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BETHESDA FAMILY CARE HOME	984 AVONDALE DR CLAYTON, NC 27520

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C 000	Initial Comments The Adult Care Licensure Section completed an initial survey on 12/15/21.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review the facility failed to ensure health care referral and follow up for 1 of 2 residents sampled (#1) who was exhibiting psychiatric symptoms. The findings are: Review of Resident #1's current FL-2 dated 10/05/21 revealed: -Diagnoses included dementia, alcoholic, and generalized anxiety disorder (GAD). -The resident was admitted to the facility from home. -The resident was intermittently disoriented. -The section titled "inappropriate behaviors" was blank. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 10/10/21. -There was no signature and date page. Review of Resident #1's current care plan dated 11/19/21 revealed: -The resident was currently receiving medications	C 246		

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for mental illness/behaviors.
-The resident had a history of mental illness and substance abuse.
-The resident was sometimes disoriented, had significant memory loss and required direction.
-The resident was independent with ambulation, required staff supervision with toileting and extensive staff assistance with dressing.

Review of Resident #1's local hospital after visit summary (AVS) dated 10/26/21 revealed:
-The resident was admitted from 10/18/21 - 10/26/21.
-Diagnoses were not documented.
-The resident was to have a one-week hospital follow up visit with his Primary Care Provider (PCP) after discharge.
-The resident was treated by an internal medicine provider and a psychiatrist during hospitalization.
-There was documentation of medication changes.
-The AVS was not signed by a medical provider.

Observation of Resident #1 on 12/15/21 at 9:50am revealed:
-The resident was sitting on his bedside.
-The resident was calm but confused.

Observation of the facility on 12/15/21 from 10:15am - 10:35am revealed:
-There was an open concept of the living room, dining room, hallway, and kitchen.
-Resident #1 was pacing in the facility.
-The resident walked out into the screened in patio.
-Each time the resident slammed the sliding glass door closed.
-The resident began smoking, picked up the cigarette butt holder, and paced back and forth on the patio.

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-The resident would occasionally slam the cigarette butt holder down on the patio floor.
-The resident walked in and out of the patio twice.
-The personal care aide (PCA) was in the kitchen.

Observation of the facility on 12/15/21 at 12:00pm revealed:
-The PCA was standing in the kitchen at the bar.
-Resident #1 approached the PCA, "don't go in my room again. I know what you're doing. You're an evil demon".
-The PCA did not respond.
-The resident sat on the couch.

Observation of Resident #1 on 12/15/21 at 12:10pm revealed the resident stood from the couch, walked to the front door, and returned to the couch.

Observation of Resident #1 on 12/15/21 at 12:15pm revealed:
-The resident stood from the couch and began pacing from the kitchen to the living room to the dining room.
-The resident went out the facility to the screened in patio twice.
-Each time the resident slammed the sliding glass patio door.

Observation of the facility on 12/15/21 from 12:30pm to 12:42pm revealed:
-Resident #1 was yelling at the Administrator.
-The resident was pacing in the living room.
-The resident opened the patio door and walked out to the patio.
-The resident turned, "Wait until I come back".
-The resident slammed the glass patio door closed.
-The resident paced on the patio while smoking.
-The resident picked up the cigarette butt holder

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from the corner of the patio and slammed it down on the ramp that goes into the facility.
-The resident picked up the cigarette butt holder, carried it to the corner of the patio, then slammed it down on the patio floor.
-At 12:40 the resident returned inside the facility.
-The resident slammed closed the glass patio door.
-The resident approached the surveyor, "Get rid of it now. You come into my house".
- The resident yelled at the Administrator, "You were in my room. You were searching through my things".
-The resident paced from the living room to the kitchen.
-At 12:42pm the resident sat on the couch in the living room.
-The Administrator nor the PCA did not approach or attempt to redirect the resident.
-The Administrator nor the PCA did not attempt to call Resident #1's PCP or emergency medical services (EMS).

