STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE COURTYARDS AT BERNE VILLAGE	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 07/08/15 - 07/10/15.	D 000		
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: Based on record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 5 residents (#5) sampled as related to faxing a resident's weights to the physician as ordered and notifying the physician of a resident's complaint of burning upon urination resulting in the resident being seen at an urgent care two days later and receiving treatment for urinary tract infection. The findings are: Review of Resident #5's current FL-2 dated 02/04/15 revealed: - Diagnoses included dementia, encephalopathy (metabolic versus cerebrovascular accident), hypomagnesemia, and iron deficiency anemia. - The resident was noted to be intermittently disoriented. A. Review of a staff charting note for Resident #5 dated 06/07/15 (Sunday) at 9:40 p.m. revealed: - The resident complained of burning when he uses the rest room. - Staff documented, "first get order for urine	D 273		

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D 273	Continued From page 1 sample". Review of Resident #5's record revealed: - No documentation the resident's physician was contacted about the complaint of burning when urinating on 06/07/15. - No documentation of an order to obtain a urine sample. Review of an incident report dated 06/09/15 (Tuesday) at 1:00 p.m. revealed: - Resident #5's family reported to Resident Care Coordinator (RCC) that Resident #5 told family his roommate threw hot water on him. - The Administrator spoke with roommate who denied throwing water on Resident #5. - The facility's Licensed Practical Nurse (LPN) did a skin assessment on Resident #5 and found no signs of burn. - Water temperature was checked and was 114.7 degrees Fahrenheit. - Resident was sent to urgent care to have area examined. Review of a charting note dated 06/09/15 (Tuesday) at 3:38 p.m. revealed: - Late entry for 06/09/15 at 12:00 noon. - Resident #5 said he went to take shower and pulled curtain back and a man threw water on him. - Resident #5 said he was not sure if it was hot or cold water. - Resident #5 was asked if he was having pain when he urinates and he said yes. - Resident went to urgent care to be evaluated. Review of a charting note dated 06/09/15 (Tuesday) at 8:57 p.m. revealed: - Late entry for 06/09/15 at 12:00 noon. - Resident #5's family reported the resident had	D 273		

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hot water thrown on him by his roommate.
- The family member also reported Resident #5 had a burning sensation when urinating.
- The facility did a skin assessment and checked the water temperature prior to the resident going to urgent care.
- Staff documented they contacted urgent care to request they do a urinalysis.

Review of a staff charting note for Resident #5 dated 06/09/15 (Tuesday) at 2:59 p.m. revealed:
- The resident was sent to urgent care.
- The resident complained of burning sensation while urinating.

Review of a facility staff note to the local urgent care dated 06/09/15 revealed facility staff wrote a note to "please check for possible urinary tract infection".

Review of a charting note dated 06/09/15 (Tuesday) at 3:37 p.m. revealed Resident #5 returned to the facility at 3:30 p.m. with order for two medications.

Interviews with the Resident Care Coordinator (RCC) on 07/10/15 at 2:52 p.m. and 3:30 p.m. revealed:
- She was unaware Resident #5 had complained of burning with urination on 06/07/15.
- She would have worked on the next day, 06/08/15, but did not recall staff reporting it to her on that day.
- Personal care aides were supposed to report any resident concerns to the medication aide on duty.
- The medication aide should document any concerns and verbally pass on the information to the next shift.
- The oncoming shift staff should review

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documentation from the previous shift then pass the information along to the RCC and LPN.
- There was no follow-up to the Resident #5's complaint of burning with urination on 06/07/15 to her knowledge.
- After the facility reported Resident #5's concerns of being burned on 06/09/15, the facility and family made a joint decision to send the resident to urgent care.
- The resident was also checked for a urinary tract infection while at urgent care on 06/09/15.

Interview with the facility's Licensed Practical Nurse (LPN) on 07/10/15 at 2:45 p.m. revealed:
- She was unaware Resident #5 had complained of burning with urination on 06/07/15.
- She did not recall anyone reporting it to her on Monday, 06/08/15, when she returned to work.
- If it had been reported to her on 06/08/15, she would have contacted the physician and documented it in the notes.

Interview with a medication aide on 07/10/15 at 3:00 p.m. revealed:
- A personal care aide had reported to her on 06/07/15 that Resident #5 complained of burning when he used the bathroom.
- She documented it in the notes.
- She could not recall if she passed the information to the next shift.
- She was unsure if anyone contacted the physician on Monday, 06/08/15, to get an order for a urine sample.
- She thought they checked the resident's urine when he went to urgent care on 06/09/15 related to family complaints.

