STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025033	A. BUILDING: _____ B. WING _____	10/25/2016

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

(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 and the Craven County Department of Social Services conducted an annual survey on October 19-25, 2016.	D 000		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to keep residents free of mental abuse by not separating residents with verbal and physical behavior issues for 2 of 2 sampled resident (Resident #2 and Resident #6). The findings are: 1. Review of Resident #2's current FL-2 dated for 01/25/16 revealed: -She was admitted to the facility on 05/04/07. -Diagnoses included Vascular Dementia, Type 2 Diabetes, Hyperlipidemia, and Hypertension. -There was no documentation about Resident #2 ' s orientation status. -There was documentation that Resident #2 was verbally abusive at times. Review of Resident #2's current Care Plan dated 09/25/16 revealed the resident was not receiving any mental health services and no referrals had been made.	D 338	The community has separated Residents #2 and #6, moving Resident #2 into a private apartment. Resident #2's and Resident #6's families have been updated regarding the situation. Resident #2's and Resident #6's physicians were notified regarding the situation. Resident #2's and Resident #6's physicians evaluated residents. Psychiatric evaluations will be requested for both residents to evaluate their behavior. Staff will monitor residents on each shift and notify supervisors immediately if any conflict issues arise between residents. The Executive Director or designee will provide an in-service to direct care staff on Resident Rights, which will go over the information included in the Resident Rights policy which is included as part of the Plan of Correction submission.	10/19/16 10/21/16 10/21/16 11/4/16 10/21/16 10/19/16 11/24/16

Reviewed and Accepted: _____ RN MSN
Facility Survey Consultant
11/28/16

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D 338	Continued From page 1 Observation of Resident #2 on 10/19/16 at 2:00 PM revealed that Resident #2 was located in the room with Resident #6 and they were roommates at the facility. Review of Resident #2's Sensitive Notes revealed: -On 06/22/16 at 4:15 PM, it was documented that Resident #2 pushed Resident #6's walker into her legs but no injuries were noted. -On 07/21/16 at 10:53 PM, it was documented Resident #2 stated that her roommate (Resident #6) keeps messing with her belongings and waiving her cane in her face. -On 8/10/16 at 8:22 AM, it was documented that on 08/09/16 Resident #2 called out complaining about her roommate. When staff went down to check on residents due to yelling being heard coming from the room Resident #2 would yell at staff and say nothing was going on. -On 08/11/16 at 7:53 AM, it was documented that on 08/10/16 Resident #2 was arguing with her roommate. -On 09/03/16 at 11:23 PM, it was documented that Resident #2 was arguing with her roommate all evening. -On 09/05/16 at 10:38 PM, it was documented that Resident #2 had another argument with her roommate this evening. -On 09/07/16 at 8:38 AM, it was documented that Resident #2 stated that her roommate was telling her to get out of my room; this is my home. -On 10/03/16 at 6:07 AM, it was documented late entry for 10/02/16 there was yelling heard at the desk that was coming from the 100 hall. The Medication Aide found the security guard with Resident #2 and her roommate was standing in the doorway. Both Resident #2 and Resident #6 were yelling and cussing at each other. Resident #2 said that Resident #6 hit her in the back of the	D 338	The Wellness Director or designee will provide an in-service to direct care staff on resident to resident conflict and handling of the same. The in-service will: 1. Review the Resident to Resident Conflict policy and Incident and Accident Reporting policy, which are included as part of the Plan of Correction submission; 2. Discuss proper documentation regarding resident to resident conflict and/or change in condition; 3. Discuss proper notification regarding resident to resident conflict and/or change in condition to the supervisor, physician and responsible party; 4. Review how to complete the 24 hour report. The Executive Director will be responsible for confirming that Resident #2 and Resident #6 remain separated and their behaviors are evaluated by their physicians. Wellness Director or designee will conduct random weekly reviews of staff notes for 5 residents and corresponding 24 hour reports to ensure reporting policies are being followed and residents who are involved in verbal altercations as defined by our policy and physical altercations have been separated in a manner appropriate to the situation. After three weeks, if no concerns are noted, monthly random reviews of 5 residents' notes will be conducted.	11/24/16 10/19/16 11/24/16

