go outside for a couple of minutes until they were allowed to go inside.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be	V 118		

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V 118	Continued From page 5 recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 3 of 3 clients audited (clients #1 #2, #6). The findings are: Finding #1: Review on 1/17/19 of client #2's record revealed: -66 year old male admitted 9/5/07. -Diagnoses included Mental Retardation, schizophrenia, COPD (chronic obstructive lung disease), cardiomyopathy, anemia, cerebral infection, clubbing of fingers and toes. -Order dated 8/7/18 for Famotidine 20 mg (milligrams) twice daily. (Treat/prevent stomach ulcers; heartburn; or gastroesophageal reflux disease.) -Orders on client #2's "Personal Care Physician Authorization" form dated 9/12/17 included: -Chart weight daily -Furosemide (Lasix) 20 mg as needed for weight gain greater than 3 pounds.	V 118		

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V 118	Continued From page 6 -Hold blood pressure and Lasix medication if systolic blood pressure is less than 100 -Order dated 8/7/18 for Lasix 20 mg daily as needed for swelling. Review on 1/17/19 of client #2's MARs for October 2018 revealed: -Famotidine 20 mg was scheduled to be administered at 8 am and 8 pm. No documentation Famotidine 20 mg had been administered at 8 pm on 10/20/18, 10/21/18, 10/22/18, or 10/26/18. No documentation of a reason the Famotidine had not been administered. -Weight documented on 10/4/18 was 171; on 10/5/18 the weight documented was 179. No Lasix was documented as given. -Weight documented on 10/19/18 was 171; on 10/20/18 the weight documented was 177. No Lasix was documented as given. Review on 1/17/19 of client #2's MARs for November 2018 revealed: -Weight documented on 11/9/18 was 172; on 11/10/18 the weight documented was 177. No Lasix was documented as given. -Weight documented on 11/28/18 was 171; on 11/29/18 the weight documented was 179. No Lasix was documented as given. Review on 1/17/19 of client #2's MARs for December 2018 revealed: -Weight documented on 12/3/18 was 174; on 12/4/18 the weight documented was 179. No Lasix was documented as given. -Weight documented on 12/11/18 was 171; on 12/12/18 the weight documented was 178. No Lasix was documented as given. -Weight documented on 12/13/18 was 177; Lasix 20 mg had been documented as administered at	V 118		

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V 118	Continued From page 7 8 am. -No weight documented on 12/14/18; Lasix 20 mg had been documented as administered at 8 am. Interview on 11/15/18 client #2 stated staff keep his medications locked in the office and give them to him. Finding #2: Review on 1/17/19 of client #1's record revealed: -37 year old male admitted 8/17/15. -Diagnoses included Mental Retardation, diabetes type 2, asthma, hypertensive heart disease, mixed hyperlipidemia, allergic rhinitis, decreased vitamin D levels, pedophilia. -Orders dated 8/14/18 and 12/19/18 to discontinue Tylenol 500 mg every 8 hours for muscle pain. Review on 1/17/19 of client #1's MARs for October 2018, November 2018, December 2018, and January 2019 revealed: -APAP 500 mg Ex-ST (Tylenol extra strength) every 8 hours for muscle pain was transcribed with dosing times of 8 am, 4 pm, and 12 am for each month. -APAP 500 mg Ex-ST was documented as follows: -October 2018 MAR: 8 am from 10/2/18 - 10/31/18 -November 2018 MAR: 8 am and 12 am from 11/1/1/ -11/30/18 -December 2018 MAR: 8 am and 12 am 12/3/18 - 12/7/18; 12/10/18 - 12/12/18; 12/14/18. -Transcribed on the January 2019 MAR, but no doses had been administered. Interview on 11/15/18 client #1 stated he always took his medications and the facility always had	V 118		

