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THE COURTYARDS AT BERNE VILLAGE MEMORY CA	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure Section and the Craven County Department of Social Services conducted an annual, follow-up, and complaint investigation survey on March 17 - 20, 2015. The complaint investigation was initiated by the Craven County Department of Social Services on February 26, 2015.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure there were no unpleasant odors (urine and feces odor) in resident commons areas, hallway and residents' rooms. The findings are: Initial tour of building on 3/17/15 at 11:15am, and subsequent observations from 3/17/15 through 3/20/15 revealed the following: - Strong smell of urine when entering the building near the TV/Activity room. - Strong smell of urine down hallway where resident rooms were located. Review of a facility "Health Inspection Report" from the local health department dated 12/11/14 revealed the following comments (comment #33):	D 075		

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- "Soiled linen shall be placed in a covered container or bag at the point of use and stored and handled so as to contain and minimize aerosolization of and exposure to any waste products".
- "Memory care unit had soiled linens in an open bag in the soiled linen room.

Observation made of room #16 on 3/17/15 at 11:35am revealed the following:
- A strong smell of urine was in in room.
- There was a wet spot in the carpet about the length of the bed.
- Dirty linen was piled on the floor.

Interview with a 1st shift nursing assistant on 3/17/15 at 11:40am revealed the following:
- The resident has been incontinent of bowels and bladder for about 2 weeks.
- The staff provided incontinent care when needed.
- The smell in the resident's room "probably" came from the carport, the wet spot was urine.
- The resident rolls self to the bathroom, but often urinate on floor if unable to get to bathroom in time.
- The facility housekeeping was responsible for cleaning the carpet, did not know how often the carpet was cleaned.

Interview with 3rd shift medication aide on 3/18/15 at 9:10am revealed the following:
- Often residents who were combative and incontinent were left in soiled clothes for hours alone with urine and feces soaked in carpet, soaked on carpets in bedrooms because the staff have not been trained to on how to "handle combative residents" when providing incontinent care.
- There were several resident rooms that

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always had urine odor including residents' rooms #2, 4 and 16 (staff was leaving diapers soaked in urine and feces).
- The odor in the hallways and residents rooms were was bad all of the time even though housekeeping did clean every day.
- Some of the staff brought their own "Pine-Sol cleaner" and bleach to work to clean up (spray and disinfect chairs).

Observations made each day from 3/17/15 through 3/20/15 at different times revealed the facility housekeeper spraying the hallways with disinfectant spray.

Interview with the housekeeper on 3/18/15 at 11:05am revealed:
- She is only allowed to clean resident room and bathrooms and dust mop the floor.
- She cleans the resident rooms every day, but she does not vacuum every day.
- She vacuums the carpet when they are dirty.
- She mops the bathroom floors every other day.
- Someone comes to the facility to clean the carpet twice a month and they clean 2-3 carpets each time they come.
- There are a couple residents that urinate on the floor every night.

Interview with a family member on 3/17/15 at 9:50am revealed the following:
- The smell in the resident's room (room #15) was "awful".
- Last Thursday, the smell was so bad, it "slapped me in the face" when I opened the door.
- The staff informed the family member the smell was coming from urine "somewhere in the room".
- The family was concerned about the

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"knowledge level of the staff" (the memory care coordinator (MCC) or Administrator did not know what to do to get "rid" of the odor even after she complained to the staff and MCC.

Observation made on 3/20/15 at 8:30 revealed the following:
- The hallway from in front of room #15 to the MCC office had a foul odor.
- The carpet in room 15 had a large wet, dark stain, and a staff member was in the room assisting the resident with personal care.
- The room had a strong foul odor of urine and feces.

Interview with a staff member on 3/20/15 at 8:35am revealed the resident had an incontinent "accident" on the floor this morning, but did not know the time.

Interview with the MCC on 3/20/15 at 9:00am revealed the following:
- She was aware of the strong foul odor in room #15.
- She was aware of the chronic odor throughout the facility.
- The carpet needed to be taken out of all of the residents' rooms, but do not know date the carpets will be removed.
- She will call housekeeping to clean the carpet in room 15 today.

Observation made on 3/20/15 at 11:15am revealed 2 staff members in room #15, on their knees, spraying wet/brown area and scrubbing area with cloth.

Observation made at 5:00pm revealed foul odor remained throughout building and in residents rooms.

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D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 2 current medication aides sampled (Staff C) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: Review of Staff C's personnel record revealed: -She was hired as a Medication Aide (MA)/Supervisor on 6/8/14.	D 164		

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-She completed her medication clinical skills validation on 9/2/14.
-She passed the Medication Aide exam on 3/1/02.
-There was no documentation of training on the care residents with diabetes.

Observation on 3/17/15 at 11:30am revealed Staff C collected a finger stick blood sugar on a resident.

Interview with Staff C on 3/17/15 at 11:30am revealed:
-She had worked as a Medication aide (MA) in the memory care building for 3 weeks.
-She had worked in the assisted living building as a MA since June of 2014.

Interview with Staff C on 3/18/15 at 12:05pm revealed:
-She had not received diabetes training since she had been employed at the facility.
-She did finger stick blood sugar testing on residents and she administered insulin to residents since she had been working at the facility, in both the assisted living and memory care buildings.

Review of Resident #4's FL-2 dated 2/19/15 revealed:
- The resident had a diagnosis of insulin dependent diabetes mellitus.
- An order for Novolin 70/30 insulin, give 6 units, subcutaneous, 2 times a day.
Review of the facility's medication administration records (MAR) revealed Staff C administered insulin to Resident #4 in February and March 2015.

Interview with the Memory Care Coordinator on 3/20/15 at 9:05 revealed:

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D 164	Continued From page 6 -None of the medication aides (MA) has had the diabetes training. -She did not realize there was a separate training for diabetes.	D 164		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interview and record review, the Administrator and Memory Care Coordinator (MCC) failed to assure that all required duties were carried out in the facility related to the rule areas of housekeeping and furnishings, training on the care of diabetic residents, test for tuberculosis, providing personal care and supervision, health care, resident activities, resident rights and medication administration.	D 176		

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D 176	Continued From page 7 The findings are: Interview with the MCC on 3/19/15 at 5:30pm revealed the following: - She had been employed at her current position since 12/01/14. - She had 1 day of orientation with the former MCC (he left on 12/01/14) - Her only other training consisted of 6 hours of dementia training, policies and procedures, the Administrator showed her where the "books" were kept, and resident assessment. - The Administrator was available if she had questions but she (the MCC) received no training on the duties and responsibilities of MCC. - The facility's Regional Director was at the facility last month but there was no communication with the MCC. 1. Based on interview and record review, the facility failed to assure 1 of 2 current medication aides sampled (Staff C) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents.[Refer to Tag 0164, 10A NCAC 13F .0505 Training on the Care of Diabetics]. 2. Based on observation, interview and record review, the facility failed to assure there were no unpleasant odors (urine and feces odor) resident commons areas, hallway and resident rooms. [Refer to Tag 0075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings]. 3. Based on interview and record review, the facility failed to assure 3 of 3 sampled residents (#1, #3, and #4) were tested for tuberculosis disease upon admission in compliance with the control measures adopted by the Commission for Health Services. [Refer to Tag 0234, 10A NCAC	D 176		

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13F .0703 Tuberculosis Test (Type B Violation)].
4.Based on observations, interview and record review, the facility failed to assure the personal care needs for 4 of 5 sampled residents (Residents # 1, 2, 3, and 6) who required assistance with toileting and incontinent care were met, resulting in 2 residents (#1 and #6) developing stage II pressure sores. [Refer to Tag 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision].
5. Based on observations, interviews and record review, the facility failed to provide adequate supervision related to repeated unwitnessed and witnessed falls, falls with injury (Residents #1, 7, and 10), smoking inside and outside of the building (Resident #8) for 4 of 7 sampled residents. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision].
6. Based on observation, interview and record review, the facility failed to assure notification of health care provider and follow-up for 3 of 5 sampled residents who had 11 pound weight loss (Resident #1) ; an ordered neurology consult after falls (Resident #7) and a fall with head injury (Resident #9). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care].

7. Based on observations, interviews and record review, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the memory care facility. [Refer to Tag 0315, 10A NCAC 13F .0905(a)(b) Activities Program].

8. Based on record review and interviews, the facility failed to provide services to maintain the physical and mental health by allowing 2 of 6 sampled residents to lie in urine and feces and

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D 176	Continued From page 9 not providing personal care service (#1 and #6) resulting in the development of a stage II pressure sores. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights]. 9. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 5 residents (#2, #6 and #12) observed during the medication pass and 2 of 3 sampled residents (#3 and #4), which included errors with the administration of potassium chloride, Quinine and Vitamin D Super Strength. [Refer to Tag 0358, 10A NCAC 13F .1004(a)(1) Medication Administration] According to the facility's Plan of Protection received on 3/20/15, dated 3/21/15, the corporate nurse and regional director are coming to town to re-train "PM, ED, & WD" [memory care coordinator, administrator, and facility nurse]. Continued training with all staff on policies and procedures. Regional support increasing to assist with training of management and line staff employees. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL19, 2015.	D 176		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as	D 234		

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specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interview and record review, the facility failed to assure 3 of 3 sampled residents (#1, #3, and #4) were tested for tuberculosis disease upon admission in compliance with the control measures adopted by the Commission for Health Services. The findings are:

1. Review of Resident #1's FL-2 dated 11/3/14 revealed:
-Diagnoses included Depression disorder, mood disorder, impulse disorder and history of concussion.
-The resident was admitted to the Special Care Unit on 8/7/14.

Review of Resident #1's record revealed no Tuberculosis Test results in the record prior to or after admission.

Interview on 3/19/15 at 9:50am with the Memory Care Coordinator (MCC) revealed:
-If the TB test is not in the record, the facility does not have it.
-There is no other book with TB test.
-The facility nurse is reviewing records and updating the TB test.

2. Review of Resident #4's current FL-2 dated 2/19/15 revealed the following:

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D 234	Continued From page 11 - The resident was admitted on 02/20/15. - The resident had diagnosis of dementia. Record review revealed no documentation of TB skin tests (admission or subsequent TB testing). Interview with the facility Memory Care Coordinator (MCC) on 3/20/15 at 11:15am revealed the following: - The resident did not have any documentation of a TB skin test in his current record. - The TB skin tests may be in the closed record from assisted living facility when transferred to facility on 2/20/15. Review of Resident #4's TB testing record from the assisted living facility revealed the following: - The resident had documentation of 1 negative TB test which was administered on 4/22/14 and read as 0 millimeters (negative) on 4/25/14. Interview with the MCC on 3/20/15 at 3:30pm revealed the following: - There was no other documentation of a 2nd step TB skin test. - According to policy, upon admission, a resident must have documentation of at least 1 negative TB skin test and the 2nd test would be completed after admission if needed. - The resident admissions were done by MCC and she did not realize the resident did not have documentation of a 2 step TB skin test. 3. Review of Resident #3's current FL-2 dated 9/16/14 revealed diagnoses included dementia and alzheimer ' s. Review of Resident #3's Resident Register revealed an admission date of 9/28/09.	D 234		

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D 234	Continued From page 12 Review of resident record revealed: - Resident #3 was given a TB skin test on 1/3/14 and read as negative on 1/5/14. - No documentation of any other tuberculosis (TB) skin test Interview on with the Memory Care Coordinator (MCC) on 3/20/15 at 11:30am revealed: - She was just recently this week made aware of a 2 step TB skin test being a requirement. - The facility nurse is working to get the 2nd step for all of the residents in the memory care building that need it. - The Nurse ordered the Purified-protein Derivative Tuberculin Skin Test Antigen Solutions earlier in the week. - When the medication came in, the staff person did not know the solution needed to be refrigerated and it was left out all night. - They had to throw all of the Purified-protein Derivative Tuberculin Skin Test Antigen Solutions in the garbage and order more. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 04, 2015.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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D 269	Continued From page 13 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interview and record review, the facility failed to assure the personal care needs were met for 4 of 5 sampled residents (Residents #1, #2, #3,and #6) who required assistance with toileting and incontinent care, resulting in 2 residents (#1 and #6) developing stage II pressure sores. The findings are: 1. Review of Resident #1's FL-2 dated 11/3/14 revealed: -Diagnoses included Depression disorder, mood disorder, impulse disorder, alcohol induced persisting dementia, and history of concussion. -Resident was admitted to the Special Care Unit on 8/7/14. -Resident was constantly disoriented. -Resident's inappropriate behaviors were verbally abusive. -Resident was ambulatory. -Resident's functional limitation was with his sight. -Resident was continent of bladder and bowel. Review of Resident #1's care plan dated 8/27/14 revealed: -Resident #1 was verbally abusive, suicidal, showed disruptive behavior, and wandered. -Resident was continent of bladder and bowel. -Resident's orientation was always disoriented. -Resident needed supervision with eating. -Resident was independent with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring. Review of physician's Encounter note for Resident #1 dated 2/18/15 revealed:	D 269		

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-The resident has a strong urine odor in room and on clothes.
-The resident is incontinent of urine where he normally is not.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 3/2/15 revealed:
-When the NP went to the facility on 2/17/15, the resident was found saturated in his own urine.
-The NP called for the aides to come and clean the resident up.

Interview with a Medication Aide on 2/26/15 revealed:
-Resident #1 had a possible urinary tract infection.
-On Saturday (2/21/15) second shift, another Medication Aide told staff Resident #1 refused all his medications and he was picking at his skin.
-He refused his medications and refused to eat.
-Resident #1 had on grey sweat pants and he had urinated on himself.
-He wanted to go to the hospital.
-Staff informed MCC and for her to go look at him.
-"The smell hit staff".
-Staff asked him if they could clean him up and he just wanted to be sent out.
-He took his wallet with him (to the hospital) and it looked like it was stained with urine.
-The chair he was sitting in was a blue chair and it was drenched with urine and urine on the floor.
-The chair had feces and urine on it.

Review of written statements obtained by the facility from 5 staff members who work in in the memory care unit regarding Resident #1 revealed the following:
-Statement #1 (not dated): On 2/21/15, the 3rd shift medication aide notified first shift that

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D 269	Continued From page 15 Resident #1 would not stand up, so staff could see if he needed to be changed. -Statement #2 (not dated): On 2/21/15 at the start of first shift, third shift let the aides on first shift know Resident #1 had refused to allow them change him or get up. Staff checked on the resident before breakfast and after breakfast. After he refused those two times, staff notified medication aide that he was acting strange and would not let them change him. - Statement #3 (not dated): On 2/21/15 the staff member went to Resident #1's room and he was sitting in his chair slightly slumped and his room smelled like urine. For the past few days, the resident has been acting strange, room messy, refusing meals and bad hygiene. -Statement #4 dated 2/22/15: On 2/21/15 when arriving to memory care, the medication aide from third shift made the staff member aware that Resident #1 was in his chair in his room. The resident had refused to get up. Approximately 20 minutes later, the staff member did check on the resident to see if he would get up to go to breakfast; and there was no response from the resident. The resident was in his chair with no shirt on and his pants were wet. Lunch time came and the resident was still in his chair slumped over and picking at his pants. The staff member noticed the resident's pants were even more soiled. -Statement #5 dated 2/22/15: When the staff member came in Saturday (2/21/15) morning, the Supervisor-in-Charge told the staff member and the other aide to wait 20 minutes to go back in Resident #1's room because he refused the medication aide. The staff member went in 20 minutes later and the resident was still sitting in his chair with his head down. When the memory care coordinator came in, the other aide told her that Resident #1 refused to take a shower and he	D 269		

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had urine on himself and smelled like he [had a bowel movement] on himself.