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D 338	Continued From page 2 head with her hand but the security guard stated that he saw Resident #6 hit Resident #2 in the back of the head with her cane. Both of the residents were separated and the Wellness Director and both families were contacted. -On 10/04/16, it was documented that Resident #2 and Resident #6 had an argument. Resident #2 stated that Resident #6 told her to get out of the room and then pushed her into the hallway and hit her in the back of the head. Both residents were separated immediately and Resident #2 was placed in another room temporarily. -On 10/05/16, it was documented that Wellness Director spoke with family via phone and with Assistance Executive Director and explained that all options had been considered and it was decided that the both residents must co-exist. Resident #2 would be issued a pendant to call out for assistance if needed. Staff were required to do 30 minute checks while both residents were in the room together. The family were accepting to the plan, but Resident #2 is resistive and expressed her concerns for being roommates with Resident #6. Both residents will continued to be monitored for further issues. Review of the facility's incident and accident reports revealed: -On 10/19/2016 it was documented that Resident #2 was talking with Resident #6 about her television being too loud. -Both residents began to fuss with one another. -Resident #2 stated that she was sick of living with Resident #6 and was removed from the room for the night. Refer to review of the facility's census report from October 1-20, 2016. Interview with Resident #2 on 10/20/2016 at 2:40	D 338	Any concerns or issues identified by the Wellness Director or her designee will be reported to Executive Director and Wellness Director and Executive Director will identify an action plan to correct any concerns or issues.	11/24/16

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D 338	Continued From page 3 PM revealed. -Resident #6 had hit her with an open hand to the back of her head as she was exiting the room about 3 weeks ago " because she was racist. " -Staff moved her out and moved her into a room by herself for safety reasons. -She stayed in another room for 3 nights and then was told she had to move back into the room with Resident #6. -Staff didn't believe her when she stated that the roommate was being mean to her. -She stayed with Resident #6 until October 19, 2016 when another verbal argument ensued. -She was told by management that she was moved this time permanently because they thought Resident #6 may try to hit her again. -Resident #6 often " hung out " in the same areas of the facility that she did. -She did not feel safe living with Resident #6 as her roommate. Attempted telephone interview with Resident #2's son on 10-20-16 at 10:45 AM was unsuccessful. Attempted interview with Resident #2's primary care provider on 10/21/16 at 12:10 PM was unsuccessful. Refer to confidential interview with a staff member. Refer to confidential interview with a second staff member. Refer to confidential interview with a third staff member. Refer to Confidential interview with a fourth staff member.	D 338		

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D 338	Continued From page 4 Refer to Confidential interview with a fifth staff member. Refer to interview with the Wellness Director on 10/21/16 at 8:46 AM. Refer to a second interview with the Wellness Director on 10/21/16 at 6:30 PM. Refer to interview with the Assistant Executive Director on 10/21/16 at 9:00 AM. Refer to interview with the Executive Director on 10/21/16 at 9:41 AM. 2. Review of Resident #6's FL-2 dated 6/7/2016 revealed: -The resident was admitted on 6/22/16. -Diagnosis included Dementia, Anxiety, Depression, hypertension, hyperlipidemia, anemia, CVA, CKD stage 3, osteoporosis, neuro-dermatitis, and gait disturbance. -Her cognitive function was checked intermittently disoriented. -It was checked that she ambulates with the use of a cane. Review of Resident #6's Sensitive Notes revealed: -On 06/23/16, it was documented that Resident #6 complained about her roommate (Resident #2) was making noises all night. -On 07/22/16, it was documented that Resident #6 rummaged through her roommates (Resident #2) belongings and showed aggressive behavior towards roommate by swinging her cane in her face. -On 08/05/16, it was documented both Resident #6 and Resident #2 were arguing. -On 08/08/16, it was documented that on	D 338		

