STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051038	A. BUILDING: _____ B. WING _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME	817 SOUTH SECOND STREET SMITHFIELD, NC 27577

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/30/17 - 08/31/17.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure walls and floors were kept clean and in good repair in the living room, a small hallway to a resident's room, two resident bathrooms and three resident bedrooms. The findings are: Observation of a small hallway leading into a resident's room on 08/30/17 at 9:05 a.m. revealed there was one board missing from the wood floor that exposed the under layer of the floor measuring approximately 27 inches long by 4 inches wide causing an uneven surface. Observation of a common resident bathroom on 08/30/17 at 9:05 a.m. revealed: -The entry had a missing threshold strip between the hall and the bathroom. -There was a section of the right door facing that had splintered, chipped and missing pieces of wood that measured 5 inches in length by 2 ½	C 074		

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C 074	Continued From page 1 inches wide. Observation of a resident room, not labeled with a room number that was at the end of the right side of the hallway on 08/30/17 at 9:15 a.m. revealed there were 3 thick, black stained areas on the right side of the floor with dust and debris embedded inside of the stain. Observation of resident room #2 on 08/30/17 at 9:29 a.m. revealed: -The baseboards and chair wall molding throughout the room had a thick buildup of gray dust. -There was a heavy build up of white gray dust material on all the blinds and window valences. -There was gray loose dust covering the top of two televisions. Observation of a second shared bathroom on 08/30/17 at 9:40 a.m. revealed: -There was a white, rough material covering the area in and around a square hole in a ceramic tile and a missing towel bar under the window. -There was a white color build up on the tub walls and tub. -There was a spider in a web near the ceiling of the shower. -There were scattered brown marks along the upper sections of the bathroom walls. -There was a heavy dust build up in the window valance of the bathroom. -There were dark colored stains scattered across the bathroom door. Observation of resident room #3 on 08/30/17 at 9:45 a.m. revealed: -The baseboards and chair wall molding throughout the room had a thick buildup of gray dust.	C 074		

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C 074	Continued From page 2 -There was a heavy buildup of white gray dust material on the blinds and window valences. -All of the walls of the room had scattered brownish marks. -The bedroom door leading to the hall had black scuffed marks in the center of the interior side of the door and a 3 inch hole with white tape above the hole on the opposite side of the door. Observation of the floor threshold between the kitchen and dining room on 08/30/17 at 12:30 p.m. revealed there was only part of the threshold strip present. The strip was either worn or broken causing an uneven floor. Observation of the exterior back door on 08/31/17 at 7:36 a.m. leading to a patio designated as a smoking area for the residents revealed the lower section of the door was splintered and missing paint exposing the bare wood. Confidential interview with 2 residents revealed: -Some of the residents cleaned their own rooms and staff would just check the rooms for cleanliness behind them. -The residents could not recall the last time staff had dusted or mopped in his room. -Staff never dusted or cleaned the resident rooms. Interview with the Personal Care Aide/Medication Aide (PCA/MA) on 08/31/17 at 8:45 a.m. revealed: -They did not have a written cleaning schedule, but she did clean one time a week and did the deep cleaning on the day before her 21 day work schedule rotation ended. -Deep cleaning consisted of dusting in window seals, wiping walls, cleaning baseboards and mopping.	C 074		

