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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Rockingham County Department of Social Services conducted an annual survey on July 31, 2017 with a telephone exit on August 1, 2017. | C 000 | | |
| C 007 | 10A NCAC 13G .0206 Capacity<br><br>10A NCAC 13G .0206 Capacity<br>(a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents.<br>(b) The total number of residents shall not exceed the number shown on the license.<br>(c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure.<br>(d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations.<br>(e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the | C 007 | | |

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| C 007 | Continued From page 1<br>Division of Facility Services for review of any possible changes that may be required to the building.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 2 of 5 residents (Resident #3 and #4) residing in the facility who had physical impairments which would prevent the residents from independently evacuating the facility.<br><br>The findings are:<br><br>Review of the Department of Health and Human Services Division of Health Regulations License for the facility dated January 1, 2017 revealed a capacity of 6 residents all ambulatory and up to 0 non ambulatory residents.<br><br>Observation during the initial tour between 9:50 am and 10:30 am revealed:<br>-One resident (Resident #3) was sitting in a wheelchair outside on the front porch.<br>-One resident (Resident #1) was sitting outside on the front porch with a walker in front of her.<br>-Another resident (Resident #4) was sitting inside on a chair in the common area with her head slumped downward, eyes closed, with a walker positioned in front of her.<br><br>Observation of the mobility of the residents to the dining room table for lunch between 12:00 pm | C 007 | | |

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| C 007 | Continued From page 2 | C 007 | | |

and 12:35 pm revealed:
-The Medication Aide (MA) announced lunch was ready for the residents.
-Resident #1 proceeded using her walker for mobility without assistance from staff to the dining room table.
-The MA went to Resident #4 who was sitting in the common area in the chair, the MA informed Resident #4 it was lunch time, the MA used both hands to assist Resident #4 to a standing position, the MA moved the walker closer to Resident #4, Resident #4 grabbed the walker using both hands, the MA held onto Resident #4 during the transfer to the dining room table using Resident #4's right upper arm.
-Resident #4 shuffled her feet to the dining room table, the MA pulled the chair out from the dining room table and assisted Resident #4 down into the chair.
-The MA went outside on the front porch to retrieve Resident #3.
-She pushed Resident #3's wheelchair inside and into the dining room area, the MA placed the wheelchair with Resident #3 in it at the end on of the dining room table.

Observation between 12:10 pm and 12:35 pm revealed all 5 residents fed themselves the lunch meal.

1. Review of Resident #3's current FL2 dated 3/8/17 revealed:
-Diagnoses included hypertension, chronic obstructive pulmonary disease, chronic kidney disease and hyponatremia.
-Ambulatory status documented was limited.

Review of Resident #3 Resident Register revealed:
-An admission date of 3/8/17.

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| C 007 | Continued From page 3<br>-Special aids for ambulation were for a wheelchair and a walker.<br><br>Review of Resident #3 Care plan dated 4/4/17 revealed:<br>-Resident functional status for ambulation was documented 4, "totally dependent."<br>-Resident functional status for transfers was documented 4, "totally dependent."<br><br>Interview on 7/31/17 at 11:35 am with Resident #3 revealed:<br>-She had used the wheelchair for mobility ever since she was admitted to the facility.<br>-Her family had brought the wheelchair to the facility for the resident.<br>-She stated, "I cannot walk."<br>-At night the staff placed a bedside commode beside her bed, she would pull herself up using the side rail, sit on the side of the bed and pivot to the bedside commode.<br>-There were no staff present in her room during the night to assist Resident #3 with transfer from bed to bedside commode.<br>-She had fell one time about a month ago while she was in the bathroom.<br>-She thought the staff person moved the wheelchair away from her while she was washing her hands, she had missed sitting down in the wheelchair and sat in the floor.<br>-She was not hurt and did not go the Emergency Room.<br><br>Telephone interview on 7/31/17 at 11:20 am with a representative from Resident #3's physician office revealed:<br>-The physician had seen Resident #3 in the office on 7/27/17.<br>-Resident #3 was non ambulatory and used a wheelchair each time she came to the office. | C 007 | | |