Interview with the Administrator on 12/15/21 at 12:30pm revealed:
-Resident #1 would get very agitated, raise his voice, and yell.
-Resident #1 would get in staff's face, ball his hand into a fist, raise his fist at staff, and act as if he was going to hit staff.
-She gathered dirty laundry from the resident's room this morning, 12/15/21.
-The resident became agitated because she was in his room.
-The resident did not like anyone going in his room.
-When Resident #1 would become agitated staff would verbally redirect the resident to calm down.
-She would medicate the resident with one of the resident's as needed (prn) medications for

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anxiety and agitation.
-Resident #1 would calm down after verbal redirection and medication.
-The Administrator was not afraid of Resident #1 because he had never physically hurt anyone.
-Resident #1 was treated by his PCP three weeks ago for his outbursts.
-The resident's family member transported the resident to the appointment.
-At that time, the resident's PCP told the family member for the facility to continue medicating the resident with prn medications during agitated states.
-Resident #1's family member said the PCP wanted the resident evaluated by mental health.
-She had not notified Resident #1's PCP of the resident's continued outbursts and agitation since the PCP visit three weeks ago.
-She did not notify the resident's PCP because the family member told her there was nothing the PCP could do for the resident.
-She took Resident #1 to see a mental health provider two weeks ago.
-The appointment was a walk-in appointment.
-Resident #1 had a follow up mental health visit scheduled for 12/23/21.
-The Administrator did not know the name or telephone number of the mental health provider or office.

Second interview with Administrator on 12/15/21 at 12:42pm revealed:
-Resident #1 was paranoid.
-Resident #1's behavior from 12:30pm - 12:42pm was normal for the resident.
-She would administer Resident #1's prn medication to the resident when he displayed the behavior displayed from 12:30pm to 12:42pm.
-She would not call Resident #1's PCP when he displayed the behaviors because the resident's

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family member told her there was nothing the resident's PCP would do.
-She would only call EMS if Resident #1 were to cause someone harm.

Observation of the facility on 12/15/21 from 12:50pm to 1:00pm revealed:
-Surveyor walked out of the facility to the patio.
-Resident #1 followed surveyor to the patio.
-Resident #1 began pacing on the patio.
-Surveyor walked into the back yard.
-Resident #1 walked up to the patio screen and began yelling at the surveyor.
-"Get out of my house".
-Resident #1 picked up the cigarette butt holder and began slamming the base of it on the patio floor.
-The resident continued up to walk up the patio screen and yell at the surveyor to leave his home.
-Surveyor walked around the patio to exit the backyard through the gate.
-In the patio, Resident #1 followed the direction of the surveyor continuing to yell, "leave my home or I'm calling the police", when trying to exit the backyard.
-Surveyor exited the back yard through the gate.
-Surveyor entered the front door of the facility.
-Resident #1 approached surveyor, "Get out of my house".
-Resident #1 walked outside to the patio.

Observation of the facility on 12/15/21 at 1:05pm revealed:
-Resident #1 returned inside the facility.
-Resident #1 sat on the couch.
-Another resident's family member entered the facility.
-Resident #1 was pacing around the kitchen/dining room area.

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C 246	Continued From page 6 Third interview with the Administrator on 12/15/21 at 1:00pm revealed: -She recognized that Resident #1 was verbally aggressive while the surveyor was outside. -She recognized that Resident #1 continued to pace. -She did not notify Resident #1's PCP of the resident's agitation and aggression. Interview with the PCA on 12/15/21 at 1:05pm revealed: -Resident #1 would normally yell at visitors to get out of his house. -Resident #1 would normally yell at staff. -In November 2021, about three weeks ago, a resident who was transitioning had family members visit on a regular basis. -At that time, Resident #1 would yell at the former resident's family members when they visited the resident. -Resident #1 would slam his hands and objects on the kitchen bar. -She would tell Resident #1 not to yell at the family members. -Resident #1 would say the facility was his home. -Verbal redirection did not calm Resident #1 at all when he paced, yelled, and slammed his hands and objects on the counter. -Verbal redirection would increase Resident #1's yelling, pacing and slamming his hands and objects on the counter. -Resident #1's yelling, pacing, and slamming his hands and objects on the counter would last anywhere from 20 minutes to 45 minutes. -She had never notified Resident #1's PCP the resident would have agitated states of yelling, pacing, and slamming his hands and objects on the counter. -Notifying Resident #1's PCP was the responsibility of the Administrator.	C 246		

