Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: _____ B. WING _____	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 10, 2016 - May 11, 2016.	D 000		
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. This Rule is not met as evidenced by: Type A2 Violation Based on observations, record reviews and interviews, the facility failed to assure assistance with transfers and ambulation was provided to 1 of 2 sampled residents (Resident #5) who required extensive assistance from staff and could not reach her call bell to request assistance, resulting in multiple falls. The findings are: Review of Resident #5's current FL-2 dated 11/24/15 revealed: - Diagnoses included Hypertension, Dementia, History of Urinary Tract Infections, Hypothyroidism, Gastroesophageal Reflux Disease, and Sleep Apnea. - The resident was semi-ambulatory and utilized a wheelchair. - The resident required assistance with bathing, feeding, and dressing. - The resident was incontinent of bowel and bladder.	D 269	Plan of correction for all rule areas attached 06.21.16 P. Ostapowicz	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patty Ostapowicz — TITLE: Regional Director — (X6) DATE: 6.21.16

STATE FORM 6899 CQ1211 If continuation sheet 1 of 32

Reviewed and Accepted 6/22/16 JPL, RN

The Village Of Kinston
HAL-05-44-067
Plan of Correction
DHSR Survey 5/11/2016

10A . 13F .0901(a)

(a) Adult care homes shall provide personal care to residents according to the residents' care plans to residents according to the residents' care plans and attend to any personal care needs residents may be unable to attend to for themselves.

Plan of Correction

- Resident #5 care plan and other residents care plans were reviewed and updated as needed. 5/11/2016
- Staff were trained on providing care per the residents needs identified on the care plan and identified on the personal care aide task sheets 5/11/2016- 5/12/2016
- As new residents are admitted the or changes of status are completed with the care plan Administrator/RCC or designee will train staff on the care plan needs of the resident. 5/11/2016 & ongoing

Monitoring System

- For Two weeks and randomly thereafter, the Administrator/ RCC or designated staff will check on the residents for each shift to ensure staff were addressing needs as identified on the residents care plan. Staff members assigned will be talked with by the Administrator/RCC or designated staff member to assure staff knew the needs of the resident and that staff were providing the care. 5/11/2016 & ongoing
- As new residents are admitted or changes of status are completed with the care plan Administrator/RCC or designee will train staff on the care plan needs of the resident. 5/11/2016 & ongoing
- Administrator/RCC/SIC or designee will randomly check on residents check on residents (talk with staff member who is assigned to work with him/her and with the resident) to ensure staff is addressing needs as identified on the care plan. 5/11/2016 & ongoing

10 NCAC 13F. .0902 Health Care (b) The Facility shall assure referral an follow up to meet the routine and acute health care needs of residents.

Plan of Correction

- Staff shall be retrained on referral and follow up based on residents needs or orders. 5/11/2016-5/13/2016
- Changes in residents medical conditions/status is reported to assure procedures are followed for referral and follow up. 5/11/2016 & ongoing
- Resident #5 physician was notified of falls and a chair alarm was implemented. 5/11/2016 & ongoing
- Resident #5' room was rearranged to allow resident access to her call bell. 5/13/2016

Monitoring System

- Resident care coordinator will complete random chart audits weekly to assure referral and follow up is being completed to the meet the routine and acute health care needs of residents. 5/11/2016 & ongoing
- Order notebook in place for RCC to review daily to assure orders are followed and referrals made as necessary. 5/11/2016 & ongoing
- Regional director/ED will randomly audit records to assure that orders are followed at the time of the order and referrals are made to meet the routine and acute health care needs of the residents. 5/11/2016 & ongoing
- Staff will check chair alarm to ensure it is working and applied correctly throughout each shift. 6/21/2016 & ongoing

10A NCAC 13F. .0905 (d) Activities Program

There shall be a minimum of 14 hours of a variety of planned and group activities per week that include activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each residents involvement in a variety of activities. Example of group activities are group singing, dancing games, exercise classes, seasonal parties, discuss groups,

drama, resident council meetings, book reviews, music appreciation, review of current event and spelling bees.

Plan of Correction

- Start and end times of all planned activities to reflect 14 hours of weekly planned activities shall be added to the monthly calendar. 5/13/16 & ongoing
- Activities shall reflect the preferences of the residents per variety of activities based on regulations. 6/1/2016 & ongoing
- Residents will assist in planning activities by offering input during the monthly resident council meeting. 6/1/2016 & ongoing

Monitoring System

- Activities Calendar shall be reviewed by the corporate Life Enrichment Director 2 weeks prior for the month upcoming to assure a variety of activities are offered and that there are 14 hours of planned activities weekly. 5/15/2016 & ongoing
- Director/ Regional/Designee shall randomly interview residents to assure that activities are being scheduled and happening per their preferences. 6/21/16 & ongoing
- Director/Regional/ Designee shall review activity participation logs to assure that activities are offered and participation is occurring. 6/21/2016 & ongoing

10 NCAC 13F .1004(a) 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) prescribing practitioner which are maintained in the resident's record; and (2) rules in this section and the facility's policies and procedures.

Plan of Correction

- Residents # 6 & #7 are receiving medication as ordered. 5/12/16 & ongoing
- Staff shall be retrained on administering medications are ordered and obtaining clarification of orders when a resident prefers medications be given different from what is ordered.

