STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	R 10/25/2017

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JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey on 10/25/17.	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 and interviews, the facility failed to assure walls, and floors were kept clean and in good repair for 1 of 1 resident bathroom, 3 of 3 resident bedrooms (#1, #2, #3) and hallways and dining room. The findings are: Observation on 10/25/17 at 9:15 a.m. of resident room #2 revealed black smear marks and dark brown smudges were on the door molding. Interview on 10/25/17 at 2:10 p.m. with a resident residing in room #2 revealed: - He thought the housekeeping was better than some months ago. - Repairs had been completed months ago and he had no concerns about the housekeeping. - No information was provided when asked about how the housekeeping was prior to today. Observation on 10/25/17 at 9:25 a.m. of resident room #1 revealed:	C 074		

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C 074	Continued From page 1 - The outside edges of the door and door frame were pitted with dark brown marks and missing paint. - The door frame and door molding had chips of paint missing and black/gray smears and fingerprints. - The room had an older covered and painted brick fireplace situated on the right wall and a floor level black painted hearth area of 18" x 3'. - The flooring at the back edge of the hearth was cracked and split apart from the brick at each end and across the back edge of the hearth. - A television cable was laid across the fireplace hearth next to the bedside table. - The black paint was peeled away from the floor at numerous spots of the hearth area. Interview on 10/25/17 at 9:25 a.m. with the resident residing in room #1 revealed: - The housekeeping was alright and the pipe repairs in the bathroom and hallway wall had been fixed. - Some floor scrapes and paint missing on a wall were left to be repaired. - He was not concerned about the floor covering in the hall and dining room needed. - Some repairs had been made over the time since he had been here about 8 - 9 months. Observation on 10/25/17 at 9:35 a.m. of resident room #3 revealed: - The door frame had numerous small spots of missing paint. - There were round dark gray gouges on the wall approximately 6 inches in length next to the resident's chair. Attempted interview on 10/25/17 at 2 p.m. with the resident residing in room #3 revealed it was unsuccessful.	C 074		

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C 074	Continued From page 2 Observation on 10/25/17 at 10:17 a.m. of the facility hallway revealed: - The walls were coated with gray-brown smudges and finger prints. - There was an oblong 2 inch piece of paint missing from the front door frame. - Above the front door on the wall and to the right was a large beige/brown water drip stain from the ceiling down the wall approximately 1- 2 feet and 10 inches to 1 foot wide. - The hallway walls had scuff and narrow gouge marks. - The threshold from the hallway to the living room had spots and areas of missing paint. - The floor at the threshold to the living room had areas of the linoleum floor missing and a tear of about 8 inches long. - The door frame to the entrance to the living room from the hallway had brown marks and paint missing. - A large area of patched repair of a hole on the wall in the hallway approximately 2-3 feet by 2-3 feet square had not been painted. Interview on 10/25/187 at 2:10 p.m. with the Administrator revealed: - She had rented the house for about 5 years. - The repairs were being completed as she could. - There had recently been a water pipe break in the bathroom and the hallway way had to be opened up for the repair of the bathroom water pipes. - The hole in the wall had been repaired. - She had not had time to paint the hole repair in the hallway near the living room. - She would see about the repainting of the walls and door frames. Observation on 10/25/17 at 10:19 a.m. of the	C 074		

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C 074	Continued From page 3 dining room revealed: - The linoleum floor had an area the size of approximately 8 - 10 inches diameter that was under the metal leg dining chair with sharp edges. - As the chair was moved the sharp foot edges of the chair leg it scraped areas of the linoleum. - The wall below the buffet shelf in the dining room had scuff marks and long scratched marks across the white paint. - The yellow wall under the windows had black scuff marks and scrapes. Observation on 10/25/17 at 10:31 a.m. of the resident bathroom revealed: - The room had one toilet, one sink, and one bathtub/shower. - The linoleum flooring on the front and sides of the commode, in front of the sink cabinet, and at the faucet end of the tub were heavily stained with dark brown circular spots. - The floor in front of the tub and in front of the sink had a spongy feel when stepping on these areas. - The floor molding at the base of the sink cabinet was broken in half at the center front of the cabinet. - The wall baseboard molding surrounding the bathroom floor was coated with yellow and dark brown stains with dark particles and black dirt along the edges where the wall met the molding in some areas. - The corners of the floor were stained a dark color. - Approximately 1 1/2 feet up from the floor the wall next to the commode had an area about 6 inches long with multiple empty screw holes and two with screws in the holes. - The vanity cabinet had a layer of black dirt on the molding of the cabinet and paint was missing on the right hand door at the bottom.	C 074		