Review of the urgent care visit form dated 06/09/15 revealed:
- Resident was with a family member and was

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being seen for multiple complaints.
- Physician noted trying to get a history from Resident #5 proved to be confusing.
- The resident initially stated he was not having any pain with urinating but then stated later in the interview that he was having pain with urination.
- No increased urinary frequency or hematuria.
- There was no penile discharge but resident stated his penis was tender to palpation.
- There was no redness or penile lesions.
- There was a 1cm circular erosion-like wound on the left medial proximal upper leg.
- There was no redness, swelling, exudate, or tenderness to the wound.
- Physician noted in the assessment area that resident may have bladder infection as well as urethritis and left leg wound etiology uncertain.

Review of a summary form from the urgent care visit dated 06/09/15 revealed:
- Reason for visit noted was urinary tract infection / back pain.
- Resident was diagnoses with urinary tract infection, left thigh wound, and scrotal masses.

Review of urgent care physician's form dated 06/09/15 revealed:
- An order for Doxycycline 50mg twice daily for 10 days. (Doxycycline is antibiotic for infection.)
- An order for Mupirocin 2% Ointment, apply sparingly to affected area twice a day. (Mupirocin is used to treat skin infections.)
- An order to clean wound daily with warm soapy water.

Interview with the urgent care physician on 07/09/15 at 4:20 p.m. revealed:
- Resident #5 was brought to the urgent care by a family member.
- The resident changed his story regarding an

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incident with his roommate.
- The resident had one small area on his inner thigh that looked like an erosion.
- It could have been a burn but there was no other wounds around it.
- It could have been a friction burn.
- If water had been thrown on the resident, there would have been more wounds around it.
- He did not recall seeing any injuries on the resident's penis.
- The resident was treated for urinary tract infection.

Interview with Resident #5 on 07/08/15 at 3:20 p.m. revealed:
- The resident did not know if he ever had a urinary tract infection.
- When asked about any current urinary symptoms, the resident did not answer and started talking about something else.

Interview with the Administrator on 07/10/15 at 4:15 p.m. revealed:
- She was new at the facility and was not working at the facility when the resident complained of urinary symptoms on 06/07/15.
- Staff should report resident concerns to the RCC or LPN so the physician can be contacted for follow-up.

B. Review of a note to Resident #5's primary physician dated 04/17/15 revealed:
- The following weights were noted: 150.6 pounds in February 2015; 133.4 pounds in March 2015; and 162.2 pounds in April 2015.
- Facility staff noted there was a discrepancy in the weights due to scale but April 2015 was accurate from new scale.
- The physician responded with an order to weigh the resident once a week and fax the weights to

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D 273	Continued From page 6 the physician in 2 months. Review of the May 2015 medication administration record (MAR) revealed the following weights: - 05/02/15 - 161.6 pounds. - 05/09/15 - 163.4 pounds. - 05/16/15 - 145 pounds. - 05/23/15 - 158.4 pounds. - 05/30/15 - 161.8 pounds. Review of the June 2015 MAR revealed the following weights: - 06/06/15 - 162 pounds. - 06/13/15 - not weighed - leave of absence. - 06/20/15 - 161 pounds. - 06/27/15 - 161 pounds. Review of the July 2015 MAR revealed the following weights: - 07/04/15 - 160 pounds. Review of Resident #5's record revealed no documentation the resident's weights had been faxed to the physician in two months as ordered on 04/17/15. Interview with the facility's Licensed Practical Nurse (LPN) on 07/10/15 at 2:45 p.m. revealed: - She just recently started working at the facility and she was not working here when the order to fax Resident #5's weights was received in April 2015. - She did not know how the previous nurse tracked her orders. - The LPN stated she would fax the weights to the physician today.	D 273		

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D935	Continued From page 7	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 8 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 5 medication aides sampled (B, E) who performed medication aide duties met the requirements to administer medications. The findings are: 1. Review of Staff E's employee file revealed: -He was hired as a medication aide on 06/02/15. -He passed the state medication aide written exam on 10/30/14. -He completed the medication clinical skills checklist on 06/24/15. -There was no documentation of completion of the 5-hour, 10 hour, or 15 hour state medication aide training courses. Review of the June and July 2015 MARs revealed Staff E administered medications from 06/24/15 to 07/08/15. Interview on 7/10/15 at 1:30 p.m. with the Resident Care Coordinator revealed: -Staff E was on today's second shift schedule as a medication aide. -She stated Staff E was also employed as a medication aide at another assisted living facility nearby. -She stated Staff E had worked as a medication aide at the other facility prior to his hire date at this facility. -She stated his medication aide training was verbally verified by his previous employer prior to	D935		

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employment.
-She could not provide a name of the person in this facility who verified his medication aide training at the previous employer.
-She was unable to locate the paperwork to verify his training.
-She would call the other assisted living facility to have them fax confirmation that he worked as a medication aide.