Monitoring System

- Administrator/Regional/ Designee shall preform random medication pass audits monthly to assure that medications are administered as ordered. 6/21/2016 & ongoing
- Any staff found not following proper medication administration shall be disciplined to include, re-training, written warnings and up to termination from being a medication. 6/21/2106 & ongoing

10 NCAC 13F. 1308(a) Special Care Unit Staff (a) staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff for up to 10 residents on third and .8 hours of staff time for each additional resident.

Plan of Correction

- Administrator shall assure that Staff are scheduled to meet the staffing requirements for census in the Special Care unit. 6/11/2016 & ongoing
- Implementation of a staffing log that will show where staff are assigned while on duty for each shift. 6/22/2016 & ongoing

Monitoring System

- Regional Director/Designee shall randomly monitor staffing through tours , punch report reviews and random interviews with staff to assure that the SCU is staffed according to regulation. 6/22/2016 & ongoing
- Regional Director/Designee will review staffing logs monthly to assure staff are assigned to designated areas to cover staffing requirements. 6/22/2016 & ongoing

10 NCAC 13F. 1308(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in paragraph (a) of this rule for units 15 or fewer residents.

Plan of Correction

- Administrator shall assure that the SCU coordinator is staffed 8 hours a day 5 days week. If the SCU Coordinator is not available another staff member (who has been trained as SCU Coordinator) shall be staffed in the SCU. 5/13/2016 & ongoing
- Implementation of a staffing log that will show that the SCU was covered by the SCU Coordinator 8 hours a day for 5 days a week.

6/22/2016 & ongoing

Monitoring System

- Regional Director/Designee shall randomly monitor the SCU to assure that the SCU is staffed with a SCU Coordinator at least 8 hours a day 5 days a week. 6/22/2016 & ongoing

10 NCAC 13F. 1309 The facility shall assure that special care unit staff receive at least the following orientation and training:

(1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources evaluations and schedules regarding training achievements. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this subchapter and the six hours of orientation required by this rule (4) staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

Plan of Correction

- Executive Director retrained on staffing requirements. 5/12/2016

- Executive Director will continue to use the new hire orientation and checklist that list staff required training for SCU. 5/11/2016 & ongoing
- SCU staff records shall be audited to assure orientation and training have been completed per licensure rules. 6/1/2016 & ongoing
- Any staff identified as not having training will receive training. 6/1/2016 & ongoing

Monitoring Plan

- ED/Regional Director shall randomly audit staff training records to assure that staffing orientation and training is completed. 6/1/2016 & ongoing

G.S 131 D-21(2) 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.

Plan of Correction

- Resident #5 care plan and other residents care plans were reviewed and updated as needed. 5/11/2016
- Staff were trained on providing care per the residents needs identified on the care plan and identified on the personal care aide task sheets 5/11/2016- 5/12/2016
- As new residents are admitted the or changes of status are completed with the care plan Administrator/RCC or designee will train staff on the care plan needs of the resident. 5/11/2016 & ongoing

Monitoring System

- For Two weeks and randomly thereafter, the Administrator/ RCC or designated staff will check on the residents for each shift to ensure staff were addressing needs as identified on the residents care plan. Staff members assigned will be talked with by the Administrator/RCC or designated staff member to assure staff knew the needs of the resident and that staff were providing the care. 5/11/2016 & ongoing

- As new residents are admitted or changes of status are completed with the care plan Administrator/RCC or designee will train staff on the care plan needs of the resident.
  5/11/2016 & ongoing
- Administrator/RCC/SIC or designee will randomly check on residents check on residents (talk with staff member who is assigned to work with him/her and with the resident) to ensure staff is addressing needs as identified on the care plan and that residents are receiving care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations.
  5/11/2016 & ongoing
- Any staff identified as not following procedures to assure health care needs are met and residents rights are not violated shall be retrained, receive a written warning up to termination.
  5/11/2016 & ongoing

G.S. 131D-21(4) Every resident shall the following rights: to be free of mental and physical abuse, neglect and exploitation.

Plan of Correction

- Staff shall be retrained on referral and follow up based on residents needs or orders.
  5/11/2016-5/13/2016
- Changes in residents medical conditions/status is reported to assure procedures are followed for referral and follow up.
  5/11/2016 & ongoing
- Resident #5 physician was notified of falls and a chair alarm was implemented.
  5/11/2016 & ongoing
- Resident #5' room was rearranged to allow resident access to her call bell. 5/13/2016

Monitoring System

- Resident care coordinator will complete random chart audits weekly to assure referral and follow up is being completed to the meet the routine and acute health care needs of residents.
  5/11/2016 & ongoing

- Order notebook in place for RCC to review daily to assure orders are followed and referrals made as necessary.
  5/11/2016 & ongoing
- Regional director/ED will randomly audit records to assure that orders are followed at the time of the order and referrals are made to meet the routine and acute health care needs of the residents.
  5/11/2016 & ongoing
- Staff will check chair alarm to ensure it is working and applied correctly throughout each shift.
  6/21/2016 & ongoing
- Director/Regional Director shall audit records and random interviews of staff/residents to assure that residents are free of neglect regarding health care. 6/21/2016 & ongoing
- Any staff identified as not following procedures to assure health care needs are met and residents rights are not violated shall be retrained, receive a written warning up to termination.
  6/21/2016 & ongoing

Kathy Ostapowicz
Signature / Executive Director

06.21.16
Date

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D 269	Continued From page 1	D 269		

Review of the Care Plan for Resident #5 dated 08/07/15 revealed:
-The resident required extensive assistance from staff for all care except eating.
-Extensive assistance was required for transfers and toileting.
-The resident required limited assistance with eating.

Review of the Resident Register revealed Resident #5 was admitted to the facility on 01/30/14.