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-She worked 12 hour shifts in the facility alone.
-Sometimes she would have to call the Administrator to go to the facility because Resident #1 would yell, pace, and slam his hands and objects on the counter.
-The last time she had to call the Administrator for Resident #1 was on 12/14/21 because the resident was pacing, yelling, and paranoid.
-Resident #1's behaviors were triggered by anything such as staff, the television or not being able to call his family members.
-The resident's family members had to take his cell phone away when first admitted because he called them and 911 often wanting to go home.

Fourth interview with the Administrator on 12/15/21 at 1:30pm revealed:
-She was concerned about Resident #1's behaviors and agitation.
-She called the resident's PCP to report the resident's agitation two days before his appointment three weeks ago.
-The resident's PCP appointment three weeks ago was a follow up visit from the resident's hospital discharge on 10/26/21.
-The facility did not have documentation from the resident's PCP visit three weeks ago.
-She was not going to notify Resident #1's PCP the resident was pacing, slamming doors, or yelling at visitors today, 12/15/21, because the resident had a mental health appointment scheduled for 12/23/21.
-Her plan regarding the resident's current state of agitation and behaviors was to continue to administer Seroquel (used to treat certain mental and/or mood conditions) as needed until she took the resident to his mental health appointment on 12/23/21.
-She still did not remember the name or contact number of the resident's mental health provider.

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C 246	Continued From page 8 -She knew the location of where Resident #1's mental health office visit was scheduled for 12/23/21 because it was where she took him previously. -She looked at her location history on the day she took Resident #1 to the walk-in mental health clinic visit. -From the internet, she provided the telephone number of the location she took Resident #1 for the walk-in mental health clinic visit. Telephone interview with a representative who was identified by the Administrator as Resident #1's mental health provider on 12/10/21 at 2:25pm revealed: -They were a mental health crisis line. -They did not have any information on Resident #1. Fifth interview with the Administrator on 12/15/21 at 2:30pm revealed she did not have another contact number for Resident #1's mental health provider. Sixth interview with the Administrator on 12/15/21 at 3:10pm revealed: -She called Resident #1's PCP and the office was closed. -She called an urgent care mental health clinic and made an appointment for the resident to be seen on 12/16/21. -She had decided to call EMS today, 12/15/21, to transport the resident to the hospital for a mental health evaluation. -The facility was not safely able to provide the care to Resident #1 that he needed to keep him safe because of his behaviors. Observation of Resident #1 on 12/15/21 from 3:15pm to 3:25pm revealed:	C 246		

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C 246	Continued From page 9 -The resident was pacing back and forth from inside the facility to the patio. -The resident was conversing to himself. -The resident's conversation rambled from subject to subject. Interview with an EMS Paramedic on 12/15/21 at 3:40pm revealed: -Resident #1 was being agitated and being verbally aggressive with EMS personnel. -He did not recommend Resident #1 stay at the facility because of his agitation. -If Resident #1 was not transported to the local hospital for a medical evaluation the resident's agitation would increase. -It was not safe for Resident #1 or the other resident for Resident #1 to remain at the facility because of his verbal aggression and increasing anxiety. Seventh interview with the Administrator on 12/15/21 at 3:45pm revealed: -Since 10/11/21, Resident #1 was agitated and did not want to be at the facility. -The resident would call 911 telling them he did not want to be there. -Staff documented resident concerns in the shift change logbook. -She administered Resident #1 Seroquel three times a day as needed for agitation, pacing, and yelling. -She would administer Resident #1 Lorazepam (used to treat anxiety disorders, severe agitation, and alcohol withdrawal) for agitation, pacing, and yelling. Review of the facility's shift change logbook revealed there was no documentation regarding Resident #1.	C 246		

