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D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted a Annual survey on January 11, 12, 13 with a phone exit on 1/18/17.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to test 1 of 5 sampled residents (Resident #3) for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services. The findings are: Review of Resident #3's current FL2 dated revealed diagnoses that included Alzheimer's disease, psychotic disorder and dysphagia. Review of Resident #3's Resident Register revealed an admission date of 8/5/16.	D 234		

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Review of Resident #3's resident record revealed:
-She had been living at a skilled nursing facility prior to admission to the current facility.
-There was no documentation of TB skin testing completed in the skilled nursing facility.
-There was no documentation of TB skin testing upon admission to the facility.

Interview on 1/12/17 at 11:07am with Staff D, Medication Aide (MA) revealed:
-Resident #3 had lived at the facility since August of 2016.
-TB skin testing was required upon admission to that facility.
-She did not know if Resident #3 had been tested for TB in the past.

Interview on 1/13/17 at 3:30pm with the Health and Wellness Director revealed:
-She had been employed since September 2016.
-She had completed an audit of TB testing after she came as she was responsible for them.
-She stated Resident #3 was admitted to the facility prior to her employment with the facility.
-She was not sure if Resident #3 had a TB test when she entered the facility but thought she had had one prior to her admission at the skilled facility.
-She could not find a TB test prior to Resident #3's admission or after her admission in Resident# 3's medical record.

Interview on 1/13/17 at 12:30pm and 3:47pm with the Executive Director revealed:
-She did not know why Resident #3 did not have documentation of TB skin testing in their records.
-She had asked staff to call the facility where she came from to obtain a copy if they had one but had not recieved one.
-She was aware of the TB skin testing upon

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D 234	Continued From page 2 admission requirement. -The Health and Wellness Director was responsible for assuring TB skin test were done. -She would assure the facility followed the regulation and all new admissions would be tested for TB disease as required. _____ The facility provided a Plan of Protection on 1/13/17 that revealed: -TB will be "planted for resident immediately". - "All patients being admitted from this day forward will have a TB skin test of chest x-ray prior to or at the date of admission." - "Will have documentation prior to move in per the Health and Wellness Director/Executive Director or the Resident Care Coordinator." - Record review will be completed and residents who have not had a TB skin test will have one done per the Health and Wellness Director." THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 17, 2017.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and	D 270		

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interviews, the facility failed to provide appropriate supervision for 1 of 5 sampled residents (Resident #2) in accordance with the resident's assessed needs, care plan and current symptoms related to decline in condition and falls.

The findings are:

Review of Resident #2's current FL2 dated 1/11/17 revealed:
-Diagnoses included hypertension, osteoarthritis, depression, tremor and history of renal insufficiency.
-Medications included Norvasc and hydrochlorothiazide (antihypertensive's), Trazodone (an antidepressant also used for insomnia), Klonopin (for insomnia), Ambien (routine) and an additional, as needed dose, may take with the routine bedtime dose or when/if she awakens during the night (for sleep), mirtazapine (an antidepressant), Sinemet (used to treat tremors in Parkinson's disease), and Melatonin (for sleep).
-She was ambulatory, continent of bowel and bladder, used glasses and required personal care assistance with bathing.
-A physician's order for a front wheeled walker and to use a wheelchair for transfers/locomotion.
-A physician's order to use a sling for her right arm as needed until the arm/shoulder is healed.
-Under the section "Skin", a notion of bruises with no location(s) specified.
-A physician's order under the section "Special Care Factors", for PT (physical therapy) three time weekly.

Review of Resident #2's Resident Register revealed an admission date of 9/4/14.

