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 _____	R 01/11/2017

FEB 17 2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 a follow - up survey and complaint investigation on January 10 - 11, 2017. The complaint investigation was initiated by the Craven County Department of Social Services on January 6, 2017.	D 000	7. The Pharmacy Consultant provided Medication Technicians training on policy and procedures of medication administration, procedures to be followed when a resident refuses medication and resident rights that are impacted by medication administration practices and how to protect those rights. This training was conducted on January 18, 2017.	
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 observations, interviews, and record reviews, the facility failed to contact the physician for 2 of 5 sampled residents (#2 and #4) for medication refusals which included medications for high blood pressure and a weight loss supplement (Resident #2) and insulin for the treatment of diabetes (Resident #4). The findings are: 1.Review of Resident #2's current FL-2 dated for 04/05/16 revealed: -Diagnoses included major depression, history of conversion disorder, hypertension, gastro esophageal reflux disease, and ambulatory dysfunction. -There was a physician's order for Metoprolol (used to help reduce blood pressure) 50 milligrams (mg) 1 tablet twice a day by mouth.	D 273	Tag D912 G.S. 131D-21(2) Declaration of Resident's Rights Please refer to the Plan of Correction for Tag 366, 10A N.C.A.C. 13F. 1004(i) Medication Administration and the Plan of Correction for Tag 273, 10A N.C.A.C. 13F.0902(b) Health Care D 273-10A NCAC 13F.0902(b) Health Care 1. On January 9, 2017 and January 11, the physicians and families/POAs for Resident #2 and Resident #4 were contacted and made aware of the residents' medication refusals. No	

Reviewed & Accepted 2/17/17 BML

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D 273	Continued From page 1 Review of a physician's order dated for 11/11/16 revealed an order for Ensure (a nutritional suppliment) 1 can twice a day between meals. Review of Resident #2's November 2016 electronic Medication Administration Record (eMAR) revealed: 1A)-On 11/12/16 at 7:11 pm, Ensure was documented as refused due to "resident refusal". 1B)-On 11/02/16 at 9:43 pm, Metoprolol was documented as refused due to "resident refusal". -On 11/08/16 at 9:45 pm, Metoprolol was documented as refused due to "resident refusal". -On 11/12/16 at 6:11 pm, Metoprolol was documented as refused due to "resident refusal". Review of Resident #2's monthly blood pressure and weights dated 11/7/16 at 1:53 am revealed: -Resident #2 had a blood pressure of 152/88. -Resident #2 had a weight of 110 pounds. Review of Resident #2's December 2016 electronic Medication Administration Record (eMAR) revealed: 1A)-On 12/05/16 at 7:29 pm, Ensure was documented as refused due to "resident refusal". -On 12/10/16 at 7:32 pm, Ensure was documented as refused due to "resident refusal". -On 12/11/16 at 7:08 pm, Ensure was documented as refused due to "resident refusal". -On 12/15/16 at 7:32 pm, Ensure was documented as refused due to "resident refusal". -On 12/16/16 at 7:30 pm, Ensure was documented as refused due to "resident refusal". -On 12/20/16 at 7:37 pm, Ensure was documented as refused due to "resident refusal". -On 12/24/16 at 7:07 pm, Ensure was documented as refused due to "resident refusal". -On 12/25/16 at 7:02 pm, Ensure was	D 273	new orders for Resident #2 or #4 were received from the physicians based on these reports. 2. District Flex Nurse reviewed QuickMAR to determine if there were other residents who had documented refusals that had not been reported to their physician. Physicians were notified as well as family/POA of all residents with documented refusals that had not previously been reported to Physicians or family members and it was confirmed that no new orders were necessary for these residents. 3. Daily Clinical Review will be completed Monday thru Friday by the Executive Director (ED), the Wellness Director or designee, and the Radiance Resident Care Coordinator to ensure medication refusal are addressed with each resident and proper notification of physician and family/POA has been completed and documented (see attached). 4. Regional Nurse Consultant (RNC) will ensure daily clinical review is completed. Wellness Director or designee scans the Daily Clinical Review to the RNC Monday thru Friday so she can review and ensure compliance. This will be completed daily for 3 months then weekly for 3 months and then random audits will be done by the RNC to ensure compliance. 5. Medication Technicians have received training on January 10 and 11, 2017, on psychotropic medications and their side effects. anti-anxiety medications, medication non-compliance and medications used for residents living with Dementia. This training was provided by Linda Klund RN, from Trillium Health Resources. 6. Medication Technicians were given an in-service by District Flex Nurse on January 18, 2017, on Medication Refusals Policy and Procedures.	