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D 338	Continued From page 5 08/07/16 Resident #6 was telling her roommate (Resident #2) that she had to get out due to her family coming tomorrow. Both residents fussed back and forth for about ten minutes. -On 08/09/16, it was documented that Resident #6 and Resident #2 were arguing back and forth most of the night. Resident #6 continued to throw food and other items in the room and at Resident #2. -On 09/03/16, it was documented that Resident #6 and Resident #2 were arguing on first shift. Resident #6 kept telling Resident #2 to get out of her room. -On 09/03/16, it was documented that both Resident #6 and Resident #2 were arguing back and forth. Resident #6 had locked the door and there was commotion; staff had to use the key to unlock door to get in the room. Upon the door being opened Resident #6 had her cane drawn back towards Resident #2. The family and Wellness Director were notified and security changed the locks. -On 09/05/16, it was documented that Resident #6 had another argument with her roommate (Resident #2) and then she called her daughter. Resident #6's family members said they would come and see her tomorrow. -On 09/07/16, it was documented that Resident #6 and Resident #2 were arguing. When asked about the argument Resident #6 denies the argument taking place and said her roommate is gone and she is " cool " . -On 09/09/16, it was documented that Resident #6 and Resident #2 had been arguing. - On 10/03/16, at 6:03 AM it was documented late entry for 10/02/16 there was yelling heard at the desk that was coming from the 100 hall. The Medication Aide found the security guard with Resident #2 and her roommate was standing in the doorway. Both Resident #2 and Resident #6	D 338		

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D 338	Continued From page 6 were yelling and cussing at each other. Resident #2 said that Resident #6 hit her in the back of the head with her hand but the security guard stated that he saw Resident #6 hit Resident #2 in the back of the head with her cane. Both of the residents were separated and the Wellness Director and both families were contacted. -On 10/05/16, at 11:58 PM it was documented that Resident #6 had her cane pointed at Resident again while staff was assisting Resident #2. Resident #6 asked them what the " H____ " they were doing in her house and told them to get out. Resident #6 came down the hallway a few minutes later saying she wanted to call the police. Resident #6 then began to curse at staff. Staff redirected Resident #6 by asking her if she wanted to call her family member. Resident #6 called her family member and the conversation did not go well. Staff then offered Resident #6 a snack and she ate a sandwich, cookie, and pineapple juice. -On 10/15/16, at 9:57 AM it was documented that Resident #6 pushed her walker in front of the room door so that her roommate (Resident #2) could not get out of the room to take her medications. Resident #6 started a verbal altercation with roommate (Resident #2) by calling her names and trying to force her out telling her she had to move out because her family members were paying for that room. Wellness Director was notified and Resident #6 was placed on Q15 minute checks. -On 10/15/16 at 5:42 PM, it was documented that Resident #6 was being uncooperative and demanding that Resident #2 get another apartment. Resident #6 pushed her walker in the path of Resident #2 to prevent her from getting by. Wellness Director spoke with family and Assistant Executive Director and they had found another resident who was willing to switch rooms	D 338		

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D 338	Continued From page 7 so that they could separate Resident #2 and Resident #6. 30 minute checks have been put in place until the move can be made on Monday. -On 10/15/16 at 11:12 PM, it was documented that Resident #6 was trying to call the police again and trying to go out the door. She was being very rude to staff and roommate (Resident #2). Review of the facility's incident and accident reports dated 10/19/16 revealed: -Resident #6 was watching television in the room when Resident #2 started complaining about her television being too loud. -Resident #6 told Resident #2 that she would get out of her house. -Resident #6 walked down the hallways to get the phone and call the police to get these people out of her house. -Resident #2 was removed from the room for the night. Observation of Resident 6# on 10/19/16 at 1:00 PM revealed: -The resident was resting in her chair. -The resident had a purple discoloration to the left side of the resident ' s face which extended to the neck which appeared to be bruising. -The resident's demeanor was calm and pleasant. Interview with Resident #6 on 10/19/16 at 1:10 PM was unsuccessful. Interview with both family members of Resident #6 on 10/19/16 at 1:23 PM revealed: -Their Resident #6 had a roommate since June, 2016. -Their Resident #6 did not get along with her roommate since June, 2016.	D 338		

