Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059032	A. BUILDING: _____ B. WING _____	01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JAMES LODGE	63 LAKEVIEW DRIVE MARION, NC 28752

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D 000	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted an annual survey and County complaint investigation on January 3, 2018 and January 4, 2018. The County initiated the complaint on November 29, 2017.	D 000	All staff meeting was held 1/19/18 in regards to this cited deficiency.	1/19/18
D 108	10A NCAC 13F .0311(b)(2) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. This rule apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free from obstructions and hazards related to one portable electric heater located in the back hall common area. The findings are: Observation of the back hall common area on 1/3/14 at 10:15am revealed: -An electric, infrared portable space heater located in the southeast corner of the room. -The heater was turned on. -The heater was blowing warm air and was warm to the touch. -The heater was not touching any pieces of furniture or other objects.	D 108 D 108	The rule was read to all staff. This rule was typed up & each member read, understood & signed. The building & outbuildings were searched - no other heaters found. Daily rounds are completed by Director M-F & SIC's daily to assure no heaters - portable are found. Transport will also assure on shopping trips with residents that no portable heater is to be purchased by	2/12/18 1/5/18 Done daily since 1/5/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Bradley TITLE: Director (X6) DATE: 2/9/18

STATE FORM 6899 BHJT11 If continuation sheet 1 of 9

Reviewed, accepted and electronically signed by CF 02/09/2018

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D 108	Continued From page 1 Interview with a Personal Care Aide (PCA) on 1/3/18 at 11:38am revealed: -He was unsure when the space heater was placed in the room. -"It might have been around 12/29/17, when it got colder." -He did not know who had placed the space heater in the room. Interview with the facility Director on 1/3/18 at 11:35am revealed: -She knew of the space heater on the back hall. -She knew the facility could not have space heaters in the building. -She thought "they wanted it warmer in the room to watch a football game". -She would have the space heater immediately removed. Interview with the Resident Care Coordinator (RCC) on 1/3/18 at 11:47am revealed: -She did not know of the space heater on the back hall. -She would "have it removed immediately". Interview with the maintenance staff on 1/3/18 at 11:50am revealed: -He knew of the space heater on the back hall. -He did not know space heaters were not allowed in the facility. -He had just removed the space heater from the back hall. -He did not know how long the space heater had been on the back hall, not who had placed it there. Observation of the back hall common area on 1/3/18 at 11:52am revealed the space heater was no longer in the back hall common area.	D 108 D108	any resident. SIC's are also aware to keep an eye out for family + friends of residents - that they are not to bring any portable heaters into building. Any staff found + id'd bringing heater in will be terminated.	cont.

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D 108	Continued From page 2 Second interview with the facility Director on 1/4/18 at 10:45am revealed: -She believed the space heater was brought into the facility "this past Sunday for a football game". -She did not know where the space heater came from or who had brought it into the facility. -She had seen it on Monday (1/1/18) and told staff in the back hall area "they needed to get it (space heater) out". -She did not follow-up to assure the space heater was removed. -It was her responsibility to assure the space heater was removed from the facility. Telephone interview with the Administrator on 1/4/18 at 11:15am revealed: -The facility Director had informed him about the space heater being in the building. -He did not know how it had gotten in the building. -He would discuss with the facility Director the need to retrain staff about space heaters not being allowed in the building.	D 108		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to assure the staff	D 270		

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D 270	Continued From page 3 provided supervision for 2 of 2 (Resident's #1 and #2) residents who were smoking inside the building. The findings are: Observation of the entrance to the facility on 1/3/18 at 8:30am revealed "No Smoking" signs were posted on both sides of the front door. Review of the facility's smoking/tobacco use policy revealed: -The Facility was a smoke free community with the exception of designated smoking areas. -Smoking is not permitted in other areas of the building. -The community also allows smoking outside the facility and ask that our residents, staff and visitors assist us in placing cigarettes buts into waste receptacle in order to keep our community litter free. -The facility has the following rules for residents who smoke in the building. -The first time is a warning, second time on a schedule and third time the cigarettes are taken away. A. Review of Resident #2's current FL2 dated 4/27/17 revealed diagnoses included chronic obstructive pulmonary disease (COPD), brain tumor with/seizures, glaucoma, restless leg syndrome (RLS), arthritis, tobacco user, anxiety and depression. Review of Resident #2's Resident Register revealed: -He was admitted to the facility on 4/19/16. -He was responsible for himself. -He had signed the facility's smoking policy upon admission.	D 270	D270 Resident #1 + 2 have both been discharged- following multiple warnings, meetings with #1's guardian, mos of 15 min checks, taking smoking materials + putting on smoking schedules. Resident #1 discharged 2/1/18. Discharge notice given 01/10/18. — 2/1/18 Resident #2 discharged 1/30/18. Discharge notice was given to Resident #2 on *12/07/17. DSS helped with placement of resident #2. — 1/30/18	