Observation of Resident #5 ' s room on 05/10/16 at 9:45 a.m. revealed:
-Her recliner was in front of the dresser with her wheelchair parallel to it, chair arm to chair arm.
-The call bell was on the opposite wall behind her recliner which was across the room beside her bed.
-The call bell cord was not within reach of where her recliner and wheelchair were positioned in front of the TV on her dresser.

Review of Care Notes and Incident Reports for Resident #5 revealed:
-On 01/06/16, resident called out for help at 8:26 p.m. Staff found resident in her room on the floor. Resident stated she was " okay " and did not want to be evaluated. Vitals taken. No concerns at this time. Guardian will be notified. Executive Director was notified.

-On 01/06/16, according to the Incident Report, resident was found by staff and was assisted back up into her chair. Resident refused to go to the emergency room. No injuries were found.

-On 01/11/16, at 2:56 p.m., the resident complained of pain in her right knee. Resident

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D 269	Continued From page 2 was sent to the emergency room per her request. -On 01/30/16, at 10:15 a.m., the resident had gotten up and fell. Staff heard the resident calling for help. Resident was found on the floor by the toilet in her bathroom. Resident complained she was hurting on her left side. Resident sent to the emergency room. Guardian and Executive Director were notified. -On 2/28/16, at 1:00 a.m., resident was found on her bedroom floor by staff yelling for help. She stated that she was trying to go use the bathroom and knew she should use her call bell when she needed assistance. Resident refused to go to the emergency room. Resident was assessed by the Medication Aide (MA) and vitals taken. Guardian was called and message left. Resident was placed on 15 minute watch for the next 24 hours. -On 02/28/16, according to the Incident Report, the resident fell once up to go to the bathroom. Resident refused to go to the emergency room. No injuries found. -On 03/01/16, resident was found by staff, 11 p.m.-7 a.m., in her room after she had gotten up by herself without assistance and not using her call bell. -On 03/06/16, resident came to staff at 6:00 p.m. to clean and bandage an area on her left arm that was bleeding. She said she had fallen while getting up. Staff conducted a full body assessment and no other injuries were found. Incident report was completed. Staff notified oncoming shift " to keep an eye on her. " On 03/06/16, according to the Incident Report,	D 269		

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resident reported to staff that she slid out of her chair in her room and hit her arm but she was not hurt and was able to get back in her chair. Staff saw a small scrape on her left arm but no other injuries were found.

-On 04/22/16, the resident was found on the floor in her room at 9:40 p.m. by staff. Her head was on the bed rail. Resident was sent to the emergency room " to be checked out. "

-On 04/22/16, according to the Incident Report, the resident was found on the floor in her room by staff. She had hit her head against the bed rail. Resident was sent to the emergency room. Head injury was noted.

Review of an additional Incident report for Resident #5 revealed:
-On 01/04/16, the resident was found on floor by staff.
-She said she slid out of her wheelchair.
-Resident refused to go to the hospital.
-No visible injuries.

Interview with a Personal Care Aide (PCA) on 05/11/16 at 8:34 a.m. revealed:
-Resident #5 needs staff assistance in order to transfer safely.
-The resident does not always ask for staff help and transfers herself.
-She has talked to the resident about calling for staff first and using her call bell.
-She was required to check on residents every 2 hours.
-She checked the residents who were at risk for falls more often than every 2 hours including Resident #5.
-Staff were not asked to check on the resident more often than every 2 hours.

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D 269	Continued From page 4 -No interventions were put in place for Resident 5 after repeated falls except for the 2 hour routine checks. -Resident #5 has had frequent falls and she has talked with her about waiting for staff to come. Second Observation of Resident #5's room on 05/11/16 at 8:50 a.m. revealed: -Call bell cord was hanging on the wall by her bed which was across the room and behind the resident's recliner and wheelchair. -The call bell cord which was on the wall by the resident's bed was not within reach from the recliner or wheelchair which were across the room. -Staff responded within 2 minutes once the call bell cord by the resident ' s bed was pulled by the surveyor. Interview with Resident #5 on 05/11/16 at 2:15 p.m. revealed: -She liked to do as much for herself as she could. -Staff had to help her transfer from her recliner to her wheelchair because she was unsteady and would fall. -She knew she should use her call bell but she could not reach it. -She said she told the staff (but could not identify who) that she could not reach her call bell which was across the room against the wall behind her recliner and wheelchair. -She said she would fall " almost every time " she tried to get up from her recliner without waiting for staff to come. -Staff were good to her but there " were not enough of them to come help her when she wants to get up." -She yelled for help when needed but " it took too long for them to come. "	D 269		

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D 269	Continued From page 5 -Staff have talked with her about using her call bell and to wait for staff to help her before getting up. -She said she would use the call bell more if the cord was longer or she could reach it. Interview with a Medication Aide (MA) on 05/11/16 at 10:08 a.m. revealed: -Resident #5 needed staff assistance in transfers. -She has had frequent falls because she would not ask for staff help or wait for staff to answer her when she called for them. -The resident had a call bell but did not use it much. -Resident #5 liked to do things for herself and would call for staff but mostly after she had fallen. -The resident would yell from her room for staff to come help her. -Staff had talked with her about using her call bell and asking for help first. -Staff were required to check on her every 2 hours. -There was not a Falls Policy at the facility. Interview with a second Medication Aide (MA) on 05/11/16 at 10:32 a.m. revealed: -She was required to perform 2 hour checks on the residents. -She checked on Resident #5 more than what was required because she knew she preferred to do for herself and would fall trying to do so. -The resident needed staff assistance in transfers to aid in preventing her falls. -Resident #5 had a call bell but preferred to yell out for help. -She had talked to the resident and encouraged her to ask for help before transferring herself to her wheelchair.	D 269		

