

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL097014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/22/2015
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NAME OF PROVIDER OR SUPPLIER WILKES COUNTY ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 REST HOME ROAD WILKESBORO, NC 28697
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D 000	Initial Comments The Adult Care Licensure Section and the Wilkes County Department of Social Services conducted a complaint investigation on April 20-22, 2015 with an exit conference via telephone on April 22, 2015. The complaint investigation was initiated by the Wilkes County Department of Social Services on April 15, 2015.	D 000		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on interview and record review, the facility failed to assure that every resident was free from mental and physical abuse, and neglect as related to four residents (Resident #2, #3, #4, and #5) being assaulted by another resident (Resident #1).</p> <p>The findings are:</p> <p>Review of Resident #1's FL2 dated 12/15/14 revealed diagnoses of schizophrenia and borderline intellectual functioning.</p> <p>Record review revealed Resident #1 was admitted to the facility on 12/15/14.</p> <p>Review of Resident #1's hospital discharge summary dated 12/15/14 revealed: -The resident was admitted for inpatient</p>	D 338		

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D 338	<p>Continued From page 1</p> <p>psychiatric care on 11/25/14 for "acute exacerbation of his Schizophrenia." -The resident was admitted "under involuntary petition" for treatment after he had assaulted another resident at a previous assisted living facility. -The resident had "been refusing his medications and staying away from the facility longer than he should."</p> <p>Review of a physician certification for Home Health Services for Resident #1 dated 12/17/14 revealed: -The resident had a long history of mental illness with a "long history of decompensations." -The resident had a history of noncompliance with his medications with increasing delusional thinking and agitated behaviors. -The resident was documented as alert and fully oriented. -The resident's thought pattern was documented as "delusional and disorganized." -The resident's judgment and insight were documented as "severely impaired." -"He displays continued delusional thinking [without] signs of behavioral disturbances at this time." -"As this patient has failed to respond to multiple psychotropic medications in the past, this individual is now being treated with Clozaril which requires frequent blood work to ensure the safety of the patient." -"This patient's tenuous stability requires frequent phlebotomy by Home Health to monitor patient safety and compliance to prevent decompensation and hospitalization." -"In addition, it is unsafe for this patient to leave the facility unattended."</p> <p>Review of a physician's order for Resident #1</p>	D 338		

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D 338	<p>Continued From page 2</p> <p>dated 12/17/14 revealed:</p> <ul style="list-style-type: none"> -Cogentin (used to treat involuntary movements due to the side effects of certain antipsychotic medications) 1mg daily at bedtime. -Clozaril (used to treat severe schizophrenia) 200mg 2 tabs daily at bedtime. -Risperidone (used to treat schizophrenia) 3mg 1 tablet twice a day. -Complete blood count (CBC) with absolute neutrophil count (required blood test for monitoring of white blood cell counts with the use of Clozaril) every week to be performed by Home Health. <p>Review of Resident #1's CBC results revealed the resident received testing on 12/19/14, 12/23/14, 12/30/14, 1/6/15, 1/13/15, 1/20/15, 1/28/15, 2/3/15, 2/10/15, 2/16/15, 2/26/15, 3/4/15, and 3/10/15.</p> <p>Review of Resident #1's Primary Care Provider (PCP) new admission visit notes dated 12/22/14 revealed:</p> <ul style="list-style-type: none"> -"Alert and oriented to person, place, and time." -"Poor eye contact, dysphoric and labile mood, poor attention span and focus, poor and impaired judgement, disorganized thoughts, delusional and paranoid thought with auditory hallucination, preoccupied with violent ideation." <p>Review of Resident #1's January 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -Clozaril was refused for 9 occurrences out of 12 opportunities from 1/1/15 to 1/13/15. -Cogentin was refused for 9 occurrences out of 12 opportunities from 1/1/15 to 1/13/15. -Risperidone was refused for 10 occurrences out of 25 opportunities from 1/1/15 to 1/13/15. 	D 338		

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D 338	<p>Continued From page 3</p> <p>Review of Resident #1's hospital discharge summary dated 1/15/15 revealed: -Diagnoses included: Schizophrenia and Noncompliant with Medications. -Resident was brought in by the [local law enforcement department's name] as an involuntary commitment. -Hand cuffs noted to be on patient upon arrival to the emergency department. -"Affect is blunted, patient's behavior uncooperative, irritable, restless." -"Delusions are unable to assess, hallucinations are suspected, will not state." -"The patient has been identified as a suicide risk." -The resident received oral doses of Geodon (used to treat schizophrenia), Clozaril, Cogentin, and Risperidone during his time in the emergency department from 1/13/15 at 12:15pm until discharge from the local emergency department on 1/15/15 at 10:46am. -Resident was to continue Clozaril, Risperidone, and Cogentin as home medications on discharge.</p> <p>Review of a physician's order for Resident #1 dated 1/15/15 revealed an additional dose of Risperidone Conc 1mg/ml 2ml in food or drink twice a day with meals.</p> <p>Review of Resident #1's FL2 dated 1/29/15 revealed: -Diagnoses of schizophrenia and borderline intellectual functioning. -An order for Cogentin (used to treat involuntary movements due to the side effects of certain antipsychotic medications) 1mg daily at bedtime. -An order for Clozaril 400mg daily at bedtime. -An order for Risperidone 3mg 1 tablet twice a day.</p>	D 338		