Review of Resident #2's record revealed

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D 270	Continued From page 4 additional diagnoses of: -Parkinson's Disease, Parkinsonism, restless leg syndrome, anxiety, insomnia, and nocturnal leg cramps documented in the "Visit Summary" by the attending physician on 6/12/16, and a fracture of the right clavicle noted on 1/13/17. -Chronic bronchitis, dyspnea, and periodic limb movement disorder probably due to dyskinesia (distortion or impairment of voluntary movement as in a spasm) from Parkinson's noted by her neurologist on 1/3/17. -Double vision and 6th nerve palsy of both eyes (weakness of the muscle that rotates the eye away from the nose) noted during an office visit with her opthamalogist on 7/29/16. Review of Resident #2's Personal Service Plan (PSP) dated 4/15/16 revealed: -She ambulated with a walker. -She had been identified at risk of falls. -Falls interventions: Consider request for further evaluation by primary care provider regarding changes and observations (may include labs and medication review), consider involvement of PT and/or OT (occupational therapy) to consult regarding strength, gait training, cognition, and adaptive equipment, place personal items within reach, ensure safe walkways with furniture placement, increased lighting, ensure proper fitting clothes and shoes, remind to use assistive devices and ensure they are in good working order, increase frequency of rounds, encourage resident to call for assistance, eye examinations as needed and to notify the Health and Wellness Director (HWD) for any changes in condition. Review of Resident #2's current PSP dated 10/11/16 revealed: -The staff to "be alert to heightened risk for falling."	D 270		

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-A history of falls and use of a walker as a mobility aid.
-Falls with harm/injury without outside treatment and/or observation.
-Showering assistance provided due to history of falls.
-She could transfer and toilet herself.
-She had been independent getting around the facility.
-Fall interventions were the same as those listed on the PSP dated 4/15/16.

Observations on 1/11/17 at 11:55am of Resident #2 revealed:
-She was sitting on the side of her bed in her room.
-Her rolling walker was in front of her and a breakfast tray had been placed on it's seat.
-The other side of the bed was against the wall.
-She did not have her right arm in a sling.
-There was old bruising and scabs on both knees and bruising on her upper right leg and thigh.
-There was bruising under her right eye, on her right forehead and on her left cheek.
-There was extensive cranberry red and yellow colored bruising from below her right ear onto her upper right shoulder, chest and back.
-She attempted to raise a half filled cup of water to her mouth with her right hand but was unable to do so.
-She tried to use her left hand to raise her right hand holding the cup but she could not lift her right hand due to the pain in her right shoulder.
-She put the cup in her left hand and lifted it to her mouth.
-When she tipped her head back to drink, she lost her balance and started to fall back onto the bed but was caught by the Medication Aide (MA) before her head hit the wall.

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D 270	Continued From page 6 Interview on 1/11/17 at 12:05pm with Resident #2 revealed: -She had fallen out of a chair several days before and broken her right shoulder. -She had fallen multiple times in the past. -She had been to the Emergency Room (ER) several times after falling and hitting her head. -This was the first time she had broken any bones. -She sometimes had difficulty with her balance but did not use her call pendant for help because she did not want to bother the staff. -She had physical therapy in November 2016, and she felt it had been good for her. -Sometimes she had difficulty managing her walker but the doctor had recently ordered her a different kind. -Since breaking her shoulder, she can not use a walker because it hurt her shoulder. -The staff told her they would take her to the dining room in a wheelchair until her shoulder healed. Review of the Licensed Health Professional Support (LHPS) evaluations in Resident #2's record revealed: -On 12/7/16: PT (due to falls); ambulation without difficulty using a rollating walker; independent with all ADLs (staff assistance with showers for safety) and no recommended changes and/or follow-up had been made. -On 1/11/17: Personal care tasks included applying and removing her sling; PT (for falls), transferring semi-ambulatory residents, and ambulation using assistive devices that require physical assistance. The resident ambulated without difficulty using a rollating walker; was independent with all ADLs (staff assistance with showers for safety), staff assisted with all ADLs and transfers to a wheelchair since unable to use	D 270		

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walker due to clavicle fracture and no recommended changes and/or follow-up had been made.

Review of Resident #2's record revealed from August 1, 2016 through January 13, 2017, the resident had fallen 22 times and had been transported to the hospital twice due to falls with head injuries and once for a fall that resulted in a fractured clavicle.

Review of Resident #2's August 2016 falls revealed:
-On 8/10/16 at 9:00pm: Found on the floor by recliner, no injury noted.
-On 8/15/16 at 9:30pm: Found on bathroom floor, had lost her balance and fell, no injury noted. Used her call pendant.
-On 8/22/16 at 8:40pm: Tried to open her refrigerator and fell, small red mark on back noted. Used her call pendant.