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D 273	Continued From page 2	D 273		

documented as refused due to "resident refusal".
-On 12/28/16 at 7:26 pm, Ensure was documented as refused due to "resident refusal".
-On 12/29/16 at 7:10 pm, Ensure was documented as refused due to "resident refusal".
1B)-On 12/05/16 at 7:29 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/10/16 at 7:32 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/11/16 at 7:08 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/15/16 at 7:32 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/16/16 at 7:30 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/17/16 at 6:19 am, Metoprolol was documented as refused due to "resident refusal".
-On 12/20/16 at 7:37 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/24/16 at 7:07 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/25/16 at 7:02 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/28/16 at 7:26 pm, Metoprolol was documented as refused due to "resident refusal".
-On 12/29/16 at 7:10 pm, Metoprolol was documented as refused due to "resident refusal".

Review of Resident #2's monthly blood pressure and weights dated 12/30/16 at 6:05 pm revealed:
-Resident #2 had a blood pressure of 150/85.
-Resident #2 had a weight of 95.2 pounds.

Review of Resident #2's January (1-11), 2016 electronic Medication Administration Record (eMAR) revealed:
1A)-On 01/02/17 at 7:22 pm, Ensure was documented as refused due to "resident refusal".
-On 01/07/17 at 7:32 pm, Ensure was documented as refused due to "resident refusal".

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D 273	Continued From page 3 -On 01/08/17 at 7:50 pm, Ensure was documented as refused due to "resident refusal". 1B)-On 01/07/17 at 7:32 pm, Metoprolol was documented as refused due to "resident refusal". -On 01/08/17 at 7:50 pm, Metoprolol was documented as refused due to "resident refusal". Review of Resident #2's monthly blood pressure and weights for January 11, 2017 at 3:45 pm revealed: -Resident #2 had a blood pressure of 138/79. -Resident #2 had a weight of 97 pounds. Review of Resident #2's record revealed there was no documentation of notification of the primary care provider regarding medication refusals. Observation of Resident #2 on 01/10/17 at 11:43 revealed she took her medications at this time did not refuse them. Interview with Resident #2 on 01/10/17 at 2:45 pm revealed she was not interview able at this time. Interview with a Medication Aide on 01/10/17 at 11:50 am revealed: -She was not aware of Resident #2 refusing to take her medications for her. -She said some of the other Medication Aides will tell her that Resident #2 has refused her medications. -She felt that Resident #2 did need some encouragement with taking her medications. Interview with a second Mediation Aide on 01/11/17 at 3:30 pm revealed: -She passed medications on all of the hallways at the facility.	D 273		

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D 273	Continued From page 4 -Sometimes Resident #2 has to have encouragement to take her medications. -She always gives the resident 3 chances to take her medications. -She has been told that if a resident refuses the medication aide should offer the medications to the resident at 3 different times. -If the resident continues to refuse after 3 times the staff documents refused on the Medication Administration Record. -Resident #2 did refuse to allow some of the Medications Aides to administer her medications. -She was not aware of why Resident #2 would refuse to some of the Medication Aides to administer her medications. -Usually it was some of the night shift Medication Aides that would document Resident #2 refused her medications. Telephone interview with a Nurse Manager at the Physician's office for Resdient #2 on 01/11/17 at 12:10 PM revealed: -She said the facility has not contacted them in regards to Resident #2 refusing any of her medications until 01/10/17; on this day the office received a fax from the facility. -It is the expectation of the doctor to be notified about any medication refusals especially the Metoprolol and the Ensure. -Resident #2 has recently had some weight loss and that is why the doctor ordered the Ensure for her, and he needs to be made aware if she has refused them. -Resident #2 has also had some elevated blood pressure readings and the doctor would need to be aware if she was refusing her blood pressure medications. Refer to telephone interview with the Executive Director on 1/11/17 at 11:47 am.	D 273		