Review of resident care notes dated 2/21/15 (3:00 PM - 11:00 PM shift) revealed:
-At 4:00pm medication aide went in resident's room to check on him.
-Resident was covered in urine, leaning over in his chair and refused to allow medication aide or staff to clean him up or assist him with getting cleaned up.
-Resident asked medication aide to send him out to local emergency room as he didn't feel he was getting any better.
-Resident had to be sent out to the local hospital.

Review of the local hospital's report dated 2/21/15 revealed:
-Resident arrived with urine stained clothing.
-Resident was cleaned on arrival and noted to have severe excoriation.
-Resident was found with an angry, red macular rash in the buttocks and groin area; with an area of maceration and skin breakdown on the left buttocks cheek approximately 3 x 2 cm stage II.
-Resident had a rash over his left flank (area on the body between the ribs and hip) with an area of skin breakdown which appears to be secondary to trauma for prolonged contact to a hard surface.
-Resident had extremely dry skin with cracking of the epidermis over the lower extremities.

Interview with the Memory Care Coordinator (MCC) on 3/19/15 revealed:
-On 2/21/15 at 1:47pm, an aide informed the MCC Resident #1 was acting "off" and MCC replied she was aware and he had a UTI.
-On 2/21/15, the medication aide brought the MCC in (the resident's room) a little before

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4:00pm. Resident #1 was in a blue chair, was soaked in urine and was unresponsive. The MCC called 911 and sent Resident #1 out of the facility.
-The MCC is unsure of how long Resident #1 had been sitting in his room saturated in his own urine and feces.
-The facility did an internal investigation and the facility did not get a full story of what happened.
-She was not aware of his skin breakdown before going to the hospital on 2/21/15.
-She became aware of his skin breakdowns when she went to the local emergency room (ER) and the nurse at the ER was changing him and saw how bad it was and the ER nurse informed the MCC of the breakdown.
-The process for staff when assisting a resident with any activity of daily living and the resident shows aggressive behavior is the same thing when the resident is refusing. Staff should give the resident a break and try again.
-Staff should also get another staff member to attempt and if the resident is still acting out then staff should inform the medication aide.

Review of Resident #1's current FL-2 dated 2/23/15 from the hospital revealed:
-Discharge diagnoses included urinary tract infection; acute renal failure; hypertension; vitamin B and D deficiency; and stage I decubitus ulcer.
-He was intermittently disoriented.
-He had no inappropriate behaviors.
-He needed assistance with bathing and dressing.
-He was semi-ambulatory.

Review of physician's Encounter note for Resident #1 dated 3/2/15 revealed:
-Per facility staff, resident was found to be sitting

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in his own urine and feces for unknown length of time.
-He was being treated for UTI.
-Left buttocks with 4 cm in diameter stage II decubitus and with a total 8 cm in diameter decubitus total surface area.

Based on record review and interviews, the resident experienced known episodes of urinary incontinence from 3/18/15 to 3/21/15; laid in urine and feces for an unknown period of time and developed a stage II pressure sore on the left buttocks as a result.

2. Review of Resident #6's FL-2 dated 2/18/14 revealed the following:
- The resident was admitted to the facility on 3/19/13.
- Diagnoses of dementia, diabetes mellitus, generalized osteoarthritis, gout, hypertensive heart disease without congestive heart failure, benign adenomatous of large intestines.
- The resident was disoriented at all times.
- The resident was incontinent of bladder and bowel.

Staff interview with 1st shift nurse aide on 3/17/15 at 11:35am revealed the following:
- Resident #6 had an open stage II decubitus on left buttock, but did not know how long the resident had the wound.
- The resident was incontinent of bowel and bladder and required total assist for personal care and transfers.
- The resident was left in bed "a lot" because of her weight, "she is big" , and the resident was in bed now.
- The resident was combative and required 2 person assistance for all transfers.
- Residents "who are combative and pissed

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and had bowel movements on the floor and bed needed to be in a mental hospital".

Observation on 3/18/15 at 8:35am, in Resident #6's bedroom, revealed the following:
- The resident was in bed with a brief on and 2 NAs were at her bedside.
- When the NA removed the resident's brief, noted left lower buttock and top of left hip with duoderm (occlusive) dressing in place.
- Noted an open stage II wound at center of left hip without dressing. The wound was small (about the size of a dime) and red.

Interview with the NA on 3/18/15 at 8:40am revealed the following:
- She did not know when the wound started but has only noticed the wound a few days ago.
- Home health nurse was providing wound care.
- The resident was incontinent of bowel and bladder and required use of briefs and incontinence care.
- Resident brief should be checked and changed every 2 hours, but not always done if the resident was combative.

Review of the resident's current care plan dated 3/6/15 revealed the following:
- The resident resisted care at times and was always disoriented.
- The resident can become agitated with incontinence care, bathing and hygiene.
- The resident was totally dependent for toileting, bathing, dressing and personal hygiene and required extensive assistance with transferring.

Review of the facility's "Initial and Quarterly Skin Risk Assessment" revealed the following:

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D 269	Continued From page 20 - On 11/9/14, the skin assessment score was "5" due to the resident was incontinent of bowel and bladder (2); diagnosed with diabetes (2) and had dementia (1). - Any score of 5 or above indicates that the resident is at risk for skin breakdown. - On 2/17/15, the skin assessment score was "8" due to reddened area of bilateral groin area (3); diabetes (2); incontinence of bowel and bladder (2) and dementia (1). Interview with registered nurse from a local home health agency on 3/20/15 at 12:00 noon revealed the following: - Resident #6 was evaluated for home health PT services on 3/13/15 and PT requested home health nursing evaluation for wound care. - Wound care was started on 3/17/15 and wound care was done on 3/19/15 for stage 2 decubiti on left buttock and left hip. - Resident was incontinent and needed to be kept clean and dry by the facility with minimal or no pressure to left hip/buttock. Interview with the home health physical therapist on 3/20/15 at 12:30pm revealed the following: - Resident #6 was evaluated for PT services on 3/13/15, looked at wound of left hip/buttock and called physician for home health nursing evaluation orders. Confidential staff interviews revealed the following: - 1st staff stated the resident was incontinent of bowel and bladder and was very difficult to bathe. The resident is not repositioned every 1-2 hours when in bed or up in wheel chair. - 2nd staff stated the medication aides had been cleaning and applying an ointment to the right lower buttock due to rash/redness, but no	D 269		

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wound treatment to the right buttock or right hip. Resident was incontinent and need to be checked and care provided more often. Some staff did not like to change the resident because she was combative.
- 3rd staff stated the resident was incontinent of bowel and bladder and required incontinence care provided by the facility staff but do not know how often incontinence care was provided.
- 4th staff stated resident was incontinent of bowel and bladder and noticed wound of hip a few days ago, but did not report to medication aide. The resident need to be changed (incontinent care) more than every 2 hours. Sometimes the resident was left wet in bed and chair.
- 5th staff stated, some staff did not like to provide care (including incontinence care) to residents who were combative and Resident #6 was left with soaked brief on often at end of shift.

Review of the facility "Care Notes" for Resident #6 revealed the following documentation:
- On 3/12/15, staff documented a local home health agency was "notified for mobility evaluation also requested nursing evaluation for open area to left hip. Top layer of skin peeling back. Surrounding skin pink and blanching. Resident scratching area when assessed by this writer. MD was faxed with update by 11-7-medication technician. Area covered with dressing to protect it".
- On 3/13/15, a local home health agency physical therapist documented "physical therapy (PT) evaluated for PT services, including gait, balance, and transfer training. Small wound on left hip area, will request nursing evaluation for treatment".
- On 3/17/15, a local home health agency documented skilled nursing to "assess the need

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D 269	Continued From page 22 for wound care: 2 wounds noted left post thigh measuring 1.5x0.5x0.1 and 0.5x0.5x0.1. One wound noted left trochanter measuring 1x0.5x0.1. All stage II. Wound care to all three areas, clean with soap and water. Apply hydrocolloid ". - On 3/18/15, a local home health agency physical therapist documented "patient required total assistance for repositioning in chair to decrease skin breakdown to sacral. Sitting upon arrival". - On 3/18/15, facility staff documented resident required 2 hour checks done; very hard to move her ". - On 3/19/15, a local home health agency nurse documented "duoderm to left posterior thigh and left hip dislodged. Both wounds cleaned with NS [normal saline] and duoderm reapplied. Pt [patient] needs strict off-loading of the left hip. Duoderm will need to be replaced by the memory care unit staff prn [as needed] dislodgement". Interview with the facility's MCC on 3/20/15 at 12:30pm revealed the following: - The resident should be receiving incontinence care or assisted to the bathroom every 2 hours. - "If resident was developing wounds, maybe incontinence care and repositioning should be done more often". - The MCC was not sure if the facility had a policy for repositioning and incontinence care of residents with decubitus. - The MCC was not sure if the resident's incontinence care was being done. - She was aware the resident had stage II wounds on left hip and lower left buttock and home health nurse was providing care.	D 269		

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D 269	Continued From page 23 3. Review of Resident #2's current FL2 dated 2/6/14 revealed: - Diagnoses included dementia with psychosis, borderline diabetic, Parkinson's disease, anxiety and respiratory distress. - Constantly disoriented. - Continent of bladder and bowel. Review of Resident #2's care plan dated 3/16/15 revealed: - Sometimes disoriented, ambulatory, and occasional incontinence. - Supervision needed for toileting/reminders. Interviews with 5 staff on various dates and times revealed: - Two staff report Resident #2 is continent and does not or should not wear pull-ups. - Two staff, including the MCC, reported Resident #2 is continent but wears a pull-up. - One staff reported Resident #2 was wearing a pull-up to avoid staff having to toilet her every 2 hours. Interview with a medication aide (MA) on 3/19/15 at 9:33am revealed: - Resident #2 had a really bad urinary tract infection around the middle of December 2014, she was really sick. - During that time, she was having episodes of incontinence. - When she got better, she no longer needed to wear a pull-up. - Resident #2 is no longer incontinent and should not be wearing pull-ups. - Some of the personal care aides (PCAs) will put her in a pull-up so they don't have to do bathroom checks on her as regular. Interview with a PCA on 3/19/15 at 5:10pm	D 269		

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revealed:
- When she was hired 3 months ago Resident #2 was wearing pull-ups.
- Sometimes Resident #2 toilets herself and sometimes the staff have to prompt her.
- Resident #2 is continent, but she does wear pull-ups.
- Resident #2 was sick about a month and a half ago and she was wetting on herself.
- It has been a long time since Resident #2 had wet herself.
- All of the residents wear pull-ups at times.
- Staff keep the pull-ups in the storage closets and they just put them on the residents, just in case they have an accident .

Observation on 3/20/15 at 8:20am revealed Resident #2 got out of bed and went directly into the bathroom independently, without staff assistance or prompting.

Interview with a second PCA on 3/20/15 at 8:20am revealed:
- Resident #2 does not wear or need pull-ups.
- The only time she needed pull-ups was when she was having a medication issue about 2-3 months ago.

Interview with the memory care coordinator on 3/20/15 at 6:05pm revealed:
- Resident #2 is continent, but she wears pull-ups.
- Resident #2 went through a phase of incontinence, before she came to work at the facility in December of 2014.
- Then about 3 weeks after she started working at the facility, Resident #2 was no longer incontinent.

4. Review of Resident #3's current FL2 dated

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9/16/14 revealed:
- Diagnoses included Alzheimer's, dementia, depression, and headache with dizziness.
- She is described as intermittently disoriented, ambulatory, continent of bowel and bladder.

Resident's care plan dated 3/16/15 revealed:
- Resident #3 required extensive assistance with toileting, and bathing, and minimal assistance with dressing and grooming.
- Resident did not require assistance with transfers, and she ambulates using a wheelchair, resident did not walk.

Observation of Resident #3's bedroom on the morning of 3/17/15 during the facility tour between 10:45am and 12:00pm revealed:
- Urine was on the floor around the resident's bed.
- A strong urine odor permeated throughout the room.
- Resident #3 was not in her room, she was in the activity room.

Interview with a personal care aide on 3/17/15 at 6:20pm revealed:
- Sometimes Resident #3 refuses care, she is able to use the bathroom on her own, but she needs to be taken to the bathroom.
- Sometimes Resident #3 will take off her own brief and sometimes she will not and will not allow staff to change her either.
- When she has dried urine on her clothing, she will not let staff change her clothes.
- When she is still wet, she will allow staff to assist her out of the wet clothing.
- She is checked for toileting every 2 hours or so.
- If she refuses incontinence care, staff will keep checking back with her and documenting

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THE COURTYARDS AT BERNE VILLAGE MEMORY CA	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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her refusal.
- Then the next shift just keep checking back with her until she lets them change her.

Observation of Resident #3 bedroom on 3/18/15 at 11:27am revealed:
- A strong urine odor in the room.
- Resident's bed had a large wet spot on the top.
- Resident #3 was in her bathroom alone.

Interview with a personal care aide (PCA) on 3/18/15 at 11:27am revealed:
- Resident #3 did not eat breakfast, because she refused.
- A tray was not taken to her room to offer.
- She was asked if she wanted breakfast and she said "no".
- Sometimes she stays up late at night and does not like to get out of bed early.
- Resident #3 just got up, she got herself out of the bed this morning.
- Resident is just starting to wear pull-ups, she used to be independent.
- When asked why Resident #3 was lying in urine soaked sheets if she could toilet herself, the PCA did not respond.

Interview with a second PCA on 3/18/15 at 5:10pm revealed:
- Resident #3 is on routine checks and sometimes she does not want to use the bathroom when prompted, she can be very stubborn.
- Staff check on her every 2 hours.
- She started wearing disposable briefs about 2 -3 months ago.
- She can use the bathroom by herself without assistance, and she can change her own briefs.