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C 074	Continued From page 3 -The PCA/MA had dusted and mopped in some of the rooms yesterday afternoon and had already done the heavy cleaning in the last resident room on the right of the hallway earlier in the week. -The PCA/MA did not "concentrate" on the blinds. -She encouraged residents to clean in their own area but would always check behind them. Interview with the Supervisor in Charge (SIC) on 08/31/17 at 8:50 a.m. revealed: -The SIC had noticed the dust build up in the residents' rooms on Tuesday (08/29/17) and had told the PCA/MA to plan to do the dusting. -The SIC had not noticed the missing towel towel bar, stains on the floors, walls and doors or missing threshold strips. -The SIC monitored the home at least one time a week for cleanliness and, other than the dusting, had not noticed any other issues with cleaning needs. Interview with the facility repairman on 8/31/17 at 9:16 a.m. revealed: -He was "self-employed" -He performed maintenance needs and repairs as needed. He was called today (08/31/17) by the Administrator to do repairs to the floors and door. -He had measured all of the door thresholds and would be replacing the strips and the missing floor board in the short hallway leading to a resident's room. -The exterior door leading to the resident's smoking area would be repaired with a metal plate. -The repairman was in the facility about a week ago repairing a knob on the office door. Interview with the Administrator on 8/31/17 at 11:30 a.m. revealed: -She did not know how long the threshold floor	C 074		

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C 074	Continued From page 4 strips had been missing but would have the repairman fix them. -She expected staff to keep all areas of the home clean. -There was not a written schedule for the expected cleaning done by staff but she would provide a copy of a shift change report staff signed with a section that included ensuring the home was clean and intact. Review of the facility's Shift Change Report Sheet dated 08/18/17 revealed: -There was a typed entry on the left side of the form that read to ensure the home was clean and intact. (Please make sure oncoming staff was aware of any repairs and maintenance and ensure management was aware of any outstanding repairs). -There was a comment section with handwritten documentation that the home was clean and intact dated 08/18/17. -There was a signature for the staff going off duty and a signature for the staff coming on duty. Review of an environmental inspection dated 10/24/16 revealed to clean the blinds throughout the facility in the comment section.	C 074		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by:	C 076		

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C 076	Continued From page 5 Based on observations and interviews, the facility failed to assure the furniture in the 3 of 4 resident bedrooms was in good repair. The findings are: Observation of a resident's room (not labeled with a room number) located in the front of the facility adjacent to the common living room on 08/30/17 at 9:06 a.m. revealed there was a night stand table with multiple areas of missing wood stain scattered across the top that exposed a rough surface and the under layer color of the wood. Interview with the resident who resides in the room located in the front of the facility and adjacent to the living room on 08/31/17 at 7:28 a.m. revealed the nightstand belonged to the facility. Observation of resident room #2 on 08/30/17 at 9:29 a.m. revealed: -There was a chest of drawers that had multiple colored white stains of various sizes on the front of the doors/drawers. -There were two night stand tables with missing wood stain in various places across the top that exposed the under layer color of the wood. Interview with one of the residents assigned to room #2 on 08/31/17 at 7:20 a.m. revealed the chest of drawers and the two night stands had been in the room for a long time. Observation of resident room #3 on 08/30/17 at 9:45 a.m. revealed there was a wooden straight back chair with a fabric covered seat that was missing the right arm rest. Interview with the Supervisor in Charge (SIC) on	C 076		

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C 076	Continued From page 6 08/31/17 at 8:50 a.m. revealed: -The SIC monitored the home for needed repairs on a weekly basis. -She had not noticed the condition of the nightstand table tops in the resident rooms because most of them were covered up with a runner the last time she observed the nightstands, and had only noticed the front of the nightstands so she thought (at that time) the nightstands "looked good". -The chest of drawers in resident room #2 had been at the facility for a long time. -The SIC was responsible to report any issues of needed repairs or replacements to the Administrator by texting or calling her. -They would replace or refurbish the furniture immediately. Interview with the Administrator on 08/31/17 at 11:30 a.m. revealed: -She expected staff to notify her of any needed maintenance for the furniture. -Staff had not notified her of any furniture needing repairs. -They would replace or refurbish the furniture immediately. Observation on 08/31/17 at 7:00 a.m. revealed the chair from resident room #3 that was missing the right arm rest was disposed of on the side of the street.	C 076		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease	C 202		