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D 270	Continued From page 4 Review of Resident #2's record revealed: -On 5/4/16 Resident #2 had been caught multiple times smoking in his room. -There was an incident/accident report dated 10/29/17 that documented Resident #2 "was smoking in his bedroom and proceeded to walk down the hallway with lit cigarette and refused to put it out". Resident #2 "walked outside and claimed no one would do anything about it". -There was an incident/accident report dated 11/26/17 that documented Resident #2 was "caught smoking in the hallway". -There was an incident/accident report dated 12/9/17 that documented Resident #2 "was smoking in the building during the 2:00pm snack". The resident was "addressed and the cigar was taken away immediately". The resident had been "given notice and management is seeking other placement". Confidential interviews with 3 residents during the survey on 1/3/18 and 1/4/18 revealed: -There were residents who smoked in the building. -One resident stated Resident #2 was "smoking in the living room last night" and "if he reported (Resident #2) to the Director, she will not do anything". -Another resident stated "we had a meeting and the Director said she was trying to get rid of him". -One resident indicated Resident #2 was "caught smoking in his room last weekend". -Another resident asked the Director if "he could smoke in his room, and the Director said, "no" because it was against the rules". -One resident said Resident #2 smoked in his bathroom and had told management about it. Observation of Resident #2's room on 1/3/18 at	D 270	D270 Updated our smoking policy with the addition of discharge notice will be given on 4th offense. Updated policy will be sent to all guardians residents to sign. 2/18/18 D270 + D912 All staff meeting was held 1/19/18 in regards to cited deficiencies. These rules were read to staff. Discussed supervision & resident rights in regards to this issue and to also 1/19/18	

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D 270	Continued From page 5 9:15am revealed: -The room was located at the end of the front hall. -The room and bathroom had a strong smell of cigarette smoke. Observation of the resident room directly across the hall (approximately 10 feet) from Resident #2's room on 1/4/18 at 9:48am revealed: -There was a no smoking, oxygen in use sign posted on door. -There was an oxygen concentrator on the floor next to a bed with oxygen flowing at 4.5L/Min through a nasal cannula. Observation of the resident room next door to Resident #2's room on 1/4/18 at 9:50am revealed a strong smell of cigarette smoke. Interview on 1/3/18 at 3:15pm with Resident #2 revealed: -He smoked in the facility. -He knew that he was not supposed to smoke in the facility. -He knew there was oxygen in the building. -He had been told by staff not to smoke in the building. Refer to the confidential interviews with 3 staff. Refer to the interview with the Facility Director on 1/3/18 at 11:00am. Refer to the interview with the Administrator on 1/4/18 at 10:20am. B. Review of Resident #1's current FL2 dated 11/7/17 revealed diagnoses included schizophrenia-paranoid type, asthma and mild mental retardation.	D 270 D270 & D912	get them involved in thought process to help with this issue. Both residents had been on 15 min ✓'s for mos. Discussed all staff needs to be extra diligent on the ✓'s to keep all safe, policies adhered to, proper supervision & protecting rights for all.	Cont 1/19/18

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D 270	Continued From page 6 Review of Resident #1's Resident Register revealed: -She was admitted to the facility on 12/7/12. -She had a guardian who had signed the facility's smoking policy upon admission. Observation of Resident #1's room on 1/3/18 at 9:30am revealed the room smelled like cigarette smoke. Interviews with Resident #1 on 1/3/18 at 9:10am and at 9:30am revealed: -She "smoked a little bit in my room because it is so cold outside". -She did smoke in the facility. -She knew that she was not supposed to smoke in the facility. -She had been caught by staff smoking in the building and was told not to smoke in the building. Refer to the confidential interviews with 3 staff. Refer to the interview with the Facility Director on 1/3/18 at 11:00am. Refer to the interview with the Administrator on 1/4/18 at 10:20am. Confidential interviews with 3 staff members revealed: -Cigarette butts were found on the floor. -All 3 staff observed Resident #2 smoking in the building (hallway and living room near the dining room). -One staff indicated nothing had done about Resident #1 smoking in the building. Interview with the Facility Director on 1/3/18 at 11:00am revealed:	D 270		

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D 270	Continued From page 7 -Another resident had reported to her that Resident #2 had done this (smoking) before in other facilities. -She was issuing a 30-day discharge. -She had spoken with the residents in the past about the importance of not smoking in the building. -The staff had told her about residents who they had caught smoking. Interview with the Administrator on 1/4/18 at 11:20am revealed: -He was going to review and amend the policy for smoking where needed. -The residents who were smoking in the building would be discharged. -The Director was working on finding placement for the residents. The facility failed to ensure staff provided supervision for 2 of 2 known residents [#1 and #2] who smoked in the facility. The actions of Resident #1 and #2 was detrimental to the other residents residing in the facility by placing them at potential risk to their health, safety and welfare from possible fire in the facility as a result of residents smoking unsupervised and constitutes a Type B Violation. The facility provided the following Plan of Protection dated 1/3/18 which included: -Cigarettes and lighters will be taken from the residents. -Residents will be placed on 15 minute checks around the clock. -A discharge notice has been given to the resident (#2). -Residents placed on smoking schedule, 1 cigarette every 2 hours with an aide to monitor. -Will continue to monitor residents until a	D 270		

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D 270	Continued From page 8 placement is found. -Administrator and Director will re-evaluate (current) smoking policy. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION IS FEBRUARY 18, 2018.	D 270		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision. The findings are: Based on observations, interviews and record reviews the facility failed to provide supervision for 2 of 2 (Resident's #1 and #2) residents who were smoking inside the building. [Refer to Rule 10A NCAC 13F .0901(b) (Type B Violation)].	D912	D912 See pages 5 + 6	