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| C 007 | Continued From page 4<br>-"I never got Resident #3 to stand to obtain her weight."<br><br>Interview on 7/31/17 at 4:15 pm with the Medication Aide (MA) revealed:<br>-She had worked in the facility for 2 years.<br>-When Resident #3 was admitted, her family brought the wheelchair to the facility.<br>-Resident #3 "cannot walk."<br>-"I have never seen her walk."<br><br>Refer to telephone interview on 7/31/17 at 2:00 pm with the Department of Health Service Regulations Construction section staff.<br><br>Refer to telephone interview on 7/31/17 at 3:10 pm with the Assistant to the Administrator.<br><br>Refer to telephone interview on 7/31/17 at 4:00 pm with the Administrator.<br><br>2. Review of Resident #4's FL2 dated 1/30/17 revealed:<br>-Diagnoses included bipolar, cognitive impaired and dementia.<br>-Ambulatory status was documented as ambulatory.<br><br>Review of Resident #4 Resident Register revealed:<br>-An admission date of 1/17/13.<br><br>Review of Resident #3 Care plan dated 7/1/16 revealed:<br>-Resident functional status for ambulation was documented " staff direction or hands on assistance with walker inside and outside 3,extensive assistance."<br>-Resident functional status for transfers was | C 007 | | |

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| C 007 | Continued From page 5 | C 007 | | |

documented "staff assist resident from bed to standing,sitting and standing 3, extensive assistance."

Observation between 9:50 am and 5:10 pm of Resident #4 revealed she remained seated in a chair in the common area with the exception of meals and one toileting occasion.

Review of Resident #4's physical therapy note revealed:
-An evaluation for Physical Therapy (PT) was completed on 4/6/17 by a licensed therapist.
-A gait balance assessment was completed with the recommendation for 2 weeks of skilled PT.
-On 4/13/17 a PT visit note increase gait distance 60' using a multiple wheeled walker. Staff reported that walker was another resident's walker. Facility staff had said they did have a two wheel walker Resident #4 could use for the time being. Will follow up with supervisor on getting Resident #4 her own walker.
-A discharge note dated 5/18/17 Resident #4 had reached her potential using a 2 wheeled walker with her gait improved but her TUG (Timed up and go test) declined.

Interview on 7/31/17 at 2:15 pm with the MA revealed:
-Resident #4 used the walker all the time.
-Resident #4 required assistance with toileting, transfers, and walking.
-Sometimes Resident #4 can "walk pretty fast."

Based on record review and attempted interview, it was determined Resident #4 was not interviewable.

Refer to telephone interview on 7/31/17 at 2:00 pm with the Department of Health Service

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| C 007 | Continued From page 6<br>Regulations Construction section staff.<br><br>Refer to telephone interview on 7/31/17 at 3:10 pm with the Assistant to the Administrator.<br><br>Refer to telephone interview on 7/31/17 at 4:00 pm with the Administrator.<br><br>_____<br><br>Telephone interview on 7/31/17 at 3:10 pm with the Assistant to the Administrator revealed:<br>-He was aware the License for the facility dated January 1, 2017 revealed a capacity of 6 residents all ambulatory up to 0 non ambulatory residents.<br>-He was aware Resident #3 was using a wheelchair for mobility and Resident #4 was using a walker for mobility.<br>-He was not aware the facility could not have non ambulatory residents if they were using walkers and wheelchairs.<br>-There was 1 staff person in the facility at all times.<br>-He would talk to the Administrator regarding Resident #3 and Resident #4's ambulatory status.<br><br>Telephone interview on 7/31/17 at 4:00 pm with the Administrator revealed:<br>-She was aware the facility license dated 2017 were for all ambulatory and 0 non ambulatory residents.<br>-She was aware Resident #3 used a wheelchair for mobility and Resident #4 used a walker.<br>-She stated, "Resident #3 can walk."<br><br>Telephone interview on 7/31/17 at 2:00 pm with the Department of Health Service Regulations Construction section staff revealed:<br>-He was aware the facility was licensed for 6 | C 007 | | |

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| C 007 | Continued From page 7<br>ambulatory residents and 0 non ambulatory residents.<br>-Resident #3 and Resident #4 did not meet the requirements for an ambulatory setting.<br>_____<br><br>Based on observation, record review and staff interviews, the facility failed to notify the Division of Facility Services and the county department of social services the evacuation capabilities of the residents changed in license for non-ambulatory residents, Resident #3 who was non ambulatory upon admission, used a wheelchair for mobility and Resident #4 who used a walker with 1 person assist for mobility. The facility failed to assure notification of Resident #3 and Resident #4 who resided in the facility as non ambulatory status had evacuation capability which is detrimental to the health and safety of residents and constitutes a Type B Violation.<br>_____<br><br>A Plan of Protection was provided by the facility on 7/31/17 as follows:<br>-We will re-assess and re-evaluate the ambulation status of all residents.<br>-Any resident found to have decreased ambulatory status will be assessed by their physician.<br>-If residents found incapable of the ability to ambulate we will notify DHSR and the facility will follow directions.<br>-All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers.<br>-Any resident incapable of ambulation will not be admitted.<br><br>DATE OF CORRECTION FOR THE TYPE B | C 007 | | |