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D 338	<p>Continued From page 4</p> <p>Review of Resident #1's Local Managing Entity (LME) face to face contact visit note dated 2/9/15 revealed: -Low risk to self or others. -"[Registered Nurse (RN)] evaluated client for presence of disturbing symptoms associated with severe and persistent mental illness." -"RN continued to encourage client to take his medications as prescribed and explored with him the importance of medication compliance towards maintaining his psychiatric and medical stability."</p> <p>Review of Resident #1's Care Plan dated 2/12/15 revealed: -The resident required staff supervision for setup for eating, prompting for bathing, dressing and grooming/personal hygiene. -The resident was independent with toileting, ambulation, and transfers.</p> <p>Review of Resident #1's Primary Care Provider visit note dated 2/20/15 revealed no changes to current care and follow up in 1 month.</p> <p>Review of Resident #1's February 2015 MAR revealed: -Clozaril was refused for 1 occurrence out of 28 opportunities from 2/1/15 to 2/28/15. -Cogentin was refused for 2 occurrences out of 56 opportunities from 2/1/15 to 2/28/15. -Risperidone tablet form was refused for 2 occurrences out of 56 opportunities from 2/1/15 to 2/28/15. -Risperidone Conc was refused for 3 occurrences out of 56 opportunities from 2/1/15 to 2/28/15.</p> <p>Review of Resident #1's March 2015 MAR revealed: -The resident had refused the 8pm dose of Clozaril, Cogentin, and Risperidone in tablet form</p>	D 338		

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D 338	<p>Continued From page 5</p> <p>on 3/7/15.</p> <p>-Clozaril was refused for 6 occurrences out of 19 opportunities from 3/1/15 to 3/19/15 when the medication was discontinued.</p> <p>-Cogentin was refused or not administered for 13 occurrences out of 31 opportunities from 3/1/15 to 3/31/15.</p> <p>-Risperidone tablet form was refused for 13 occurrences out of 38 opportunities from 3/1/15 to 3/19/15 when the medication was discontinued.</p> <p>Review of Resident #1's Accident/Injury Report dated 3/8/15 revealed:</p> <p>-Reported incident occurred at 4:20pm.</p> <p>-There had been a "physical confrontation" between Resident #1 and another resident.</p> <p>-No injuries occurred.</p> <p>-A notification message had been left with Resident #1's guardian.</p> <p>-Resident #1's physician had been notified.</p> <p>-No description of incident.</p> <p>Review of Resident #1's Local Managing Entity (LME) face to face contact visit note dated 3/10/15 revealed:</p> <p>-The resident had presented as "delusional."</p> <p>-The resident had told the RN that he had been refusing his medications '...because I don't need medications.'</p> <p>-The LME and a home health nurse were able to persuade the resident to have his blood drawn for a CBC.</p> <p>-"He refused his medications on the 7th, but took them on the 8th and refused on the 9th."</p> <p>-The resident was aware that not taking his medication could lead to him being hospitalized.</p> <p>-The resident "denied being a danger to self or others."</p>	D 338		

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D 338	<p>Continued From page 6</p> <p>Review of Resident #1's LME indirect note dated 3/11/15 revealed Resident #1's psychiatric physician was notified and informed of "client medication refusal."</p> <p>Review of Resident #1's physician order dated 3/17/15 revealed Seroquel 300mg tab daily at bedtime.</p> <p>Review of Resident #1's physician order dated 3/19/15 revealed: -Clozaril was discontinued. -May crush meds if necessary. -Seroquel (used to treat Schizophrenia) 400mg daily at bedtime. -Risperidone Conc 1 mg/ml, 3ml in food or drink three times a day. -Abilify (used to treat Schizophrenia) 5mg daily.</p> <p>Review of Resident #1's physician order dated 3/25/15 revealed: -Abilify Maintena 400mg intramuscular injection every month. -Discontinue oral Abilify 7 days following Abilify Maintena injection.</p> <p>Review of Resident #1's Accident/Injury Report dated 3/28/15 revealed: -Reported incident occurred at 8:15pm on 3/28/15. -Resident #1 had "hit another resident in the nose." -A notification message had been left with Resident #1's Guardian. -Resident #1's physician had been notified.</p> <p>Review of Resident #1's PCP consultation sheet dated 3/30/15 revealed: -Face to face visit with PCP. -Labs were reviewed.</p>	D 338		

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D 338	<p>Continued From page 7</p> <p>-No changes and follow up 1 month.</p> <p>Review of Resident #1's Local Managing Entity (LME) face to face contact visit note dated 3/31/15 revealed: -"...continues to be delusional as evidenced by statements like 'They were drinking my blood.' -The resident refused his Abilify Maintena injection.</p> <p>Review of Resident #1's Accident/Injury Report dated 4/8/15 revealed: -Reported incident occurred at 9:00am 4/8/15. -Resident #1 "drew back and hit" Resident #2. -Resident #1's guardian and physician were not documented as having been notified.</p> <p>Review of Resident #1's Local Managing Entity (LME) face to face contact visit note dated 4/8/15 revealed: -When referring to his medications, "They are sucking my blood, I am not taking them anymore." -The resident did not want to discuss the incident with the LME contact. -The resident denied hitting the other resident who was taken to the hospital. -Facility staff had earlier reported that Resident #1 was involved in a fight with another resident and Resident #1 had "punched" the other resident. Police were involved and had filed a report. -When Resident #1 heard about his injection, he completely refused to talk. -"Efforts to process with [the resident] were not successful and he became anxious and somehow 'agitated'." -Resident #1 had been taking his other medications, but refused to get his injection. -Resident #1 denied being a danger to self or</p>	D 338		