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C 074	Continued From page 4 - The wall to the left of the vanity sink cabinet had a white patched repair to the wall but had not been painted. - The door on the inside of the bathroom and the side toward the hallway had black/gray smears and finger prints along the molding where the handle was located. Interview on 10/25/17 at 10:40 a.m. with the Supervisor-In-Charge (SIC) revealed: - Routine cleaning 1-2 times per week included mopping floors, dusting baseboards and cleaning "top to bottom" by the staff member on duty. - The bathroom was mopped more frequently and cleaned more often and as needed. - Deep cleaning weekly included pulling beds out sweeping and mopping behind furniture and beds. - There was no specific check sheet for cleaning to be signed off. - Some repairs had been completed but the men were hard on the home. Interview on 10/25/17 at 2:50 p.m. with the a personal care aide revealed: - She had been working at the facility for 2-3 years and she worked only about 4 hours as a fill-in staff member a few days per week. - She cooked and watching the residents. - The dining room chairs had been replaced over time with wooden ones. - Now metal chairs with the upholstered fabric seats and backs were being used. - She knew the chairs with the metal legs scratched the linoleum and might suggest something in the bottom of the legs to prevent the tears in the flooring. - The wall in the hallway near the entrance to the living room had been recently repaired, but the Administrator had not had a chance to paint it yet.	C 074		

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C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide adequate supervision based on current symptoms for 1 of 3 residents sampled (Resident #1) while smoking who had involuntary arm and leg movements resulting in burn holes in the resident's clothing from dropped cigarette ashes. The findings are: Observation on 10/25/17 at 9:35 a.m. revealed: - Resident #1 was in his room sitting in the chair. - The resident had on a blue sweatshirt with multiple small 2-4 millimeter burn holes on the front of the shirt. Interview on 10/25/17 at 9:35 a.m. with Resident #1 revealed: - He was a smoker and had burn holes in his shirts before he came to the facility and since he had been here as well. - He had not had any skin burns and his clothing had not caught on fire from the cigarette ashes falling on his clothes while smoking. - He had gone out to smoke by himself. He was able to do it himself. - Sometimes the staff would be out there with him.	C 243		

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C 243	Continued From page 6 Review of Resident #1's current FL-2 dated 3/23/17 revealed: - Diagnoses included Huntington's disease, seasonal allergies, irritability and anxiousness. - The resident was listed as intermittently disoriented and ambulatory. Review of Resident #1's Assessment and Care Plan dated 4/20/17 revealed: - He needed supervision with bathing. - The resident required limited assistance with eating, dressing, grooming and personal hygiene. - The resident required extensive assistance with toileting. - He was ambulatory and could transfer on his own. - He was oriented and had adequate memory. - There was no documentation of assistance or supervision with smoking. Interview on 10/25/17 at 10:02 a.m. with the Supervisor-In-Charge (SIC) revealed: - Resident #1 had been admitted at the facility with a disease that caused increased muscle movements in his body. - He required assistance with dressing, grooming and food preparation but could bathe himself. - He was able to get out of his bed, which was low to the ground on the floor, easily and as quickly as needed. - He was not disoriented but was forgetful. - His hands and arms moved all over while smoking. - He was able to smoke but would drop hot ashes on his clothing each time. - "He has burned up all of his clothes." - He actually had multiple burn holes all over the fronts of his shirts from smoking and dropping hot ashes on his clothing.	C 243		