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D 338	Continued From page 8 -Their Resident #6 and the roommate were " mean " to each other. -They had been roommates for just over three months. -The family members had visited Resident #6 approximately 3 weeks ago and expressed to staff that they would like to transfer Resident #6 to another room. -Resident #6 had told them that she was scared of the roommate. -They were unaware of any assaults by Resident #6's roommate. -They had witnessed the roommate talking ugly to Resident #6. -They were made aware by staff that Resident #6 had hit her roommate with a cane. -They were unaware of the exact date that Resident #6 had hit Resident #2 but estimated 2-3 weeks ago. -After the incident the roommate was removed from the room for 3-4 days. -After 3-4 days the roommate was brought back to Resident #6's room and was told it was due to a " hiccup in the system " . -They were told by the Assistant Executive Director that the roommate was moved back into the room because the room she had resided in during the 3-4 days was promised to another resident who was paying for a private room. -Resident #6's roommate will frequently unplug the TV in the room. -They had received several calls from the facility related to Resident #6 and her roommate not getting along. -On October 3, 2016, one of the family members had noticed bruising on her mother's arms extending from the top of her hands to her elbows. -The staff could not explain the cause of the bruising on Resident #6.	D 338		

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D 338	Continued From page 9 -Resident #6 was sent to the Emergecny Department on their insistence due to a swollen middle finger. -They had not spoken to the current Administrator due to him being new to the position. -They had not notified the previous Administrator. -One of the family members spoke with the primary care physician to see about her mother being moved to another facility. Confidential interview with a staff member revealed: -Resident #2 and #6 argued one to two times during the shift since they have been roommates. -The most recent argument between Resident #2 and #6 was on 10/19/16. -Resident #2 and #6 had only one physical argument. -When Resident #2 and #6 argued, staff would separate them into different rooms for approximately 1 hour until they calmed down. -The last argument Resident #2 and #6 had was on October 19, 2016. -All of the arguments between Resident #2 and #6 had been verbal, except on October 2, 2016 when Resident #6 hit Resident #2. -Resident #2 and #6 do not like to have roommates each claiming " ownership of their room. " -Resident #2 and #6 do not have the skills to just ignore each other. -Resident #2 was moved out of the room after the October 2nd incident and returned 3 days later per management. -They were good for 2 days when they became roommates again then they began to argue. -They were put back into the same room after the October 2, 2016 incident because there were no double rooms available. -Management was well aware of the argument	D 338		

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D 338	Continued From page 10 history between Resident #2 and #6. -We were told only to separate them until they calmed down. -Staff member did not feel they were safe as roommates and should be in separate rooms. Confidential interview with a second staff member revealed: -Resident #2 and #6 argued one to two times during the shift since they have been roommates. -Resident #6 does not like anyone else in her room. -Resident #2 and #6 argued daily but it was only documented on occasion. -The staff had not seen any physical confrontation between Resident #2 and #6. -The staff member had noticed the bruising on both arms on Resident #2 last week but did not know the cause. -The facility had placed Resident #2 in another room for 3 days after the October 2nd argument. -The staff had moved Resident #2 back into the same room as Resident #6 and the confrontations had resumed. -The staff had witnessed Resident #6's family tell Resident #6 that they were inquiring about getting her moved to another room permanently. -Staff do not fill out an incident report just for arguing as it's so common. -When Resident #2 and #6 argue, other residents come into the hallway to see the commotion. -Resident #2 and #6 are separated for an hour or two after an argument. -It's not safe for Resident #2 and #6 to be roommates. Confidential interview with a third staff member revealed: -Resident #2 and #6 argued on 10/19/16 in the evening.	D 338		