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D 269	Continued From page 6 Interview with the Resident Care Coordinator on 05/11/16 at 4:40 p.m. revealed: -Staff are required to check on all the residents every two hours. -Resident #5 required a staff to assist her in transfers due to falls. -She encouraged the resident to use her call bell or to yell out for help when needed. -Resident #5 had gotten better about asking for help more often. -The facility does not have a Falls Protocol or policy. -Resident #5 was checked on most of the time more often than every 2 hours because staff were always available in the hallways or close by her. -When residents went to the emergency room for a fall, they received 15-minute checks for 72 hours. If a fall occurred with no injury, 15-minute checks were performed for 24 hours. Interview with the Executive Director on 05/11/16 at 5:15 p.m. revealed: -She was aware Resident #5 had frequent falls with and without injury. -Staff were required to perform 2 hour checks on all residents. -Resident #5 had a call bell that she as well as staff have encouraged her repeatedly to use. -She was not aware the call bell cord was too short and the resident could not reach it unless she was in bed. -The resident does yell out for assistance by saying " hello " at times but does not always wait for staff to get to her. -The resident was independent in her mind and preferred to do things for herself. -There was not a Fall Protocol/Policy or a policy regarding call bell use at the facility.	D 269		

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D 269	Continued From page 7 Attempted Interviews with guardian of Resident #5 on 05/10/16 at 11:45 a.m. and 05/11/16 at 1:45 p.m. were unsuccessful. Review of the facility's Plan of Protection dated 05/11/16 revealed: -For the identified resident who has fallen 9 times, along with other residents who have fallen, the care plans will be reviewed immediately by the Administrator, Resident Care Coordinator, Regional Director and updated if needed. -Direct care staff will be trained on each shift over the next several days until all staff have been trained by the Resident Care Coordinator, Administrator, or a designee of the care plan needs for this resident. -The Administrator, Resident Care Coordinator, and/or a designee of the chart will check on resident each shift for two weeks to ensure staff is addressing needs as identified on the care plan. (The people listed will talk with staff member who is assigned to work with her and the resident) -For all other current residents, over the next two weeks, the Administrator, Resident Care Coordinator or designee will train all staff (based on which residents they are assigned to) on the care plan needs. -As new residents are admitted or changes of status are completed with the care plan, Administrator, Resident Care Coordinator or designee will train assigned staff of the care plan needs of the resident. -Administrator, Resident Care Coordinator, SIC or designee will randomly check on residents check on residents (talke with staff member who is assigned to work with him/her and with the resident) to ensure staff is addressing needs as identified on the care plan.	D 269		

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D 269	Continued From page 8 THE CORRECTION DATE FOR THE TYPE A2 SHALL NOT EXCEED JUNE 10, 2016.	D 269		
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 B VIOLATION Based on observation, record review, and interview, the facility failed to notify the physician of a resident's multiple falls resulting in injury and hospital visits for 1 of 2 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 11/24/15 revealed: - Diagnoses included Hypertension, Dementia, History of Urinary Tract Infections, Hypothyroidism, Gastroesophageal Reflux Disease, and Sleep Apnea. - The resident was semi-ambulatory and utilized a wheelchair. - The resident required assistance with bathing, feeding, and dressing. - The resident was incontinent of bowel and bladder. Review of the Resident Register revealed Resident #5 was admitted to the facility on 01/30/14.	D 273		

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Review of Care Notes for Resident #5 revealed:
-On 01/06/16, resident called out for help at 8:26 p.m. Staff found resident in her room on the floor. Vitals were taken. Guardian and Executive Director were notified. The primary care provider was not noted as notified.

-On 01/11/16, at 2:56 p.m., resident complained of pain in her right knee. Resident was sent to the emergency room per her request. The primary care provider was not noted as notified.

-On 01/30/16, at 10:15 a.m., the resident had gotten up and fell. Staff heard the resident calling for help. Resident was found on the floor and was sent to the emergency room. Guardian and Executive Director were notified. The primary care provider was not noted as notified.

-On 02/28/16, at 1:00 a.m., resident was found on her bedroom floor by staff yelling for help. Resident refused to go to the emergency room. Vitals were taken. Guardian was called and message left. The primary care provider was not noted as notified.

-On 03/01/16, resident was found by staff, 11 p.m.-7 a.m., in her room after she had gotten up by erself without assistance and not using her call bell. Guardian, the Executive Director, and the primary care physician were not noted as notified.

-On 03/06/16, resident came to staff at 6:00 p.m. to clean and bandage an area on her left arm that was bleeding. She said she had fallen while getting up. No other injuries were found. Incident report was completed. Staff notified

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oncoming shift " to keep an eye on her. " The Guardian, the Executive Director, and the primary care physician were not noted as notified.

-On 04/22/16, resident was found on the floor in her room at 9:40 p.m. by staff. Resident was sent to the emergency room "to be checked out." The Guardian, the Executive Director, and the primary care physician were not noted as notified.

Review of Resident #5's Incident reports on 05/11/16 revealed:
-On 01/04/16, the resident was found on floor by staff. She said she slid out of her wheelchair. Resident refused to go to the hospital. No visible injuries.
-The Guardian and Executive Director were notified of the incident.
-The Executive Director signed off on the incident report.
-The box was checked " no " on the incident report for the physician being notified.