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D 273	Continued From page 5 2.Review of Resident #4's current FL-2 dated 4/11/16 revealed: -Diagnoses included chronic kidney disease stage 3, diabetes mellitus type II, hypertension, gout, hypercholesterolemia and bilateral lower extremity weakness. -There was a physician's order for Lantus insulin (used to treat high blood glucose in those with diabetes) 75 units subcutaneously (SQ) at bedtime. -There was a physician's order for Novolin R insulin (a short acting insulin used to treat high blood glucose in those with diabetes) 35 units SQ before meals. Review of a subsequent physician's order dated 12/7/16 for Resident #4 revealed decrease Novolin R insulin 25 units three times a day before meals. Review of a subsequent physician's order dated 12/9/16 for Resident #4 revealed Lantus 60 units at bedtime. Review of Resident #4's November 2016 electronic Medication Administration Record (eMAR) revealed: -Lantus insulin 75 units was scheduled daily at 8:00 pm. -Novolin R insulin was scheduled three times a day at 6:30 am, 11:30 am and 4:30 pm. -On 11/16/16 at 9:02 pm, Lantus insulin was documented as refused due to finger stick blood sugar results of "62". -On 11/22/16 at 6:08 am, Novolin R insulin was documented as refused due to finger stick blood sugar results being "low". -On 11/24/16 at 6:21 am, Novolin R insulin was documented as refused.	D 273		

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D 273	Continued From page 6 -On 11/26/16 at 8:56 pm, Lantus insulin was documented as refused. -On 11/30/16 at 8:18 pm, Lantus insulin was documented as refused. -The resident's finger stick blood sugar results ranged from 55 mg/dL - 279 mg/dL. Review of Resident #4's December 2016 electronic Medication Administration Record (eMAR) revealed: -Lantus insulin 75 units was scheduled daily at 8:00 pm from 12/1/16 - 12/9/16. -Lantus insulin 60 units was scheduled daily at 8:00 pm from 12/10/16- 12/31/16. -Novolin R insulin 35 units was scheduled three times a day at 6:30 am, 11:30 am and 4:30 pm from 12/1/16 - 12/7/16. -Novolin R insulin 25 units was scheduled three times a day at 7:30 am, 11:30 am and 4:30 pm from 12/8/16 - 12/31/16. -On 12/1/16 9:13 pm, Lantus insulin was documented as refused. -On 12/5/16 at 7:58, Lantus insulin was documented as refused. -On 12/6/16 at 6:11 am, Novolin R insulin was documented as refused. -On 12/7/16 at 9:22 pm, Lantus insulin was documented as refused. -On 12/8/16 at 7:29 pm, Lantus insulin was documented as refused. -On 12/9/16 at 8:56 pm, Lantus insulin was documented as refused. -On 12/10/16 at 7:55 pm, Lantus insulin was documented as refused. -On 12/15/16 at 3:47 pm, Novolin R insulin was documented as refused with finger stick blood sugar "89". -On 12/15/16 at 8:03 pm, Lantus insulin was documented as refused. -On 12/16/16 at 8:18 pm, Lantus insulin was	D 273		

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D 273	Continued From page 7 documented as refused. -On 12/24/16 at 8:39 pm, Lantus insulin was documented as refused. -On 12/27/16 at 4:03 pm, Novolin R insulin was documented as refused. -On 12/28/16 at 8:01 pm, Lantus insulin was documented as refused. -On 12/29/16 at 7:51 pm, Lantus insulin was documented as refused. -The resident's finger stick blood sugar results ranged from 66 mg/dL - 332 mg/dL. Review of Resident #4's January 1-11, 2017 electronic Medication Administration Record (eMAR) revealed: -Lantus insulin 60 units was scheduled daily at 8:00 pm. -Novolin R insulin 25 units was scheduled three times a day at 7:30 am, 11:30 am and 4:30 pm. -On 1/7/17 at 6:21 pm, Novolin R insulin was documented as refused. -On 1/7/17 at 7:58 pm, Lantus insulin was documented as refused. -On 1/8/17 at 6:09 pm, Novolin R insulin was documented as refused. -On 1/8/17 at 9:00 pm, Lantus insulin was documented as refused. -On 1/9/17 at 7:37 pm, Lantus insulin was documented as refused. -The resident's finger stick blood sugar results ranged from 74 mg/dL - 451 mg/dL. Review of Resident #4's chart notes dated 10/5/16 - 1/11/17 revealed: -There was no documentation of notification of the primary care provider (PCP) regarding medication refusals until 1/10/17. -The chart note on 1/10/17 noted "physician communication", PCP notified of insulin refusals for 1/7/17, 1/8/17 and 1/9/17 and a record of	D 273		