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D 338	Continued From page 11 -Resident #6 told Resident #2 to turn down the volume of her television which started an argument. -----Resident #6 said to Resident #2: " You're a b_____. I'm going to call my family members and the police and then you will see what happens. " Confidential interview with a fourth staff member revealed: -Resident #2 and #6 caused extra work for the staff when they argued because they had to take time out from their duties to separate the residents. -The residents argued usually 5 times per week since they became roommates about 4 months ago. -Other residents would frequently come out of their rooms to witness the arguments causing a crowd. -Resident #2 and #6 both used curse words, calling each other a b_____. -Both residents were calm after 1-2 hours apart from each other and sometimes would invite each other to a meal, appearing as though they never had an argument an hour earlier. -They should not be roommates for safety reasons. Confidential interview with a fifth staff member revealed: -Resident #2 and Resident #6 frequently argued between 1:00 AM and 2:00 AM, as well as 5am and 6am. -Resident #2 frequently told Resident #6 a " b_____ " and to " f___ off. " -Resident #6 frequently called Resident #2 a " b____. " -Staff member would rarely work their shift without at least one fight. -If medication aides were passing out	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 12	D 338		

medications, they would often have to stop medication pass to calm Resident #2 and #6.
-Resident #2 and #6 should not be roommates for safety reasons.
-Resident #2 and #6's behaviors were more common in the early morning hours when they woke up.

Interview with the Wellness Director on 10/21/16 at 8:46 AM revealed:
-There were a total of 3 arguments and 1 physical incident that she was aware of since Resident #2 and #6 became roommates in June 2016.
-Staff was supposed to notify her if any issues, including arguments, so she could resolve them.
-As of 10/19/16, Resident #2 and #6 were placed in separate rooms due to an argument the night before.
-Staff were instructed to try to resolve, fix or abate resident issues as the occurred.
-Resident #6 had the impression that the room was hers solely and she did not have to have a roommate " as she paid all the bills in the room. "
-She was aware of a physical altercation on 10/2/16 between Resident #2 and #6.
-The immediate response of the facility was to separate them, placing Resident #2 in room 207 down the hall for 3 days.
-The facility had moved Resident #2 back in with Resident #6 after 3 days because room 207 was a private pay room and was promised to someone already.
-Bed placement assignments were the responsibility of the Assistant Executive Director.
-She documented in Resident #6's nursing notes that Resident #6 would be moved to another room on 10/15/16.
-She did not move Resident #6 on 10/15/16 because the facility would be uprooting another double-room resident and the facility practice was

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	HAL025033	A. BUILDING: _____ B. WING _____	10/25/2016

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D 338	Continued From page 13 to notify the family first of the uprooted residents prior to moving them; the family could not be contacted on 10/15/16. -Resident #6 was not moved until the evening of 10/19/16 because the facility could not contact the family of another resident who would be displaced. -The facility procedure was to not do any bed transfers without notifying family members so those family members would not enter the facility and go to the wrong room. -The facility instituted 30-minute checks whenever Resident #2 and #6 had an argument. -If all shifts documented that there was " calm " for 3 days, we stopped monitoring. A second interview with the Wellness Director on 10/21/16 at 6:30 PM revealed: -Resident #6 would often yell to Resident #2 that she paid all the bills for the room. -Resident #6 did not like having a roommate. -Resident #6 was easier to have change rooms when there was an issue because Resident #2 had dementia. -The facility placed Resident #2 in room 209 on 10/21/19, then swapped them again, placing Resident #6 in room 209 and placing Resident #2 back in the original room. Review of the facility's census report for October 1-20 revealed: -On October 1-2, 2016 there were 4 empty beds available in the facility. -On October 3-9, 2016 there were 7 empty beds available in the facility. -On October 10-16, 2016 there were 5 empty beds available in the facility. -On October 17-20, 2016 there were 6 empty beds available in the facility.	D 338		