-On 01/06/16, resident was found by staff and was assisted back up into her chair. Resident refused to go to the emergency room. No injuries were found.
-The Guardian and Executive Director were notified of the incident.
-The Executive Director signed off on the incident report.
-The box was checked "no" on the incident report for the physician being notified.

-On 02/28/16, the resident fell once up to go to the bathroom. Resident refused to go to the emergency room. No injuries found.
-The Guardian and Executive Director were notified of the incident.

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-The Executive Director signed off on the incident report.
-The box was checked "no" on the incident report for the physician being notified.

On 03/06/16, resident reported to staff that she slid out of her chair in her room and hit her arm. Staff saw a small scrape on her left arm but no other injuries were found.
-The Guardian and Executive Director were notified of the incident.
-The Executive Director signed off on the incident report.
-The box was checked "no" on the incident report for the physician being notified.

-On 04/22/16, the resident was found on the floor in her room by staff. She had hit her head against the bed rail. Resident was sent to the emergency room. Head injury was noted.
-The Guardian and Executive Director were notified of the incident.
-The Executive Director signed off on the incident report.
-The box was checked "no" on the incident report for the physician being notified.

Review of the Hospital Discharge Summary form on 05/11/15 revealed:
-11/02/15 - Fall and Urinary Tract Infection. No visible signs of injury were found.
-12/08/15 - Abrasion of forehead and nose as a result of a fall.
-01/11/16 - Minor head injury without loss of consciousness and knee pain as a result of a fall.
-01/30/16 - Contusion of left shoulder as a result of a fall.
-04/22/16 - Scalp hematoma as a result of a fall.

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D 273	Continued From page 12 Attempted Interviews with guardian of Resident #5 on 05/10/16 at 11:45 a.m. and 05/11/16 at 1:45 p.m. were unsuccessful. Interview with a Medication Aide (MA) on 05/11/16 at 10:08 a.m. revealed: -When falls and injuries occur, an incident report was completed. -She did not call the physician when incident reports were completed but did notify the guardian and Executive Director of incidents. -She was unaware that she had to notify the physician and checked "no" on incident reports. Interview with second Medication Aide (MA) on 05/11/16 at 10:32 a.m. revealed: -Incident reports were filled out and completed when falls and injuries occurred. -She was not aware she had to notify the physician and thought the Resident Care Coordinator (RCC) would contact the physician. -She checked "no" for notifying the physician on incident reports and did not contact the physician as incidents with and without injury occurred. Interview with the resident's Nurse Practitioner on 05/11/16 at 4:11 p.m. revealed: -She assumed responsibility for providing care to Resident #5 in November 2015. -She was made aware of the three emergency room (ER) visits on 12/08/15, 02/09/16, and 04/22/16 for Resident #5 after these had occurred during her routine visits to the facility. -Their office could be reached by telephone 24 hours a day and 7 days a week. -Staff were available in the office from 7:00 a.m. - 6:30 p.m. -She had not been made aware of falls with or without injury by the facility.	D 273		

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D 273	Continued From page 13 -She wanted to be made aware of all falls with or without injury immediately. -She wanted to be called first before residents were sent out to the emergency room. -She saw Resident #5 last on 04/26/16 following her fall on 04/22/16. Interview with the Resident Care Coordinator on 05/11/16 at 4:40 p.m. revealed: -The Medication Aides' (MA's) notified the physician by telephone during and after hours as incidents occurred. -She kept a notebook of the Patient Information (ER) sheets and asked the physician to sign off on them when they came to visit the facility. -The RCC would usually let the physician know about any ER visits or hospitalizations when the physician came for on-site visits. -She was not aware the MA's were not calling the physician. -The RCC did not follow up with the MA's to ensure they had notified the physician. Interview with the Executive Director on 05/11/16 at 5:15 p.m. revealed: -She was unaware the MA's were not notifying the physician of residents falls with or without injury. -She thought the RCC notified the physician as needed. -The RCC was responsible for ensuring the MA ' s had notified the physician as needed. -She was not aware the "no" boxes were checked for the physician being notified on Resident #5's incident reports. -She had signed off on all incident reports completed. -She had not notified the physician of any falls with or without injury.	D 273		

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D 273	Continued From page 14 Review of the facility's Plan of Protection dated 10/02/15 revealed: -Staff shall be retrained on referral and follow-up based on residents needs or orders. -Training to be held by Friday May 13th, 2016 by the Regional Director, starting on May 11th, 2016. -Regional Director, Executive Director, and/or Resident Care Coordinator will randomnly audit charts to ensure that orders are followed in at the time of order. -Changes in residents medical condition/status is reported to assure procedures are followed for referral and follow-up. -The Resident Care Coordinator is to perform chart audits weekly. THE CORRECTION DATE FOR THE TYPE B SHALL NOT EXCEED JUNE 25, 2016.	D 273		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident	D 317		

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council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to provide 14 hours of planned group activities per week for 5 of 5 sampled residents (#1, #2, #3, #4, and #5).

The findings are:

Review of the activity calendar on 05-10-16 at 9:20 am revealed:
-The types of activities posted for the month of May 2016 included Exercise, Ball Toss, Shopping, Walking Club, Word Search, The Game of Life, Bingo, Jewelry Making, The Park & Train Rides.
-Exercise was listed five times during the month and Ball Toss was listed four times during the month.
- "Resident shopping trip" was noted on the activities calendar without start and end times specified.
-There were no start times for all of the activities listed.
-There were no end times for all of the activities listed.
-There were a total of 4 hours of activities listed each week with start and end times specified.