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D 338	<p>Continued From page 8</p> <p>others.</p> <p>Review of Resident #1's physician order dated 4/9/15 revealed Seroquel was increased to 600mg daily at bedtime.</p> <p>Review of Resident #1's April 2015 MAR revealed: -Risperidone Conc had been administered 45 occurrences out of 45 opportunities from 4/1/15 to 4/15/15. -Seroquel had been administered 15 occurrences out of 15 opportunities from 4/1/15 to 4/15/15. -Abilify had been administered 15 occurrences out of 15 opportunities from 4/1/15 to 4/15/15.</p> <p>Review of Resident #1's Accident/Injury Report dated 4/16/15 revealed: -Staff witnessed incident occurred at 2:15am 4/8/15. -Resident began hitting another male resident knocking him to the floor, where he continued to hit the other resident. -Staff broke them up. -"He [said] the other resident tried to touch his cigs so he hit him." -Resident #1's Guardian was documented as notified.</p> <p>Review of Resident #1's Nurses Notes dated 4/16/15 at 2:15am revealed: -Resident attacked another resident in the hall. -"He hit him knocking him to the floor where he continued to hit him in the head and face." -The police were called. -Resident #1 told the police the other resident had tried to take his "cigs, so he beat him up." -The police took Resident #1 to jail.</p> <p>Interview with Resident #1's Psychiatric Physician</p>	D 338		

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D 338	<p>Continued From page 9</p> <p>on 4/21/15 at 11:40am revealed:</p> <ul style="list-style-type: none"> -He began treating Resident #1 for the first time when he was admitted to the facility in December 2014. -After researching the residents medical history he realized "He hasn't responded to anything well ever." -It was difficult to treat mental retardation, because it was not a chemical imbalance in the brain. -Mental retardation (MR) causes "impulse control issues, aggressive issues, and there's no cure for MR just sedation more than anything else" to help manage. -He stated "with Seroquel in food" the resident had been doing "fairly well." -"I was up there a couple times a week to see what we could do with him." -"Others precipitated his behaviors. Something attracted people to attack him." -"We can't predict when he's gonna be aggressive." -He stated the RCC and Operations Director were communicating with him regularly about how to best manage Resident #1. -The facility was "one of the few locked facility's" available and the staff had "a lot of exposure" to residents with similar needs to Resident #1. -"Don't know where else [Resident #1] would have gone." -"You send them to the emergency room now [for mental health issues] the average stay is 9 to 14 days." -"People [with mental illness] are now living on the streets because shelters won't take them." -"[Resident #1] came there on [LME name], I was seeing him at least 2 to 3 times a month 15 to 20 minutes at a time, the facility was calling me." -"Wouldn't have recommended any other facility." -He stated it was almost impossible to do an 	D 338		

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D 338	<p>Continued From page 10</p> <p>immediate discharge of a resident because "the emergency room sends them right back if they are calm" when they are there.</p> <p>Review of records, interviews, and observations of the four residents identified that Resident #1 had assaulted revealed the following: A. Review of Resident #4's most current FL2 dated 3/5/15 revealed: -Diagnoses that included schizoaffective disorder and borderline intelligence functioning. -The resident had inappropriate behaviors that included "injurious to property." -The resident was "passive" and intermittently disoriented.</p> <p>Review of a Care Plan dated 3/13/15 revealed Resident #4 was independent in ambulation and transfers.</p> <p>Interview with Staff F, Personal Care Aide (PCA), on 4/20/15 at 5:02pm revealed: -She had "walked in on a fight" between Resident #1 and Resident #4. -When "I walked in [Resident #4's name] was on the ground holding his head in his arms to protect himself and [Resident #1's name] was kicking him with his foot." -Resident #1 was wearing tennis shoes. -"[Resident #1] must have pulled some hair, because there was some of [Resident #4's] hair on the ground next to him." -"When I walked in I immediately said 'Let's break it up' that's when [Resident #1's name] went on down the hall and [Resident #4's name] went on out to smoke." -"I asked [Resident #4's name] if he was okay. He said he was, but his face was red/flushed all over. No blood. No marks. No swelling. Just his hair, a few strands pulled out."</p>	D 338		

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D 338	<p>Continued From page 11</p> <p>-The Medication Aide (MA) had called the Resident Care Coordinator to report the incident. -Resident #1 had been put on 15 minute watch.</p> <p>Follow up telephone interview with Staff F, PCA, on 4/22/15 at 11:30am revealed: -Staff A's, (Medication Aide), medication cart had been in the hall near the smoking porch. -Staff F had seen Resident #1 kicking Resident #4 in the head and he was making contact with his head. -"I went and told [Staff A] I had just broke up a fight with [Resident #4's name] and [Resident #1's name]." -Staff A had not seen the incident, however Staff F had told her what she had seen. -The Staff A had been made aware Resident #4 had been kicked in the head by Resident #1. -"I was standing beside [Staff A] when she called [RCC's name]." -"[Staff A] told [RCC's name] [Resident #1's name] was kicking [Resident #4's name] in the head and pulled his hair out." -Staff F was not asked to document what she saw.</p> <p>Interview with Resident #4 on 4/20/15 at 4:50pm revealed: -The resident was alert and oriented. -The resident stated "I keep to myself...I don't want to get in trouble." -The resident repeatedly denied any physical altercations ever with other residents while at the facility.</p> <p>Review of an incident report documented by Staff A, Medication Aide (MA) dated 3/8/15 at 4:20pm revealed: -Resident #4 reported "a physical confrontation" with Resident #1.</p>	D 338		