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D 338	Continued From page 14 Interview with the Assistant Executive Director on 10/21/16 at 9:00 AM revealed: -She became aware of the October 2nd incident between Resident #2 and #6 the following morning. -She heard that Resident #2 had hit Resident #6 had gotten hit in the back of the head. -She had separated Resident #2 and #6 placing Resident #2 in another room, room 207, for 3 days. -She placed both Resident #2 and #6 back in the same room after 3 days because room 207 was already assigned for an incoming private pay resident. -There were no alternate double occupancy Medicaid rooms available to place Resident #2 into so she had placed her back into the same room with Resident #6. -There were private pay rooms available. -She had spoken to Resident #2's daughters who were very receptive of the idea of Resident #2 going back to the same room as Resident #6. -She had spoken to the Power of Attorney for Resident #6 who was very receptive to the idea of moving Resident #2 back in with Resident #6. -She had given Resident #6 an alarm pendant that she could press if there was any incident. -She had personally switched roommates for Resident #6 multiple times prior to June 2016. -She did not think Resident #2 or Resident #6 could understand that they would always have a roommate being Medicaid residents because they both have cognitive issues. -She did not know why the nursing note documenting the intent to move Resident #2 to another room by 10/15/16 never happened. -The facility had always moved residents when there were social issues. -Resident #2 was moved to a private pay room during the evening of 10/19/16 due to another	D 338		

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D 338	Continued From page 15 argument where she will remain until a notice of discharge is issued to Resident #6 for provoking behavior. -Resident #2 could not go to any other rooms at the facility because " there are no Medicaid double rooms available. " -She felt that after the 10/2/16 incident that they were safe to resume being roommates after the facility had put interventions in place and made several phone calls to family, and stated that it was a judgement call on her part. -If after the 10/2/16 incident there were any more issues, they would be moved, and on 10/19/16 were separated. Interview with the Executive Director on 10/21/16 at 9:41 AM revealed: -He had been employed by the facility beginning the 2nd week of October 2016. -He was not employed during the 10/2/16 incident between Resident #2 and #6. -Resident #2 and #6 were roommates since his arrival. -He was aware of approximately 6 incidents between Resident #2 and #6, with one incident being physical on 10/2/16. -Resident #2 and #6 are Medicaid patients and he was looking for an appropriate double-room placement for both residents. -He felt that Resident #2 and #6 had " sundowner " issues and he did not want to " just move the problem around without researching an appropriate roommate. " -It was the responsibility of the Executive Director to determine resident placement. -He was aware of the documented 10/15/16 nurse's note stating intent to move one of the residents to another room but he decided to proceed slowly since Resident #6's family had filed a DSS complaint and did not want the family	D 338		

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D 338	Continued From page 16 to perceive the move as retaliation. -Resident #2 was not moved prior to 10/19/16 because they did not have another Medicaid resident room available. -Resident #2 was moved to a private pay room on 10/19/16 permanently for safety reasons after an argument between Resident #2 and #6 -His intent was to issue a discharge to Resident #2 due to a history of being adversarial. -The first time of any agitation since the 10/2/16 incident between Resident #2 and #6 was aware of was during the evening of 10/19/16 prompting the move of Resident #2. -The facility had in place a 3-day log to be filled out after any observation of agitation between Resident #2 and #6. -If the log had 3-days of " calm " entries on all shifts by staff, then the log sheet was discontinued. -Both Resident #2 and #6 have a history of being instigators. -Historically, the Administrator had not moved any resident to another room without prior approval or notification. -He had the power to move any resident without family notification or approval to another room. -Resident #2 and #6 would not be allowed to be roommates again for safety reasons as it was a caustic environment. _____ Review of the facility's plan of protection dated for 10/21/16 revealed: -The community will seperate the residents in question (completed 10/19/16) and will notify both families and physician's. -Physicians will be asked to see both residents as soon as possible to evaluate residents. -Staff will frequently monitor residents and notify supervisors immediately if any issues arise.	D 338		