Review of Resident #2's Incident Reports and Post Fall Evaluation sheets for August 2016 revealed:
-On 8/10/16: No identifiable factors. Interventions: Encourage resident to call for assistance when needed, educate on use of emergency call system/pendant, increase frequency of monitoring (rounds, group activities etc...), report any changes to supervisor, remind to use assistive devices, has 4 wheeled rolling walker and physical therapy.
-On 8/15/16: No change in interventions. No documentation of a post-fall evaluation.
-On 8/22/16: No change in interventions. No documentation of a post-fall evaluation.

Review of Resident #2's September 2016 falls revealed on 9/15/16 at 5:50pm she had been

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found on the bathroom floor, had lost her balance and fell, small scratch above her right elbow noted. Had used her call pendant

Review of Resident #2's Incident Reports and Post Fall Evaluation sheet for September 2016 revealed:
-No identifiable factors.
-Added intervention: Keep room clean and clutter free.

Review of Resident #2's October 2016 falls revealed:
-On 10/8/16 at 2:10pm: Staff noticed a bruise on her right cheek, she had tripped over a chair in her room about 7:30am and hit her cheek on the chair.
-On 10/22/16 at 1:40pm: Found on floor next to bed, stated she slid off, no injury noted.

Review of Resident #2's Incident Reports and Post Fall Evaluation sheet for October 2016 revealed:
-On 10/8/16: Change noted in ability to transfer or ambulate. Noted resident has a walker and PT. No change in interventions.
-On 10/22/16: No identifiable factors. Change noted in ability to transfer or ambulate. Added intervention: Encourage her to sit and rest when fatigued. Has walker and PT.

There were no falls documented for Resident #2 in November 2016.

Review of Resident #2's December 2016 falls revealed:
-On 12/6/16 at 8:00pm: Found on floor by bed, stated she slipped and fell, no injury noted.
-On 12/8/16 at 2:00pm: Found on floor by her dresser, stated lost her balance and fell, no injury

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noted.
-On 12/11/16 at 8:00pm: Found on floor in front of her dresser, stated lost her balance and fell, small red area middle back noted.
-On 12/18/16 at 6:20pm: Found on her bathroom floor, stated lost her balance and fell, no injury noted.
-On 12/21/16: Seen by physician, identified as a high falls risk, PT ordered.
-On 12/21/16 at 10:00pm: Found on her bathroom floor, lost her balance and fell, no injury noted.
-On 12/22/16 at 4:00am: Found on bathroom floor, lost her balance and fell backwards, red spot middle of her back noted.
-On 12/22/16 at 9:10am: Found on her bathroom floor, no injury noted.
-On 12/22/16 at 7:40pm: Found on her bathroom floor, no injury noted.
-On 12/22/16 at 9:35pm: Found on her bathroom floor, lost her balance and fell, "pump knot" and bruise on right forehead and bruising on left thigh, to Emergency Room (ER). Computerized Tomography (CT) scan of the head-negative for acute hemorrhage/infarction; CT scan of the neck-negative for fracture. Diagnosis-Urinary tract infection (UTI).
-On 12/23/16: An entry stating the resident had been unsteady and staff assisted her to the bathroom and dining room. The staff had been informed to do frequent checks and send her back to the ER if she declined.
-On 12/24/16 an entry noting the staff were assisting the resident with some activities of daily living (ADLs).
-On 12/28/16 at 7:30am: Found on bathroom floor, laying on right side with part of walker under her, lost her balance, no injury noted.
-On 12/29/16 at 7:05am: Found on the floor in her room, she "got dizzy and fell" hitting her head,

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new bruising and swelling to right forehead, abrasions to both knees, very unsteady and walking leaning forward, to ER for evaluation. Negative findings.

Review of Resident #2's Incident Reports and Post Fall Evaluation sheet for December 2016 revealed:
-On 12/6/16: No change in interventions. No documentation of a post -fall evaluation.
-On 12/8/16: No documentation of an incident report or a post fall evaluation.
-On 12/11/16: No identifiable factors. No change in interventions.
-On 12/18/16: Improper footwear identified but not addressed. Interventions unchanged.
-On 12/21/16: Change in ability to transfer or ambulate, has unsteady gait. No change in interventions.
-On 12/22/16 (4:00am): No documentation of an incident report or a post fall evaluation.
-On 12/22/16 (9:10am): No documentation of an incident report or a post fall evaluation.
-On 12/22/16 (7:40pm): No identifiable factors. Noted to have walker and PT. No change in interventions.
-On 12/22/16 (9:35pm): No identifiable factors. Noted to be second fall in 2 hours. This fall with head injury, sent to ER. Returned with falls prevention literature. No change in interventions.
-On 12/28/16: Staff to make sure walkways are clear and clutter free and apartment rearranged to help with independence with safe transfers and safe walkways. Noted the resident had a urinary tract infection (UTI).
-On 12/29/16: Noted resident was dizzy and unsteady, had a walker and PT. No change in interventions.