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V 118	Continued From page 8 his medications on hand. Finding #3: Review on 1/17/19 of client #6's record revealed: -24 year old male admitted 7/13/16. -Diagnoses included borderline intellectual functioning; disruptive mood disorder; ADHD (attention deficit hyperactive disorder); antisocial personality disorder; substance abuse. -Order dated 10/25/18 for Ventolin inhaler 90 mcg (micrograms), 2 puffs every 6 hours as needed for shortness of breath. -Order dated 10/25/18 for Nicotine patch 21 mg/24 hours; apply to skin daily. -No order to discontinue the Nicotine patch. Review on 1/17/19 of client #6's MARs for October 2018, November 2018, December 2018, and January 2019 revealed: -2 orders for Ventolin Inhaler had been transcribed. One order read to administer every 4 hours as needed, the other order read to administer every 6 hours a needed. -No Ventolin had been documented as administered from 10/1/18 - 1/17/19. -No Nicotine patch documented as applied in the months of October 2018 and January 2019. The Nicotine patch was documented in November and December 2018 daily. Observations on 1/17/19 at 4:10 pm of client #6's medications on hand revealed: -No Ventolin inhaler in client #6's medication drawer. -Nicotine patches with a dispense date of 3/23/18. Interview on 1/17/19 client #6 stated: -He had asthma. -The last time he remembered using his inhaler	V 118		

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V 118	Continued From page 9 was when he was 13 or 14 years old. -He only needed the inhaler when he ran too hard and would have trouble breathing. -Currently, he never did anything to cause him to need his inhaler. -The last time he saw his inhaler the staff had it in the medicine cabinet. Interview on 1/18/19 the Licensee stated: -Staff were to follow client #2's order to administer Lasix 20 mg as needed for weight gain greater than 3 pounds. -She did not realize client #1's Tylenol 500 mg had been discontinued on 8/14/18. -Staff should have documented on the back of the MARs if clients refused any medications. This would include the Nicotine patches for client #6. -She thought client #6's Ventolin inhaler had been discontinued. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug	V 123		

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V 123	Continued From page 10 shall be charted. .	V 123		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the physician or pharmacist of medication errors and document refusals affecting 2 of 3 audited clients (#6, #1). The findings are:

Finding #1:
Review on 1/17/19 of client #6's record revealed:
-24 year old male admitted 7/13/16.
-Diagnoses included borderline intellectual functioning; disruptive mood disorder; ADHD (attention deficit hyperactive disorder); antisocial personality disorder; substance abuse.
-Order dated 10/25/18 for Nicotine patch 21 mg (milligrams)/24 hours; apply to skin daily.

Review on 1/17/19 of client #6's Medication Administration Records (MARs) for October 2018, November 2018, December 2018, and January 2019 revealed:
-No Nicotine patch documented as applied in the months of October 2018 and January 2019. The Nicotine patch was documented in November and December 2018 daily.
-No documentation the physician or pharmacist was notified of the medication refusals.
-No documentation client #6 refused medications.

Finding #2:
Review on 1/17/19 of client #1's record revealed:
-37 year old male admitted 8/17/15.
-Diagnoses included Mental Retardation, diabetes type 2, asthma, hypertensive heart

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V 123	Continued From page 11 disease, mixed hyperlipidemia, allergic rhinitis, decreased vitamin D levels, pedophilia. -Order dated 8/14/18 to discontinue Tylenol 500 mg every 8 hours for muscle pain. -Staff documented client #1 had refused his "pm" Tylenol 500 mg on 11/17/18, and his 8 am, 4 pm, and 12 am doses on 11/18/18. -No documentation the physician or pharmacist was notified of the medication refusals; no documentation it was identified the medication had already been discontinued. -Staff documented client #1 continued to receive Tylenol in November and December 2018 until a second discontinue order was written 12/19/18. -(Refer to V118 for additional documentation of administration after the medication had been discontinued 8/14/18.) Interview on 1/18/19 the Licensee stated: -Staff should have documented and reported client #6's refusal of the nicotine patch. -She did not realize client #1's Tylenol had been discontinued in August 2018. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 123		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the	V 291		

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V 291	Continued From page 12 qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting 1 of 3 audited clients (#2). The findings are: Review on 1/17/19 of client #2's record revealed: -66 year old male admitted 9/5/07. -Diagnoses included Mental Retardation, schizophrenia, COPD (chronic obstructive lung disease), cardiomyopathy, anemia, cerebral infection, clubbing of fingers and toes. -Orders on client #2's "Personal Care Physician Authorization" form dated 9/12/17 included: -Chart weight daily -Furosemide (Lasix) 20 mg as needed for	V 291		