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D 269	Continued From page 27 Observation of Resident #3 on 3/19/15 at 8:30am revealed: - She was lying in bed sleeping directly on top of the plastic covering on her mattress. - Her sheets were balled up and laying on the floor in the corner of the room and there was a wet incontinence pad on the floor in front of the bathroom door. - There was a strong odor of urine in the room. Interview with a third PCA on 3/19/15 at 9:45am (while surveyor observing) revealed: - Staff went in to get resident up and picked up the wet sheets and wet pad that were on the floor in resident's room. - The incontinent pad was wet, soaked with urine. - When the PCA pulled the covers back and awakened Resident #3, she did not have anything on below her waist. - She had not eaten breakfast because she was sleeping. - She often stays up late and does not want breakfast in the morning, because she is too tired. - Resident #3 had been toileted by the night shift before they left. Interview with the memory care coordinator on 3/20/15 at 6:05pm revealed: - Resident #3 was continent of urine back in December 2014. - She has been incontinent for about the last six weeks. - She should be checked by staff a minimum of every 2 hours. - She does need assistance to be toileted. She cannot change herself adequately. - Resident #3 is independent with limited assistance, to ensure she has on a clean brief	D 269		

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D 269	Continued From page 28 and not just put the one she had on back on. According to the facility's Plan of Protection dated 3/18/15, the facility's medication technicians will check on all incontinent residents every 2 hours to ensure the nursing assistants were providing incontinent care and will document in the residents' chart. This will be done until toileting schedule is inserviced and implemented tomorrow. Toileting schedule will be implemented/inserviced on residents identified as being incontinent. The Executive Director [Administrator] will do weekly audits to ensure this is being done. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	D 269		
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 A1 VIOLATION Based on observations, interviews and record review, the facility failed to provide adequate supervision related to repeated unwitnessed and witnessed falls, falls with injury (Residents #1, #7, and #10), smoking unsupervised outside of the	D 270		

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building (Residents #8) for 4 of 7 sampled residents.
The findings are:

Observation of the facility layout during the survey revealed:
-The facility had the shape of a capital "L".
-Resident rooms were on the long end of the L-shaped building (main corridor) on short hallways off from the main corridor.
-Entrance to resident rooms was accessible by turning off the main corridor onto an approximate 10-foot hall with one room on each side of the 10-foot hall.
-The kitchen/dining/activity area were located on the short end of the L-shaped building and included an aide workstation in the back of the dining room area.
-The kitchen/dining/activity area and aide workstation were not visible from the Memory Care Coordinator's (MCC) office located on the main corridor.
-Entranceway to resident rooms on the main corridor were not visible from the kitchen/dining/activity area or the Memory Care Coordinator's (MCC) office.
-A small sitting area was on the long end of the L-shaped building, just outside the MCC's office, and was not visible from the kitchen/dining/activity area and aide workstation.
-Observation during the survey revealed doors to resident rooms were closed and some of the doors were locked. Residents were able to exit their rooms, however, for residents, staff or visitors to enter a resident's room or for staff to observe a resident, a staff member had to unlock some of the residents' doors with a key.

1. Review of Resident #1's FL-2 dated 11/3/14 revealed:

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D 270	Continued From page 30 -Diagnoses of Depression disorder, mood disorder, impulse disorder, alcohol induced persisting dementia, and history of concussion. -He was admitted to the Special Care Unit on 8/7/14. -He was constantly disoriented. -His inappropriate behaviors were verbally abusive. -He was ambulatory. -His functional limitation was with his sight. -He was continent of bladder and bowel. Review of Resident #1's care plan dated 8/27/14 revealed: -The resident had tried to escape and was aggressive. -The resident goes to the patio but doesn't try to take the fence apart anymore. -The resident does all of his ADL's by himself with reminders to come and eat. -The resident is always disoriented. -The resident has significant memory lost and must be directed. -The resident is independent with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring. Review of facility incident reports and physician notification reports revealed Resident #1 has been found on the floor 8 times between March 5, 2015 and March 20, 2015. Four of the 8 incidents involved skin tears, abrasions and/or cuts. Review of a facility incident report for Resident #1 dated 3/5/15 at 2:30pm revealed: -Resident #1 was helped off the floor by his primary care physician. -The resident stated he just slipped in his room. -The occurrence was "probable fall; not	D 270		

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witnessed".
-There was no apparent injury.

Review of the action plan/intervention to prevent further occurrences documented by the MCC on the bottom of the 3/5/15 incident report revealed:
-Remind resident to wear his non-slip bedroom shoes when ambulating.
-Offer assistance regularly.

Review of a Physician Notification of Resident Incident/Condition report for Resident #1 dated 3/9/15 at revealed:
-The resident was found on the floor in the bathroom
-The facility will continue to monitor.
-The report was signed by a medication aide.

Review of facility incident report for Resident #1 dated 3/11/15 at 7:00pm revealed:
-Several tears were found on the resident's left arm; "bleeding slightly heavy".
-Cuts on fingers/knuckles only bleeding a small amount.
-What or how it happened was not seen.

Review of the action plan/intervention to prevent further occurrences documented by the MCC on the bottom of the 3/11/15 incident report revealed:
-Monitor closely.
-Offer assistance regularly.
-Remind resident to ask for help.

Review of facility incident report for Resident #1 dated 3/11/15 at 2:59 (am or pm not indicated) revealed:
-Resident #1 was found on floor in his room.
-Resident stated he was coming out of the bathroom and tripped over a clear plastic toy.
-The medication aide did not find any toy on the

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floor other than the resident's walker laying beside the resident.
-The medication aide found a skin tear on the resident's left elbow; the resident's left elbow was bleeding.
-There were no witnesses documented on the report.

Review of the action plan/intervention to prevent further occurrences documented by the MCC on the bottom of the 3/11/15 incident report revealed:
-Monitor closely.
-Offer assistance regularly.
-Remind resident to ask and wait for assistance.

Review of facility incident report for Resident #1 dated 3/14/15 at 6:40am revealed:
-Resident #1 was found sitting in a chair in the hall with 2 small cuts on the right side of his forehead.
-The resident stated that he fell on the patio and came back inside.
-The occurrence was "probable fall; not witnessed".

Review of the action plan/intervention to prevent further occurrences documented by the MCC on the bottom of the 3/14/15 incident report revealed:
-Have resident evaluated due to multiple falls.
-Monitor closely.
-Increase wellness checks.
-Offer assistance regularly.

Review of the local hospital notes dated 3/14/15 regarding Resident #1 revealed:
-Patient states that he slipped on the floor this morning.
-He did sustain an abrasion on the right side of his forehead and on bilateral hands.

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D 270	Continued From page 33 -Patient does suffer from some dementia but he is able to answer my questions appropriately and is alert and oriented. -Patient states that he fell about 3 weeks ago and has been suffering from some intermittent neck pain since the fall. -He does not have any neck pain now. -There is a 3cm superficial abrasion with mild bruising noted on the right temple area. -There is a 2cm superficial abrasion noted between the index and middle finger on the dorsum of the right hand. -No visible foreign body noted. -There is a 2cm superficial abrasion noted on the dorsum of the left hand overlying the second MCP. -Abrasions are superficial. -CT scan of the brain without contrast was obtained and was interpreted by radiology as, "Small soft tissue hematoma. Old right PCA infarct. No evidence of acute intracranial process." -Wounds cleansed with saline, Neosporin applied, and dressings applied. - Clinical impression included Scalp and Hand abrasions. Review of Resident #1's Facility Progress Notes revealed: -3/14/15 (3rd shift) Resident was sent to Emergency Room due to a probable fall; resident has two deep cuts on the right side of his forehead, called family, no answer, left message to call the facility. -3/14/15 (07:00-23:00) Resident returned from local hospital Emergency Room around 12:30-12:45am. -Medication Aide caught resident in the midst of another fall and took (the resident) to his room.	D 270		

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D 270	Continued From page 34 Review of facility incident report for Resident #1 dated 3/16/15 at 2:30pm revealed: -The aide heard Resident #1 yell for help. -The medication aide saw the resident on the floor in his room. -The resident lost balance and fell. -The occurrence was "probable fall; not witnessed". The resident sustained a "cut" to left hand. Review of the action plan/intervention to prevent further occurrences documented by the MCC on the bottom of the 3/16/15 incident report revealed: -Monitor resident closely. -Increase wellness check. -Request MD evaluation. Interview with Personal Care Aide on 3/17/15 revealed: - The medications aide told her this morning that Resident #1 fell yesterday. -He had a knot on his head from the fall last night (3/16/15). Observation on 3/17/15 from 10:45 AM through 1:50 PM revealed: -Resident #1 sat unsupervised on couch (blue sofa), slumped over sleeping with one shoe on and one shoe off. -The resident wore grey sweat pants, grey shirt w/ orange stripes and green jacket. -The resident's sweatpants remained wet. Interview with memory care coordinator on 3/17/15 revealed: -She checked in the Resident #1's record and the resident was up until 3:00am. -He has his days and nights mixed up -Resident #1 is on 15 minute checks.	D 270		

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D 270	Continued From page 35 -She has paperwork to show staff is doing 15 minute checks. Review of Resident #1's care notes dated 3/17/15 at 11:30am revealed: -Resident #1's physician was called about resident's frequent falls recently. -Requested he come by to evaluate resident. -Message left with the receptionist due to office being "closed for training". Interview on 3/17/15 at 4:10pm with the medication aides revealed: -Resident #1 has falls. -Resident #1 had last fall last week on first shift. -The resident hit his head on the patio. -Usually no staff is on the patio when he smokes. Observation on 3/20/15 at 9:22am revealed: -Resident #1 was lying on the floor in his bathroom. -The administrator was in resident's room with the medication aide and a personal care aide. -Medication Aide and Aide assisted resident up. Observation on 3/20/15 at 10:08am revealed: -Resident #1 fell on floor again and was lying in the bathroom floor with his walker beside him. -The medication aide and personal care aide were assisting. -The resident was lying on the floor when the aide found him. -This was his second fall this morning. -The MCC and Administrator walked into his room. Observation on 3/20/15 at 10:26am revealed: -Resident #1 was in his room by himself. -He was sitting in his blue chair, slumped over to the right side.	D 270		

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D 270	Continued From page 36 Interview with Resident #1 on 3/20/15 at 10:30am revealed he was feeling light-headed. Observation on 3/20/15 at 10:34am revealed the MA and aide walked in Resident #1's room to check on him. Observation on 3/20/15 at 10:42am revealed EMS came in to get Resident #1. Interview with the personal care aide on 3/20/15 revealed: -She did not witness either of the 2 incidents involving Resident #1 today. -She found him on the floor both times. -She came in at 7:00am today (3/20/15). -The first time (fall), he was in the bathroom, he said his back was hurting. -The second time (fall), he was found on floor in the bathroom, he had his walker in the bathroom with him. -The MA checked him out and stated she didn't see anything. -Lately, she had been doing 15 minute checks on him. Review of local hospital final report notes for Resident #1 dated 3/20/15 revealed: -Staff states patient has fallen twice and believe him to have a UTI which he was sent out for 2 days ago and admitted. -Patient states he has fallen only once. -Denies pain, dizziness or syncope. -He has fallen several times in the last several days and they believe that he has a UTI. -The resident was seen here several days ago for the same. -Patient states he fell this morning does not recall the fall several days ago.	D 270		

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D 270	Continued From page 37 -The resident has a history of dementia, mood disorder. -Low blood pressure noted on arrival. -Patient is unable to give detailed history secondary to his dementia. -Denies any pain. 2. Review of Resident #7's current FL-2 dated 11/20/14 revealed the following: - Resident was admitted to the memory care unit on 8/22/14. - The resident's diagnoses included senile dementia with behavioral issues, osteoarthritis of bilateral hips and left shoulder, bradycardia with pacemaker and atrial fibrillation. - The resident was disoriented constantly and was ambulatory. Review of Resident #7's care plan dated 1/13/15 revealed the following assessment: - The resident had a history of wandering. - The resident was alert and disoriented to person, place and time. - The resident was unable to be reoriented or follow cues and continued to have falls due to poor safety awareness. - On 1/13/15, the resident sustained a fracture of the left humerus and an immobilizer was in place. - The resident's skin had bruises to bilateral arms/hands and legs/knees. - The resident had daily incontinence of bowel/bladder and was always disoriented. - The resident required extensive assistance with toileting, bathing, dressing and grooming/personal hygiene. - The resident required limited assistance with transfers and supervision with ambulation. Interview with a hospice registered nurse on	D 270		

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D 270	Continued From page 38 3/17/15 at 11:20am revealed the following: - She was aware that Resident #7 had sustained 27 or more falls since December 2014. - The resident fell at the facility and fractured left arm in January 2015. - The resident fell and hit her head at the facility in February and sustained a hematoma and subdural hemorrhage in February after the fracture. - The resident was placed on hospice services because of the continued bleeding in the resident's brain. The resident was diagnosed as terminal because of the fall and the brain bleed. - The resident's physician informed the resident's family of the subdural hemorrhage and the resident's poor prognosis. The family made the decision to for the resident to come back to the facility. - The resident was wheelchair bound and did not ambulate due to increased weakness. - The resident should be watched close to prevent her from falling. Review of a facility's "Fall Risk Evaluation" document revealed the following assessment scores: - On 1/12/15, Resident #7's fall risk assessment score was 24 (high risk for falls). - On 1/13/15, 1/19/15 and 1/29/15, the resident's fall risk assessment score was 25 (high risk for falls) - On 2/17/15 the resident's fall risk assessment score was 26 and 27 on 2/20/15. - According to the document's scoring legend, a score of 9+ is high risk for falls. Review of documentation on the facility's "Incident Reports" revealed the following: - Resident #7 had 32 documented falls between 12/12/14 and 3/20/15	D 270		

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D 270	Continued From page 39 - 25 of 34 documented falls were unwitnessed by staff. - In December 2014, the resident had 4 unwitnessed falls (sustained injuries in 2 falls) - On 12/24/14, at 9:45am, the resident was found in her bathroom on the floor and had a skin tear on right arm alone with a "knot on the back of her head". - On 12/28/14, on 1st shift, the resident was found on the floor beside her bed and had some swelling" on the back of her head. The resident was transported to the local emergency room (ER) by local emergency medical service (EMS) for evaluation and treatment. - In January 2015, the resident had 9 unwitnessed falls (sustained injuries in 4 falls). - On 1/08/15 at 12:30pm, the resident was found on the floor in the TV/Activity room crying. The resident had attempted to get up on her on. - On 1/08/15 at 1:05pm, the resident "wandered" into another resident's room and was found lying on the floor between the nightstand and the bed. The other resident stated Resident #7 was trying to get in her bed and the other resident pushed Resident #7 down and the resident hit her head when she fell. Resident #7 was transported to the local ER by local EMS. - On 1/24/15 at 5:10pm, the resident was found on the floor in the doorway of another resident's bedroom. The resident was complaining of head pain and stated she had a headache. The resident was lying on her back. The resident was transported to the local ER by EMS. - On 1/28/15 at 5:01pm, the resident was found on the floor, in her bedroom, by the door, on her right side. The resident had a bruise/skin tear on her right elbow. - In February, 2015, the resident had 7 unwitnessed falls (sustained injuries in 3 falls).	D 270		