Review of Resident #2's January 2017 falls

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revealed:
-On 1/3/17 at 8:30pm: Found on the floor in front of recliner, slid onto the floor, no injury noted.
-On 1/4/17 she told the staff, "I feel dizzy with my eyes open and closed and my eyes are so sensitive to the light."
-On 1/9/17 at 2:00pm: While putting on her shoes and socks, after podiatrist trimmed her toenails, she leaned forward and fell out of her chair onto the floor, complained of right shoulder pain which looked "displaced" to the staff. To ER. Diagnosis: Right clavicle shaft fracture. Returned with orders for pain medication, a sling to use as needed and to make an appointment with an orthopedist. Note to remind her to call for assistance for all ADL's.
-On 1/9/17 at 10:00pm staff noted the resident had been helped to the bathroom and to bed.
-On 1/11/17 at 6:20pm: Found on the floor outside her bathroom, no injury noted.
-On 1/12/17 staff noted the resident had been using her call pendant and frequent checks had been done.
-On 1/13/17 at 4:30am: Found sitting on the floor in front of the bathroom door, small scrape on her left knee, staff noted she had been trying to walk by herself.

Review of Resident #2's Incident Reports and Post Fall Evaluation sheet for January 2017 revealed:
-On 1/3/17: Clutter removed from environment to ensure safe walkway and safe furniture placement. Increase frequency of monitoring. On PT.
-On 1/9/17 (1:15pm): Increase frequency of monitoring (frequency not specified). Has walker and sling.
-On 1/9/17 (3:30pm): No change in interventions. No documentation of a post fall evaluation.
-On 1/11/17: No change in interventions. Noted to

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have PT, a wheelchair and sling to right arm.
-On 1/13/16: No documentation of an incident report or a post fall evaluation.

Review of the physician's notes for Resident #2's revealed:
-On 8/17/16: He noted a recent pattern of recurrent falls especially after dose(s) of Ambien. The resident had been staying in her room due to significant cognitive impairment, deconditioning and difficulty walking without assistance and PT was ordered. He stated his doubt about adding Azilect for Parkinsonism due to risk of drug interaction and side effects such as falls
-On 8/24/16: He noted a recent pattern of falls especially in the late evening after dose(s) of Ambien, "as staff points out."
-On 8/31/16: He noted recent falls of uncertain cause/mechanism with no injuries; pattern of recurrent falls often in late evening after dose(s) of Ambien, "but not necessarily", continue PT.
-On 11/2/16: He ordered PT.
-On 11/30/16: He noted uncertain improvement in movements or decreased falls ("they often go unreported by the resident"); she was not feeling well, with sluggish movement and speech, fatigue and worse insomnia for the past two weeks, about the same time her neurologist had added Azilect (for the treatment of Parkinson's Disease).
-On 12/9/16: He had spoken with the resident's neurologist and the Azilect was discontinued.
-On 12/21/16: He had noted gait instability with fairly frequently falls, she seemed to be more stable with four footed walker, she was a fairly high falls risk; would restart PT and later consider adding Remeron (used for depression) in place of her Trazodone.
-On 1/13/17: He noted recent falls often attributed to dizziness; had fallen over clutter in her room the day before, with dementia she often declined

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to use the walker placing her at significant risk, needs reminders; will follow-up in a few weeks as scheduled regarding falls.

Confidential interviews with three staff members regarding Resident #2 revealed:
-The resident is very determined and independent.
-The family and the staff had been reminding her to use the call pendant.
-She does not want to use her call pendant and "be a bother."
-They had seen a decline in the resident since "around Thanksgiving."
-She had been falling more, and spending more time in her room.
-She didn't have the energy she used to have.
-Her eyes are sensitive to the light and she doesn't like to walk in the hall or eat in the dining room.
-She tried wearing sun glasses but they made her feel out of place.
-When the resident fell, the staff had been told to encourage her to use her call pendant and to increase the frequency of their rounds to every one to two hours.
-The HWD had told the staff, and also posted a message by the time clock, the resident was to be in a wheelchair until her clavicle healed and for her not to use her walker.