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| C 007 | Continued From page 8<br>VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2017. | C 007 | | |
| C 100 | 10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan<br><br>10A NCAC 13G .0316 Fire Safety And Disaster Plan<br><br>(e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, interviews, and record reviews, the facility failed to perform at least four rehearsals of the fire evacuation plan, including all shifts within the appropriate time frame for evacuation of five resident's residing in the facility, two of the five residents were non ambulatory.<br><br>The findings are:<br><br>Observation on 7/31/17 at 9:50 am revealed the facility had 2 outside ramps one at the front door entrance, and another from the side door entrance.<br><br>Confidential interview with three of the five | C 100 | | |

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residents who resided in the facility revealed:
-One resident had participated in a fire drill she thought it had been in April 2017.
-Two residents could not remember the last time the facility had a fire drill.
-Three residents were unaware a fire drill had been conducted in July 2017.
-One resident said when they had a fire drill and she was told to go out the side door and stand on the side walk.

Interview on 7/31/17 at 2:15 pm with the Medication Aide (MA) pm revealed:
-A fire drill had been completed in July 2017.
-In July she announced to the residents, "the front of the house caught on fire."
-"I took all the residents outside the facility through the side door of the facility located at the end of the hallway.
-"I was the only one available for all 5 residents."
-"There is no one else available".
-She removed the resident in the wheelchair first, then returned and removed the resident that used a walker for mobility.
-The other resident who used a walker the MA removed last.
-The drills were done as though it were an actual fire.
-She had documented in the fire drill log book a fire drill had been completed on July 3, 2017.

Review of the facility's fire drill rehearsal log book revealed a fire drill dated 7/3/17 at 1:30 pm had been completed with an evacuation time of 20 minutes.

Further review of the facility fire drill rehearsal log book revealed:
-On 3/1/17 at 9:00 am documentation a fire drill rehearsal had been completed for 5 residents

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with an ending time of evacuation 9:30 am (30 minutes), one staff person had documented performing the fire drill on 3/1/17.
-The description documented on 3/1/17, "Fire started in the TV room and front of the house and I take them out the side door into the yard".
-On 4/1/17 at 2:30 pm documentation a fire drill rehearsal had been completed for 5 residents with an ending time of evacuation 2:30 pm, the time was the same beginning and ending times, one staff person had documented performing the fire drill on 4/1/17.
-The description documented on 4/1/17, " The fire started and the back bedroom I took the clients out the front door and the ramp and the yard."
-On 5/1/17 at 1:30 pm documentation a fire drill rehearsal had been completed for 5 residents with an ending time of evacuation was 20 minutes, one staff person had documented performing the fire drill on 5/1/17.
-The description documented on 5/1/17, "The kitchen caught on fire and I had to take the clients out the back door and went to the yard.
-On 6/1/17 at 2:00 pm documentation a fire drill rehearsal had been completed for 5 residents with an ending time of evacuation was 15 minutes, one staff person had documented performing the fire drill on 6/1/17.
-The description documented on 6/1/17, " the last bedroom in the back on the right side of the house caught fire and I take the clients out the front door down the ramp."
-On 7/3/17 at 1:30 pm documentation a fire drill rehearsal had been completed for 5 residents with an ending time of evacuation was 20 minutes, one staff person had documented performing the fire drill on 7/3/17.
-The description documented on 7/3/17, The front of the house caught on fire and I had to take the clients down the hall and out the backdoor and