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(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
D 338	<p>Continued From page 12</p> <ul style="list-style-type: none"> -Resident #1 began "fussing and yelling" at Resident #4 "for no reason". -No injuries present. -No first aid was administered. -Resident #4 refused to go to hospital. -A notification message had been left with Resident #4's Guardian. -Resident #4's physician had been notified. -No description of incident. <p>Review of a Nurse's Note dated 3/8/15 at 4:20pm documented by Staff A, MA, revealed:</p> <ul style="list-style-type: none"> -Resident #4 had reported to Staff A there had been a physical confrontation on the smoking porch with Resident #1. -Staff A had checked on both residents and both stated they were "OK." -Staff A contacted Resident #4's guardian and physician. -Both residents were placed on 15 minutes checks. <p>Interview with Staff A, MA, on 4/21/15 at 11:05am and 4:30pm and revealed:</p> <ul style="list-style-type: none"> -Staff A had worked at the facility since January 2015, was now a medication aide and normally worked second shift. -She stated she had not witnessed the incident between Resident #4 and Resident #1 the evening of 3/8/15 and did not know if there was a witness. -She had first learned about it when Resident #4 came up to her during medication pass and reported Resident #1 had "hit him in the face". -Staff A stated she could tell Resident #4's "nerves were getting on him real bad." -Staff A stated she called the Resident Care Coordinator (RCC) and reported the incident. -The RCC told Staff A to place both residents on 15 minute checks. 	D 338		

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D 338	<p>Continued From page 13</p> <p>-Staff A stated she had "looked over" Resident #4 who "did not have any cuts or anything" but his face was a "little red".</p> <p>-Staff A stated she did not confer with any other staff (who worked that evening), only went by what Resident #4 had told her which was Resident #1 been cursing everybody then hit Resident #4 in the face and walked off.</p> <p>-Staff A stated Resident #1 had refused to talk to her about the incident.</p> <p>Interview with the Resident Care Coordinator (RCC) on 4/20/15 at 6:30pm revealed:</p> <ul style="list-style-type: none"> - She did not remember Staff A contacting her about the 3/8/15 incident regarding Resident #4 and Resident #1. - She learned of the incident the following Monday when she came to work. <p>Follow up telephone interview with the RCC on 4/22/15 at 11:40am revealed:</p> <ul style="list-style-type: none"> -She found the incident report (regarding Resident #4 on 3/8/15) on her desk Monday 3/9/15. -She had talked with Staff A, MA, who told her there was an "argument" between the two residents and Resident #1 had pushed Resident #4, but Staff A had not witnessed it. -She had spoken with Resident #1 and told him he could not push residents, but should take his problems to staff. -She had tried to talk with Resident #4, but he would not talk to her. -The RCC "assumed" the physical confrontation [on the incident report] was the pushing of [Resident #4 by Resident #1] and she was not aware of anything more. -She did not document the interviews she had with the residents or staff concerning investigation of the incident. 	D 338		

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D 338	<p>Continued From page 14</p> <p>Interview with the Operations Director on 4/21/15 at 2:40pm revealed: -He had seen the incident report concerning the argument between Resident #1 and Resident #4, however he was unaware of "how physical it had been." -He stated he had already put a new procedure in place for how staff were to report incidents and how incidents would be investigated in the facility.</p> <p>Telephone interview with the facility's psychiatrist on 4/21/15 at 11:30am revealed: -The Psychiatrist stated the facility had called him about the [Resident #4] incident (3/8/15).</p> <p>Refer to interview with Staff I (Medication Aide) on 4/20/15 at 4:30pm.</p> <p>Refer to the facility's policy for aggressive residents.</p> <p>Refer to the facility's policy for internal reporting.</p> <p>B. Review of Resident #5's most current FL2 dated 10/30/14 revealed diagnoses that included schizoaffective disorder and borderline intelligence functioning.</p> <p>Review of Resident #5's Plan of Care dated 9/30/14 revealed the resident needed supervision with ambulation and was independent with transfers.</p> <p>Observation of Resident #5 on 4/20/15 at 4:50pm revealed the resident had a nickel sized green colored bruise on the left side of the upper part of his nose.</p> <p>Interview with Resident #5 on 4/20/15 at 4:50pm</p>	D 338		

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D 338	<p>Continued From page 15</p> <p>revealed:</p> <ul style="list-style-type: none"> -The resident stated yes he had been hit in the nose by Resident #1. -The resident was unable to remember when the incident had occurred. <p>Review of an incident report documented by Staff B (Medication Aide) dated 3/28/15 at 8:15pm revealed:</p> <ul style="list-style-type: none"> -Staff B "was told" Resident #5 was hit by another resident [Resident #1]. -Injury: "busted nose." -No other description of the incident. <p>Review of the Nurse's Note dated documented by Staff B (Medication Aide) on 3/28/15 at 8:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #5 was hit by another resident [Resident #1] in the nose. -"It busted his nose". -The bleeding was stopped and ice packs were placed on the nose. -Staff B contacted the Resident Care Coordinator (RCC). -"Kept an eye on the resident the rest of the night." <p>Interview with Staff B, MA, on 4/20/15 at 3:50pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 was on a lot of 15 minute checks. -Resident #1 did not have a lot of physical aggression but would "switch his personality so fast" and would scream if he did not get a cigarette when he wanted one. -Resident #1 was not aggressive with staff or residents but had "jumped the fence" and "locked himself in the front room." -No residents had ever expressed fear of Resident #1. 	D 338		