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D 273	Continued From page 8 finger stick blood sugar results was sent to PCP for the last 30 days. Interview with Resident #4 on 1/10/17 at 3:00 pm revealed: -The resident was a diabetic and received insulin injections 3-4 times a day. -The resident was unsure of the types of medications given to him. -He felt his finger stick blood sugar results had been within a "good" range for him. -The resident would "never" refuse any medications from the Medication Aides. -The resident could tell if his blood sugar was low because he "couldn't think right". -The resident could not remember the last time his blood sugar had been low. Interview with a Medication Aide (MA) on 1/10/17 at 3:10 pm revealed: -She worked on first shirt from 7:00 am - 3:00 pm. -Resident #4 was alert and oriented and he had never refused medications during her shift. -If a resident refused a medication, she would document the refusal on the electronic medication administration record (eMAR). -She knew to document refusals on the eMAR because she learned that at her previous job. -She was not instructed to document the refusals anywhere else. -She was not responsible for notifying anyone at the facility. -She was not responsible for contacting the primary care provider. Interview with a second MA on 1/10/17 at 3:15 pm revealed: -She typically worked second shift from 3:00 pm - 11:00 pm.	D 273		

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D 273	Continued From page 9 -Resident #4 was alert and oriented. -Resident #4 would sometimes refuse his insulin depending how he felt. -When a resident refused a medication, she would notify the nurse or leave a note if the nurse was not there. -The previous nurse had instructed her that way. -She was not sure if there was a policy on medication refusals. Interview with the Regional Nurse on 1/11/17 at 9:20 am revealed: -She had notified the primary care provider (PCP) of Resident #4's insulin refusals for January 2017 on 1/10/17. -She had not received any new medication orders from Resident #4's PCP. -She was unsure of what the previous Health and Wellness Director had instructed staff to do in the event of a resident refusing medications. -The previous Health and Wellness Coordinator left in the middle of December 2016. -She had been filling in until a new HWC could be hired. -She had implemented a policy on 1/6/17 for staff to follow regarding medication orders and medication refusals. Telephone interview with a Medical Assistant at Resident #4's Primary Care Providers (PCP) office on 1/11/17 at 9:35 am revealed: -Resident #4 was seen by the PCP in the office on 12/9/16. -The PCP notes documented that Resident #4 was alone at the time of the appointment. -The PCP notes documented Resident #4 would refuse his Lantus insulin at times due to low blood sugar. -The PCP's office did not have a set protocol on when a facility should notify them regarding	D 273		

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D 273	Continued From page 10 medication refusals. -The facility should have a policy that required them to notify the PCP regarding medication refusals. -With the number of insulin refusals by Resident #4, the PCP should have been notified. -There was no documentation of the facility's effort to notify the PCP until 1/10/17. Refer to telephone interview with the Executive Director on 1/11/17 at 11:47 am. The facility failed to assure referral and follow-up to meet the routine medical needs of 2 of 5 residents which had a total of 54 medication refusals in 3 months, these medications included medications for weight management, blood pressure and diabetes. The failure of the facility to notify the Primary Care Provider was detrimental to the health of the residents and constitutes a Type B Violation. Telephone interview with the Executive Director on 1/11/17 at 11:47 am revealed: -He was not aware of all the medication refusals. -He was not aware of the policy for medication refusals but there was a policy at the facility that the staff could provide. Review of the Plan of Protection provided by the facility on 1/11/17 revealed: -The Health and Wellness Director (HWD) will discuss medication refusal procedure with each medication aide to ensure their understanding. -Refusals of medications or treatments will be reported to the HWD after at least 2 attempts have been made to administer the medication to the resident. -The HWD would speak to the resident to determine the reason the resident refused.	D 273		