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D 338	Continued From page 17 -This will be the responsibility of the Executive Director. -Resident A (Resident #2) will be moved into a private apartment. -Psychiatric evaluation will be requested for both resident's physicians to evaluate behaviors. -Staff will be educated on notifying their supervisors immediately if they see or hear issues with a resident or if resident to resident conflicts arise in the community. -Follow up with residents medical physicians will be completed within the week. -This process will be overseen by the Executive Director.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to respect the rights of residenents of two residents that lived together in the same room. The findings are: Based on observations, interviews, and record reviews, the facility failed to keep residents free of mental abuse by not separating residents with verbal and physical behavior issues for 2 of 2 sampled resident (Resident #2 and Resident #6). [Refer to TAG 338, 10A NCAC 13F .0909, Resident Rights. (Type A2 Violation)]	D911	Refer to Plan of Correction for Tag 338, 10A NCAC 13F.0909, Resident Rights, set forth above for plan of correction to address Tag D911, G.S. 131D-21(1).	11/24/16

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EVERY RESIDENT (OF A NORTH CAROLINA ADULT CARE HOME I.E. ASSISTED LIVING FACILITY) SHALL HAVE THE FOLLOWING RIGHTS:

1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
3. To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.
4. To be free of mental and physical abuse, neglect, and exploitation.
5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
6. To have his/her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom disclosure may be made, except as permitted or required by applicable State or federal statute, regulations, or third party contracts. In the case of an emergency, disclosure can be made to agencies, institutions or individuals who are providing the emergency medical services.
7. To receive a reasonable response to his or her requests from the facility administrator and staff.
8. To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
9. To have access at any reasonable hour to a telephone where he or she may speak privately.
10. To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationary, and postage.
11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the residents, administrator and supervisor-in-charge.
13. To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.
14. To be notified when the facility is issued a provisional license or notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.
15. To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation.
16. To receive upon admission to the facility a copy of this section.
17. To not be transferred or discharged from a facility except for medical reasons, the resident's own or other residents' welfare, nonpayment for the stay, or when the transfer

is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident. The resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law.

Accident and Incident Reporting

Document #:	CP-###-P	**Publish Date:**	11/01/16
Department:	Compliance	**Last Review Date:**	11/01/16
Function:	Accident and Incident Reporting	**Author: Regional Nurse Consultants**	
Process Contacts:	DVPN		

Scope

Assisted Living and Memory Care communities

Policy

All incident and injuries will be documented and reported. An accident or injury is any action involving a resident resulting in an injury or potential injury on any property of the community.

Procedure

Upon being informed of or witnessing an incident that could result in injury:

1. Stay with the resident and call for help as appropriate.
2. Call the supervisor in charge or the Executive Director immediately after making sure the resident is not in immediate danger. If the resident is in immediate danger, call 911 and notify the supervisor in charge and/or Executive Directive.
3. Stay with the resident until the 911 EMS crew arrives.
4. The EMS 911 crew will give any necessary directions. If the resident refuses to be transported, obtain a copy of the EMS paperwork for refusals and place into the resident's clinical record and report the refusal immediately to the family/POA and Physician. The Refusal of Treatment form should be filled out and placed with the incident report.

All incidents must be followed up as soon as the resident is not in immediate danger:

1. Notification of the resident's physician and resident's family member or responsible party (POA).
2. The incident charted in the resident's chart notes in Quick MAR. The incident report should not be referenced in your chart note. They are for internal use only and not part of the resident's permanent record.
3. Notification of your Regional Nurse Consultant (RNC)
4. Completion of the Incident Report

5. Incident reports need to be scanned to your RNC on the same day the incident occurred if it's a significant event. (See significant events listed below)

An incident is defined as any situation, event, accident or occurrence that is outside the course of normal operations.