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D 338	<p>Continued From page 16</p> <p>Interview with the RCC on 4/20/15 at 6:30pm revealed: -Staff had called her and reported the 3/28/15 incident where Resident #1 had hit Resident #5. -The RCC told staff to call the physician, put ice on the nose, and fill out an incident report and progress note. -Both residents were placed on 15 minute checks for three days.</p> <p>Interview with the Operations Director on 4/21/15 at 2:40pm revealed: -He was not made aware of the incident that had occurred between Resident #1 and Resident #5 until the assault occurred with Resident #2. -"That's when I initiated the 30 day discharge" for Resident #1. -The RCC "should have reported [the assault on Resident #5] to me." -"I will be meeting with staff tomorrow to go over more in depth how to do incident reporting."</p> <p>Interview with the RCC on 4/21/15 at 3:25pm revealed: -Law enforcement was not notified after the assault on Resident #5. -"All I know is that if law enforcement comes out here they will not arrest anyone for assault unless that person goes to the magistrates office and takes out a warrant." -"The only time they will [arrest someone] is when the police officer himself presses charges and [the police officer's] won't do that." -Resident #5 had a guardian "and his guardian would have had to press charges."</p> <p>Refer to interview with Staff I (Medication Aide) on 4/20/15 at 4:30pm.</p> <p>Refer to telephone interview with the facility's</p>	D 338		

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D 338	<p>Continued From page 17</p> <p>psychiatrist on 4/21/15 at 11:30am.</p> <p>Refer to the facility's policy for aggressive residents.</p> <p>Refer to the facility's policy for internal reporting.</p> <p>C. Review of Resident #2's most current FL2 dated 10/30/14 revealed diagnoses which included dementia.</p> <p>Review the care plan dated 9/30/14 revealed Resident #2: -Was independent with toileting, ambulation and transfer. -Needed supervision with dressing. -Needed one person assistance with bathing and grooming.</p> <p>Review of an incident report dated 4/8/15 at 9:00am revealed: -Staff K (Medication Aide) had witnessed Resident #2 being hit "in the nose" by Resident #1. -The incident occurred outside. -Resident #2 was transported to the hospital by emergency medical services.</p> <p>Review of a Nurses Note dated 4/8/15 at 9:00am revealed documentation by Staff K that included: -Resident #2 would not let Staff K and Resident #1 pass by. -Staff K told Resident #2 to move so Resident #1 could go smoke. -Resident #2 stated "No" because he "was going to get [Resident #1] so move". -Resident #1 "took off to the kitchen and ran in the kitchen and shut the door". -Resident #2 "would not leave so Resident #1 could come out of the kitchen".</p>	D 338		

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D 338	<p>Continued From page 18</p> <ul style="list-style-type: none"> -Staff K went around to the back [of the facility] and Resident #1 was out there smoking. -Resident #2 came around the building and Resident #1 "started walking away". -Staff K "tried to get [Resident #2] to leave [Resident #1] alone "but he wouldn't". -Resident #2 "finally caught up" with [Resident #1] and "kept coming close to [Resident #1]". -"Resident #1 kept backing up til he was backed into a corner and fought his way out." -"[Resident #1] hit [Resident #2] twice in the face and when [Resident #2] fell [Resident #1] hit [Resident #2] two more times." -By the time Staff K reached them, other staff had intervened and stopped Resident #1. -EMS (emergency medical services) and law enforcement were contacted. <p>Interview on 4/21/15 at 10:10am with Staff K (Medication Aide) revealed:</p> <ul style="list-style-type: none"> -Staff K had worked at the facility five years, was a Medication Aide and worked first shift. -Staff K stated Resident #2 would "talk" but had never physically acted out to her knowledge. -Staff K stated she had witnessed Resident #1 yell and curse other residents, was very agitated and would "punch the air" but had never heard Resident #1 verbally threaten anyone. -The 4/8/15 incident with Resident #2 was the first time Staff K had ever seen Resident #1 "put hands on" another resident. <p>Review of the hospital emergency department admission record dated 4/8/15 revealed diagnosis of facial fractures.</p> <p>Interview with Resident #2 on 4/20/15 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -The resident was alert and oriented. -The resident repeatedly stated "I should have left 	D 338		

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D 338	<p>Continued From page 19</p> <p>[Resident #1] alone." -Resident #2 stated he told Resident #1 "I am coming to get you" (gave no reason). -Resident #1 "had never bothered" Resident #2 before. -Resident #2 had never been afraid of Resident #1. -The resident had been advised by staff "to leave him [Resident #1] alone".</p> <p>Interview with the Resident Care Coordinator (RCC) on 4/20/15 at 6:30pm revealed: -Resident #2 was "after [Resident #1] that morning". -Resident #2 was told by staff to leave Resident #1 alone. -Resident #2 "bullied" other people but had never been physically aggressive.</p> <p>Interview with the Operations Director on 4/21/15 at 2:40pm revealed: -He stated he had not initiated an immediate discharge for Resident #1 after the assault on Resident #2 because "with an immediate discharge we have to find placement right then." -"The Sheriff's Department saw [the assault] as self defense." -"We spoke with [Resident #1's physician] and it seemed self defense to him too." -Resident #2 was following Resident #1 around "cussing at him" and "telling him he was going to hit him." -Resident #2 "even followed [Resident #1] outside." -Resident #2 "pushed and swung at [Resident #1's name] then [Resident #1] fought back." -"We can't discharge to a homeless shelter if self defense." -Residents "have to be discharged in a safe manner where they can have their medications</p>	D 338		