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D 270	Continued From page 40 - On 2/11/15 at 2:35pm, the resident was found on the floor in her bedroom. The resident had a small bruise/carpet burn on right forehead. - On 2/12/15 at 5:55pm, the resident was found on the floor beside her bed with part of her body on the pad beside the bed, but head had hit the floor. The resident had a small "knot" on the back of her head. The resident was transported to the local ER by EMS. - On 2/20/15 at 10:55am, the resident was found lying on the floor next to her bed with a cut on left "jawline", left foot and reopened a cut above her right eyebrow. - In March, 2015, the resident has 5 unwitnessed falls with no injuries. - On 3/20/15 at 11:20pm, the resident had a witnessed fall in the TV/Activity room while sitting in her wheel chair and attempted to " push back " and stand up. The resident " flipped " backwards in the wheelchair hit her head. The resident had swelling on back of head and was transported to the local ER by EMS. Review of 7 Emergency Room reports from 12/7/14 through 3/20/15 revealed the following: - On 12/7/14, the resident was evaluated at the local ER after fall at the facility, which facility staff reported she broke fall with right elbow. The resident sustain a skin tear to the right elbow. An X-ray of right elbow and Head CT scan confirmed no other injuries. The resident was discharged back to the facility. - On 12/8/14, the resident was evaluated at the local ER after she fell out of bed according to the facility staff. The resident had a small hematoma on the back of head and complained of pain when touched. A head and spine cervical CT scan confirmed no acute process and no other injuries were suspected. The resident was discharged back to the facility.	D 270		

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D 270	Continued From page 41 - On 01/08/15, the resident was transported to the local ER after falling at the facility at least twice (once onto the back of the head). A head CT scan confirmed no acute process. The resident was discharged back to the facility. - On 01/12/15, the resident was transported to the local ER after a fall at the facility with left shoulder injury and complaint of left upper arm pain.. An X-ray of left shoulder confirmed a comminuted fracture of the proximal humerus. The resident was discharged back to the facility after coaptation splint applied to left arm and placed in sling. - On 01/24/15, the resident was transported to the local ER after a fall at the facility with head injury. According to the ER physician's documentation, " based on patient's history and physical, I would be concerned about possible intracranial bleed. No evidence of acute fracture or dislocation. The resident was discharged back to the facility and patient education fall prevention material was sent back to the facility. - On 2/12/15, the resident was transported to the local ER after a fall which the facility staff reported she fell and hit her head. A CT head scan confirmed a small right subdural and subarachnoid hemorrhage along the right temporal and right frontal lobes. The imaging result was reported as a critical result. An x-ray of the resident's left shoulder confirmed increased impaction of previously noted comminuted (broken into pieces) proximal left humerus fracture. The ER physician spoke with the resident's family member and explained the resident had a brain bleed. The ER physician discussed the resident's poor prognosis with the resident's family who decided to bring the resident back to the facility for comfort measures only. - On 2/20/15, the resident was transported to	D 270		

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the local ER after a fall at the facility. The resident was diagnosed with fall, head abrasion, high fall risk and chronic left proximal humerus fracture and discharged back to the facility.

Six confidential staff interviews revealed the following:
- The 1st staff stated when Resident #7 was in bed, supervisory checks were done every 2 hours.
- After a fall, the resident was checked every 30 minutes when in bed, but was "watched closer" when up and in the facility's TV room.
- The resident "falls all the time" even though she did not ambulate after the fall and brain bleed. The resident tried to get up out of her wheelchair without assistance.
- The resident's family member brought a baby monitor for staff to monitor in room and a helmet for resident to wear while up to prevent head injury when fall occur, but resident did not wear helmet and do not know if monitor was used.
- The 2nd staff stated she did not know how often Resident #7 was "supposed to be checked" but think checks were done every 2 hours and was checked more often when in the TV room.
- The 3rd staff stated Resident #7 was difficult to monitor. She always tried to get out of bed and out of wheelchair. The resident has dementia and think she can still walk. That's why she falls so much. The NA stated she checks on resident every 30 minutes sometimes but usually every 2 hours.
- The 4th staff stated Resident #7 fell about every other day and need NA to watch her at all times.
- The facility's nurse stated the resident needed 1 on 1 supervision/care.
- The resident was "supposed" to be on 15

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D 270	Continued From page 43 minute supervisory checks but the staff do not check the resident every 15 minutes, but maybe every 30 minutes or every 1 hour. - The 5th staff stated the resident has been falling since the end of 2014. - The resident was falling 3-4 times a week. - The resident had swelling of her head several times in the past after a fall/hit head. - The resident has dementia and her attention span was short. - She did better when she was kept busy (example folding wash cloths). - The staff was aware the resident sustained a "brain bleed" after a fall in February which she hit her head and was receiving hospice care. - The resident "broke" her left arm in the shoulder area in January, 2015 and had to wear a sling. - The resident kept falling and " messed up" her left shoulder again. - The staff was not providing 15 minutes checks and complained to MCC about having to "baby sit" Resident #7. - There was a question whether the staff was actually sitting with the resident in the TV room/the staff don ' t always watch the resident. - The MCC was aware the staff was not providing 15 minute checks or staying in TV room with the resident. - The resident has been on hospice for about 1 month and has slowed down, but still attempts to get up out of wheelchair. - The 6th staff stated when caring for Resident #7 on 2nd shift, "I keep constant watch on resident". - "I kept resident with me at all times unless providing care for other residents, then other staff would "watch" her for me". - The resident has fallen a few times on 2nd shift, but most falls on 1st shift.	D 270		

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D 270	Continued From page 44 Interview with the Memory Care Coordinator (MCC) on 3/20/15 at 12:40pm revealed the following: - Resident #7 was placed on 15 minute checks to help prevent falls (did not recall date). - Staff was required to "lay eyes on the resident" every 15 minutes and document checks. - The MCC has not checked to confirm if staff was checking on resident every 15 minutes or providing any care during checks, but assumed the staff was checking on the resident because they document the 15 minute checks. - The medication aides were responsible for assessing the residents for injuries after a fall or injury. Interview with the resident's primary physician on 3/20/15 at 10:05am revealed the following: - The resident was placed on hospice care because of a fall at the facility in February 2015. - The resident sustained a subdural hemorrhage and the family only wanted comfort measures. - The resident has sustained multiple recurrent falls due to the progression of her dementia. Observation made in the TV/Activity room on 3/20/15 at 10:05am revealed the following: - 12 residents were sitting in the room (including Resident #7). There were no staff in the room supervising the residents. - The MCC came in the TV room and attempted to call several staff on a walkie talkie. - After about 5 minutes, 3 staff came in the room and 1 staff stated she had to go out of the room for a few minutes. - The MCC reminded the staff there should be someone in the TV room with the residents at all	D 270		

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D 270	Continued From page 45 times. Observation made on 3/20/15 at 11:30am in the TV/Activity room revealed the following: - Resident #7 was lying backwards on the floor, in her wheelchair. - The resident was moaning and crying and complaining of pain of the back of her head. - The MCC was on the floor next to the resident attempting to comfort her. - The resident had a " knot on the back of her head. - A staff member stated she was in the room with the residents and the resident fell backward in her wheelchair and hit her head on the floor (a few minutes ago). - 7 other residents and 3 visitors were in the TV room at the time of the fall. - EMS arrived on 3/20/15 at 11:35am and transported the resident to local ER. Interview with the MCC on 3/20/15 at 12:40pm revealed the following: - A staff member (NA) was in the TV/Activity room at the time Resident #7 fell. - The NA was "doing something" near the TV and Resident #7 was behind her. - The NA could not get to the resident in time to prevent the fall. - The staff assigned to supervise the residents in the TV/Activity room should be interacting with the residents. - "I do not know what she (the NA) was doing". Interview with Resident #7's family member on 3/20/15 at 4:50pm revealed the following: - The resident forgets she cannot walk without assistance and attempts to get up without assistance. - If the staff "turns their back" on the resident,	D 270		

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she will get up.
- The staff reported checking on the resident every 15 minutes.
- Most of the resident's falls occurred in mid-morning to early afternoon (10:00am - 2:00pm).
- The resident fell in room (January 2015) and fractured arm, but I think the arm had a lot of arthritis and she does not use the arm now.
- After the resident fell and hit her head in February, which caused the "brain bleed", resident was placed on hospice for terminal care.
- The resident fell today and bumped her head hard but she will be transferred back to the facility from the ER.
- The facility recommended the family provided a private sitter for the resident (after the resident fell and sustained the brain bleed on 02/12/15), but we could not afford to pay a sitter.
- The resident has not attempted to get up unassisted for the last 1 and ½ weeks until today.

Interview with a nursing assistant (NA) on 3/20/15 at 5:00pm revealed the following:
- The NA was assigned by the MCC to supervise the residents in the TV/Activity room at the time Resident #7 fell.
- Resident #7 was sitting in her wheelchair (the wheel chair wheels were locked) in the TV/Activity room with other residents.
-The NA had turned away from Resident #7 to assist another resident (but was close to Resident #7.
- Resident #7 attempted to get up, but was she pushed backwards with her legs, the wheel chair fell backwards and the resident hit the back of her head "hard".
- The NA stated "I could not get to her in time to stop her from falling".
- The NA stated "Resident #7 always tried to

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D 270	Continued From page 47 stand up and it was very hard to watch her and keep her from falling" Review of documentation of a local hospital ER report dated 3/20/15 revealed the following: - The resident was transported to the ER by EMS from the facility. - Facility staff had called the ER and reported the resident fell when her wheelchair tipped backwards and the resident struck her head. - A large hematoma was noted by EMS and a c-collar and backboard was in place. - The impression of a CT scan of the head was a large left-sided subdural hematoma. There is a subdural hematoma along the anterior aspect of the interhemisphric fissure as well. There is a mass effect with effacement of sulci (slight depression/grove in the brain) and several millimeter of midline shift. There is a chronic right-sided subdural hygroma. - The patient is under hospice care and family does not wish any further care provided. The patient was discharged back to the facility. 3. Review of Resident #8's current FL-2 dated 8/1/14 revealed the following: - Diagnoses of dementia, depression, chronic obstructive pulmonary disease, benign essential hypertension. - The resident was disoriented intermittedly, was ambulatory and was a wanderer. Review of Resident #8's current care plan dated 8/19/14 revealed the following assessment/ documentation: - " The resident is very confused. She will have a conversation and a few minutes later, have the same conversation " . - " The resident is a heavy smoker. Sometimes	D 270		

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she cries because her daughter won't visit. Other times she is pleasant" .
- The resident is sometimes disoriented and is forgetful, needs reminders.

Observation made on 3/17/15 at 5:25pm revealed the following
- Resident #8 was outside of building in secured patio area (near MCC office).
- The resident was using a plastic spoon to push old cigarette butts in the small opening at the top of a cigarettes butt container.
- Resident #8 had a pouch inside the band of her pants which contained a pack of cigarettes with several missing cigarettes and 2 lighters.

Interview with Resident #8 on 3/17/15 at 5:30pm revealed the following:
- She usually smokes outside on the secured patio alone.
- Facility staff never come outside with her to smoke.
- Another resident, who smoked, came outside with her at times and they smoke together.
- "It's okay to smoke outside alone as long as I don't burn anything down".
- The resident kept her lighters and cigarettes with her at all times.

Interview with the MCC on 3/17/15 at 6:35pm revealed the following:
- The facility did not have a smoking policy .
- The MCC stated "We [the facility] just trust them [the residents] and Resident #8 kept cigarettes and 1 lighter".
- The facility only had 2 residents who smoked.
- The staff did not supervise the residents when they smoked.
- The secured patio was the only designated smoking area.

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D 270	Continued From page 49 - She was not aware Resident #8 kept 2 lighters. Two confidential staff interviews revealed the following: - The staff was not aware of a facility smoking policy. - The staff did not supervise Resident #8 when she smoked on the facility's secured patio area. - There were 2 or 3 residents who smoked. 4. Review of the current FL-2 for Resident #10 dated 8/28/14 revealed: - Diagnoses included senile dementia, alzheimers, anxiety, schizophrenia, hallucinations, falls, macular degeneration and hearing loss. Review of the Resident Register revealed Resident #10 was admitted to the facility on 12/4/2011. Review of the most recent Licensed Health Professional Support (LHPS) report dated 3/16/14 revealed: - Resident #10 was described as legally blind, confused, incontinent, and ambulatory with a steady gate. - The recommendations staff to encourage safety monitoring. Review of accident /incident reports for Resident #10 between January 16, 2015 and February 2015 revealed: - Resident had 10 falls and was sent to the emergency room with head injuries on 2 of those occasions. - On 1/16/15 at 1:45pm Resident #10 was assisted to the floor in the dining room.	D 270		

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D 270	Continued From page 50 - Resident was attempting to sit down and missed the chair, no injury sustained. - On 1/16/15 at 6:30pm Resident #10 was found lying on the dining room floor crying and holding the left side of her head in the temporal lobe area, where she hit it when she fell. - She was sent to the emergency room. - A falls investigation confirmed resident had similar incidents, due to her unsteady gate. - On 2/16/15 at 4:00pm staff witnessed Resident #10 lose her balance and fall on her bottom in the common area. No injury noted she was placed on falls alert. - On 2/19/15 at 2:05pm Resident #10 was found screaming, sitting on the floor in another residents' room, causing an abrasion to her elbow. - The other resident was not in the room at the time. - There was a notation to make sure Resident #10 was supervised at all times. - A falls investigation confirmed Resident visually impaired with an occasional unsteady gate. - On 2/20/15 at 7:50am Resident #10 was witnessed attempting to sit in the dining room and missed the chair, landing on her bottom. No injury noted. - The immediate action taken to prevent this from happening again was to provide more supervision on the resident. - On 2/23/15 at 6:35am Resident was sitting on the floor by the foot of her bed. No injury noted. - The medication aide (MA) got resident up and sat her on the side of the bed while she looked for her shoes and Resident slid to the floor. Review of resident care notes for Resident #10 revealed:	D 270		

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D 270	Continued From page 51 - On 2/16/15 she had a witnessed fall with no injury. - On 2/17/15 at 1:15pm she had a fall, no injury noted and denied pain. - On 2/20/15 at 7:50am she had a fall attempting to sit down in a chair, landing on buttock, no injury noted. - On 2/23/15 at 6:30am she slid off the bed while PCA was getting her out of bed, no injury noted. - On 3/10/15 during the 7:00am-3:00 pm shift Resident #10 fell while being walked to lunch with staff. - She hit her head and was sent to emergency room of the local hospital. - On 3/18/15 at 10:20am was found on the floor the MA was informed by another resident that Resident #10 was trying to sit on the chair and missed the chair. - When resident's family was notified of the fall, she informed the staff she was concerned about all of the falls and said her mother cannot see well, so could they please take extra care of her mother. Observation on 3/18/15 at 11:40am revealed: - 9 residents sitting in the dining room and activity room and no staff present for five minutes. - After 5 minutes a PCA returned from the kitchen, and another PCA walked up from the direction of the resident's room. - Resident #10 was one of the residents in the dining room sitting at the table, unsupervised. Interview with a PCA on 3/20/15 at 5:15pm revealed: - Resident #10 has to be constantly redirected. - Staff has to take her by the hand to get her to do anything.	D 270		