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C 246	Continued From page 10 Second interview with the PCA on 12/15/21 from 3:50pm to 3:56pm revealed: -Resident #1 was agitated every night after being admitted to the facility. -The resident would yell, wander, pace, and said he did not belong at the facility. -Within about 6 days of admission, the resident called 911 about 10 times wanting to go home. -One day Resident #1 was pacing and agitated because a healthcare provider was in the facility. -The resident stood at the window and watched the healthcare provider leave. -The resident went out the back door onto the patio, exited the patio, opened the gate and started walking away from the facility. -The resident was admitted to the local hospital. -Resident #1 took the shift change logbook from staff. -She did not say when. -Resident #1 ripped out every page in the shift change logbook that contained any documentation regarding him. -Resident #1 kept the shift change logbook in his room. -Staff had not documented in the book since the resident took the book from staff. -She never notified Resident #1's PCP the resident was agitated, yelling, pacing, wandering, and wanting to go home. Interview with a local city police officer on 12/15/21 at 3:58pm revealed: -Resident #1 did not want to go to the hospital. -EMS could not transport the resident to the local hospital for a medical evaluation because the resident refused. -He recommended staff have the resident Involuntarily Committed (IVC'd). Eighth interview with the Administrator on	C 246		

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C 246	Continued From page 11 12/15/21 at 4:00pm revealed: -She notified Resident #1's family the resident was yelling, pacing, calling 911, and wanted to go home after admission to the facility. -She never notified the resident's PCP the resident was yelling, pacing, calling 911, and wanted to leave. -She did not think she should have notified Resident #1's PCP to report his behavior at that time because the reason the resident was agitated was because he did not want to be at the facility. -She notified the resident's family because she wanted them to talk with the resident and calm him. -She notified the resident's family members of his behavior every day after the resident was admitted. Ninth interview with the Administrator on 12/15/21 at 4:30pm revealed: -She was going to have the PCA transport Resident #1 to the police department for IVC papers. -She was not concerned regarding transporting the resident to the police department for IVC papers. -She would not accept the resident back to the facility after he was IVC'd because she could not safely care for the resident. Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 50mg three times a day as needed for mild agitation. -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented.	C 246		

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C 246	Continued From page 12 -There was documentation Lorazepam was administered at 7:47am on 10/13/21 for anxiety. -There was documentation Lorazepam was administered at 8:18am on 10/14/21 for anxiety. -There was documentation Seroquel was administered at 7:42am on 10/29/21 for agitation. -There was no documentation the resident's PCP was notified of the agitation/anxiety. Review of Resident #1's November 2021 eMAR revealed: -There was an entry for Seroquel 50mg three times daily as needed for mild agitation. -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented. -There was documentation Seroquel was administered 49 occasions from 11/05/21 - 11/17/21 and 11/19/21 - 11/30/21 for anxiety/agitation. -There was documentation Lorazepam was administered 12 occasions from 11/05/21 - 11/15/21 for anxiety. -There was no documentation the resident's PCP was notified of the agitation/anxiety. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for Seroquel 50mg three times daily as needed for mild agitation. -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented. -There was documentation Seroquel was administered 41 occasions from 12/01/21 - 12/15/21 for anxiety/agitation. -There was no documentation Lorazepam was administered.	C 246		

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C 246	Continued From page 13 -There was no documentation the resident's PCP was notified of the agitation/anxiety. Review of Resident #1's facility record revealed: -There were no PCP visit notes from the time of admission on 10/10/21 to 12/15/21. -There was no documentation the resident's PCP was notified of agitation, yelling, pacing, paranoia, slamming his hands and objects on the counter, balling his fist in staff face, wanting to leave the facility, or eloping. Attempted telephone interview with Resident #1's PCP on 12/15/21 at 1:10pm was unsuccessful. Attempted telephone interview with Resident #1's family member on 12/15/21 at 4:00pm was unsuccessful. _____ The facility failed to notify the Primary Care Provider for Resident #1 who had a diagnosis of dementia with behavioral disturbances and was paranoid, yelling at staff and visitors, pacing, and slamming his hands on counters. The resident's behavior escalated causing the need for EMS notification and the recommendation of an involuntary commitment. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	C 246		