Observations of large living room on 05/10/16 at 9:35 a.m. and 05/11/16 at 2:00 p.m. revealed:
-No activities were scheduled or occurring with the residents.
-Residents were in their rooms or seated in their wheelchairs in the hallways or day areas not actively engaged in an activity.

Interview with the Activities Director on 05/10/16

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D 317	Continued From page 16 at 10:24 a.m. revealed: -She created the large calendar with the residents input and based on their preferences. -Smaller activity calendars were given to the residents by her. -The residents were headed to go shopping sometime that day at a department store. -She was not aware that the large calendar did not have start and end times for all of the activities listed. -She would correct the calendar by the end of the day to reflect start and end times. Interviews with six residents on 05/11/16 at 3:00 p.m. revealed: -They were not asked what activities they enjoyed or preferred. -They were not given a small calendar of monthly activities. -Three out of six residents asked the "activity lady" to play Bingo but have not played in "a long time." -The residents enjoyed going shopping and out on trips once and sometimes twice a month. -Two of the six residents did not usually participate in activities, but would consider it if more preferred activities were offered and occurred as scheduled. -Four of six residents said that what was noted on the activity calendar may not happen at that time or even on that day. Interview with the Administrator on 05/11/16 at 2:30 p.m. revealed: -She was aware of no start and end times for the activities listed on the calendar. -She would ensure the Activity Director corrected the calendar. -The residents' activity preferences would be discussed at the next Residents Council Meeting.	D 317		

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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. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 residents (Resident #6 and Resident #7) during the medication pass., including a scheduled inhaler and a blood pressure medication that was to be administerd with food. The findings are: The medication error rate was 5% as evidence by observation of 2 errors out of 38 opportunities during the 7:00 AM/ 9:00 AM medication pass on 05/11/16. 1. Review of Resident #6's current FL-2 dated for 07/10/15 revealed: - There were diagnoses of Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Vitamin D deficiency, Insomnia, upper back pain, and Hiatal Hernia. -There was an order for Advair Diskus (a prescription medication used to help improve lung function in residents who have a diagnoses of Chronic Obstructive Pulmonary Disease) 250-50	D 358		

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D 358	Continued From page 18 milligrams take 1 puff twice daily and rinse mouth after use. Review of February 2016 Medication Administration Record (MAR) revealed: -This was the most current MAR available at the facility due to Resident #6 having to go out to the doctor's office and the March, April, and May MAR ' s had to be sent with the Resident to the doctor's office. -There was an entry for Advair Diskus 250/50 milligrams to inhale 1 puff twice per day and rinse mouth after use. Observation of a medication pass on 05/11/16 at 7:36 AM revealed: -The Medication Aide administered the Advair Diskus 250/50 milligrams and had the resident take 3 different puffs on the inhaler. -After administration the Medication Aide placed the medication back on the mediation cart. -She did not have Resident #6 rinse her mouth out after taking in the medication. Interview with the Resident Care Coordinator who was working as a Medication Aide on 05/11/16 at 7:38 AM revealed: -When she administered Advair Diskus she would have the resident swish and spit after administration of the medication. -She felt that Resident #6 did not get any of the inhaler medication. -There was a popping sound the inhaler made when the resident received the medication. -She would have to contact the primary medical doctor today about possibly changing this medication because she did not think that Resident #6 could use it properly. 2. Review of Resident #7's FL-2 dated 11/10/15	D 358		

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revealed diagnoses that included Acute Encephalopathy, Dementia with behavioral disturbances, Hypertension, Type II Diabetes, Diastolic Congestive Heart Failure, Atrial Fibrillation, and Hallucinations.

Review of current physician's orders dated for 11/18/15 revealed an order for Hydralazine (a vasodilator used to treat high blood pressure) 25 milligrams 1 tablet three times per day with food.

Review of Resident #7's Medication Administration Record for May 2016 revealed an entry for Hydralazine 25 milligrams 1 tablet three times per day with food.

Observation of a medication pass on 05/11/16 at 7:55 AM revealed:
-The Medication Aide administered 25 milligrams of Hydralazine to Resident #7.
-Resident #7 did not receive any food with the administration of this medication.

Observation of Resident #7 on 05/11/16 at 8:35 AM revealed the Resident received her breakfast meal at this time.

Interview with the Resident Care Coordinator who was working as the Medication Aide on 05/11/16 at 8:57 AM revealed:
-She always gave medications with food if it was ordered by the Medical Doctor unless the family requested it to be given at a different time.
-Resident #7's family had requested to give her medications before her meals because she did not like to take the medication with her food.
-She had received training on how to administer medications when she first started working for the facility in 2013.
-She had received annual training through

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in-services and online training for medication administration.
-She was trained at this facility on how to administer medications.

Interview with the Administrator on 05/11/16 at 9:14 AM revealed:
-The Medication Aides (MA) received training yearly on medication administration through in-services and online training modules.
-The MA's will follow one of the management staff for 3 days and then the MA is shadowed by the Administrator.
-The MA is required to have a medication skills check off done before medications can be administered.
-If they are hired as a MA and have already received training the must provide documentation that they have passed meds within the last 24 months.
-When a medication error happens the primary Medical Doctor is to be notified and a medication error sheet filled out.
-The facility is then to follow Medical Doctors orders on how to correct the medication error.