Attempted telephone interview on 1/13/17 at 9:05am with Resident #2's family member was unsuccessful.

Interview on 1/13/16 at 9:50am with the Executive Director (ED) revealed:
-She had returned to this position in April 2016.
-When a resident fell, the fall was reviewed at the all staff meeting each morning.

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D 270	Continued From page 14 -Falls were reviewed to identify patterns (time, location etc...) and determine what interventions to put in place. -The fall information was entered into the falls management computerized system by a Medication Aide or the Resident Care Coordinator. -Information regarding residents with specific needs was discussed at a Collaborative Care Meeting held every 2 weeks. -She was aware Resident #2 had fallen multiple times, "maybe 20 or so". -Interventions had been put into place, for Resident #2, including increased monitoring (every 1-2 hours) by the staff and for them to be sure she was wearing her call pendant and was reminded to use it and her walker. -Two weeks ago she had met with Resident #2's family member, and the resident, and asked her to please call for help. -She would be meeting with the resident and her family member today to obtain a Negotiated Risk Agreement. -The Negotiated Risk Agreement described the resident's choice related to falls. It acknowledged this choice to be an exercise of her resident rights, outlined the risks, benefits and possible consequences of that choice, identified alternatives offered to decrease risk and the final agreement between the parties. Interview on 1/13/16 at 10:30am with the HWD revealed: -She had been in the position since September 2016. -She had noted the resident had "neuro-dyskinesia" (difficulty or distortion in performing voluntary movement). -She was aware the resident had multiple falls and interventions had been put into place.	D 270		

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D 270	Continued From page 15 -The staff were to make sure she was wearing/using her call pendant and reminding her to use her walker. -The resident had been asked to call for assistance, "which she will not do because she does not want to give up her independence" and staff had been doing more frequent rounds (every 1-2 hours), observed (someone had to see her), around the clock. -It was the Medication Aides (MA) responsibility to ensure the rounds were done. -The staff were not required to document these rounds. -Other interventions for Resident #2 included PT, "which she's been on since I arrived", and wearing sun glasses while in the hallways and dining room (too dark, she would not wear them) or a visor, which she declined. -The resident had a rollator and had just gotten a regular walker for better stability but due to the shoulder fracture, she cannot use a walker. -She had told the staff to use a wheelchair to transport the resident and "hopefully, this will prompt her to call." -They had tried leaving a light on in her bathroom at night but she "sometimes" turns it off because she wanted it dark. -The resident's family had come in 2 weeks ago and decluttered her room. -She had spoken with the facility physician on a weekly basis and kept him informed of the resident's falls. -She did not know why a significant change assessment had not been completed in light of the number of falls and the resident's decline in her ability to perform her ADL's. -The residents family recognized her need to be independent and had no concerns related to falls. -All changes in a resident's condition were discussed at the morning all staff meeting the	D 270		

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next working day.
-If a fall, it was reviewed for a pattern such as time of day, location, acute illness (UTI or upper respiratory infection etc.), or new medications and interventions, if warranted, were put in place.
-Most of Resident #2's falls had been between 7:00pm or 8:00pm and 3:00am.
-She was not aware 13 of the resident's 22 falls had been related to toileting (5 on the 7:00am to 7:00pm shift and 8 on the 7:00pm to 7:00am shift) and had not considered placing the resident on a toileting program.
-In August, she had asked the resident's physician whether the Ambien might be related to her falls. He didn't think so.
-Her Parkinson's was progressing and the family had been okay with the falls as they wanted the resident to be independent.
-The next step would be a meeting with the family, the resident and the ED to discuss a Negotiated Risk release.
-The Negotiated Risk release stated the condition (falls), the risks (up to and including death), that they accept consequences of her choice(s) which is her right as a resident and signatures are obtained.