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	fcl051077	A. BUILDING: _____ B. WING _____	12/15/2021

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C 321	Continued From page 14	C 321		
C 321	10A NCAC 13G .1002 (g) Medication Orders 10A NCAC 13G .1002 Medication Orders g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure psychotropic medications ordered as needed for 1 of 2 sampled residents (#1) included the exact time frames of administration for an antipsychotic and detailed behavior-specific written instructions including symptoms that might require the use of an antianxiety medication. The findings are: Review of Resident #1's current FL-2 dated 10/05/21 revealed: -Diagnoses included dementia, alcoholic, and generalized anxiety disorder (GAD). -The resident was intermittently disoriented. -The section titled "inappropriate behaviors" was	C 321		

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C 321	Continued From page 15 blank. Review of Resident #1's local hospital after visit summary (AVS) dated 10/26/21 revealed: -The resident was admitted from 10/18/21 - 10/26/21. -There were no diagnoses documented. -The resident was treated by an internal medicine provider and a psychiatrist during hospitalization. -There was documentation of medication changes. -There was no documentation of Lorazepam (used to treat anxiety disorder, severe agitation, and alcohol withdrawal. -The AVS was not signed by a medical provider. a. Review of Resident #1's local hospital physician's order dated 10/26/21 revealed: -Diagnoses included dementia with behavioral disturbances. -There was an order for Seroquel 50 milligrams (mg) three times a day as needed (prn) for mild agitation (used to treat mental and/or mood disorders). -The specified timeframes between administration was not documented. -There was no documentation specifying the maximum amount of doses to be administered within a 24 hour period. Review of Resident #1's electronic physician's order sheet dated 11/17/21 revealed: -Diagnoses included dementia with behavioral disturbances, alcoholic, general anxiety disorder, and traumatic brain injury. -There was an entry for Seroquel 50mg three times daily prn for mild agitation. -The specified timeframes between administration was not documented. -There was no documentation specifying the	C 321		

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maximum amount of doses to be administered within a 24 hour period.

Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 50mg three times a day as needed for mild agitation.
-There was documentation Seroquel was administered at 7:42am on 10/29/21 for agitation.

Review of Resident #1's November 2021 eMAR revealed:
-There was an entry for Seroquel 50mg three times daily as needed for mild agitation.
-There was documentation Seroquel was administered 49 occasions from 11/05/21 - 11/17/21 and 11/19/21 - 11/30/21 for anxiety/agitation.
-There was documentation Seroquel was administered from 3 hours and 15 minutes - 6 hours and 51 minutes apart for 12 days during November 2021.

Review of Resident #1's December 2021 eMAR revealed:
-There was an entry for Seroquel 50mg three times daily as needed for mild agitation.
-There was documentation Seroquel was administered 41 occasions from 12/01/21 - 12/15/21 for anxiety/agitation.
-There was documentation Seroquel was administered from 3 hours and 11 minutes - 7 hours and 33 minutes for 14 days during December 2021.

Interview with the Administrator/medication aide (MA) on 12/15/21 at 12:30pm revealed:
-When a prn medication was ordered for an administration frequency of three times a day, a

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specified timeframe between administration was not required.
-As a general rule, when administering a medication that was ordered three times a day prn she would try to administer the medication between six to eight hours between doses.
-The usual time frames of a prn medication to be administered three times a day was sometime in the morning, between 12:00pm to 1:00pm, and at 7:00pm.
-She did not know Seroquel needed a maximum amount of doses to be administered within 24 hours to be documented in the order.