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D 273	Continued From page 11 -The HWD or a designee would notify the Primary Care Provider and Family/Power of Attorney of each resident ' s refusal and document the notifications. -A daily clinical review would be completed Monday - Friday by the Executive Director, HWD and the Resident Care Coordinator to ensure medication refusals are addressed with each resident and proper notifications and documentation. -Regional Nurse Consultant will provide training to Medication Aides on 1/18/17 on medication refusal policy. -Regional Nurse Consultant will ensure daily clinical review is completed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2017.	D 273		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the Electronic Medication Administration Records (eMARs) were	D 366		

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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 366	Continued From page 12 accurate to include the initials of the Medication Aides which administered the medications for 2 of 3 sampled residents (Resident #4 and Resident #5) with orders for medications to be administered at 6:00 am. The findings are: 1. Review of Resident #4's current FL-2 dated for 4/11/16 revealed: -Diagnoses included chronic kidney disease stage 3, diabetes mellitus type II, hypertension, gout, hypercholesterolemia and bilateral lower extremity weakness. -A physician's order for Prednisone 2.5 milligrams (mg) (used to treat inflammation) take 1 tablet twice a day. Review of December 2016 eMAR's for Resident #4 revealed: -Prednisone 2.5 mg was scheduled to be given twice a day at 6:00 am and 6:00 pm. -Prednisone 2.5 mg was documented as administered daily at 6:00 am. -Staff A's initials were documented as the Medication Aide which administered the medication at 6:00 am. -Staff A's initials were documented daily at 6:00 AM from 12/11/16 - 12/31/16. -Staff A was not working on 12/13/16, 12/14/16, 12/18/16, 12/19/16, 12/23/16, 12/24/16, 12/27/16 and 12/28/16. -Staff A's initials were used to document the administration of medications which Staff B administered. Refer to interview with Staff A on 1/11/17 at 10:30 AM. Refer to interview with Staff B on 1/11/17 at 10:55	D 366	D 366-10A NCAC 13F.1004 Medication Administration 1. Medication Technicians have been in-serviced on QuickMAR's Policies and Procedures, which includes not sharing your login information with other staff members. 2. They were also trained on how to request new login information if their logins stop working. 3. Staff B was given her own login information on January 11, 2017 and can access QuickMAR and has been trained on how to request new login information if her login information stops working. 4. Regional Nurse Consultant visited community on January 24, 2017, and verified that the Medication Technicians have their own logins. 5. District Flex Nurse has audited current users in QuickMAR to ensure Medication Technicians have their own login and they are correct to access QuickMAR.	

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D 366	Continued From page 13 AM. Refer to telephone interview with the Executive Director on 1/11/17 at 11:47 AM. Refer to interview with the Regional Nurse on 1/11/17 at 12:00 PM. 2..Review of Resident #5's current FL-2 dated for 12/01/16 revealed: -Diagnoses included dementia, osteoarthritis, hypertension, hyperlipidemia and sleep apnea. -There was a physician's order for Omeprazole 20 milligrams (used to treat acid reflux) delayed release take 1 capsule by mouth every day. Review of December 2016 eMAR's for Resident #5 revealed: -Omeprazole 20 mg was documented as administered daily at 6:00 am. -Staff A's initials were documented as the Medication Aide who administered the medication. -Staff A's initials were documented daily at 6:00 AM from 12/11/16 - 12/31/16. -Staff A was not working on 12/13/16, 12/14/16, 12/18/16, 12/19/16, 12/23/16, 12/24/16, 12/27/16 and 12/28/16. -Staff A's initials were used to document the administration of medications which Staff B administered. Review of time cards for December 2016 for Staff A revealed Staff A was not documented as working on 12/13/16, 12/14/16, 12/18/16, 12/19/16, 12/23/16, 12/24/16, 12/27/16 and 12/28/16. Review of time cards for December 2016 for Staff B revealed Staff B was documented as working	D 366	6. Wellness Director or designee will conduct random weekly audits of Medicatlon Technicians to ensure all logins are operated correctly. After three weeks in which no concerns are identified, the Wellness Director or designee will conduct monthly record reviews to ensure logins are operational, or if there has been an issue with login information, the Medication Technician took appropriate steps to obtain new login information. Any concerns or issues identified by the Wellness Director or designee will be reported to the Executive Director and the WD and ED will develop an action plan to correct any concerns or issues. 7. The Pharmacy Consultant provided Medication Technicians training on policy and procedures of medication administration, procedures to be followed when a resident refuses medication and resident rights that are impacted by medication administration practices and how to protect those rights. This training was conducted on January 18, 2017.	