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C 202	Continued From page 7 in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 residents sampled (#1) had received a 2 step tuberculosis (TB) test upon admission to the facility in accordance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 03/31/17 revealed diagnosis include psychotic, mild mental retardation, asthma, history of thoracotomy, chronic obstructive pulmonary disease, gastro esophageal reflux disease, vitamin D deficiency. Review of Resident #1's Resident Register revealed an admission date of 05/8/15. Review of Resident #1's TB testing revealed: -A TB test was placed on 09/21/15 and read as negative on 09/23/15. -There was no documentation of a second TB test in the resident's record. Interview with the Supervisor In Charge (SIC) on 08/31/17 at 2:50 p.m. revealed: -The SIC was sure Resident #1 had a 2 step TB test upon admission.	C 202		

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C 202	Continued From page 8 -The SIC would look for "a thinned record" for Resident#1 that might have the documentation for a second TB test for Resident #1. Interview with the Administrator on 8/31/17 at 3:00 p.m. revealed: -All residents were supposed to have a two-step TB skin test. -They would look for a second TB test for Resident #1. No additional information was provided by the facility for Resident #1 at the time of exit on 08/31/17.	C 202		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the	C 254		

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C 254	Continued From page 9	C 254		

resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews the facility failed to assure the registered nurse completed an assessment and on-site Licensed Health Professional Support (LHPS) review for inhalation of medication by nebulizer and medication through injections for 1 of 1 sampled residents (#1).

The findings are:

Review of Resident #1's current FL-2 dated 03/31/17 revealed:
-Diagnoses included psychotic, mild mental retardation, asthma, history of thoracotomy, chronic obstructive pulmonary disease, gastro esophageal reflux disease, vitamin D deficiency.
-There was an order for Albuterol Sulfate 0.083% (a medication used to increase air flow to the lungs) inhale solution, use one vial every 4 hours as needed for shortness of breath or wheezing.
-There was an order for an Epipen (used to treat severe allergic reactions) injection 0.3 mg inject as needed for anaphylaxis.

Review of the LHPS quarterly review for Resident #1 dated 06/17/17 revealed:
-The nurse documented that the resident was seen by his primary care provider (PCP) on 05/12/17 and no concerns were reported.
-The nurse did not document a need for inhalation medications by a machine.
-The nurse did not document if she checked the resident's lung sounds or breathing status.
-The nurse did not document the resident's status in regards to allergies and if the resident had

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required the administration of an Epipen injection or the route of injection.
-The nurse did not document if staff were competency validated for inhalation of a medication via a nebulizer and did not address the need for medication through injection.

Review of Resident #1's June 2017 Medication Administration Record (MAR) revealed:
-There was an entry for Epipen Injector 1:1000 inject 0.3 mg IM (given in the muscle) STAT (immediately) as needed for anaphylaxis. Call 911. May repeat with second if needed in 5 minutes to be administered as needed. There was no documentation that the resident received the medication in June.
-There was an entry for Albuterol Sulfate 0.083% use one vial every 4 hours as needed for cough, shortness of breath, or wheezing to be administered as needed. There was no documentation that the resident received the medication in June.

Review of Resident #1's July 2017 MAR revealed:
-There was an entry for Epipen Injector 1:1000 inject 0.3 mg IM STAT as needed for anaphylaxis. Call 911. May repeat with second if needed in 5 minutes to be administered as needed. There was no documentation that the resident received the medication in July.
-There was an entry for Albuterol Sulfate 0.083% use one vial every 4 hours as needed for cough, shortness of breath, or wheezing to be administered as needed. There was documentation that the resident received the medication on 07/08/17, 07/09/17 and 07/10/17 for wheezing and "better" was documented in the response section on the back of the MAR.