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D 338	<p>Continued From page 20</p> <p>given to them and get the care they need." -"I didn't have any options for [Resident #1]." -"Jail is not safe, homeless shelter is not safe." -"Doctor said he did not want to do an involuntary committment." -The physicians in the local emergency department would not do an involuntary committment if the resident was calm when he was taken to the hospital. -The emergency room "doctors are not standing here when the resident is being violent and aggressive...[Resident #1's] calm when he gets to the hospital." -"I called [Resident #1's Guardian] and she wasn't willing to come and pick him up." -"Its almost impossible to do an immediate discharge." -"I can't put him out on the street." -"We try to give ourselves a little more time with a 30 day discharge."</p> <p>Telephone interview with the facility's psychiatrist on 04/21/15 at 11:30am revealed: -Resident #2 had "a bad habit" of going "on a streak, pressuring and saying things he should not". -Resident #1 had been doing "pretty well" until the recent aggressive episodes where other residents "provoked/attacked" him.</p> <p>Refer to interview with Staff I (Medication Aide) on 4/20/15 at 4:30pm.</p> <p>Refer to the facility's policy for aggressive residents.</p> <p>Refer to the facility's policy for internal reporting.</p> <p>D. Review of Resident #3's current FL2 dated 11/30/14 revealed:</p>	D 338		

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D 338	<p>Continued From page 21</p> <p>-Diagnoses included Dementia and Schizophrenia Chronic Undifferentiated type. -The resident was admitted to the facility on 12/10/12.</p> <p>Review of Resident #3's Care Plan dated 9/30/14 revealed: -The resident required limited assistance with eating and grooming/personal hygiene. -The resident required extensive assistance with bathing and dressing. -The resident was independent with toileting, ambulation, and transfers.</p> <p>Review of Resident #3's Accident and Incident Report documented by Staff C, MA, dated 4/16/15 revealed: -At 2:15am, facility staff witnessed "A male resident had resident in the floor hitting him in the face and head" in a hallway in the facility. -Resident #3 reported "That the other resident jumped him." -Resident #3 sustained a "knot on head." -Resident #3 received first aid "Pressure was applied to the bleeding areas." -The resident was not taken the emergency room for evaluation. -The residents responsible party was notified of the incident at 2:45am on 4/16/15.</p> <p>Observation of Resident #3 on 4/17/15 at 4:30pm revealed there were scabbed abrasions three inches across the resident's right forehead and extending down his upper right cheek and right outer ear.</p> <p>Interview with Resident #3 on 4/17/15 at 4:30pm revealed: -The resident stated Resident #1 attacked him outside of his room "two days ago" at about two</p>	D 338		

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D 338	<p>Continued From page 22</p> <p>o'clock in the morning.</p> <p>-The resident stated Resident #1 ran up behind him "and pushed me down, and then he bent down and punched me in the face three or four times."</p> <p>-The resident said he did not know what triggered the attack.</p> <p>-Resident #1 had not threatened him prior to the incident.</p> <p>-The resident stated he laid in the floor for 10 minutes before staff got there and he had called for help while on the floor.</p> <p>-He said male staff came and but he could not remember the name of the male staff member or what the male staff member did.</p> <p>-He stated emergency medical services came and said they would take him to the hospital, but that all the hospital would do would be to stop the bleeding and send him back so he decided not to go to the hospital.</p> <p>Interview with Staff C, Medication Aide, on 4/20/15 at 4:00pm revealed:</p> <p>-Staff C had never seen Resident #1 be physically aggressive.</p> <p>-After the report of the 4/8/15 altercation between Resident #1 and Resident #2, Resident #1 had been placed on 15 minute checks which meant staff had to "lay eyes" on the resident every 15 minutes.</p> <p>-Staff C stated some residents would "provoke" each other.</p> <p>-Staff C stated no residents had ever complained about Resident #1.</p> <p>Interview with Staff G, Personal Care Aide, on 4/21/15 at 7:42am revealed:</p> <p>-He worked third shift.</p> <p>-Third shift now performed hourly rounds on all residents.</p>	D 338		

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D 338	<p>Continued From page 23</p> <p>-"We have a lot of residents that get up at night...out on the smoking porch or in the dining room."</p> <p>-Last week "I witnessed an altercation at 2:30 or 3:00 oclock in the morning."</p> <p>-"I heard a noise."</p> <p>-"I saw [Resident #1 on Resident #3] on 400 hall right close to [Resident #3's name] room."</p> <p>-"[Resident #1] was hitting [Resident #3's name] up side his head."</p> <p>-"Fist blows to the head."</p> <p>-"I hollered for my [Supervisor In Charge]."</p> <p>-"I asked [Resident #1's name] to please get up off [Resident #3]."</p> <p>-He stated he called the Operations Director and he said for "us to call the law."</p> <p>-The paramedics were called to treat Resident #3.</p> <p>-Resident #3 had a "knot on his head and scrapes and bruises around his eye."</p> <p>-"Paramedics said all the hospital would do would be to clean the abrasions, so they cleaned him up and he didn't go to the hospital."</p> <p>-He stated he had not witnessed any other incidents of resident to resident aggression.</p> <p>-"Sometimes I would see [Resident #1's name] talking to himself in the TV room, but no other aggressive actions."</p> <p>-He stated Resident #1 had once "balled up his fists and held his arms at his sides before when I asked him to get a shower, but he didn't draw back or anything."</p> <p>-The Operations Manager, EMS and law enforcement were called.</p> <p>Telephone interview with Staff C, Medication Aide, on 4/21/15 at 8:05am revealed:</p> <p>-Staff C had worked at the facility for four months and worked thirdshift.</p> <p>-Resident #1 "stayed to himself" but "it did not</p>	D 338		