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C 243	Continued From page 7 - On one occasion, when she went out with him while he was smoking, she smelled smoke. - She looked down at his shirt and saw smoke coming up from it. - She looked down and saw his shirt was smoldering without flames. - She immediately patted the area with her hand to ensure flames did not catch on and to stop the smoldering smoky area of the shirt. - The resident was not burned. - She had never seen burn marks on him. - She did not know about a "fire apron" and did not think the facility had one. - Staff were to give the resident 5 cigarettes in the morning and 5 cigarettes later in the day to keep and use at will. - Then she said, "We had been trying to get him to cut down on smoking." - "The staff had decreased the number of cigarettes per day as per physician instructions." - He had a lighter with the child safety guard on. - The resident would come to the staff to get the child safety guard removed from the lighter and they would take the guard off and then he would go out to smoke. - She had not been given instructions for supervision for Resident #1 - to supervise him while smoking. - The staff members tried to go out with the resident as much as possible when he went out to smoke. - Staff could not go out with the resident each time he smoked. - He would not wait for a staff person to be finished with other residents/duties as staff requested so he would go out to smoke without anyone with him. - There was not a specific procedure or policy in place to ensure Resident #1 had supervision each time he smoked.	C 243		

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C 243	Continued From page 8 - She and the other staff members knew staff had to be careful with him while smoking but no one had suggested constant supervision with his smoking. - The resident's physician and family knew about the smoking issues including the burn holes and encouraged a reduction in smoking. - The family brought him to the facility because his home care giver was not able to supervise and care for him anymore. - There was no physician order for supervision for the resident while smoking. - There was a smoking policy about no smoking in the facility. - There was not a specific procedure or facility policy for supervision of a resident smoker with his diagnoses and assessed needs. Review of an undated note written by the facility prior to an office visit with the resident's physician related the changes in Resident #1's behaviors as follows: - The resident recently had some physical changes with incontinence and aggression toward staff. - He had been dropping ashes on himself and had some burn holes in his clothes. - His lit cigarette ashes had gotten on others while he was smoking. Review of the same undated office visit note included the physician's response from the visit which revealed: - Huntington Disease with compulsive behaviors. - There is mild chorea. (Involuntary movement disorder.) - Mild balance difficulty with a staggering gait. - Recommended medication changes included increasing dosages in two of his medications to treat aggression and the increase in compulsive	C 243		

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C 243	Continued From page 9 behaviors. Review of a physician note dated 7/14/17 revealed the facility caretaker, the family member and the resident understood no smoking was best for him at this time. Observation of Resident #1 on 10/25/17 at 11:45 a.m. and 12:45 p.m. revealed: - The resident went out of the facility to the smoking area on the back deck. - He had a cigarette lighter which he was observed not to be able to get it to work. - He was not smoking at those times. - No staff were observed to go with him or to check on him when he went out. Interview on 10/25/17 at 1:05 p.m. with the Administrator revealed: - Resident #1 had Huntington's Disease and had uncontrollable arm and leg movements. - His physician wanted him to stop smoking. - The physician knew about the burn holes in his clothing. - He would get the patches to help stop smoking. - He had decreased smoking down to under 1 pack per day. - He was to be receiving only 1 cigarette at a time from the staff. - He was on 5 cigarettes twice daily for him to smoke at will previously. - There was not a specific smoking schedule or process or policy in place to ensure the resident would be supervised each time when smoking. - "I do not know what to do about the smoking." - She was aware of the him dropping lit ashes on his clothing causing the burn holes. - Some of the burn holes had been from before he was admitted. - Staff tried to go with him while smoking, but	C 243		

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C 243	Continued From page 10 could not always go out with him due to other facility duties. - She was aware on one occasion, a staff member had seen the resident's shirt smoldering with smoke was coming from the area. - The shirt was not on fire with flames, but staff vigorously patted the area to ensure no flames started. - She would ensure a policy of no smoking alone. - The resident would have to wait to smoke until staff could go with him while smoking. - She would ensure a fire apron was secured for him. - She would ensure staff supervision every time he smoked. Observation on 10/25/17 at 1:28 p.m. of Resident #1's clothing revealed: - Three blue shirts with multiple small burn holes that went through the shirt and one hole was large approximately 2-3 centimeters (cm) in length with black/brown burned edges. - One red shirt had a burn hole approximately 1 cm. in length. - Two black shirts had large and small burns holes from a few millimeters to 1/2 cm in diameter. - Numerous multi-colored shirts and other black shirts with multiple medium sized to small burn holes in them. Observation on 10/25/17 at 1:32 p.m. of the resident revealed: - There were multiple small 3-4 mm sized cigarette burn holes in his shirt. - There were no burn holes in his pants. - The SIC assisted the resident to show his forearms which were free of burns and scars. - With the assistance of the SIC the resident showed his chest and abdomen.	C 243		