Review of Resident #1's August 2017 MAR

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C 254	Continued From page 11 revealed: -There was an entry for Epipen Injector 1:1000 inject 0.3 mg IM stat as needed for anaphylaxis. Call 911. May repeat with second if needed in 5 minutes to be administered as needed. There was no documentation that the resident received the medication in August. -There was an entry for Albuterol Sulfate 0.083% use one vial every 4 hours as needed for cough, shortness of breath, or wheezing to be administered as needed. There was documentation that the resident received the medication on 08/29/17 and 08/30/17. Interview with Resident #1 on 08/31/17 at 7:20 a.m. revealed: -He had severe allergies. -The staff at the facility had never given him "a shot" for an allergic reaction but "the doctor did a long time ago". -When the resident had shortness of breath, staff would give him medicine in his machine. Review of Resident #1's medications on hand revealed there was an Epipen 0.3 mg injection with a quantity of two. Interview with the Administrator/Registered Nurse for the facility on 08/31/17 at 12:00pm revealed: -She performed the quarterly LHPS reviews for all the residents at the facility. -She did not review the task for inhalation medications because the resident had not used the as needed medication Albuterol Solution in the previous quarter. -She was aware that staff in the home were not qualified to administer intramuscular (IM) injections. She would contact the PCP for clarification of the injection route, directions when to give, and purpose of the Epipen injection. She	C 254		

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C 254	Continued From page 12 thought that the pharmacy probably added the injection route of IM on the MAR because the primary care provider did not specify the route on the original order. -She routinely performed physical assessments to include the related LHPS tasks for the residents when the LHPS quarterly reviews were done but did not document the physical assessment. -Going forward, she would document her physical assessment related to the current conditions and LHPS tasks needed for the resident and would include as needed tasks or as needed medications.	C 254		
C 301	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; (4) If the whereabouts of a resident are unknown	C 301		

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C 301	Continued From page 13 and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) and the appropriate law enforcement agency for 1 of 1 residents (Resident #3) who did not return to the facility on 08/21/17, and the facility did not know the whereabouts of the resident for 10 days. The findings are: Review of Resident #3's current FL2 dated 11/04/16 revealed: -Diagnoses included paranoid schizophrenia. -There was an order for the following medications: Benzotropine 1 mg twice daily (used to treat involuntary bodily movements due to the effects of some psychiatric medications), Depakote 250mg at bedtime (used to treat mood disorders), Risperdal 1 mg twice daily and 3 mg at bedtime (used to treat schizophrenia), and Lisinopril 5 mg daily (used to treat high blood pressure). Review of a subsequent primary care provider's order for Resident #3 dated 01/11/17 revealed and order to discontinue Lisinopril and start	C 301		

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	FCL051038	A. BUILDING: _____ B. WING _____	08/31/2017

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C 301	Continued From page 14 Amlodipine 5 mg (used to treat high blood pressure) daily. Review of Resident #3's care plan dated 11/04/16 revealed: -The resident was receiving mental health services and medications for mental illness/behavior. -There was documentation that the resident was oriented, wandered and memory was adequate. Review of Resident #3's Medication Administration Records (MARs) for August 2017 revealed: -There was a list of charting codes listed on the back of the MAR. Charting Code "C" was used for "patient out of facility" -There was an entry for Amlodipine 5 mg daily to be administered at 8:00 a.m. There was documentation Resident #3 received Amlodipine from 08/01/17 through 08/19/17 and "C" was documented from 08/20/17 through 08/29/17. -There was an entry for Benztropine 1 mg twice daily to be administered at 8:00 a.m. and 8:00 p.m. There was documentation Resident #3 received the Benztropine from 08/01/17 through 08/19/17 and "C" was documented from 08/20/17 through 08/29/17. -There was an entry for Depakote 250 mg at bedtime to be administered at 8:00 p.m. There was documentation Resident #3 received Depakote from 08/01/17 through 08/19/17 and "C" was documented from 08/20/17 through 08/29/17. -There was an entry for Risperdal 1 mg twice daily to be administered at 8:00 a.m. and 8:00 p.m. There was documentation Resident #3 received Risperdal from 08/01/17 through 08/19/17 and "C" was documented from 08/19/17 through 08/29/17.	C 301		