Interview with the Regional Director on 05/11/16 at 9:22 AM revealed:
-All Medications Aides (MA) have to receive the 15 hour training course.
-The MA then gets 5 days on the cart with the Resident Care Coordinator (RCC) or a supervisor.
-They also get 1 day with the Administrator to shadow them to make sure the MA can pass medications correctly.
-The MA will get 2 days observing the RCC pass medications and then 2 days where the RCC observes them passing medications.
-The MA staff get training done yearly in

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D 358	Continued From page 21 medication administration. -Some of the training is schedules if there are areas of concerns with medication administration. -Some of the training is done by in-services through the in house pharmacy and some is done by the Regional Director. -If there are errors in medication administration then they are to fax an error report to the MD and then notify the Regional Director. -She was not aware of there being any medication administration errors at this facility within the last year.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure minimum staffing requirements to meet the personal care and supervision needs of the 25 residents residing in the Special Care Unit (SCU). The findings are: Review of the facility census sheet provided by the facility revealed there were 25 residents listed	D 465		

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	HAL054067	A. BUILDING: _____ B. WING _____	05/11/2016

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THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 465	Continued From page 22 on the SCU and 19 residents on the assisted living side. Review of the Staff Schedule for May 2016 revealed: -There were 3 PCA's staffed from 7:00 AM - 7:00 PM and 3 PCA's from 7:00 PM - 7:00 AM. -There was 1 MA scheduled from 7:00 AM - 7:00 PM and 1 MA scheduled from 7:00 PM - 7:00 AM. -There was a SCU floater scheduled for 5 out of 10 days from 11:00 AM - 7:00 PM. -The RCC/SCC was schedule to work as a MA on 5/11/16 from 7:00 AM-7:00 PM. -There were 2 PCA's scheduled for 25 SCU resident's. -The SCU did not meet the staffing requirements for any Saturday or Sunday on the schedule. -The SCU was below staffing requirements Monday - Friday from 7:00 PM until the RCC arrived around 9:00 AM. Interview with a Medication Aide on 5/10/16 at 10:00 AM revealed: -She had worked at the facility for about 2 years. -Since she started working there, there had always been 1 PCA on 200 hall and 1 PCA on 300 Hall. -There were over 20 residents on the SCU. -She would float between the assisted living side and the SCU to pass medications during each shift. Interview with a Personal Care Aide (PCA) on 5/11/16 at 8:00 AM revealed: -She had worked at the facility for 2 years. -She worked 7:00 AM - 7:00 PM. -She did not feel there was enough staff that worked in the facility on any shift. -The facility had been short staffed for a few months.	D 465		

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D 465	Continued From page 23 -Even when the facility was fully staffed they still only worked with 1 PCA on the 200 hall of the SCU and 1 PCA on the 300 hall off the SCU. -The facility had recently changed all PCA's and MA to 12 hour shifts from 7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM. -The normal staffing on the SCU would consist of 2 PCA's and a MA that floated from the Assisted Living side to the SCU. -The MA did not help with resident care, only to cover the floor if the PCA went to break or lunch. -There were only 2 PCA's for 25 residents in the SCU. Observation of the 200 hall of the SCU on 5/11/16 at 9:10 AM revealed there was only 1 PCA on duty on the hall. Interview with a PCA on 5/11/16 at 9:10 AM revealed: -She was the only PCA staffed on the 200 hall of the SCU at that current time. -She had worked at the facility for about 1 year. -Since she had worked there, they had only staffed 1 PCA on the 200 hall and the 1 PCA on the 300 hall of the SCU. -The 200 hall of the SCU had 12 residents and the 300 hall of the SCU had 13 residents. -About 2 weeks ago the facility implemented a PCA floater that would come in and work 11:00 AM - 7:00 PM. -Any of the staff could sign up to work as a floater on their day off for overtime pay but most do not. -Some residents on the 300 hall SCU required a 2 person assist to get them up. -The PCA that worked the 300 hall had to call the Assisted Living side and have a staff come over to help with 2 person assisted residents. -The 300 hall had very heavy care residents. -She could not watch all the residents at all times	D 465		

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D 465	Continued From page 24	D 465		

if she was in a room assisting another resident.
-There was one PCA for 12 residents on the SCU 200 hall and one PCA for 13 residents on the 300 hall.

Observation of the 300 hall of the SCU on 5/11/16 at 9:25 AM revealed there was only 1 PCA on duty on the hall.

Interview with a PCA on 5/11/16 at 9:25 AM revealed:
-She had worked at the facility for over a year.
-She was the only PCA staffed on the 300 hall of the SCU at that current time.
-There had been a lot of heavier care residents admitted since January 2016.
-The 300 hall of the SCU had the heaviest care residents.
-There were 2 residents on the 300 hall SCU that required 2 people to transfer them from their wheelchair to the bed.
-The facility had just started last week trying to staff a floater PCA daily from 11:00 AM - 7:00 PM.

Interview with the Resident Care Coordinator (RCC) on 5/11/16 at 1:25 PM revealed:
-She had worked at the facility at 2 different times since 2012.
-She now worked the facility as a RCC/Special Care Unit Coordinator (SCC).
-The RCC and the SCC were the same role.
-She typically worked Monday - Friday 9:00 AM - 5:30 PM.
-She would split her time between the assisted living side and the SCU.
-She occasionally had to work as a MA because of the facility being short staffed or if someone called out of work.
-When she had to work as a MA, she would perform her duties as an RCC/SCC in between

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D 465	Continued From page 25 her medication passes. Interview with the Executive Director on 5/11/16 at 2:20 PM revealed: -She has worked at the facility as the Executive Director for over 1 year. -She typically worked Monday - Friday 9:00 AM - 5:30 PM and other times as needed. -She had been in the facility on all shifts. -She was not aware that the SCU was not meeting minimal staff requirements. -She thought 1 PCA on the 200 hall of the SCU and 1 PCA on the 300 hall of the SCU was sufficient. -The SCU had always only staffed 1 PCA for each 200 and 300 hall. -There was a MA that floated between the assisted living side and the SCU. -The facility had implemented a PCA floater that would work 11:00 AM - 7:00 PM between the 200 hall and the 300 hall. -The PCA floater position started on 5/2/16. -She was conducting interviews to try and hire new staff.	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in	D 466		

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the special care unit (SCU) at least eight hours a day, five days a week.