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| C 100 | Continued From page 11<br>down the ramp."<br>-There was no documentation a fire drill rehearsal had been conduced in the facility on 3rd shift the months of March 2017- July 2017.<br><br>Review of the County Fire Marshall inspection dated 6/1/17 revealed no violations.<br><br>Observation of the facility fire extinguishers located in the kitchen and at the end of the hallway revealed an inspection date of May 2017.<br><br>Observation of the facility smoke detectors located in each resident bedroom, staff bedroom, and 2 in the hallways, for a total of 6, revealed all were in working condition.<br><br>Telephone interview on 7/31/17 at 2:00 pm with the Department of Health Service Regulations Construction section staff revealed the Fire Marshall code for evacuation of the residents from the facility was 8 minutes.<br><br>Telephone interview on 8/1/17 at 1:00 pm with the Assistant to the Administrator revealed he relied on the facility staff to conduct the fire drill rehearsals.<br><br>Based on observation, record review and staff interviews, the facility failed to perform at least four rehearsals of the fire evacuation plan, including all shifts within the appropriate time frame for evacuation residents from the facility. The Fire Marshall code for evacuation of the residents from the facility was 8 minutes. There were five resident's residing in the facility two of the five residents were non-ambulatory. The facility documented times of rehearsal for evacuation for 5 residents from the facility was between 15 to 30 minutes which exceeded the | C 100 | | |

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| C 100 | Continued From page 12<br>Fire Marshall code of 8 minutes, which was detrimental to the health and safety of all the residents and constitutes a Type B Violation.<br>_____<br>A Plan of Protection was provided by the facility on 8/17/17 as follows:<br>-The facility reviewed the fire and disaster plan with the staff and staff was re-trained on proper documentation of the fire drill logs.<br>-The facility will ensure all fire and evacuation drills are conducted in the specified times.<br>-The facility will ensure all residents are aware of the evacuation procedures.<br>-The staff will conduct and document drills accurately and ensure residents are able to exit the facility independently.<br>-The Administrator will review these areas quarterly and without notice to the staff or clients to ensure compliance.<br><br>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2017. | C 100 | | |
| C 272 | 10A NCAC 13G .0904(d)(2) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(d) Food Requirements in Family Care Homes:<br>(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure 5 of 5 | C 272 | | |

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| | FCL079089 | A. BUILDING: _____ B. WING _____ | 08/01/2017 |

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| SAFE HAVEN # 2 | 157 GLENDALE DRIVE EDEN, NC 27288 |

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| C 272 | Continued From page 13<br>residents ( Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) residing in the facility were being offered a snack 3 times a day in between meals.<br><br>The findings are:<br><br>Observation on 05/16/17 from 9:50 am to 4:10 pm revealed there were no snacks offered or served to the residents in the facility.<br><br>Observation between 9:50 am and 10:40 am during the initial tour of the facility revealed the facility kitchen was stocked with multiple snacks for the residents which included crackers and peanut butter, cereal, can fruit and applesauce.<br><br>Review of the kitchen menu revealed the am snack consisted of V8 juice 4 oz or 1 small carrot sliced, and the afternoon snack consisted of 4 oz of grapefruit juice or ½ grapefruit, there was no snack on the menu for an evening snack.<br><br>Interview with three residents in the facility on 07/31/17 at 11:00 am and at 2:40 pm revealed:<br>-The facility staff had not offered or served snacks on 7/31/17.<br>-They could not recall the last time snacks were served.<br>-"We use to get a snack 3 times a day, but I don't know what happened."<br>-They had never asked for snacks.<br>-"I would like a snack sometimes before my lunch."<br><br>Telephone interview with the Assistant to the Administrator on 7/31/17 at 3:10 pm revealed:<br>-He was not aware snacks were not being served or offered to the residents 3 times daily.<br>-He was aware the kitchen was stocked with | C 272 | | |

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| C 272 | Continued From page 14 | C 272 | | |

snacks to serve.
-He was aware snacks were to be served three times daily.
-It was the Medication Aide's (MA) responsibility to offer snacks to the residents 3 times daily.

Telephone interview with the Administrator on 7/31/17 at 3:20 pm revealed:
-The Medication Aide knows to offer and serve snacks 3 times daily to the residents.
-She was unaware the residents had not received a snack today or for several days.
-She was unaware the residents said "they could not remember when they last had a snack."
-She was aware the kitchen was stocked with food and snacks for the residents in the facility.
-The MA had told the Administrator she had been busy getting the survey team items they needed and forgot to serve snacks on 7/31/17 in the morning and the in the afternoon.

Interview on 7/31/17 at 4:00 pm with the MA revealed:
-She was aware snacks were to be served three times daily to the residents in the facility.
-She was aware the kitchen was stocked with snacks for the residents.
-She was busy getting things for the survey team to get snacks for the residents on 7/31/17.
-She offered snacks to the residents at 10:00 am, but none of the residents wanted it.
-She denied offering snacks at 3:00 pm to the residents.