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C 301	Continued From page 15 -There was an entry for Risperdal 3 mg at bedtime to be administered at 8:00 p.m. There was documentation Resident #3 received Risperdal from 08/01/17 through 08/18/17 and "C" was documented from 08/19/17 through 08/29/17. Review of Resident #3's record revealed there was no documentation of the medications provided for the resident's leave of absence. Review of the facility's "Index of Attendance Census" for Resident #3 revealed: -There was a column for each month and the days of the week for 2017. -There were instructions to place a check for each day of contact, a "T" for a therapeutic leave, and an "H" for hospitalization -The resident had a check mark documented from 08/01/17 through 08/18/17 and "H" documented from 08/20/17 through 08/30/17. Review of the facility's Sign Out Register revealed: -There was a section to document the name of the resident, the time out, the time returned, destination, responsible party name/number and a comment section. -Resident #3 signed out on 08/18/17 at 11:00 (there was not an am or pm documented) and the responsible party name/number section had "self" documented. There was no documentation for the destination. Review of the facility's admission policies signed by Resident #3 on 11/04/16 revealed: -Residents needed to be in the facility no later than 10:00 p.m. If a resident needed to be out later than that, the resident should call the SIC or Administrator.	C 301		

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C 301	Continued From page 16 -Residents must sign out when leaving the home and when possible leave a contact number where the resident could be reached. Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 08/30/17 at 8:30 a.m. revealed: -Resident #3 was not at the facility today (08/30/17). -Resident #3 was at "home" because a family member had surgery. The resident wanted to be with his family. Interview with the Supervisor in Charge (SIC) on 08/30/17 at 12:48 p.m. revealed: -Resident #3 had a job and was able to sign in and out of the facility. -On 08/20/17, Resident #3 said he was going home for the weekend and would return on Monday, 08/21/17. The resident signed out of the facility but did not come back on Monday, 08/21/17. -The SIC had spoken with the family member over the phone who told the SIC she had talked to Resident #3. However, the family member did not know where the resident was staying. -The SIC asked the family member if she wanted her to file a missing person's report, but the family member reported "no" because she had talked with him, and the resident was going to work. -The SIC did not have any documentation of the phone conversations with the resident's family member. -No call had been made to the local police department or the local DSS but the SIC would do so today (08/30/17). A second interview with the PCA/MA on 08/30/17 at 1:30 p.m. revealed: -The PCA/MA thought the resident documented	C 301		

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C 301	Continued From page 17	C 301		

the wrong date on the facility's Sign Out log and did not leave the facility on 08/18/17, but on 08/19/17 around 11:00 a.m.
-The PCA/MA had given the resident enough medication to last until 08/21/17.
-The resident returned to the facility on Saturday, 08/19/17, "around lunch time".
-The PCA/MA gave Resident #3 a bologna sandwich, a bag of chips, an apple and water. Resident #3 ate and left "on a bike".
-The PCA/MA did not request for Resident #3 to sign out again on Saturday (08/19/17) because he was already signed out for the weekend.
-On Sunday, 08/20/17, the PCA/MA did not hear from Resident #3.
-On Monday, 08/21/17, the PCA/MA did not hear from Resident #3.
-The PCA/MA called the family member (named). The family member reported that she had talked with the resident between 08/19/17 and 08/20/17, but the family member was unsure where the resident was. The PCA/MA asked the family member to let the resident know to call about his medications since he was only given enough medications through 08/21/17. The family member told the PCA/MA that the resident was coming back to the facility on Friday, 08/25/17.
-The PCA/MA thought the resident would possibly return on Tuesday, 08/22/17.
-On Tuesday, 08/22/17, the PCA/MA did not see or hear from Resident #3.
-On Wednesday, 08/23/17, Thursday 08/24/17, and Friday, 08/25/17, the PCA/MA did not see or hear from Resident #3. The PCA/MA called the family member each day and there was no answer and no voice mail to leave a message.
-On Saturday, 08/26/17, the PCA/MA received a call from Resident #3's family member. The family member asked the PCA/MA if she had heard from the resident. The PCA/MA told the