The following incidents arise to the level of "significant events" and, in addition to the immediate verbal reporting as stated above, a RM-001 (Risk Management) form MUST be completed and scanned to your RNC for review before the form is faxed to Risk Management at 1-877-215-4364. Significant events include the following (related to residents, associates, or visitors/vendors):

1. Elopement with or without injury;
2. Fire of any degree or event;
3. Allegation of assault or abuse (physical, mental, or sexual);
4. Situations attracting media attention or inquiries;
5. Suicide or attempted suicide;
6. Suspected infectious disease outbreak;
7. Death of unknown or suspected origin;
8. Any time law enforcement is called;
9. Injuries sustained requiring hospitalization;
10. Medication error with injury or potential adverse effect;
11. Major property damage;
12. Stage III or IV pressure ulcer discovery;
13. Resident, family, visitor or third party threatens to sue or call a regulatory agency;
14. Falls involving injury;
15. Resident to resident altercations with or without injury;
16. Resident to staff altercation with or without injury;
17. Staff to staff altercations with or without injury, or staff to staff altercation with or without injury;
18. Injuries to employees requiring medical attention or hospitalization;
19. Motor vehicle incidents involving injury.

Altercation includes repeated, abusive verbal exchanges or a single heated verbal exchange coupled with physical action and does not generally include minor, isolated emotional or angry verbal exchange unless initiated by staff toward a resident.

Incident Report Specific

1. The staff member at the community who knows the most about the circumstances surrounding an incident will typically be requested to complete the incident report.
2. Each line of the Incident Report must be filled in. If there is not an answer, place "NA" for not applicable indicating the question was considered but was not applicable in this situation.
3. The Incident Report is NEVER placed in the resident's medical record, care plan or in his or her files unless required by applicable state or local law.

4. ALL Incident Reports are kept in 3-ring binders according to the month and year of the occurrence and maintained in the office of the Executive Director.
5. ALL Incident Reports are to be kept for a period of 5 years.
6. Incident Reports are NEVER photocopied or distributed to residents, families, visitors, contractors, or staff.
7. Incidents involving associates and/or staff injuries should immediately be reported to the community's BOM. The BOM will then report all associates incidents in accordance with company's workers compensation program.
8. Associate injuries and workers compensation claim information is maintained in the community's BOM's office.
9. DO NOT DOCUMENT IN THE RESIDENT'S CHART THAT AN INCIDENT REPORT WAS COMPLETED OR FILED. DO NOT REFER TO THE INCIDENT REPORT IN THE CHART DOCUMENTATION.
10. Witness statements are requested of those individuals who directly heard or saw the incident, as well as anyone that was present at the time incident occurred. Such statements are kept with the Incident Report and not in the resident's record.
11. Photos can be taken of the surroundings, property, equipment, autos, etc. Photos are NOT to be taken of our residents. Photos taken are kept with the Incident Report.

References

Incident Report form

RM-001 Form

Refusal of Treatment form

REFERENCE:

Resident to Resident Conflict

A resident to resident conflict is any altercation between two or more residents. This can come in the form of a repeated, heated or abusive verbal altercation or any physical altercation. If you come in contact, or you witness such an altercation, you MUST:

1. Separate the two residents immediately
2. If a physical altercation has occurred, contact EMS for transfer to the emergency room for assessment and treatment as necessary
3. Notify your supervisor immediately
4. Contact the residents' physicians and responsible parties
5. Fill out an incident report on both residents
6. Document conflict in both residents' chart notes
7. WD or designee to notify Craven County within 48 hours of incident
8. WD or designee to notify Regional Nurse Consultant within 24 hours of incident

Both residents will be evaluated by their physicians as soon as possible after the incident.