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D 366	Continued From page 14 on 12/13/16, 12/14/16, 12/18/16, 12/19/16, 12/23/16, 12/24/16, 12/27/16 and 12/28/16. Refer to interview with Staff A on 1/11/17 at 10:30 am. Refer to interview with Staff B on 1/11/17 at 10:55 am. Refer to telephone interview with the Executive Director on 1/11/17 at 11:47 am. Refer to interview with the Regional Nurse on 1/11/17 at 12:00 am. Interview with Staff A on 1/11/17 at 10:30 am revealed: -She worked on third shift from 7:00 pm - 7:00 am as a Medication Aide. -On third shift there is only 1 Medication Aide. -Some of the documentation on the eMAR for December 2016 was not actually hers. -She was told by the previous Health and Wellness Director to allow another MA to use her login information due to computer problems. -The other MA had problems with the computer and was unable to log in the eMAR to administer medications. -She was not sure how many days the other MA used her log on information, she thought about 2-3 times. -She thought it was alright to give her log on information to the other MA because management told her to do so. -She thought management had documentation of when the other MA utilized her log on information. Interview with Staff B on 1/11/17 at 10:55 am revealed: -She worked as a Medication Aide on third shift	D 366		

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D 366	Continued From page 15 from 11:00 pm - 7:00 am. -There was only one MA that worked on third shift. -She had problems in December 2016 with her computer log on to document medications on the eMAR. -She utilized another MA's log on information to document the administration of medications. - She was told by the Executive Director to utilize another MA's computer log on to document the administration of medications until hers could be fixed. -She was "locked out" of the computer for about 3 weeks. -She was not sure how many days she utilized the other MA's log on to administer medications. Telephone interview with the Executive Director on 1/11/17 at 11:47 am revealed: -He was aware that a Medication Aide was having problems logging onto the computer to administer medications. -He instructed Staff B to use Staff A's log on information to administer medications. -There was documentation for the days that Staff B used Staff A's log on information. -Someone at the facility could run the report to show which days the Medication Aide used the wrong log on. -The MA was allowed to utilize another MA's log on to ensure the resident's received their medications as prescribed. -He felt the resident's receiving their medications as ordered was the priority. Interview with the Regional Nurse on 1/11/17 at 12:00 pm revealed: -She was not aware there was a MA utilizing another MA's log on information to administer medications.	D 366		

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D 366	Continued From page 16 -She was not aware of any way to document which MA actually administered medications other than by the log on information.	D 366		
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 adequato, 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 residents records, care, and services; which are adequate, appropriate, and in compliance with relevant federal and state rules and regulations related to health care. The findings are: Based on observations, interviews and record reviews the facility failed to assure the Electronic Medication Administration Records (eMARs) were accurate to include the initials of the Medication Aides which administered the medications for 2 of 3 sampled residents (Resident #4 and Resident #5) with orders for medications to be administered at 6:00 am. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care. (Type B Violation)].	D912		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her	D917		

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D917	Continued From page 17 requests from the facility administrator and staff. This Rule is not met as evidenced by: The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to respond to 1 of 1 sampled resident (Resident #5) requests to move to another room due to the behaviors issues of the roommate that resulted in sleep disturbances. The findings are: Review of Resident #5's current FL-2 dated 12/01/16 revealed diagnoses included dementia, osteoarthritis, hypertension, hyperlipidemia and sleep apnea. Review of Resident #5's Resident Register revealed an admission date of 12/26/14. Observation of Resident #5's room on 01/10/17 at 10:15 am during the initial tour revealed the room smelled of urine. Interview with Resident #5 on 01/10/17 at 10:15 am revealed: - The resident apologized twice because her room smelled of urine. - She had been roommates with Resident #6 for "about a year". - The resident had observed Resident #6 deteriorating for approximately 6 months but much faster the past 2 months. - Resident #6 had not been able to find the bathroom in their room for the past 2 months. - Resident #6 had been urinating on the floor and on the table beside her chair. - Resident #5 was "tired of her room smelling like	D917		