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family member that she had not heard from the Resident #3 and asked the family member if she should call the police. The family member told the PCA/MA "no", the family member was "putting it in the Lord's hands and pray about it". The family member reported that it was typical of Resident #3 "when he wanted to run the streets". The PCA/MA did not call the police after the family member told her not to but felt she should have "went with her gut" and called the police.
-On 08/28/17, the family member called the PCA/MA and questioned if the resident had picked up his medication.
-The PCA/MA never called DSS or law enforcement about Resident #3 not returning as planned on 08/21/17 but kept the SIC informed.

Telephone interview with the local police department on 08/30/17 at 2:34 p.m. revealed there had not been a missing person's report filed for Resident #3 from 08/21/17 through 08/29/17.

Observation on 08/30/17 at 3:30 p.m. revealed two local police officers were at the facility talking with the SIC on the outside of the facility.

Interview with the SIC on 08/30/17 at 3:32 p.m. revealed:
-The SIC had made contact today (08/30/17) with the local police department.
-The police officer had made contact with Resident #3's family member today (08/30/17) and the family member had informed the police officer that Resident #3 went to the family member's home "first after leaving the facility, then left" the family member's home.
-The police officer reported the police department in the town where the family member resided needed to be contacted instead of the local police department (in the town of the facility).

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C 301	Continued From page 19 -The SIC had called DSS regarding Resident #3 today (08/30/17). -The SIC had not called Resident #3's primary care provider (PCP) or mental health provider but would today (08/30/17). Interview with the same PCA/MA on 08/31/17 at 7:50 a.m. revealed: -The PCA/MA knew that Resident #3 had been working with someone performing farm work. -The PCA/MA did not know the person that Resident #3 had been working with but was able to make several calls to "associates" who worked with the same employer and was able to get up with Resident #3 last evening (08/30/17). -Resident #3 was angry because the police had called his family member. -Resident #3 reported that he was going to the facility today to pick up his belongings. -The PCA/MA thought that Resident #3 had been in contact with his family member (named) every day from 08/19/17 until today 08/31/17, because the resident talked to the family member every day. -The PCA/MA had also spoken with the family member (named) last evening (08/30/17) and she told her she was not answering any more questions about Resident #3 because she did not want "her money to be cut off". Telephone interview with Resident #3 on 08/31/17 at 8:20 a.m. revealed: -He left the facility on 08/18/17 to go stay with his family over the weekend. -The resident told staff he would return to the facility on 08/21/17. -The resident had planned to come back to the facility on 08/21/17 but "something came up". -The resident had been staying with "a friend girl of mine".	C 301		

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C 301	Continued From page 20 -The resident's last day at the facility was today (08/31/17) and he would be coming to pick up his personal items and his medications and then would be going to live with his family member. -The resident had been working and was "fine". -The resident had been taking his medication everyday and thought he was given enough medications when he left the facility to last through today (08/31/17), but he would run out of those medications today. Interview with the SIC on 08/31/17 at 9:29 a.m. revealed: -The PCA/MA told the SIC that Resident #3 was leaving on Friday, 08/18/17, in the morning to go home for "a couple of days" and would return on Monday, 08/21/17. -On Monday, 08/21/17, the SIC asked the PCA/MA if Resident #3 had returned and the PCA/MA reported "no" but the PCA/MA had spoken with the family member (named). -The SIC had spoken with the family member on 08/22/17 (unsure of time), and the family member reported that she had spoken to Resident #3 and the resident would be returning to the facility but did not say when. The family member did not know what the resident was going to do. -The SIC was not alarmed when Resident #3 did not return the week of 08/21/17 and "assumed" he had left because he had given the Administrator a 2 week notice on 08/07/17 that he would be leaving the facility. -The SIC made several other calls to Resident #3's family member after 08/22/17, but the family member did not answer. -The SIC thought she might have spoken with the family member one more time after 08/22/17 but could not recall the exact date. -The family member said she had talked to Resident #3 "a couple of times".	C 301		