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THE COURTYARDS AT BERNE VILLAGE MEMORY CA	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 270	Continued From page 52 - She has to be helped to sit down and to get up from a chair or she will fall. - After her fall the other day in the dining room, her family asked staff to keep a better eye on her because she is blind and she keep falling. - She has placed on 15 minute checks. Interview with the memory care coordinator on 3/19/15 at 4:25pm revealed: - The receptionist that was working in the activity room this morning was, "I don't want to call her a warm body, but ... " - She is on light duty and cannot assist anyone or stop them from falling. - If a resident were to fall, at least it would be a witnessed fall. - She would be able to tell you what happened. Interview with the memory care coordinator on 3/20/15 at 4:55pm revealed: - Resident #10 is legally blind, but she is not totally blind. - She can see straight on, but she does not have peripheral vision. - That is why she often falls when she is trying to get up from the table. - Staff should be assisting her more frequently because of her visual impairment and frequent falls. _____ According to the facility's Plan of Protection dated 3/18/15, medication aides will monitor the nursing assistant's 15 and 30 minutes checks and documentation of checks on residents who are fall risks and and will initial after every check. the facility will implement a "zone" system where the nursing assistants are designated to specific areas to ensure better monitoring. Staff will be inserviced immediately. The Medication aides are responsible for making sure the nursing	D 270		

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D 270	Continued From page 53 assistants are in their zones. The program manager (MCC) will monitor daily. Staff will be assigned to provide supervision to residents who smoke while smoking. The residents will return cigarettes and lighters to staff after smoking. The facility will implement new smoking policy that provides supervision for all residents who smoke. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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 A2 VIOLATION Based on observation, interview and record review, the facility failed to assure notification of health care provider and follow-up for 3 of 5 sampled residents who had 11 pound weight loss (Resident #1) ; an ordered neurology consult after falls (Resident #7) and a fall with head injury (Resident #9). The findings are: 1. Review of Resident #1's FL-2 dated 11/3/14 revealed: -Resident was admitted to the Special Care Unit on 8/7/14.	D 273		

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D 273	Continued From page 54 -Resident was constantly disoriented. -Resident's inappropriate behaviors were verbally abusive. -Resident was ambulatory. -Resident's functional limitation was with his sight. Review of Resident #1's care plan dated 8/27/14 revealed: -Resident #1 was verbally abusive, suicidal, showed disruptive behavior, and wandered. -The resident was always disoriented. -The Resident needed supervision with eating. -Resident was independent with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring. Observation on 3/17/15 at 12:00pm revealed the aide approached Resident #1and asked him if he wanted to get up and eat; the resident did not respond. Interview with Personal Care Aide on 3/17/15 revealed: -Resident #1 did not eat breakfast this morning, he only drank his coffee. -She reported it to the Medication Aide. -The resident was not eating lunch. -Staff asked Resident #1 to get up for lunch but he didn't move. -He didn't eat pudding for snack this morning and she was the one who passed out the snacks at 10:00am. -The medication aide told her this morning that Resident #1 fell yesterday. -He had a knot on his head from the fall last night (3/16/15). Observation on 3/17/15 at 12:45pm revealed: -Resident #1 was sitting on the sofa in this same spot with a bump on his right top side of his head.	D 273		

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D 273	Continued From page 55 -The bump was larger than a quarter. -The resident had a wet spot on his pants in the the right outer thigh area measuring approximately 6x5 inches in diameter. Interview with Medication Aide on 3/17/15 revealed: -If aides don't see residents in the dining room then staff will do a room check. -If residents refuse (to go to the dining room), the aides will tell the medication aide and the medication aide will go check to see what is going on or take the resident a tray. Interview with Personal Care Aide on 3/17/15 at 1:50pm revealed: -She told kitchen staff to hold 2 plates, one for Resident #1 and one for another resident. -If the residents don't eat then the aide will throw it out before she leaves. Interview with kitchen staff on 3/17/15 at 1:55pm revealed: -She wraps up the meals and dates the plates for the residents. -She was new and didn't know the residents' names. -The staff will tell her who to hold plates for and how many. -Today she will hold 2 plates for people but she did not know their names. Observation on 3/17/15 at 5:50 PM revealed: -An aide went into Resident #1 room, shut door and then came out. -No food was taken to Resident #1. -The resident did not go down to the dining room for dinner at 5:00pm. Review of Resident #1's care notes dated 3/17/15	D 273		

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D 273	Continued From page 56 at 11:30am revealed: -Resident #1's physician was called about resident's frequent falls recently. -Requested he come by to evaluate resident. -Message left with the receptionist. Review of Resident #1's care notes dated 3/17/15 (7-3) revealed: -Resident was offered his Ensure at 8:00am. -Resident was asked by both medication aide and aide if he would like breakfast. -The resident said no and shook his head from side to side. -The resident was also asked if he would walk to breakfast and resident said, "No". Observation of Resident #1 on 3/18/15 at 12:28pm revealed: - Resident #1 was in his room eating his lunch. -The plate of food was on his lap. -The aide walked in and asked him if he is ready for dessert; the resident responded, "Yes". Interview with Personal Care Aide on 3/18/15 at 12:31pm revealed: -This was the first time the resident has eaten in his room. -The facility doesn't have trays for residents to eat off of. -Snacks are on the trays the facility has. Interview with Memory Care Coordinator on 3/18/15 at 12:35pm revealed: -Resident #1 was the only one who eats in his room. -The aides can bring residents' food to them. -The resident has a table beside his chair and a table beside his bed. -The resident doesn't have an adjustable table or tray to eat on.	D 273		

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D 273	Continued From page 57 -The resident has been eating in his room for the last month, sometimes he eats in the dining room, but mainly in his room. Interview with another aide on 3/18/15 at 5:20pm revealed: -Resident #1 didn't come down to the dining room for dinner. -When the aide asked the resident about dinner, he told the aide to leave him alone. -The aide put his plate in his room. Observation of Resident #1 on 3/18/15 at 5:25pm revealed: -Resident was lying on his bed with a wrapped plate of food sitting on the table bedside his bed. -The red plate wrapped in plastic contained a baked potato, corn and steak. -He was lying on the edge of the bed. -He stated he was ok, didn't want anything. Observation on 3/19/15 at 8:35am revealed a personal care aide took the plate of food, which was still wrapped, out of Resident #1's room. The plate contained a baked potato, corn and steak. Review of physician's order dated 3/9/15 revealed an order for Ensure 1 can three times a day. Review of the March 2015 medication administration record revealed Resident #1 was not given Ensure 17 times during the month, which was documented as follows: -On 3/9/15, two cans were documented as, pharmacy notified, awaiting delivery. -On 3/10 15, one can was documented as withheld per physician orders; one can was documented as pharmacy notified, awaiting delivery; and, one can was documented as resident refused.	D 273		

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-On 3/11/15, two cans were documented as pharmacy notified, awaiting delivery.
-On 3/12/15, one can was documented as resident refused.
-On 3/13/15, two cans were documented as resident refused.
-On 3/14/15, one can documented as resident out of facility, and one was documented as resident refused.
-On 3/15/15, three cans were documented as resident refused.
-On 3/16/15, three cans were documented as resident refused.

Interview with Memory Care Coordinator on 3/19/15 revealed:
-The MCC was aware Resident #1 did not get his ensure 17 of 25 times for the month of March 2015.
- The facility originally got the powdered kind and it gave the resident diarrhea.
-Now the facility got canned Ensure and the resident does better with the canned Ensure.

Review of the weight sheet for February 2015 revealed Resident #1's weight was documented as 190 pounds (no date specified).

Observation of the resident being weighed on 3/19/15 at 10:30am revealed Resident #1 weighed 179 pounds.

Interview with Resident #1's physician on 3/20/15 at 10:30am revealed he was not aware of Resident #1's 11 pound weight loss.

2. Review of Resident #7's current FL-2 dated 11/20/14 revealed the following:
- Resident was admitted to the memory care unit on 8/22/14.

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D 273	Continued From page 59 - The resident's diagnoses included senile dementia with behavioral issues, osteoarthritis of bilateral hips and left shoulder. - The resident was disoriented constantly and was ambulatory. Review of 5 Emergency Room reports for Resident #7 from 12/7/14 through 1/24/15 revealed the following: - On 12/7/14, the resident was evaluated at the local ER after a fall at the facility, which facility staff reported she broke fall with right elbow. The resident sustain a skin tear to the right elbow. An X-ray of right elbow and Head CT scan confirmed no other injuries. The resident was discharged back to the facility. - On 12/8/14, the resident was evaluated at the local ER after she fell out of bed according to the facility staff. The resident had a small hematoma on the back of head and complained of pain when touched. A head and spine cervical CT scan confirmed no acute process and no other injuries were suspected. The resident was discharged back to the facility. - On 01/08/15, the resident was transported to the local ER after falling at the facility at least twice (once onto the back of the head). A head CT scan confirmed no acute process. The resident was discharged back to the facility. - On 01/12/15, the resident was transported to the local ER after a fall at the facility with left shoulder injury and complaint of left upper arm pain. An X-ray of left shoulder confirmed a comminuted fracture of the proximal humerus. The resident was discharged back to the facility after coaptation splint applied to left arm and placed in sling. - On 01/24/15, the resident was transported to the local ER after a fall at the facility with head injury. According to the ER physician's	D 273		

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documentation, "based on patient's history and physical, I would be concerned about possible intracranial bleed. No evidence of acute fracture or dislocation. The resident was discharged back to the facility and patient education fall prevention material was sent back to the facility".

Review of documentation on the facility's "Incident Reports" revealed the following:
- Resident #7 had 32 documented falls between 12/12/14 and 3/20/15
- 25 of 34 documented falls were unwitnessed by staff.
- In December 2014, the resident had 4 unwitnessed falls (sustained injuries in 2 falls)
- On 12/24/14, at 9:45am, the resident was found in her bathroom on the floor and had a skin tear on right arm alone with a "knot on the back of her head".
- On 12/28/14, on 1st shift, the resident was found on the floor beside her bed and had some swelling" on the back of her head. The resident was transported to the local emergency room (ER) by local emergency medical service (EMS) for evaluation and treatment.
- In January 2015, the resident had 9 unwitnessed falls (sustained injuries in 4 falls).
- On 1/08/15 at 12:30pm, the resident was found on the floor in the TV/Activity room crying. The resident had attempted to get up on her on.
- On 1/08/15 at 1:05pm, the resident "wandered" into another resident's room and was found lying on the floor between the nightstand and the bed. The other resident stated Resident #7 was trying to get in her bed and the other resident pushed Resident #7 down and the resident hit her head when she fell. Resident #7 was transported to the local ER by local EMS.
- On 1/24/15 at 5:10pm, the resident was found on the floor in the doorway of another

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resident's bedroom. The resident was complaining of head pain and stated she had a headache. The resident was lying on her back. The resident was transported to the local ER by EMS.
- On 1/28/15 at 5:01pm, the resident was found on the floor, in her bedroom, by the door, on her right side. The resident had a bruise/skin tear on her right elbow.
- In February, 2015, the resident had 7 unwitnessed falls (sustained injuries in 3 falls).
- On 2/11/15 at 2:35pm, the resident was found on the floor in her bedroom. The resident had a small bruise/carpet burn on right forehead.
- On 2/12/15 at 5:55pm, the resident was found on the floor beside her bed with part of her body on the pad beside the bed, but head had hit the floor. The resident had a small "knot" on the back of her head. The resident was transported to the local ER by EMS.
- On 2/20/15 at 10:55am, the resident was found lying on the floor next to her bed with a cut on left "jawline", left foot and reopened a cut above her right eyebrow.
- In March, 2015, the resident had 5 unwitnessed falls with no injuries.
- On 12/29/14 at 5:45pm, the resident had 1 witnessed fall in TV/Activity room while walking unassisted and bruised right elbow.
- On 3/20/15 at 11:20pm, the resident had a witnessed fall in the TV/Activity room while sitting in her wheel chair and attempted to " push back " and stand up. The resident " flipped " backwards in the wheelchair hit her head. The resident had swelling on back of head and was transported to the local ER by EMS.

Review of a facility's "Physician Notification of Resident Incident/Condition " dated 2/11/15 revealed the following documentation

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D 273	Continued From page 62 - [Resident #7] " Was found on the floor during checks (15 min). She must have woken up from nap and attempted to get up and fell, she has a small bruise/carpet burn on [right] side of forehead, but seems fine". Review of an order from the resident'sprimary physician faxed to the facility on 2/11/15 revealed an order for " neurology consult for evaluation of worsening dementia/falls". Interview with a medication aide (MA) on 3/19/15 at 9:35am revealed the following: - She was not aware of an order for a neurology consult. - The resident has not been transported to any medical appointments. Interview with the facility's Memory Care Coordinator (MCC) on 3/19/15 at 10:40am revealed the following: - She was not aware of an order for a neurology consult. - If the resident's physician ordered a consult, then an appointment would have been made by the physician's office and the facility would have been notified. - The resident never had an appointment for neurology consult. - Resident appointments not scheduled by the physician, would be made by the MCC or MA. - The resident was admitted to hospice on 2/28/15 and hospice would have followed up with the neurology consult and would have requested an order to cancel the consult. - According to facility policy, any consult orders were followed up as soon as possible (within 1-3 days). - "Maybe the facility should have clarified the order for the neurology consult."	D 273		

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D 273	Continued From page 63 Interview with the resident's hospice nurse on 3/19/15 at 12:10pm revealed the following: - The resident was admitted for hospice services on 2/28/15. - She was not aware of orders for a neurology consult at time of admission or since admission. - The facility did not inform hospice nurse of an order for a neurology consult. - She has never discussed neurology consult with the resident's physician. Interview with the Resident's primary physician on 3/20/15 at 10:15am revealed the following; - The neurology consult (2/11/15) was related to the resident's frequent/multiple falls with injuries. - The physician office did not make neurology appointment, order was faxed to the facility. - If consult sent to the facility without appointments made by his office, the facility should make appointment. - The facility contacted him this week (did not know date) and asked for and received a verbal order to cancel the neurology consult order. - The resident was receiving hospice services due to subdural hemorrhage related to head injury from fall and the family's desire is for comfort care only at this time. Interview with Resident #7's family member on 3/20/15 at 4:50pm revealed the family member was not aware the resident's physician had ordered a neurology consult in February 2015. 3. Review of Resident #9's current FL2 dated 2/6/14 revealed: - Diagnoses included malignant neoplasm of the brain, malignant neoplasm of the bone and cartilage.	D 273		

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D 273	Continued From page 64 - Resident was noted to be constantly disoriented. Review of Resident #9's resident register revealed she was admitted to the facility on 3/18/13. Interview with the Memory Care Coordinator on 3/17/15 at 12:15pm revealed: - Resident #9 was no longer at the facility, she passed away on 3/15/15. - She had been on hospice prior to her death. Review of an accident/injury report for Resident #9 dated 2/24/15 (12:20am) and a resident care note revealed: - Resident #9 awakened from sleeping in the television room and was walking into her room. - Resident had a probable fall, not witnessed. - Resident was found on the floor holding her head. - She has knot/swelling in frontal lobe area. - Staff got resident up and the MA evaluated her and took vital signs. - Resident was taken to her room and ice was placed on her head and she was given an 800mg ibuprofen. - Resident was not sent to the hospital. - The MA contacted hospice. - Resident went to sleep and had no other issues that shift. - The facility administrator was notified on 2/25/15 at 12:25am. - The family was contacted on 2/25/15 at 12:30am. - The doctor was notified via fax on 2/25/15 at 11:00am. Interview with the Hospice agency on 3/19/15 at 9:05am revealed:	D 273		