Telephone interview with a lead pharmacy technician for Resident #1's pharmacy on 12/15/21 at 1:20pm revealed:
-The pharmacist was unavailable for telephone interview.
-Resident #1 had an order for Seroquel 50mg three times a day prn for agitation.
-She expected the facility to have called the resident's PCP to clarify the times of administration for Seroquel three times daily prn for agitation.

Second interview with the Administrator/MA on 12/15/21 at 3:55pm revealed:
-She administered Resident #1 Seroquel three times a day as needed for agitation.
-She did not think she need to contact the resident's PCP to clarify the exact timeframes allowed between times of administration between doses.
-She would administer Resident #1 Seroquel for agitation, pacing, and yelling.

Refer to interview with the Administrator/MA on 12/15/21 at 3:55pm.

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C 321	Continued From page 18 b. Review of Resident #1's electronic physician's order sheet dated 11/17/21 revealed: -Diagnoses included dementia with behavioral disturbances, alcoholic, general anxiety disorder, and traumatic brain injury. -There was an entry for Lorazepam 1 milligram (mg) every 8 hours as needed (used to treat anxiety disorders and severe agitation). -The indication for administration was not documented. -There was no documentation specifying the maximum amount of doses to be administered within a 24 hour period. Review of Resident #1's physician orders dated from 10/05/21 - 11/16/21 revealed there was no order for Lorazepam 1mg every 8 hours prn. Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented. -There was documentation Lorazepam was administered at 7:47am on 10/13/21 for anxiety. -There was documentation Lorazepam was administered at 8:18am on 10/14/21 for anxiety. Review of Resident #1's November 2021 eMAR revealed: -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented. -There was documentation Lorazepam was administered 12 occasions from 11/05/21 - 11/15/21 for anxiety.	C 321		

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C 321	Continued From page 19 Review of Resident #1's December 2021 eMAR revealed: -There was an entry for Lorazepam 1mg every 8 hours as needed. -The indication for administration was not documented. -There was no documentation Lorazepam was administered. Interview with the Administrator/MA on 12/15/21 at 1:30pm revealed: -Resident #1 was prescribed Lorazepam prior to his hospitalization in October 2021. -The resident's Lorazepam was discontinued when the resident was discharged from the hospital on 10/26/21. -She knew the resident had a current Lorazepam order dated 11/17/21 but the resident's pharmacy told her she could not administer it because the Lorazepam was discontinued on hospital discharge 10/26/21. -She did not know she was to follow the resident's most recent physician orders. Second interview with the Administrator/MA on 12/15/21 at 3:55pm revealed she would administer Resident #1 Lorazepam for agitation, pacing, and yelling. Third interview with the Administrator/MA on 12/15/21 at 3:55pm revealed: -Lorazepam was ordered to treat Resident #1's anxiety. -She did not call to clarify the prn reasons for administering Lorazepam to the resident because she knew it was used to treat anxiety. -She did not know Lorazepam needed a maximum amount of doses to be administered within 24 hours to be documented in the order.	C 321		

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C 321	Continued From page 20 Refer to interview with the Administrator/MA on 12/15/21 at 3:55pm. _____ Interview with the Administrator/MA on 12/15/21 at 3:55pm revealed: -It was the responsibility of Resident #1's pharmacy staff to review the resident's physician's orders. -No one in the facility was responsible to review Resident #1's physician's orders. -No one in the facility had reviewed Resident #1's physician's orders since admission on 10/10/21. -She would fax Resident #1's physician's orders to the pharmacy once received. -Pharmacy would enter the orders in the electronic medication administration record (eMAR). -She would compare the resident's physician's orders to the eMAR once pharmacy entered the orders in the eMAR. -She would compare the orders to the eMAR to ensure they matched. -She would not compare the orders to ensure they were complete orders or needed clarification. -She did not respond when asked why she did not review Resident #1's physician's orders once they were signed to ensure they were complete.	C 321		
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:	C 912		

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C 912	Continued From page 21 Based on observations, interviews, and record review the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record review the facility failed to ensure health care referral and follow up for 1 of 2 residents sampled (#1) who was exhibiting psychiatric symptoms. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)].	C 912		