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C 301	Continued From page 21 -The family member did not want a missing person's report filed but the SIC felt she should have "went on my own instinct". -Resident #3 normally worked. The SIC thought that Resident #3 must have been working because his employer was not coming by the facility to pick him up. -The SIC had not tried to contact the employer to verify if the resident had been working. -The SIC had not documented the telephone calls with Resident #3's family member. Interview with the Administrator on 08/31/17 at 11:30 a.m. revealed: -Resident #3 was given a 30 day discharge notice on 08/07/17. -Resident #3 had told the Administrator on 08/07/17 that he was giving a 2 week notice as a discharge and "did not mix his words". -She did not feel that the resident's whereabouts were unknown or that he was not safe and was keeping his word of a verbal 2 week notice. Attempted telephone interview with Resident #3's family member was unsuccessful on 08/30/17 at 2:13 p.m., 6:30 p.m. and on 08/31/17 at 12:50 p.m. Telephone interview with Resident #3's mental health provider on 08/31/17 at 12:40 p.m. revealed Resident #3's Case Manager was not available. Telephone interview with a Adult Home Specialist at DSS on 08/31/17 at 2:58 p.m. revealed: -DSS was not notified until yesterday (08/30/17) about Resident #3 not returning to the facility as planned. -She would have expected to have been notified about Resident #3 and local law enforcement	C 301		

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C 301	Continued From page 22 called. Telephone interview with Resident #3's PCP on 08/31/17 at 2:43 p.m. revealed: -The PCP had been Resident #3's PCP for 3-4 months. -The staff at the facility had not reported any behaviors or concerns about Resident #3. -The PCP was not notified that Resident #3's whereabouts were unknown since 08/21/17. -The PCP felt someone should have looked for the resident if there was a question about the resident's whereabouts. -The PCP felt that somebody responsible for the resident's care should have been informed of what was going on. -Resident #3 followed mental health for his psychological needs. -Resident #3 had psychiatric illnesses and took psychiatric medications to manage his illness. -When psychiatric medications were missed or not taken as ordered, there was a possibility of manic phases, hallucinations and delusions and the resident could possibly "hurt himself". The facility failed to notify the appropriate law enforcement agency and the county DSS when the whereabouts of Resident #3, who had paranoid schizophrenia, was unknown and the resident did not return to the facility as planned and expected on 08/21/17. The facility knowingly provided the resident with a 3 day supply of medications to control and manage the resident's illnesses. The resident's whereabouts were unknown to the facility staff for ten days resulting in serious neglect to the resident, and significant risk for physical harm which constitutes a Type A2 Violation. Review of a Plan of Protection provided by the	C 301		

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C 301	Continued From page 23 facility dated 08/31/17 revealed: -The facility would in-service the direct care staff to ensure that the sign in/out register was properly completed. -The direct care staff would at all times know the whereabouts of all the residents. -The direct care staff would report to the local department of social services, law enforcement, and family member when the resident's whereabouts is unknown immediately. -The direct care staff would monitor the progress daily. -The Supervisor in Charge (SIC) would monitor weekly for compliance proper completion of the sign in/out register, call local law enforcement, inform family members. -The SIC/Administrator will monitor quarterly for compliance. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2017.	C 301		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident was free of neglect as related to Other Resident Services. The findings are: 1. Based on observation, interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) and the	C 914		

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C 914	Continued From page 24 appropriate law enforcement agency for 1 of 1 residents (Resident #3) who did not return to the facility on 08/21/17, and the facility did not know the whereabouts of the resident for 10 days. [Refer to Tag C0301, 10A NCAC 13G .0906 Other Resident Services (Type A2 Violation)].	C 914		