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D917	Continued From page 18 an outdoor toilet". Interview with a first shift Personal Care Aide on 01/10/17 at 10:35 am revealed Resident #6 is confused most of the time and urinates on the floor and on the table in her room at least a couple of days a week. Interview with a first shift Medication Aide on 01/10/17 at 11:00 am revealed resident #5 had complained to her more than 10 times that Resident #6 had been keeping her up at night by talking and walking around which had prevented Resident #5 from sleeping. Interview with the facility secretary on 01/11/17 at 8:25 am revealed: - She had been aware that Resident #5 wanted to be separated from Resident #6. - Resident #5 had talked with her and the Administrator a couple of times during the past month about wanting to be separated from Resident #6. -Resident #5 had informed her that Resident #6 needed more care than she was receiving. Interview with a Wellness Care Coordinator on 01/11/17 at 9:10 am revealed: -She had been made aware approximately a month prior that Resident #6's mental status had deteriorated. -She had not evaluated Resident #6 regarding changing her level of care because she had not been instructed by the Executive Director. -She was not sure if Resident #6's family had not wanted her to be moved at all or they wanted to wait until there was a Medicaid available bed in their special care unit. Telephone interview with Resident #6's Power of	D917	D 917 G.S. 132D-21(7) Declaration of Resident's Rights 1. Resident #5 and #6 were moved to separate rooms. Both residents' families/POAs were notified. Room transfer was completed on January 30, 2017. 2. Resident #6 was moved to Memory Care on February 8, 2017. 3. Review of records and complaints did not reveal any other residents who were requesting new roommates due to behavior issues or concerns with current roommates. 4. Resident room change requests will be reviewed with the Regional Nurse Consultant by the Wellness Director or designee and the Executive Director when the request is made. Staff will be in-serviced by the Wellness Director or designee on reporting any issues between residents, to include altercations, either verbal or physical, to WD or designee. This in-service will be completed by February 17, 2017. 5. Wellness Director of designee will review requests for room changes/behavioral concerns weekly to ensure actions are being taken and appropriate notification and documentation is completed. After 3 weeks in which no concerns are identified, the Wellness Director or designee will conduct monthly record reviews to ensure request for roommate changes/changes on resident's behavior are being appropriately documented and addressed.	

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D917	Continued From page 19 Attorney on 01/11/17 at 9:55 am revealed: -He had attended a family meeting at the facility on 12/28/16 and discussed the worsening mental condition of Resident #6 with the Executive Director. -It was decided at the family meeting that Resident #6 needed to be assessed by a physician to see if there was a need for a higher level of care. -He had been informed by the Executive Director last week that a physician assessed Resident #6 and indicated that she needed to be moved to a special care unit. -He had been informed by the Executive Director that their special care unit was full and Resident #6 would be moved as soon as a bed became available. -He had been made aware by the Executive Director and Resident #5 that Resident #5 had asked to be separated from Resident #6. Interview with Resident #5 on 01/11/17 at 10:20 am revealed: - She had talked with the Executive Director at least twice the past two months about wanting to be separated from Resident #6. - She had been having headaches every morning due to not being able to sleep because Resident #6 was wandering around the room, talking and using the bathroom in the floor. - She had pushed her call button 3 times within 30 minutes last night because Resident #6 had been "talking and ripping the sheets off her bed". Interview with a first shift housekeeper on 01/11/17 at 10:27 am revealed: -Resident #6 used to be able to use the telephone in her room but during the past couple of months she had lost that ability and depended on Resident #5 to assist her.	D917		

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D917	Continued From page 20 -Resident #6 had been unable to find the dining room the past couple of months and Resident #5 had assisted her. - Most resident rooms were cleaned twice weekly but the room that Resident #5 and Resident #6 shared had to be cleaned at least once a day due to the odor of urine. Telephone interview with the Executive Director on 01/11/17 at 11:50 am revealed: - Resident #5 had asked him about a month ago to be separated from Resident #6 due to the increase in Resident #6's worsening dementia. -The two residents had not been separated because they only had 3 available beds. - The available beds were located in rooms with other residents that had issues so he did not feel that the move would have improved the situation for either resident. - Staff had not informed him that Resident #6 had been keeping Resident #5 awake at night. - He planned to move one of the residents to a recently vacated bed later this week. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to respond to 1 of 1 sampled resident (Resident #5) requests to move to another room due to the behaviors issues of the roommate that resulted in sleep disturbances. The findings are: Review of Resident #5's current FL-2 dated 12/01/16 revealed diagnoses included dementia,	D917		