Observation on 7/31/17 at 4:10 pm revealed:
-The MA served a snack after speaking to the Administrator and the survey team:
-The snack consisted of 4 peanut butter crackers and a glass of water.
-All 5 residents had eaten the snack at the dining

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| C 272 | Continued From page 15<br>room table. | C 272 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure medications Norvasc 5 mg (used to treat high blood pressure) and Celebrex 200 mg (an anti-inflammatory) were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents ( Resident #3).<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 3/8/17 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, chronic kidney disease and hyponatremia.<br><br>Review of Resident #3's medication orders revealed an order dated 7/27/17 to discontinue Celebrex 200 mg daily and Norvasc 5mg daily.<br><br>Review of Resident #3's Medication Administration Record (MAR) for July 2017 revealed:<br>-There was an entry for Norvasc 5mg once daily. | C 330 | | |

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| C 330 | Continued From page 16<br>-There was an Norvasc 5mg was documented as administered at 8:00 am on 7/27/17, 7/28/17, 7/29/17, 7/30/17 and on 7/31/17.<br>-An entry for Celebrex 200 mg once daily.<br>-Celebrex 200 mg was documented as administered at 8:00 am on 7/27/17, 7/28/17, 7/29/17, 7/30/17 and on 7/31/17.<br><br>Telephone interview with staff from the contracted pharmacy on 7/31/17 at 11:15 am revealed:<br>-They were not aware of the order to discontinue Resident #3's Norvasc 5 mg daily or Celebrex 200 mg daily.<br>-They had not received an order from the facility to discontinue the Celebrex 200 mg or the Norvasc 5 mg for Resident #3.<br>-It was the facility's responsibility to fax the orders from the physician to the pharmacy for refills or new orders.<br>-The procedure for order entry in the MAR system involved the facility faxing the order to the pharmacy, the pharmacy entering the order, and a new MAR would be generated from the pharmacy to the facility to document administration of medications.<br><br>Review of Resident #3's medications on hand on 7/31/17 at 2:50 pm revealed there was a pharmacy generated bubble pack with Celebrex 200 mg and Norvasc 5 mg located in the pack along with the other morning medications.<br><br>Interview with the MA on 7/31/17 at 10:30 am revealed:<br>-She had worked on 7/27/17 at the facility.<br>-Another staff had transported Resident #3 to the physician's office.<br>-The transporter stopped at the pharmacy and dropped Resident #3's prescription off but "she must have forgotten to give them the order." | C 330 | | |

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| C 330 | Continued From page 17<br>-"I am responsible for faxing orders to the pharmacy."<br>-"I did not see the order for Norvasc 5mg and Celebrex 200 mg to be stopped."<br>-She had administered Celebrex 200 mg and Norvasc 5 mg to Resident #3 on 7/31/17 at 8:00 am.<br>-"I will fax the order to pharmacy now."<br><br>Interview with the Assistant to the Administrator on 7/31/17 at 11:10 am revealed:<br>-He was unaware Resident #3 had been administered Norvasc 5mg and Celebrex 200 mg after an order to discontinue on 7/27/17 had been written by the physician.<br>-It was the Medication Aide's (MA) responsibility to fax all orders to the pharmacy.<br>-He would immediately get the MA to fax Resident #3's order dated 7/27/17 to the pharmacy.<br><br>Telephone interview on 7/31/17 at 11:20 am with the nurse from the prescribing physician's office revealed:<br>-Resident #3 was seen in the office by the physician on 7/27/17.<br>-The physician had written an order to discontinue the Norvasc 5mg and the Celebrex 200 mg for Resident #3.<br>-It was the facilities responsibility to assure Resident #3 gets the medications or discontinues the medications, as ordered the physician. | C 330 | | |
| C 912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with | C 912 | | |

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| C 912 | Continued From page 18<br>relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to capacity and to evacuation of resident from the facility.<br><br>The findings are:<br><br>A. Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 2 of 5 residents (Resident #3 and #4) residing in the facility who had physical impairments which would prevent the residents from independently evacuating the facility. [Refer to tag 0007 10A NCAC 13G 0206(b) (e) Capacity(Type B Violation)].<br><br>B. Based on observation, interviews, and record reviews, the facility failed to perform at least four rehearsals of the fire evacuation plan, including all shifts within the appropriate time frame for evacuation of five resident's residing in the facility, two of the five residents were non ambulatory. [Refer to tag 0100 10A NCAC 13G .0316 Fire Safety And Disaster Plan (Type B Violation)]. | C 912 | | |