The findings are:

Review of the facility census sheet revealed there were 25 residents listed on the SCU.

Review of the Staff Schedule for May 2016 revealed the RCC/Special Care Coordinator (SCC) was scheduled to work as a Medication Aide (MA) on 5/11/16 from 7:00 AM-7:00 PM.

Interview with a Medication Aide on 5/10/16 at 10:00 AM revealed:
-There was a Resident Care Coordinator (RCC) at the facility.
-The RCC had to work as a MA if someone called out of work.
-The RCC would be working as a MA on 5/11/16 from 7:00 AM - 7:00 PM.

Interview with a Personal Care Aide (PCA) on 5/11/16 at 8:00 AM revealed the RCC was working as a MA for the assisted living and the SCU that day.

Observation on 5/11/16 at 8:02 AM revealed the RCC was passing medications to the residents.

Interview with the RCC on 5/11/16 at 1:25 PM revealed:
-She had worked at the facility at 2 different times since 2012.
-She now worked the facility as a RCC/SCC.
-The RCC and the SCC were the same role.
-She typically worked Monday - Friday 9:00 AM - 5:30 PM.
-She would split her time between the assisted living side and the SCU to perform her RCC/SCC

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D 466	Continued From page 27 duties. -She occasionally had to work as a MA because of the facility being short staffed or if someone called out of work. -When she had to work as a MA, she would perform her duties as an RCC/SCC in between her medication passes. Interview with the Executive Director on 5/11/16 at 2:20 PM revealed: -She has worked at the facility as the Executive Director for over 1 year. -She typically worked Monday - Friday 9:00 AM - 5:30 PM and other times as needed. -She was conducting interviews to try and hire new staff. -The RCC/SCC was the same position. -The RCC split her days between the SCU and the assisted living side.	D 466		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the	D 468		

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special care unit shall complete six hours of orientation on the nature and needs of the residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assure that all staff working in the special care unit had completed 20 hours of special care unit training within 6 months of being hired for 2 of 6 sampled staff members (Staff E and Staff F).

The findings are:

1. Review of Staff E's personnel file on revealed:
-Staff E was hired on 06/09/14 as the Resident Care Coordinator and is now working as the Executive Director.
-Staff E was certified to work as a Medication Aide for the facility.
-Staff E had completed 7.5 hours of training to work on the Special Care Unit.
-There was no documentation that Staff E had completed 20 hours of training to work in the special care unit.

Interview with the Executive Director on 5/11/16

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at 2:20 PM revealed:
-She was not aware the required 20 hour SCU training for some staff had not been completed.
-She was unsure if she had completed the 20 hour SCU training herself.
-There were a lot of times when she had to staff the facility so that other employees could attend their required classes.

Interview with the Regional Director on 05/11/16 at 11:15 AM revealed:
-She was unable to locate Staff E's 20 hour special care unit training.
-She was pretty sure that Staff E had done the training but was not sure when the training was done or why it was not in the personnel file.
-She would make sure that Staff E would get her training done this week.

2. Observation of Staff F on 05/11/16 at 7:28 AM revealed that Staff F was administering medications to residents in the Special Care Unit.

Review of Staff F Personnel File on 05/11/16 revealed:
-Staff F was hired on 07/09/14 as a Medication Aide and is now the Resident Care Coordinator.
-Staff F was certified to work as a Medication Aide for the facility.
-Staff F had completed 7.5 hours of training to work on the Special Care Unit.
-There was no documentation that Staff E had completed 20 hours of training to work in the special care unit.

Interview with Staff F on 05/11/16 at 11:24 AM revealed:
-She has had some training to work in the Special Care Unit.
-She had received this training through corporate

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D 468	Continued From page 30 in-services. -She thought she had done 15-20 hours of Special Care Unit Training. -She was unsure of how many total hours were required for her to work in the Special Care Unit. -The training she had completed was done when she first started working at the facility. Interview with the Regional Director on 05/11/16 at 11:15 AM revealed: -She was unable to locate Staff F's 20 hour special care unit training. -She was pretty sure that Staff F had done the training but was not sure when the training was done or why it was not in the personnel file. -She would make sure that Staff F would get her training done this week.	D 468		
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 observations, interviews and record reviews the facility failed to assure resident rights for care and services. The findings are: Based on observation, interview and record review, the facility failed to provide personal care for a resident who required staff assistance which	D912		

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D912	Continued From page 31 resulted in falls for 1 of 2 sampled residents (#5). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision. (Type A2 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, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility neglected to maintained the residents' rights regarding health care. The findings are: Based on observation, record review, and interview, the facility failed to notify the physician of a resident's multiple falls resulting in injury and hospital visits for 1 of 2 sampled residents (#5). [Refer to TagD273, 10A NCAC 13F .0902(b) (Type B Violation)]	D914		