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NAME OF PROVIDER OR SUPPLIER WILKES COUNTY ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 REST HOME ROAD WILKESBORO, NC 28697
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D 338	<p>Continued From page 24</p> <p>take much to set him off quick".</p> <p>-Staff C had witnessed the incident between Resident #1 and Resident #3 on 4/16/15 and Resident #1 was arrested at that time.</p> <p>-Hourly checks were done on third shift.</p> <p>-"50 %" of the residents are up and down the hallways during the night shift.</p> <p>Interview with the Operations Director on 4/21/15 at 2:40pm revealed:</p> <p>-After Resident #1 assaulted Resident #3 and immediate discharge was given to Resident #1.</p> <p>-Resident #1 was taken into custody by law enforcement and at that time they discovered he had an outstanding warrant in another county.</p> <p>-He was arrested and taken to the other county to address the warrant.</p> <p>-On 4/17/15, he stated he received a courtesy call from a receptionist from the other county law enforcement stating officers were in route to bring Resident #1 back to the facility.</p> <p>-He immediately placed a call to Adult Protective Services and they notified the Sheriff's Department and told them the resident was discharged and could not come back to the facility.</p> <p>-"The guardian had actually told the Sheriffs Department to bring [Resident #1] back here."</p> <p>Refer to interview with Staff I (Medication Aide) on 4/20/15 at 4:30pm.</p> <p>Refer to telephone interview with the facility's psychiatrist on 04/21/15 at 11:30am.</p> <p>Refer to the facility's policy for aggressive residents.</p> <p>Refer to the facility's policy for internal reporting.</p>	D 338		

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D 338	<p>Continued From page 25</p> <p>Interview with Staff I, Medication Aide, on 4/20/15 at 4:30pm revealed: -Staff I had worked at the facility for 1 and 1/2 years on second shift. -Staff I stated Resident #1 was "quiet" but would "scream or holler" if he wanted a cigarette. -Staff I had never seen any physical aggression from Resident #1. -Staff I stated no residents had ever complained of being afraid of Resident #1. -Any residents who became aggressive "or argue" were placed on 15 minute checks as an intervention "just in case of conflict".</p> <p>Telephone interview with the facility's psychiatrist on 04/21/15 at 11:30am revealed: -Resident #1 had not really responded well to any medication due to the resident's mental status. -He was "at a loss of what to do" because Resident #1's behavior could not be predicted. -He could not say whether or not Resident #1 should have been admitted to the facility as he did not "know where [Resident #1] would have gone" and did not know "what more the facility could have done". -The local mental health team was involved with Resident #1 and he [the psychiatrist] saw Resident #1 "three times a month".</p> <p>Review of the facility's policy for aggressive residents revealed: -It was the facility's policy to maintain the safety of all residents while dealing with an aggressive resident. -Safety of all residents was ensured by placing aggressive resident on 15 minute watches. -The Operations Director and the Resident Care Coordinator (RCC) are notified immediately of residents aggressive behaviors.</p>	D 338		

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D 338	<p>Continued From page 26</p> <ul style="list-style-type: none"> -The facility psychiatric physician is called for possible medications changes or involuntary committment of resident. -The aggressive resident's crisis response team was notified about the residents' aggressive behaviors for intervention. -Residents' guardians are to be notified of the resident's aggressive behaviors. <p>Review of the facility's policy for internal reporting revealed:</p> <ul style="list-style-type: none"> -Personal Care Aides or any other non-clinical staff that were informed of an incident are to notify the Medication Aide for proper documentation of the incident. -The Medication Aide must notify the Resident Care Coordinator (RCC). -The RCC then notifies the Operations Director of the incident. -Once the Operations Director is notified, an investigation is immediately initiated and staff and residents are interviewed and notes about the incident are taken. -Once the investigation is completed, the Operations Director notifies the Administrator with the findings and any response needed are put into action by the Operations Director. <hr/> <p>A plan of protection was received from the facility on 4/17/15 and 5/5/15 and included the following:</p> <ul style="list-style-type: none"> -Facility Operations Director will immediately meet with all staff to have them read, understand, and sign a copy of the Residents' Rights. -Staff will be instructed to immediately notify the Facility Operations Director of known Residents' Rights volations. <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 29,</p>	D 338		

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D 338	Continued From page 27 2015.	D 338		
D 454	<p>10A NCAC 13F .1212(e) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting Of Accidents And Incidents</p> <p>(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:</p> <p>(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and</p> <p>(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the contact person for 1 of 1 resident who required medical treatment from an injury. (Resident #2).</p> <p>The findings are:</p>	D 454		

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D 454	<p>Continued From page 28</p> <p>Review of Resident #2's most current FL2 dated 10/30/14 revealed diagnoses which included dementia.</p> <p>Review the care plan dated 9/30/14 revealed Resident #2: -Was independent with toileting, ambulation and transfer. -Needed supervision with dressing. -Needed one person assistance with bathing and grooming.</p> <p>Review of an incident report dated 4/8/15 at 9:00am revealed Resident #2 had been physically assaulted by another resident and was transported to the hospital by emergency medical services. Review of an incident report dated 4/8/15 at 9:00am revealed: -Staff K, Medication Aide, had witnessed Resident #2 being hit "in the nose" by Resident #1. -The incident occurred outside. -Resident #2 was transported to the hospital by emergency medical services. -No documentation that Resident #2's RP was notified.</p> <p>Review of the hospital emergency department admission record dated 4/8/15 revealed diagnosis of facial fractures.</p> <p>Telephone interview with Resident #2's emergency Contact Person/Responsible Party (RP) on 4/17/15 revealed: -The facility had not notified the RP of the incident on 4/8/15. -The RP found out about the incident when the hospital called to notify the RP Resident #2 would need facial surgery.</p> <p>Interview with Staff K (Medication Aide) on</p>	D 454		