Interview on 1/18/17 at 10:22am with Resident #2's physician revealed:
-He had first met the resident in August 2015 and described her as "someone you could have gone out and had fun with."
-She had a history of depression and currently, he felt she was declining because she was "discouraged and had given up especially since fracturing her clavicle."
-In September 2016, she had received Azilect for 6 weeks, discontinued due to the development of multiple symptoms.
-She complained of not feeling well in general,

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D 270	Continued From page 17 with sluggish movement and speech, fatigue and worse insomnia for the past two weeks", about the same time her neurologist had added and been titrating Azilect up to a full 1mg daily (for the treatment of Parkinson's Disease). -He had spoken with the neurologist and the Azilect was discontinued. -He felt the resident's decline was due to her emotional state and mild dementia. -He also felt she may have been having small strokes. -He knew the resident had fallen multiple times but was not aware from 6/11/16 to the time of the interview, she had fallen 24 times. -He was not aware 10 of the 13 falls between 7:00pm and 7:00am had occurred after the 8:00pm medication administration. -He felt he was unaware because "not all things are mentioned " when he sees each resident. -He would be looking at decreasing the number of medication for Resident #2. The facility failed to provide adequate supervision of Resident #2 in accordance with her assessed needs and current symptoms related to her decline in condition and increasing falls. The resident had fallen 22 times in a six month period, sustaining multiple soft tissue injuries, striking her head on two occasions and most recently, a fracture of her right clavicle with loss of physical function and mobility. The failure of the facility to provide supervision for this resident has been detrimental to the safety and the psychological and physical health of the resident and constitutes a Type A2 Violation. A Plan of Protection was provided by the facility on 1/13/17 and included: -A conference will be held 1/13/17 at 1:00pm with Resident #2 and her family family member to	D 270		

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D 270	Continued From page 18 obtain a Negotiated Risk Agreement. -The resident will be re-educated on the use of her call bell and call pendant. -The resident would be placed on a 1-2 hour toileting schedule. -Staff to be reminded to assist resident with all activities of daily living, to include dressing and grooming, set up of meals and to assist as needed. -The resident will continue with physical therapy and primary care physician and neurologist involvement. -The facility would recommend the resident use hipsters. -Review of falls, risk for falls and the corporation's falls management program with all staff. -Identify residents with frequent falls and identify interventions to minimize the number and injury. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 17, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to follow-up for 1 of 1 resident (Resident #3) requiring follow-up with a referral to a Gero-psychiatric unit for agitation and	D 273		

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aggression.

The findings are:

Review of Resident #3's current FL2 dated 8/5/16 revealed:
-Diagnosis included Alzheimer's disease, psychotic disorder, anemia and hypothyroidism.
- Recommended level of care was "secured memory unit".
-Medications included Seroquel (antipsychotic used to treat schizophrenia, bipolar disorder and depression), Ativan , Depakote(anticonvulsant used to treat seizures and bipolar disorder), Zoloft (antidepressant), Remeron (used to treat anxiety and depression), Neurontin (anticonvulsant used to treat seizures and nerve pain) and Synthroid (used to treat hypothyroidism).

Review of Resident #3's Resident Register revealed an admission date of 8/5/16.

Review of a physicians note for Resident #3 dated 12/28/16 revealed:
- "Recently accelerating confusion and variable combativeness."
- He attempted to adjust medication with current approach being inadequate.
-"We will try to get her admitted ASAP to a local impatient [geri] psych program."
- "She can't remain in this environment in this state."

Review of a physicians note for Resident #3 dated 1/4/17 revealed:
- "Today patient was seen in hallway halfway between sedation and relatively mild agitation."
- He continued same medications for "further improvement seems unlikely at this point unless we succeed in arranging admission into a local

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Geropsychiatry hospital or other facility for further med adjustment as appropriate."

Review of the "Resident Log" for Resident #3 revealed:
- 18 entries between 12/20/16 and 12/30/16 included documentation regarding agitation and acts of aggression.
- Agitation and acts of aggression were noted as "taking clothes off and refusing to put them on", two incidents of "tearing down the Christmas tree", tearing the "mannequin apart", breaking an outlet cover and "pulled it off the wall, hitting, kicking, grabbing staff and other residents, yelling at staff, family and other residents, "taking things off the walls and throwing them",spitting medications out on staff and holding a butter knife towards staff and other residents on 2 separate occasions.
- 11 entries between 1/1/17 and 1/9/17 documented resident sleeping, eating poorly, unable or difficult to arouse to eat.

Review of the medication administration record (MAR) revealed:
- Prescribed as needed (PRN) Ativan was administered 31 times in the month of November.
- PRN Ativan was administered 44 times in the month of December.
- PRN Ativan was administered 7 times from January 1 through January 7, 2017.