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V 291	Continued From page 13 weight gain greater than 3 pounds. -Hold blood pressure and Lasix medication if systolic blood pressure is less than 100 -Order dated 8/7/18 for Lasix 20 mg daily as needed for swelling. -Order dated 8/17/18 (FL2) to check blood pressures daily. Review on 1/17/18 of client #2's Medication Administration Records from 10/1/18 through 1/17/19 revealed: -"Check Blood Pressure Twice a Week" had been transcribed to client #2's MARs. -No blood pressures documented on the following dates in December 2018: 2, 3, 14, 15, 16, 18, 19, 21, 22, 23, 25, 26, 28-31. -No blood pressures documented on the following dates in January 2019: 2, 3, 5-10, 12, 13, 15, 16. -Lasix had not been documented for daily weight increases greater than a 3 pounds on the following dates: 10/5/18, 10/20/18, 11/10/18, 11/29/18, 12/4/18, 12/12/18. (Refer to V118 for additional information.) Interview on 1/18/19 the Licensee stated: -It was the facility policy to check client blood pressures twice weekly if the client was on a blood pressure medication. She did not realize client #2 had an order for daily blood pressure checks. -The facility staff were supposed to be following the orders dated 9/12/17 to determine when Lasix should be administered for swelling.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 366		

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V 366	Continued From page 14 (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy;	V 366		

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V 366	Continued From page 15 (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment	V 366		

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V 366	Continued From page 16 area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I incidents. The findings are: Review on 1/18/19 of facility records from October 2018 until present revealed no documentation of client #1 or #6's medication refusals. Review on 1/17/19 of client #6's record revealed: -24 year old male admitted 7/13/16. -Diagnoses included borderline intellectual functioning; disruptive mood disorder; ADHD (attention deficit hyperactive disorder); antisocial personality disorder; substance abuse. -No documentation client #6's Nicotine Patch had been applied daily as was transcribed on his October 2018 and January 2019 MARs. Review on 1/17/19 of client #1's record revealed:	V 366		

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V 366	Continued From page 17 -37 year old male admitted 8/17/15. -Diagnoses included Mental Retardation, diabetes type 2, asthma, hypertensive heart disease, mixed hyperlipidemia, allergic rhinitis, decreased vitamin D levels, pedophilia. -Order dated 8/14/18 to discontinue Tylenol 500 mg every 8 hours for muscle pain. -Staff documented client #1 had refused his "pm" Tylenol 500 mg on 11/17/18, and his 8 am, 4 pm, and 12 am doses on 11/18/18. -No documentation of response to client "refusals;" no identification the order should already have been discontinued. -(Refer to V118 for additional documentation of administration of Tylenol 500 mg after the medication had been discontinued 8/14/18.) Interview on 1/18/19 the Licensee stated there were no level 1 incident reports for the medication refusals. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep the facility free of insects. The findings are:	V 738		

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V 738	Continued From page 18 Interview on 11/15/18 the Licensee stated: -There had been bed bugs in the facility a few months prior. -A heat treatment was done by a licensed exterminator. -The exterminator had not provided any documentation the home had been re-inspected for bed bugs following the heat treatment. Telephone interview on 11/15/18, the Exterminator staff stated: -The records of the Exterminator documented a "routine service" in May 2018, a heat treatment for bed bugs in June 2018, and another routine quarterly treatment service in September 2018. -A re-inspection for the presence of bed bugs by the exterminator staff following heat treatments was not done unless requested by the customer (the facility). -The service in September 2018 was a routine service; it was not a re-inspection or treatment for bed bugs. Continued interview on 11/15/18 the Licensee stated: -She would get a re-inspection for bed bugs by the exterminator. -Once this was done, the Licensee would notify the surveyor for the survey to continue. Interview on 1/17/19 the Licensee stated: -The Exterminator had returned and did not find any bed bugs. -The Licensee presented the exterminator's Invoice/Inspection Report dated 12/10/18, page #2 that read under "Pest Activity ... None Noted." Further review on 1/17/19 of the exterminator's Invoice/Inspection Report dated 12/10/18	V 738		

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V 738	Continued From page 19 revealed: -Service description, "Bedbug Recurring." -General Comments/Instructions: "Treated the whole interior of facility for bedbugs hitting all the beds, bedframe's, furniture and baseboards and only found bedbugs in the room down the hallway on the right hand side. The far end. Also patient had removed the bed liner from the bed." On 1/17/19 a call was made to the exterminator to clarify the report, but no return call was received prior to the end of the survey on 1/18/19. The Licensee stated she would follow up to make sure the problem was resolved.	V 738		