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C 243	Continued From page 11 - There were no burns or scars. Interview with Resident #1 on 10/25/17 at 1:32 p.m. revealed: - He had not had any burn holes in his pants. - There had not been any fires on his clothing or burns on his skin. - He had burned his clothes here and then he said the burn holes had happened before he was admitted. Interviews on 10/25/17 at 11:04 a.m. three residents revealed: - Two residents had observed Resident #1 drop hot ashes on his clothing. - One resident had not observed ashes dropping on Resident #1's clothing. - Sometimes staff were there when Resident #1 smoked and sometimes not. Interview on 10/27/17 at 2:40 p.m. with a personal care aide who worked from 2 p.m. to 6 p.m. several days per week revealed: - She had worked in the facility for 2-3 years. - Resident #1 had been here for some months and he had a problem controlling his movements. - He had burn holes in his clothes. - She had seen him drop ashes on his shirt. - There had been times when she could not go out with the resident when he smoked because she was working with another resident and he would not wait for her to be finished. - When questioned about a specific policy related to the resident's smoking concerns she said staff previously gave the resident several cigarettes in the morning and some in the afternoon. - Personal care aides and SICs were now supposed to give the resident one cigarette at a time and he should not have a lighter. - The personal care aides should go out with him	C 243		

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C 243	Continued From page 12 when he smoked because he dropped hot ashes on himself, but due to caring for other residents staff could not always go out with him when he wanted to smoke. - There had not been any fires when he dropped the ashes during her time on duty in the facility. Observation on 10/25/17 at 2:45 p.m. revealed the resident was was in and out of the facility repeatedly over a 15 minute observation. - He had a cigarette butt and a lighter. - He was observed to try to light the cigarette butt without success. - At one point he was on his knees, with his face bent over an empty juice can used for ashes trying to light the cigarette. - A fire extinguisher was at the back entrance to the deck where he was going in and out. - There was a fire extinguisher in the front hall area. - The personal care aide staff member was not observed to have gone out with the resident to check if he was attempting to smoke. Interview on 10/27/17 at 2:58 p.m. with the fill in staff member revealed: - She was not aware he had found a butt and was trying to see if he could smoke. - He can not activate the lighter he had because of the child safety lock. - He goes in and out like that trying to smoke when he gets the urge. Attempted telephone interview on 10/25/17 at 1:40 p.m. with Resident #1's family revealed it was unsuccessful. _____ The facility failed to provide adequate supervision for 1 of 3 sampled residents (#1) while smoking	C 243		

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C 243	Continued From page 13 who had involuntary arm and leg movements resulting in burn holes in clothing from dropped cigarette ashes resulting in an increased risk of fire for all residents. The facility's failure to supervise Resident #1 while smoking was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 10/25/17 revealed: - Immediately, staff will go out with the resident every time to smoke because of his medical condition. - The resident's smoking materials will stay locked up to ensure the resident does not smoke alone. - The Administrator will speak with staff, the family and the physician about the safety of this matter. - Staff will have a review on fire extinguishing methods for a resident on fire. - To prevent further risk of harm the administrator will put into place a smoke schedule so the resident will have supervision when he smokes. - Ash cans will be removed to prevent butts being used. - Any cigarettes will be removed from the resident. - A sign off sheet for staff to indicate smoking times and supervision of the resident will be started. - Goal is to get resident on the smoking cessation patch per the physician. - There will be periodic unannounced monitoring checks on a daily basis of the system by the Administrator. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	R 10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 243	Continued From page 14 9, 2017.	C 243		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide adequate supervision based on current symptoms for 1 of 3 residents sampled (Resident #1) while smoking who had involuntary arm and leg movements resulting in burn holes in the resident's clothing from dropped cigarette ashes. [Refer to Tag 243, 10A NCAC 13G.0901 (b) Personal Care & Supervision (Type B Violation)]	C 912		