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D917	Continued From page 21 osteoarthritis, hypertension, hyperlipidemia and sleep apnea. Review of Resident #5's Resident Register revealed an admission date of 12/26/14. Observation of Resident #5's room on 01/10/17 at 10:15 am during the initial tour revealed the room smelled of urine. Interview with Resident #5 on 01/10/17 at 10:15 am revealed: - The resident apologized twice because her room smelled of urine. - She had been roommates with Resident #6 for "about a year". - The resident had observed Resident #6 deteriorating for approximately 6 months but much faster the past 2 months. - Resident #6 had not been able to find the bathroom in their room for the past 2 months. - Resident #6 had been urinating on the floor and on the table beside her chair. - Resident #5 was "tired of her room smelling like an outdoor toilet". Interview with a first shift Personal Care Aide on 01/10/17 at 10:35 am revealed Resident #6 is confused most of the time and urinates on the floor and on the table in her room at least a couple of days a week. Interview with a first shift Medication Aide on 01/10/17 at 11:00 am revealed resident #5 had complained to her more than 10 times that Resident #6 had been keeping her up at night by talking and walking around which had prevented Resident #5 from sleeping. Interview with the facility secretary on 01/11/17 at	D917		

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D917	Continued From page 22 8:25 am revealed: - She had been aware that Resident #5 wanted to be separated from Resident #6. - Resident #5 had talked with her and the Administrator a couple of times during the past month about wanting to be separated from Resident #6. -Resident #5 had informed her that Resident #6 needed more care than she was receiving. Interview with a Wellness Care Coordinator on 01/11/17 at 9:10 am revealed: -She had been made aware approximately a month prior that Resident #6's mental status had deteriorated. -She had not evaluated Resident #6 regarding changing her level of care because she had not been instructed by the Executive Director. -She was not sure if Resident #6's family had not wanted her to be moved at all or they wanted to wait until there was a Medicaid available bed in their special care unit. Telephone interview with Resident #6's Power of Attorney on 01/11/17 at 9:55 am revealed: -He had attended a family meeting at the facility on 12/28/16 and discussed the worsening mental condition of Resident #6 with the Executive Director. -It was decided at the family meeting that Resident #6 needed to be assessed by a physician to see if there was a need for a higher level of care. -He had been informed by the Executive Director last week that a physician assessed Resident #6 and indicated that she needed to be moved to a special care unit. -He had been informed by the Executive Director that their special care unit was full and Resident #6 would be moved as soon as a bed became	D917		

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D917	Continued From page 23 available. -He had been made aware by the Executive Director and Resident #5 that Resident #5 had asked to be separated from Resident #6. Interview with Resident #5 on 01/11/17 at 10:20 am revealed: - She had talked with the Executive Director at least twice the past two months about wanting to be separated from Resident #6. - She had been having headaches every morning due to not being able to sleep because Resident #6 was wandering around the room, talking and using the bathroom in the floor. - She had pushed her call button 3 times within 30 minutes last night because Resident #6 had been "talking and ripping the sheets off her bed". Interview with a first shift housekeeper on 01/11/17 at 10:27 am revealed: -Resident #6 used to be able to use the telephone in her room but during the past couple of months she had lost that ability and depended on Resident #5 to assist her. -Resident #6 had been unable to find the dining room the past couple of months and Resident #5 had assisted her. - Most resident rooms were cleaned twice weekly but the room that Resident #5 and Resident #6 shared had to be cleaned at least once a day due to the odor of urine. Telephone interview with the Executive Director on 01/11/17 at 11:50 am revealed: - Resident #5 had asked him about a month ago to be separated from Resident #6 due to the increase in Resident #6's worsening dementia. -The two residents had not been separated because they only had 3 available beds. - The available beds were located in rooms with	D917		

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 _____	R 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
D917	Continued From page 24 other residents that had issues so he did not feel that the move would have improved the situation for either resident. - Staff had not informed him that Resident #6 had been keeping Resident #5 awake at night. - He planned to move one of the residents to a recently vacated bed later this week.	D917		