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D 454	<p>Continued From page 29</p> <p>4/21/15 at 3:00pm revealed: -Staff K had filled out the incident report on 4/8/15 but had not notified the RP. -Staff K thought only a "legal guardian" had to be notified in case of an incident resulting in injury.</p> <p>Interviews with the Administrator in Charge (AIC) and the Operations Manager on 4/21/15 at 2:50pm revealed: -The Operations Manager thought only a resident's legal guardian needed to be notified about incidents. -The AIC stated the RP should be contacted by the staff person that completed the incident report.</p>	D 454		
D 457	<p>10A NCAC 13F .1212 (h) Reporting Of Accidents And Incidents</p> <p>10A NCAC 13F .1212 Reporting Of Accidents And Incidents</p> <p>(h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to immediately report to law enforcement an incident of physical assault by Resident #1 on Resident #5.</p> <p>The findings are:</p>	D 457		

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D 457	<p>Continued From page 30</p> <p>Review of Resident #5's most current FL2 dated 10/30/14 revealed diagnoses that included schizoaffective disorder and borderline intelligence functioning.</p> <p>Review of Resident #5's Plan of Care dated 9/30/14 revealed the resident needed supervision with ambulation and was independent with transfers.</p> <p>Review of an incident report documented by Staff B, Medication Aide, dated 3/28/15 at 8:15pm revealed: -Staff B "was told" Resident #5 was hit by another resident [Resident #1]. -Injury: "busted nose." -No other description of the incident.</p> <p>Review of the Nurse's Note documented by Staff B on 3/8/15 at 8:15pm revealed: -Resident #5 was hit by another resident [Resident #1] in the nose. -"It busted his nose". -The bleeding was stopped and ice packs were placed on the nose. -Staff B contacted the Resident Care Coordinator (RCC). -"Kept an eye on the resident the rest of the night."</p> <p>Observation of Resident #5 on 4/20/15 at 4:50pm revealed the resident had a nickel sized green colored bruise on the left side of the upper part of his nose.</p> <p>Interview with Resident #5 on 4/20/15 at 4:50pm revealed: -The resident stated yes he had been hit in the nose by Resident #1. -The resident was unable to remember when the</p>	D 457		

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D 457	<p>Continued From page 31</p> <p>incident had occurred.</p> <p>Interview with Staff B, Medication Aide, on 4/20/15 at 3:50pm revealed: -Resident #1 was on a lot of 15 minute checks. -Resident #1 did not have a lot of physical aggression, but would "switch his personality so fast" and would scream if he did not get a cigarette when he wanted one. -Resident #1 was not aggressive with staff or residents but had "jumped the fence" and "locked himself in the front room." -No residents had ever expressed fear of Resident #1.</p> <p>Interview with Staff E, Personal Care Aide, on 4/20/15 at 4:33pm revealed: -Resident #5 "came into the dining room during 8pm snack with a nose bleed and [Resident #1's name] had punched him in the nose." -It was "just a bloody nose and a little swollen." -"I called the Med Tech and we cleaned him up and she took over." -"We called [Resident Care Coordinator's name] to let her know."</p> <p>Inteview with the Resident Care Coordinator (RCC) on 4/20/15 at 6:30pm revealed: -Staff had called her and reported the 3/28/15 incident where Resident #1 had hit Resident #5 "in the nose." -I told staff to "call the physician, put ice on the nose, and fill out an incident report and progress note." -Both residents were placed on 15 minute checks for three days.</p> <p>Interview with the RCC on 4/21/15 at 3:25pm revealed: -Law enforcement was not notified after the</p>	D 457		

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D 457	<p>Continued From page 32</p> <p>assault on Resident #5. -All I know is that if law enforcement comes out here they will not arrest anyone for assault unless that person goes to the magistrates office and takes out a warrant." -"The only time they will [arrest someone] is when the police officer himself presses charges and [the police officer's] won't do that." -Resident #5 had a guardian "and his guardian would have had to press charges."</p> <p>Interview with the Operations Director on 4/21/15 at 2:40pm revealed: -He was not made aware of the incident that had occurred between Resident #1 and Resident #5 until the assault occurred with Resident #2. -The RCC "should have reported [the assault on Resident #5] to me." -"I will be meeting with staff tomorrow to go over more in depth how to do incident reporting."</p> <p>_____</p> <p>A plan of protection was received from the facility on 4/21/15 and included the following: -Facility Operations Director will immediately meet with all staff on proper procedure for filling out incident/accident reports. -Training will include but is not limited to calling the local law enforcement if an assault occurs.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 6, 2015.</p>	D 457		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,</p>	D914		

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D914	<p>Continued From page 33</p> <p>neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that every resident be free from mental and physical abuse, and neglect as related to residents' rights and notification of law enforcement after a physical assault.</p> <p>The findings are:</p> <p>A. Based on interview and record review, the facility failed to assure that every resident was free from mental and physical abuse, and neglect as related to four residents (Resident #2, #3, #4, and #5) being assaulted by another resident (Resident #1). [Refer to Tag 0338, 10A NCAC 13F .0909 Residents Rights (Type A1Violation).]</p> <p>B. Based on observation, interview, and record review, the facility failed to immediately report to law enforcement an incident of physical assault by Resident #1 on Resident #5. [Refer to Tag 0457, 10A NCAC 13F .1212(h) Reporting of Accidents and Incidents (Type B Violation).]</p>	D914		