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D 273	Continued From page 65 - Resident #9 had been receiving services from the hospice agency. - The agency received a call on 2/25/15 at 2:10am informing them Resident #9 fell and hit her forehead. - The emergency medical systems (EMS) had been called, but they did not take the resident out of the facility. - Resident was given ibuprofen and put back to bed. - The hospice agency did not advise the MA to keep resident in facility or to send her out. - She was informed by the MA the resident was not sent out. - The agency was unable to visit Resident #11 at the facility on 2/25/15 due to inclement weather and did not see her until 2/27/15. Interview with a MA on 3/19/15 at 9:23am revealed: - She was working on the night of 2/24/15 when Resident #9 fell. - Resident #9 often slept in the television room in a chair, she seldom slept in her bed. - She fell on the floor on the way back to her room in the wee hours of the morning. - She hit her head on the arm of a chair and a large knot formed on her forehead immediately. - Her first thought was to send the resident out. - The policy is to send out any resident that has a head injury. - She called Resident #9's power of attorney (POA) and informed them she would be sending Resident #9 to the hospital for evaluation, and they were planning to meet her there. - She called 911 and when EMS arrived she remembered Resident #9 was on hospice. - EMS told the MA she could not send Resident #9 out because of her hospice status, if the resident was sent out it would void her	D 273		

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D 273	Continued From page 66 hospice benefit. - She called the POA back and informed them that Resident #9 would lose her hospice status if she was taken to the hospital. The POA said to her if sending her out will void her hospice then do not send resident out. - She called the memory care coordinator (MCC) at home and told her about Resident #9 falling and hitting her head causing immediate swelling and she informed her that she was not sending the resident out, the MCC said okay. - She gave Resident #9 an ibuprofen and put her to bed and monitored her the rest of the night, because she was worried about her. - She called the hospice nurse after EMS left, and they told her to give Resident #9 a prn (as needed) medication and an ice pack. - Resident was given ibuprofen and put back to bed. - Hospice did not visit the facility that night because of bad weather, so the resident was not seen by a nurse or the hospital. - Resident #9 was not seen by the facility wellness nurse. - Resident #9 did not act any different after the fall. - When she returned to work a couple of days later the resident's forehead was not swollen anymore. Interview with the MCC on 3/19/15 at 4:25pm revealed: - The facility's falls policy says if a resident has a head injury they must be sent to the hospital, regardless of their hospice status. - When the MA told her she spoke with the POA and they were okay with Resident #9 not being sent out, she said okay. - She did not call the POA and speak with them personally.	D 273		

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D 273	Continued From page 67 - She was told the EMS would not want to take Resident #9 and she made the decision to leave it in the hands of the POA. Review of resident record revealed: - An EMS Refusal of treatment/transport form dated 2/25/15 at 1:11am. - No boxes were checked. - The resident or legal guardian signature line was blank. - The facility MA signed the form and dated it on 2/25/15 as witness to the Resident or legal guardian signature. Interview with the Hospice Nurse on 3/19/15 at 12:49pm revealed: - If a resident is acutely injured they advise to send the resident out, even though the resident is receiving hospice benefits. - Hospice status is not affected by hospital visits. - The agency would not have discontinued a resident ' s benefits because they were sent to the hospital. Attempts to contact EMS were unsuccessful. _____ According to the facility's Plan of Protection dated 3/19/15, the facility's program manager (MCC) will follow up on all outstanding referrals and follow up appointments to be covered by the end of business day on 3/20/15. This will include all orders which required follow up. The facility will implement a new policy that requires the program manager to follow up on all referrals and follow up appointments within 3 business days of receipt and continue daily until complete. This will include orders as well as appointments.	D 273		

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D 273	Continued From page 68 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015.	D 273		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record review, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the memory care facility. The findings are: Record review and observation revealed the facility had a current census of 23 residents. Review of the activity calendar posted in the hallway of the facility revealed activities scheduled for 3/17/15 included Sunshine Club 1	D 315		

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on 1 visits (no time listed); devotions in the activity room at 9:00am (no end time); exercises in the activity room at 11:00am (no end time); bingo at 2:00pm (no end time) and happy hour at the club house at 3:30pm (no end time).

Observation made in the facility's TV/Activity room on 3/17/15 at 11:15am revealed 10-12 residents in room. The TV was on with a movie playing (observed violence and foul language). 1 staff member was sitting in the room and not interacting with the residents. Several residents were attempting to get out of wheelchairs and chairs without assistance and had to be redirected by staff member.

Interview with the staff member on 3/17/15 at 11:20am revealed the following:
- The movie playing was an activity for the residents.
- The residents seem to like watching TV.
- There was a St. Patrick's Day party planned for this afternoon.
- The residents usually did not have any activities other than an occasional party and 1 resident participated in "beading".

Observation made in the TV/Activity room on 3/17/15 at 3:30pm revealed the residents were participating in a planned party (about 15 residents).

Review of the activity calendar revealed activities scheduled for 3/18/15 included Sunshine Club 1 on 1 visits (no time); crafting at 11:00am in activity room (no end time listed for activities); exercise in activity room at 1:00pm (no end time listed); and Southern Gentlemen in the main dining room (no end time listed).

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D 315	Continued From page 70 Observations made in TV/Activity room on 3/18/15 at 11:10am revealed the following; - No activities were occuring, 4 residents were arguing and threatening each other, very confused. A staff member separated the residents. - No activities observed at 1:15pm or 2:50pm, but 10 residents were sitting in the activity room. - The TV was on throughout the day. Review of the activity calendar revealed activities scheduled for 3/19/15 included Sunshine Club 1 on 1 visits; sittercise at 9:30am in activity room; beading at 10:30am; and crafty time at 1:00pm in activity room (no end time listed for activities). Observations made in the TV/Activity room on 3/19/15 at, 8:30am, 9:40am, 1:00pm, 3:30pm, and 4:30pm revealed no activities were being led. The TV was on throughout day. A Staff interview on 3/19/15 at 10:50am revealed the following; - The staff was a receptionist at the assisted living facility (on same campus). - The staff member had been assigned to remain in the activity room with the residents throughout shift (9:00am until 3:00pm). - The staff member stated the only activity this morning was 1 resident made a necklace, no other activity. Interview with the facility Activity Director on 3/19/15 at 11:30am revealed the following; - She has worked as the Activity Director for the facility for about 1 year. - Even though the calendar on the facility wall in the hallway listed activities, sometimes the activities were changed.	D 315		

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D 315	Continued From page 71 - There were no planned activities with the residents off the property. - Stimulation activities included a plastic bin filled with rice with fun items for the residents to find by digging in the rice, memory games (3 times a week), and karaoke. - Activities were not listed on the calendar but she tried to do activities when she could. - There were more things she could be doing in a more productive way. - She was working on activities for the facility, but it was a "work in progress". - Since she was activity director for 2 facilities (including the assisted living facility on the campus), she had to continuously multitask. Interview with a 1st shift nursing assistant on 3/19/15 at 2:45pm revealed the following; - No residents were taken to any activities today. - There are never any activities at the facility other than beading with 1 resident and an occasional party. - The Activity Director was here this morning but she did not do any activities with the residents. - The residents may not be as combative and confused, if they has something to do. Review of the activity calendar revealed activities scheduled for 3/20/15 included Sunshine Club 1 on 1 visits; pet therapy at 10:0am in activity room; walking club at 10:00am; bingo at 2:00pm in activity room; and happy hour at 3:30pm (no end time listed for activities). Observations made on 3/20/15 revealed only 1 activity, (pet therapy) in the afternoon.	D 315		

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D 315	Continued From page 72 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review and interviews, the facility failed to provide services to maintain the physical and mental health by allowing 2 of 6 sampled residents to lie in urine and feces and not providing personal care service (#1 and #6) resulting in the development of stage II pressure sores. The findings are: 1. Review of Resident #1's FL-2 dated 11/3/14 revealed: -Diagnoses included Depression disorder, mood disorder, impulse disorder and history of concussion. -Resident was admitted to the Special Care Unit on 8/7/14. -Resident was constantly disoriented. -Resident's inappropriate behaviors were verbally abusive. -Resident was ambulatory. -Resident's functional limitation was with his sight. -Resident was continent of bladder and bowel. Review of Resident #1's care plan dated 8/27/14	D 338		

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revealed:
-Resident #1 was verbally abusive, suicidal, showed disruptive behavior, and wandered.
-Resident was continent of bladder and bowel.
-Resident's orientation was always disoriented.
-Resident needed supervision with eating.
-Resident was independent with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring.

Review of resident care notes for Resident #1 dated 2/18/15 (7:00 AM - 3:00 PM shift) revealed:
-Resident had a good day.
-He took all medications.
-Resident ate his breakfast and lunch.
-No issues.

Review of the physician's Encounter note for Resident #1 dated 2/18/15 revealed:
-Facility staff stated patient has not been himself in the past two days, speaking nonsense.
-The resident appears tired; incontinent and had wet himself, strong urine odor.
-The resident requires significant effort to leave the facility due to behavioral issues and dementia.
-Physician was asked by facility staff to see resident for possible UTI.
-Resident had strong urine odor in room and on clothes; is incontinent of urine where he normally is not.
-He also is not acting himself and is more confused than usual.
-Facility staff had been unable to obtain a urine specimen as requested by physician.

Review of resident care notes for Resident #1 dated 2/20/15 (3:00 PM - 11:00 PM shift) revealed:
-Resident has been in his room most of the day.
-He ate 40% of his dinner, took all his

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medications and refused a snack.
-Resident was still acting out of it.

Review of resident care notes dated 2/21/15 (7:00 AM - 3:00 PM shift) revealed:
-Resident has been in his room all day.
-He has refused medications, breakfast, and lunch.
-Resident isn't being himself.

Review of resident care notes for Resident #1 dated 2/21/15 (3:00 PM - 11:00 PM shift) revealed:
-Medication aide (MA) went in resident's room to check on him.
-Resident was covered in urine, leaning over in his chair and refused to allow medication aide or staff to clean him up or assist him with getting cleaned up.
-Resident refused food as well as medications.
-Resident asked medication aide to send him out to the local emergency room as he didn't feel he was getting any better.
-The MA informed the Memory Care Coordinator (MCC).
-The MCC and medication aide sent resident out to local emergency room.
-Resident had to be sent out to the local hospital.
-Medication aide did incident report and the appropriate people were notified about the situation.

Review of the history and physical section of the local hospital report dated 2/21/15 revealed:
-Facility reported patient had a bad UTI, unable to ambulate or take medications.
-His mental status is altered.
-He arrived with urine stained clothing.
-He was cleaned on arrival and noted to have severe excoriation.

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-He had been refusing medications, food and care for the past 24 hours and had reportedly been lying in his urine.
-He was found to have Urinary Tract Infection and Acute Renal Failure (ARF).
-Resident #1 was found with an angry, red macular rash in the buttocks and groin area; with an area of maceration and skin breakdown on the left buttocks cheek approximately 3 x 2 cm stage II.
-He had a rash over his left flank (area on the body between the ribs and hip) with an area of skin breakdown which appears to be secondary to trauma for prolonged contact to a hard surface.
-He had extremely dry skin with cracking of the epidermis over the lower extremities.

Review of the assessment and plan section of the local hospital report dated 2/21/15 revealed:
-He had acute renal failure due to dehydration and poor mouth intake.
-IV fluids continue to monitor renal function and watch urine output.
-Avoided nephrotoxic agents.
-Lisinopril and ibuprofen was put on hold.

Review of discharge diagnoses section of the local hospital report dated 2/23/15 revealed:
-Sepsis from Urinary tract infection
-Urinary tract infection with E coli
-Acute renal failure due to dehydration and poor by mouth intake and UTI
-Acute metabolic encephalopathy from #1
-Stage I decubitus ulcer

Review of Resident #1's current FL-2 dated 2/23/15 from the hospital discharge revealed:
-Diagnoses included urinary tract infection; acute renal failure; hypertension; vitamin B and D

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deficiency; and stage I decubitus ulcer.
-He was intermittently disoriented.
-He had no inappropriate behaviors.
-He needed assistance with bathing and dressing.
-He was semi-ambulatory.

Review of physician's Encounter note for Resident #1 dated 3/2/15 revealed:
-Per facility staff, resident was found to be sitting in his own urine and feces for unknown length of time.
-The resident was being treated for UTI.
-The resident's physician was not informed that the resident was sent to the hospital until after the fact, when a hospital follow-up was requested and was not informed of this current situation until today.
-Left buttocks with 4 cm in diameter stage II decubitus and with a total 8 cm in diameter decubitus total surface area.

Interview with a Medication Aide on 2/26/15 revealed:
-Resident #1 had a possible urinary tract infection.
-On Saturday (2/21/15) second shift, another Medication Aide told staff Resident #1 refused all his medications and he was picking at his skin.
-He refused his medications and refused to eat.
-Resident #1 had on grey sweat pants and he had urinated on himself.
-He wanted to go to the hospital.
-Staff informed MCC and for her to go look at him.
-"The smell hit staff".
-Staff asked him if they could clean him up and he just wanted to be sent out.
-He took his wallet with him and it looked like it was stained with urine.

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-The chair he was sitting in was a blue chair and it was drenched with urine and urine on the floor.
-The chair had feces and urine on it.
-The general procedure if a resident refuses care, staff just walk away and will go back.
-Aides are sent in and if residents refuses care they are to go back.
-After 3 attempts, staff need to report to their SIC and sometimes 2 times.
-She was not sure if they have a policy and procedures.
-Staff had training with local behavioral health in December 2014.
-The instructor showed an aide how to deal with a resident when they refuse care.
-The instructor stated residents can refuse.
-The question did come up during training of what to do with residents who are soiled and she stated you cannot let them walk around soiled.
-You do what you have to do to get them changed.
-If staff needs 3 or 4 people to change them you do what you have to do or it will be considered neglect.
-The instructor did say you can't restrain people.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 3/2/15 revealed:
-When the NP went to the facility on 2/17/15, the resident was found saturated in his own urine.
-The NP called for the aides to come and clean the resident up.
-The NP was not aware Resident #1 had gone out to the hospital.
-It was not until resident was discharged from the hospital on 2/23/15 that the doctor was made aware of his hospitalization. This was so the doctor could follow up with the resident in two weeks.
-The NP made a visit today (3/2/15) and

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discovered the decubiti which is now a stage II.
-The NP was very upset that no one consulted with her about the situation.

Review of resident care notes for the month of February 2015 revealed no documentation of skin breakdown on the resident's buttocks.