Interview on 7/10/15 at 2:30 p.m. with the facility's former administrator revealed:
-Staff E's other employer would not confirm that Staff E worked as a medication aide.
-She was only able to confirm his current role at the other facility was in housekeeping.
-She did not know Staff E needed the 5 hour training in addition to passing the medication aide written exam.

Interview on 07/10/15 at 4:10 p.m. with Staff E, medication aide (MA) revealed:
-He was hired on 06/02/15 for the position of Medication Aide.
- He last administered medications to residents 2 days ago on Wednesday, 07/08/15, on second shift.
- He had worked for the facility as a MA for 1-1/2 months and did not realize until today the required 15 hour medication administration training documentation was not in his personnel folder.
- He had worked as a MA at another assisted living facility just prior to coming to work at this facility.
-He primarily worked in housekeeping at the other facility.
- He completed the 15 hours medication administration training at the previous facility and had passed the state exam for medication

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D935	Continued From page 10	D935		

administration.
- He was in the process of trying to get his previous employer to release the documentation.

Refer to interview with the Business Office Manager (BOM) on 07/10/15 at 1:53 p.m.

2. Review of Staff B's employee file revealed:
- Staff B was hired on 10/15/14 as a personal care aide and medication aide (MA).
- Staff B completed the 15 hour medication training on 04/15/15.
- Staff B completed the medication aide clinical skills checklist on 04/15/15.
- No documentation of Staff B passing the medication aide written exam.

Interview with the Administrator on 07/08/15 at 10:45 a.m. revealed:
- Two medication aides were working on first shift that morning on 07/08/15.
- Staff B was one of the medication aides administering medications that morning on 07/08/15.

Interview with the Resident Care Coordinator (RCC) on 07/08/15 at 11:50 a.m. revealed:
- Staff B had been pulled off the medication cart because they were waiting on Staff B's paperwork.
- Staff B had not administered medications since last week.
- RCC was unsure what kind of paperwork they were waiting on for Staff B.

Interview with a medication aide on 07/08/15 at 12:10 p.m. revealed:
- Staff B had been pulled from the cart that morning on 07/08/15.
- Staff B's paperwork had expired.

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D935	Continued From page 11 - She was unsure what kind of paperwork had expired for Staff B. Review of the May 2015, June 2015 and July 2015 medication administration records revealed: - Staff B administered medications in all 3 months. - Staff B last administered medications on 07/08/15. Interview with Staff B on 07/09/15 at 2:25 p.m. revealed: - She took the medication aide written exam in November 2014. - She thought she had passed the exam. - She has rescheduled to take the exam again on next Friday, 07/17/15. - She was pulled from the medication cart last week. - She administered medications yesterday morning on 07/08/15 to help the other medication aide because she was so busy and needed help. Interview with the former Administrator on 07/10/15 at 1:10 p.m. revealed: - She was no longer the Administrator at the facility but she was helping the new Administrator transition into her new position. - She was auditing personnel records about a week ago and discovered Staff B was missing the medication aide written exam requirement. - Staff B was pulled from the cart last week and should not have been administering medications on 07/08/15. - The Business Office Manager was responsible for tracking personnel files. - She did not know how the medication exam requirement was overlooked for Staff B. Interview on 7/10/15 at 1:53 p.m. with the	D935		

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D935	Continued From page 12 Business Office Manager (BOM) revealed: - The BOM was not aware Staff B had not passed the medication aide exam. - Two weeks ago an audit was done of all employees records and it was noted that Staff B had not done the testing for medication administration. - Staff B told the RCC there was a paper mix up and Staff B did not take the exam. - The Administrator pulled Staff B off the medication cart 2 weeks ago. Refer to interview with the Business Office Manager (BOM) on 07/10/15 at 1:53 p.m. Interview on 7/10/15 at 1:53 p.m. with the Business Office Manager (BOM) revealed: - The BOM was responsible for setting up the computer training for new employees. - For medication aide positions, the health care personnel and medication aide registries were consulted. - For on the job training, a nurse worked with the medication aides, and was also responsible for the 5,10,15 hour trainings. - If a medication aide had not passed or taken the state exam, a "tickler" (reminder) was placed on the calendar to remind the employee that they had to complete the exam. - The BOM was not employed until 02/02/15 and the facility "tickler" system was not in place until then. - The Administrator was in the process of developing a system for auditing medication aide requirements and a checklist had been developed to assure staff were in compliance with the regulations.	D935		