Review of Resident #1's Initial and Quarterly Skin Risk Assessment dated 2/18/15 revealed any score of "5" or above indicates the resident is at risk for skin breakdown. The resident's total score was "1" because of the resident's diagnosis of Dementia.

Review of written statements obtained by the facility from 5 staff members who work in in the memory care unit regarding Resident #1 revealed the following:
-Statement #1: On 2/21/15, the 3rd shift medication aide notified first shift that Resident #1 would not stand up, so staff could see if he needed to be changed.
-Statement #2: On 2/21/15 at the start of first shift, third shift let the aides on first shift know Resident #1 had refused to allow them change him or get him up. Staff checked on the resident before breakfast and after breakfast. After he refused those two times, staff notified medication aide that he was acting strange and would not let them change him.
- Statement #3: On 2/21/15 the staff member went to Resident #1's room and he was sitting in his chair slightly slumped and his room smelled like urine. For the past few days, the resident has been acting strange, room messy, refusing meals and bad hygiene.
-Statement #4: On 2/21/15 when arriving to memory care, the medication aide from third shift made the staff member aware that Resident #1

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was in his chair in his room. The resident had refused to get up. Approximately 20 minutes later, the staff member did check on the resident to see if he would get up to go to breakfast; and there was no response from the resident. The resident was in his chair with no shirt on and his pants were wet. Lunch time came and the resident was still in his chair slumped over and picking at his pants. The staff member noticed the resident's pants were even more soiled.
-Statement #5: When the staff member came in Saturday (2/21/15) morning, the SIC told the staff member and the other aide to wait 20 minutes to go back in Resident #1's room because he refused the medication aide. The staff member went in 20 minutes later and the resident was still sitting in his chair with his head down. When the memory care coordinator came in, the other aide told her that Resident #1 refused to take a shower and he had urine on himself and smelled like he [had a bowel movement] on himself.

Review of the Health Care Personnel Registry 5-working day report submitted on 2/26/15 by the administrator revealed:
-Incident date 2/21/15 at 4:00 PM.
-Incident location was in resident room in memory care unit.
-Description of incident included resident was found on second shift at beginning of the shift to be slumped over in chair and covered in urine.
-Resident was being treated for a UTI and (staff) had documented (the resident) to not be himself.
-Checks were not documented however collecting statements from all of the aides and medication aide claimed to have checked on him throughout the shift.
-Upon further conversation with medication aides she felt that staff was concerned "to force" the resident to get up and get changed because he

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had been physically aggressive in the past and we have a pending investigation of a medication aide holding a resident's hands down to stop the resident from hitting her that was terminated.
-The facility has decided not to terminate anyone because it does not seem that it was malicious in nature and a matter of being retrained.
-The facility is pulling the medication aide off the SIC role and she will spend at least two weeks being retrained.
-The facility is doing an in-service on combative residents, alert charting and proper documentation in ADL books and 15/30 minute checks.
-Incident resulted in physical injury/harm was found.
-Skin breakdowns on resident's bottom had to be addressed by home health.

Interview with the Wellness Director (facility nurse) on 3/11/15 revealed:
-She was not aware of what had happened to Resident #1 regarding the incident on 2/21/15 until after he was sent out to the hospital.
-She was aware Resident #1 had a UTI.
-She was aware he was saturated with urine at the time and at the hospital he had a stage I pressure sore.
-She was aware the resident had a UTI before he went to the hospital.
-She received an email from the administrator and the MCC on Saturday 2/21/15 in late evening about Resident #1 and the incident.
-She is not aware how long Resident #1 was sitting in his room saturated in his own urine and feces.
-She was not aware of his skin breakdowns before he went to the hospital.
-She was not aware of Resident #1's skin breakdowns until the following day when MCC

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went to the hospital and saw his bottom when the MCC was there at the hospital.
-She thinks the facility notified Resident #1's physician when the facility sent him out to the hospital.
-Resident #1's physician was notified by sending an incident report.
-Resident #1's last Care Plan was completed on 8/27/14.
-She was not aware the facility had to complete a resident's care plan every quarter. She was told within 30 days of admission and annually.
-She is not aware if Resident #1's guardian is aware of the incident.
-If an aide is dealing with a resident who has aggressive behaviors they are supposed to re-approach and try a different person.
-If someone who requires incontinence care is showing aggressive behaviors, staff is to inform the SIC.
-Aides have received continued education in dealing with residents who refuse care.
-She thinks the Personal Care Records are reviewed by the MCC but is not sure when they are reviewed or how often.
-Since Resident #1's incident on 2/21/15, they have set up audits and the Medication Aide should be checking behind the Personal Care Aides to make sure they are completing their ADL's.

Interview with the Memory Care Coordinator on 3/19/15 revealed:
-On 2/20/15 at 7:00pm, Resident #1 was dry and not feeling well.
-On 2/21/15 at 1:47pm, an aide informed the MCC that Resident #1 was acting "off"; the MCC replied she was aware and he had a UTI.
-The Medication Aide brought the MCC into the resident ' s room a little before 4:00pm and

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D 338	Continued From page 82 Resident #1 was in a blue chair and he was soaked in urine and was unresponsive so we sent him out to the hospital. -She was aware of the situation with Resident #1. -She did not check on Resident #1 because the aides said he was acting out of sort and she knew he had been acting out already. -She called 911 and sent Resident #1 out of the facility. -The MCC is unsure of how long Resident #1 had been sitting in his room saturated in his own urine and feces. -The facility did an internal investigation and the facility did not get a full story of what happened. -The medication aide's documentation indicated that one person saw him at 8:00am and he was not in urine but he refused his medications. -There is documentation from 3rd shift staff that 1st shift staff needed to go back and check on Resident #1. -She was not aware of his skin breakdown before going to the hospital on 2/21/15. -She became aware of his skin breakdowns when she went to the local emergency room (ER) and the nurse at the ER was changing him and saw how bad it was and the ER nurse informed the MCC of the breakdown. -Resident #1's physician was notified by fax when we sent him an incident report. -Resident #1's last care plan was 8/27/14. -Resident has a care plan dated 2/23/15 when he came back from the hospital. -The facility was doing care plans annually and as needed, but the MCC had just been told by the Wellness Director (facility nurse) to do them every three months. -The MCC does not do the Care plans. -Resident's #1's guardian was notified by the MCC and he was fine with the incident. He thanked the MCC for looking out for him. MCC	D 338		

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did not think the family member really knew what was going on.
-MCC has never seen the guardian for Resident #1 visit him.
-MCC was not sure of the facility's policy and procedure when staff is dealing with a resident who has aggressive behaviors.
-She would have to look at the policy and refresh her memory by looking at it.
-She would make sure residents are in a safe position and walk away. We send residents out if they are hitting other residents.
-The facility will change staff members to approach a resident.
-The process for staff when assisting with a resident with any ADL's and the resident shows aggressive behavior is the same thing when the resident is refusing. Staff should give the resident a break and try again.
-Staff should also get another staff member to attempt and if the resident is still acting out then staff should inform the medication aide.
-Staff had an in-service on policy and procedures when dealing with residents with aggressive behaviors. It was my first day on the job 12/1/14.
-When the staff completes the residents' Personal Care Records at the end of the month, they are placed on the records.
-The Personal Care Records have not been reviewed until recently. MCC and Administrator have been pulling 4 records twice a week to review. We started pulling records 2 weeks ago.

2. Review of Resident #6's FL-2 dated 2/18/14 revealed the following:
- The resident was admitted to the facility on 3/19/13.
- Diagnoses included dementia, diabetes mellitus, generalized osteoarthritis,and gout.
- The resident was disoriented at all times.

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D 338	Continued From page 84 - The resident was incontinent of bladder and bowel. Staff interview with 1st shift nursing assist (NA) on 3/17/15 at 11:35am revealed the following: - Resident #6 had an open stage II decubitus on left buttock, but did not know how long the resident had the wound. - The resident was incontinent of bowel and bladder and required total assist for personal care and transfers. - The resident was left in bed "a lot " because of her weight, "she is big", and the resident was in bed now. - The resident was combative and required 2 person assistance for all transfers. - Residents who are combative and "pissed" and had bowel movements on the floor and bed needed to be in a mental hospital. Observation made on 3/18/15 at 8:35am revealed the following: - The resident was in bed with a brief on and her room had strong odor of urine. - When the NA removed the resident's brief, noted left lower buttock and top of left hip with duoderm (occlusive) dressing in place. - Noted an open stage II wound at center of left hip without dressing. The wound was small (about the size of a dime) and red. Review of the resident's current care plan dated 3/6/15 revealed the following: - The resident resisted care at times and was always disoriented. - The resident can become agitated with incontinent care, bathing and hygiene. - The resident was totally dependent for toileting, bathing, dressing and personal hygiene and required extensive assistance with	D 338		

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transferring.

Confidential staff interviews revealed the following:
- 1st staff stated the resident was incontinent of bowel and bladder and was very difficult to bathe. The resident was not repositioned every 1-2 hours when in bed or up in wheel chair.
- 2nd staff stated some staff did not like to change the resident because she was combative.
- 3rd staff stated the resident was incontinent of bowel and bladder and required incontinence care provided by the facility staff but do not know how often incontinence care was provided.
- 4th staff stated resident was incontinent of bowel and bladder and open area of hip occurred a few days ago. The resident need to be changed (incontinent care) more than every 2 hours. Sometimes the resident was left wet in bed and chair.
- 5th staff stated, some staff did not like to provide care (including incontinence care) to residents who were combative and Resident #6 was often left with soaked brief on often at end of shift.

Interview with a 3rd shift medication aide (MA) on 3/18/15 at 9:10am revealed the following:
- Resident #6 had a "bad" body odor due to she was incontinent of bowel and bladder and was often left for long periods in soaked briefs.
- The resident was combative during showers/baths and the staff had difficulty providing care (baths and changing briefs).
The resident was not being repositioned every 2 hours in bed or when in wheelchair.

Review of the facility "Care Notes" for Resident #6 revealed the following documentation:
- On 3/12/15, a staff documented a local home

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health agency was " notified for mobility evaluation also requested nursing evaluation for open area to left hip. Top layer of skin peeling back. Surrounding skin pink and blanching. Resident scratching area when assessed by this writer. MD was faxed with update by 11-7-medication technician. Area covered with dressing to protect it " .
- On 3/13/15, a local home health agency physical therapist documented " Small wound on left hip area, will request nursing evaluation for treatment " .
- On 3/17/15, a local home health agency documented skilled nursing to " assess the need for wound care: 2 wounds noted left post thigh measuring 1.5x0.5x0.1 and 0.5x0.5x0.1. All stage II. Wound care to all three areas, clean with soap and water. Apply hydrocolloid " .
- On 3/18/15, a local home health agency physical therapist documented " patient required total assistance for repositioning in chair to decrease skin breakdown to sacrum. Sitting upon arrival.
- On 3/18/15, facility staff documented resident required 2 hour checks done; very hard to move her " .
- On 3/19/15, a local home health agency nurse documented " duoderm to left posterior thigh and left hip dislodged. Both wounds cleaned with NS [normal saline] and duoderm reapplied. Pt [patient] needs strict off-loading of the left hip. Duoderm will need to be replaced by the memory care unit staff prn [as needed] dislodgement.

Interview with the facility's MCC on 3/20/15 at 12:30pm revealed the following:
- The resident should be receiving incontinent care or assessed to the bathroom every 2 hours.
- If resident was developing wounds, maybe

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D 338	Continued From page 87 incontinence care and repositioning should be done more often. - The MCC stated she was not sure if the facility had a policy for repositioning and incontinence care of residents with decubitus. - The MCC stated she was not sure if the resident's incontinence care was being done. According to the facility's Plan of Protection dated 3/17/15, the staff will be educated on ways to provide better care for residents, including talking to the residents instead of just walking by the residents for wellness checks starting today. The facility will enforce staff compliance of policies and procedures involving wellness checks and incontinent care. The facility will ensure staff provides more than just verbal offers of care such as bringing food to resident to see/smell food instead of just asking if she/he wants to eat. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 19, 2015	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 88 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 5 residents (#2, #6 and #12) observed during the medication pass and 2 of 3 sampled residents (#3 and #4), which included errors with the administration of potassium chloride, Quinine and Vitamin D Super Strength. The findings are: 1. The medication error rate was 14% as evidenced by the observation of 5 errors out of 35 opportunities during the 8:00 am medication passes on 03/18/15 and 03/20/15. A. Review of Resident #2's current FL-2 dated 02/06/14 revealed: - Diagnoses included dementia with psychosis and Parkinson's disease. Review of physician's orders revealed: - Order dated 12/08/14 for Ketoconazole 2% cream (used for skin infections) 2 times a day. - Clarification order to physician dated 12/11/14 to apply Ketoconazole 2% cream to perineal area 2 times a day. Observation during the 8:00am medication pass on 03/18/15 revealed: - Staff C medication aide (MA) administered only oral medications to Resident #2. - Resident asked to have her topical medications applied when she returned to her room. - Resident returned to her room to have her topical medications applied at 10:15am.	D 358		

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D 358	Continued From page 89 - Staff C did not administer the Ketoconazole cream to Resident #2. Interview with medication aide on 03/18/15 at 10:15am revealed: - She had not administered the Ketoconazole to the resident because she did not know the location the topical cream was ordered to be applied. - She had not administered the medication to the resident in the three weeks she worked in the memory care building, because she did not know where the medication was to be administered. - The MCC and Wellness nurse were responsible for getting medication order clarifications. - She checked, but had not been able to find a clarification for the Ketoconazole in the resident record. Interviews with 3 MAs revealed, two out of the 3 MAs did not know the location to administer the Ketoconazole 2% cream. Review of the March 2014 MAR for Ketoconazole 2% cream revealed: - The medication was not administered on 19 out of 35 occasions. - The MAs who did know the location to apply the Ketoconazole documented resident " refused " on 17 of the 19 occasions the medication was documented not given. Review of physician orders revealed: - The MA sent a note to the physician 3/18/15 saying the cream was no longer needed. - The physician discontinued the Ketoconazole 2% cream on the afternoon of 3/18/15. Refer to Interview with the administrator on	D 358		

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D 358	Continued From page 90 3/20/15 at 12:15pm. B. Review of Resident #6's current FL-2 dated 2/18/14 revealed: - Diagnoses included dementia, diabetes, and hypertensive heart disease without congestive heart failure. Review of physician orders for Klor-con 10mEq 1 tablet daily (used to prevent or to treat low blood levels of potassium). Observation of the 8:00am medication pass on 3/20/15 revealed: - The MA crushed Resident #6's medications, mixed it up in pudding and administered. - The Klor-con 10mEq ER tablet was one of the tablets administered in pudding. Interview with the medication aide on 3/20/15 at 9:05am revealed: - She had been working alone on the medication cart administering medications since 3/13/15. - She crushed all of Resident #6's medications every day she worked. - When she was being trained Staff C crushed all of the medications for Resident #6 Klor-con and all, so she was just doing as she had been trained to do. - She did not know if there was a physician order giving permission to crush medications. - She did not know a physician order was required to crush medications. - She was not aware there were medications that could not be crushed. - She did not know potassium could not be crushed. - She did not know Klor-con could not be crushed.	D 358		

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D 358	Continued From page 91 Interview with the MCC on 3/20/15 at 9:13am revealed: - She was not sure if there was an order to crush medications for Resident #6 or not. - Staff C had been working on getting a crush order from the physician. - When the facility staff get a physician order permitting them to crush resident's medications, the physician tell them to check with pharmacy to see what medications can be crushed and what medications cannot be crushed. - She will complete a medication error sheet and notify the pharmacy and the doctor of the error immediately. - Staff D had just recently been signed off by the nurse to administer medications on her own. - She had administered medications to Resident #6 and she swallowed them just fine for her, so she was curious as to why they would need to crush her medications. - She does not think Staff D is " safe to administer medications independently " . - Staff D shadowed Staff C during training and Staff D saw Staff C crushing the medication so she thought it was safe to crush. Interview the facility's pharmacist on 3/20/15 at 9:18am revealed: - Potassium tablets are never to be crushed "it can eat up the esophagus ". - Any tablet labeled ER is never to be crushed, it releases the medication into the bloodstream slowly. - The expectations is the facility would check with pharmacy before crushing medications for clarity prior to crushing any medication. Refer to Interview with the administrator on 3/20/15 at 12:15pm.	D 358		

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D 358	Continued From page 92 C. Review of Resident #12's current FL-2 dated 10/24/14 included diagnoses of dementia, diabetes, hypertension, renal insufficiency, hyperlipidemia and osteoarthritis. 1. Review of a physician's order dated 12/9/14 revealed: - Miralax (a laxative) 17gm/1 dose powder fill cap with powder and mix in 8 oz. of fluid and drink daily ordered. Review of physician orders dated 2/9/15 revealed: - Miralax discontinued. - Pericolace 1 daily ordered (Pericolace relieves constipation). Observation of the 8:00am medication pass on 3/18/15 revealed: - Staff C administered 17gm of Miralax to Resident #12. - Staff C did not administer the Pericolace to Resident #12. Interview with medication aide on 3/18/15 at 12:05pm revealed: - She withheld the Pericolace because she had received a note from the MCC saying Pericolace was to be withheld because she had an order change. - She was not aware the Miralax order had been discontinued. Interview with the MCC on 3/18/15 at 11:20am revealed: - The Pericolace had not been delivered by pharmacy. - The pharmacy said it was delivered on 2/28/15, but the staff at the facility said they did	D 358		

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D 358	Continued From page 93	D 358		

not receive it.
- The MA was told on 3/12/15 it could not be reordered at this time since the medication had already been dispensed.
- She would call and inform the physician of the medication being unavailable.

Review of the administration history for the Pericolace revealed the Pericolace had not been administered 2/19/15 through 3/18/15.

2.Review of a physician's order dated 3/11/15 revealed an order for Ferrous Sulfate (used to treat iron deficiency) 220mg/5ml solution take 3.8 ml (159 mg)by mouth two times daily with meals.

Observation of the 8:00 medication pass on 3/18/15 revealed:
- The Ferrous Sulfate was poured into a medication cup to the 2.5ml fill line and administered to resident #12.
- The medication cup used did not have a measurement for 3.8 ml.
- Staff C did not use a dropper to measure 3.8 ml (159 mg) of ordered medication.

Interview with medication aide on 3/18/15 at 12:05pm revealed:
- She always poured the medication in the medication cup and administered the first line on the medication cup.
- She had never used a dropper to measure the Ferrous Sulfate for Resident #12, because a dropper did not come with the medication, so she did not think she needed one.
- She did not call pharmacy and request a dropper.

Interview with the MCC on 3/18/15 at 11:20am revealed:

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D 358	Continued From page 94 - She had not seen any medication dropper on the medication cart. - It was her understanding the MAs were taught to measure exact liquid dosages in small amounts in a dropper, because that was what she was taught. - No one had come to her to request a dropper for the Ferrous Sulfate for Resident #12. Refer to interview with the administrator on 3/20/15 at 12:15pm. _____ Interview with the Administrator on 3/20/15 at 12:15pm revealed: - At one point she and the MCC were discussing taking Staff C off of the medication cart and putting her on the floor to work as a patient care aide (PCA). - They knew she was documenting patient refuse, when she did not have the medication available. - They had discussed looking into making 2 of the more seasoned MAs official trainers for all new staff. - Instead of new staff shadowing MAs assigned that day, they would assign the new MAs to shadow the official trainers. 2. Review of Resident #3's Current FL-2 dated 9/16/14 revealed: - Diagnoses included diagnoses of Alzheimer's, dementia, depression, esophageal reflux, osteoarthritis and headache with dizziness. Review of Physician order dated 12/11/14 for Lidoderm patch 5% 700 mg 1 every 24 hours 12 hours on 12 hours off apply to right knee (used to reduce sharp/burning/aching pain) .	D 358		

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D 358	Continued From page 95 Review of Resident #3's record revealed: - There was documentation of rejection of insurance for Lidoderm Patch 5% 70mg dated 2/25/15. - There was a physician's order dated 3/5/15 to discontinue Lidoderm patch 5% 70mg adhesive patch. Review of pharmacy dispensing records for Resident #3 from 12/1/14 through 3/19/15 revealed: - Lidoderm 5% 70mg adhesive (30) patches were delivered to the facility on 12/12/14 at 10:19pm. Review of Resident #3's December 2014 medication administration record (MAR) revealed: - Staff documented pharmacy notified awaiting delivery on 12/13/14 at 8:36pm. - Staff documented Lidoderm Patch 5% 70mg administered 11 times in December 2014 (beginning 12/14/14 through 12/31/14). - Staff documented resident refused Lidoderm Patch 5% 70mg 7 times (between 12/13/14 and 12/31/14). - Staff documented withheld per physician order for Lidoderm Patch 5% 70mg 2 times (between 12/13/14 and 12/31/14). - Staff documented physically unable to take Lidoderm Patch 5% 70mg 2 times (between 12/13/14 and 12/31/14). Review of Resident #3's January 2015 MAR revealed: - Staff documented Lidoderm Patch 5% 70mg administered 16 times (between 2/1/15 and 2/18/15). - Staff documented pharmacy notified, awaiting delivery of Lidoderm Patch 5% 70mg (every day between 1/19/15 and 1/31/15).	D 358		

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D 358	Continued From page 96 Review of Resident #3's February 2015 MAR revealed: - Staff documented Lidoderm Patch 5% 70mg not administered in February 2015. - Staff documented resident refused Lidoderm Patch 5% 70mg 24 times (between 2/1/15 and 2/28/15. - Staff documented pharmacy notified, awaiting delivery of Lidoderm Patch 5% 70mg 27 times (between 2/1/15 and 2/28/15). - Staff documented withheld per physician order for Lidoderm Patch 5% 70mg 20 times (between 2/1/15 and 2/28/15). Review of Resident #3's March 2015 MAR revealed: - Staff documented Lidoderm Patch 5% 70mg not administered the entire month of March 2015. - Staff documented resident refused Lidoderm Patch 5% 70mg 1 time 3/6/15 at 9:20am. - Staff documented withheld per physician order for Lidoderm Patch 5% 70mg 3 times (between 3/1/15 and 3/9/15). - Staff documented pharmacy notified, awaiting delivery of Lidoderm Patch 5% 70mg 14 times (between 3/1/15 and 3/9/15). Interview with the MCC on 3/19/15 at 5:45pm revealed: - She was unable to provide fax confirmations of her faxes sent to the physician unanswered to inform him of the insurance refusing to refill the medication. - She was aware staff had on occasion documented resident refused when the Lidoderm patches were not in the facility. - The Lidoderm patches were only delivered to the facility one time and that was in December 2014.	D 358		

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D 358	Continued From page 97 - The pharmacy contacted the facility to inform them the insurance rejected the medication in February 2015, when they were inquiring about missing medications. - The Lidoderm patches were not discontinued by the physician until 3/5/15. - Staff often document resident refusals , pharmacy notified and withheld per physician order on the electronic MAR, to document medications not administered because they have to choose from the pull down menu and they cannot write in other options. Review of Resident #3's MARs for 12/12/14 to 3/9/15 revealed: - Lidoderm was documented as not applied as ordered 59 of 87 times - Lidoderm was documented as not available for administration 50 of the 59 times not applied. Interview with Resident #3's physician on 3/20/15 at 10:10am revealed: - Resident #3 has significant osteoarthritis of the right knee, which causes a lot of pain. - He just recently discontinued the order for the Lidoderm patch this month, due to problems with insurance. 3. Review of Resident #4's current FL-2 dated 2/19/15 revealed the following: - The resident was admitted on 02/20/15. - The resident had diagnoses of dementia, insulin dependent diabetes mellitus, pernicious anemia, hypertension, cervical arthritis, hyperlipidemia, and coronary artery disease. - Medication orders included Quinine Sulfate 324mg, at bedtime (used to treat leg cramps); Vitamin D Super Strength, 1000 unit, every day	D 358		

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D 358	Continued From page 98 (used to treat Vitamin D deficiency). Review of subsequent orders dated 2/24/15 revealed orders for Quinine 324mg, 1 capsule, at bedtime for diagnosis of muscle cramps and Vitamin D Super Strength 2000 unit tablet, take 1 tablet, every day for diagnosis of Vitamin D deficiency. Review of Resident #4's Medication Administration Record (MAR) for February 2015 and March 2015 revealed the following: - The resident's Quinine documentation for doses not administered was "pharmacy notified, awaiting delivery" every day from 2/20/15 through 3/18/15 except on 2/21/15, 2/22/15, 3/11/15 and 3/17/15 (documented as administered). Interview with the 1st shift medication aide(MA) on 3/18/15 at 11:10am revealed the following: - The facility was awaiting delivery of the resident's Quinine and Vitamin D Super Strength since admission (02/20/15). - The pharmacy was contacted on 3/17/15 regarding delivery of the medications. - The MA has not reported missed medications to the resident's physician. Interview with the resident's pharmacist on 3/18/15 at 11:35 revealed the following: - Resident #4's Quinine has not been dispensed in February or March 2015. (Last dispensed on 1/12/15, 30 day supply). - No dispensing recordings or orders for Vitamin D 1000 units or 2000 units. Review of the pharmacy dispensing records (from January 2015 through March 2015) revealed the following: - The resident's Quinine 260 mg was last	D 358		

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D 358	Continued From page 99	D 358		

dispensed on 01/12/15 (30 day supply) before admission to the facility.
- The resident's Quinine 260 mg was 1st dispensed to the current facility on 3/18/15 (30 day supply) and the resident's Vitamin D, 1,000 units was 1st dispensed to the current facility on 3/18/15 (30 day supply).
- No dispensing records for Quinine 324mg.

Interview with the 3rd shift medication aide (MA on 3/18/15 at 9:10am revealed the following:
- The resident did not sleep well at night and was often out of bed walking throughout facility for hours before going to bed.
- The resident never complained of leg cramps or any pain, but the resident was confused and forgetful.
- The resident's Quinine and Vitamin D was not scheduled to be administered on 3rd shift and the MA was not aware the resident had not received the medications.

Interview with the facility's Memory Care Coordinator (MCC) on 3/18/15 at 3:35pm revealed the following:
- The resident had Quinine 260 mg not Quinine 324 mg (as ordered).
- The medication was taken out of the cart and refill requests for Quinine 324mg and the Vitamin D was faxed to the physician.
- The MCC thought the pharmacy needed a new prescription for both medications because the prescriptions had expired.
- MCC did not fax the current FL-2 to the pharmacy or the subsequent orders dated 2/24/15 to the pharmacy.
- The MCC did not have the original fax document or a copy of the document available.
- The MCC had not contacted the resident's physician to report missed medication.

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D 358	Continued From page 100 - If a resident did not have a current medication available to administer, the physician was to be contacted (usually by fax) as soon as possible. - The facility should not wait 3-4 weeks before contacting the physician. According to the facility's Plan of Protection, a binder will be put in the facility's medication room for copies of all incoming orders, to be reviewed by program manager (MCC) every morning. A binder will also be put in medication room for copies of all outgoing faxes/order requests for the program manager to review and follow up on. Medication aides will be inserviced on the new binders and re-inserviced on current medication tracking policy. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 358		
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 observation, record reviews, 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 the rules and regulations as	D912		

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D912	Continued From page 101 related to tuberculosis skin tests, activities program, and medication administration. The findings are: 1. Based on interview and record review, the facility failed to assure 3 of 3 sampled residents (#1, #3, and #4) were tested for tuberculosis disease upon admission in compliance with the control measures adopted by the Commission for Health Services. [Refer to Tag 0234, 10A NCAC 13F .0703 Tuberculosis Test (Type B Violation)]. 2. Based on observations, interviews and record review, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the memory care facility. [Refer to Tag 0315, 10A NCAC 13F .0905(a)(b) Activities Program (Type B Violation)]. 3. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 5 residents (#2, #6 and #12) observed during the medication pass and 2 of 3 sampled residents (#3 and #4), which included errors with the administration of potassium chloride, Quinine and Vitamin D Super Strength. [Refer to Tag 0358, 10A NCAC 13F .1004(a)(1) Medication Administration (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,	D914		

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D914	Continued From page 102	D914		

neglect, and exploitation.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure all residents were free from neglect related to management of the facility, personal care and supervision, health care and resident rights.

The findings are:

1. Based on observation, and interview and record review, the Administrator and Memory Care Coordinator (MCC) failed to assure that all required duties were carried out in the facility related to the rule areas of housekeeping and furnishings, training on the care of diabetic residents, test for tuberculosis, providing personal care and supervision, health care referral and follow-up, resident activities, medication administration and resident rights. [Refer to Tag 176, 10A NCAC 13F .0601 Management of Facilities (Type A1 Violation)].

2. Based on observations, interview and record review, the facility failed to assure the personal care needs for 4 of 5 sampled residents (Residents #1, #2, #3, and #6) who required assistance with toileting and incontinent care were met, resulting in 2 residents (#1 and 6) developing stage II pressure sores. [Refer to Tag 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)].

3. Based on observations, interviews and record review, the facility failed to provide adequate supervision related to repeated unwitnessed and witnessed falls, falls with injury (Residents #1, #7, and #10), smoking inside and outside of the building (Residents #8) for 4 of 7 sampled

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D914	Continued From page 103 residents. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 4. Based on observation, interview and record review, the facility failed to assure notification of health care provider and follow-up for 3 of 5 sampled residents who had 11 pound weight loss (Resident #1); an ordered neurology consult after falls (Resident #7); and a fall with head injury (Resident #9). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 5. Based on record review and interviews, the facility failed to provide services to maintain the physical and mental health by allowing 2 of 6 sampled residents to lie in urine and feces and not providing personal care service (#1 and #6) resulting in the development of a stage II pressure sores. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights, Type A1 Violation].	D914		