Review of a physician order on 11/3/16 revealed: Ativan 0.5mg every two hours as needed for anxiety or agitation.

Review of physician order for 12/28/16 revealed:
- "Arrange ASAP admission to [geri]psych program".
- Increased Depakote to three times a day.

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D 273	Continued From page 21 Random observations of Resident #3 throughout the survey revealed: - Sitting in her wheelchair, leaning over asleep during exercise activity in the special care unit. - Asleep in her wheelchair in the dining room. - Resident being fed by staff, holding head down with eyes closed, staff making numerous attempts to get resident to open her eyes, hold her head up and take a bite of food or drink. Interview on 1/13/17 at 9:50am with Staff B, medication aide (MA) revealed: - Resident #3 was originally admitted to the facility and shared a room with her family not on the "secured unit". - Resident #3 was moved to the secure unit due to increased agitation and behaviors. - Resident #3 had an increase in her medications and is more sedated now than she was. -"She is way more sedated!" - Staff B was not aware of any further attempts for placement for Resident #3 and resident was more agreeable to taking her medications as she "is more sedated now, and I don't have any problems giving her meds." - She had been very aggressive and threatening to staff and residents before they increased her medications. - She had not been assisted up at this point as she was still sleeping. Interview on 1/13/17 at 3:30pm with the Health and Wellness Director revealed: - Resident #3 had been agitated and tearing things up and being aggressive with staff and residents. - "I tried different places to get her placed but no one could take her then." - The physician "increased her medications".	D 273		

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D 273	Continued From page 22 - "I have not spoken with any facility since then.(referring to the initial call for placement on 12/28/16). - "We check her frequently and keep her away from the other residents, we do not have a flow sheet or anything documented to show we did checks, we only have what the (medication aide) was charting but "15 minute checks are the ideal." - "There was no incident reports for those dates of December 26 and 27" where Resident #3 was aggressive and threatening staff and residents with a butter knife. Interview on 1/13/17 at 4:15pm with the Executive Director revealed: - When Resident #3 was admitted she was "totally medicated as she could not walk or talk". - She said the MD worked to reduce her medications. - Resident #3 started having "more behavior needs". - "When Resident #3 sundown's she focuses on a traumatic time in her life and becomes very agitated" was what her family told the facility. - "In December she had a period of 3-4 days of lashing out and tearing up things." - "We spoke with with several different places in attempts to get her placed but were unable to." - "With the medication changes she has become more manageable." - She could not offer an explanation as to why no one had followed up on placement that Resident #3's physician had ordered. - "She is more manageable now." - She verbalized Resident #3 was sedated and her behaviors varied between aggression and sedation and was a challenging resident to care for.	D 273		

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D 273	Continued From page 23 Interview on 1/17/16 at 10:50am with Resident #3's legal Guardian revealed: - She had become the residents Guardian on 12/16/15. - Her last visit with the resident was 1/4/17. - "She couldn't look at me or interact with me on my last visit." - "She (Resident #3) has been decompensating over the past few months." - "She looked like she had lost weight also at my last visit." - "They either overmedicate her or not enough." - A local Geropsychiatry hospital had called her earlier on 1/17/17 and Resident #3 was going to be admitted there 1/17/17. - Resident #3's family was concerned about her sedation and had discussed it with her. - The facility physician had lowered some of her medications and then increased them due to her aggressive behaviors. - She was aware of Resident #3's aggressive and threatening behaviors towards others. - She was in the local Geropsychiatry hospital in March of 2016 for aggressive behaviors. - She had been notified by the facility in December that Resident #3 would be going to a geri psych unit for her behaviors and she "was in agreement with that." Interview on 1/18/17 at 10:2am with facility physician revealed: - He had wanted for a long time to get her (Resident #3) "leveled out". - "I decreased her meds when she first came in then I had to start increasing them again because of her behaviors." - Resident #3 was "either too sedated or too agitated". - "If there too sedated they fall out of the chair, if there too agitated they get up out of the chair."	D 273		

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D 273	Continued From page 24 - "Unfortunately residents don't stay at baseline." - "She was a danger to herself and others, taking weapons to people." - The staff had made multiple attempts to get the resident admitted to a Geropsychiatry unit without success. - On 12/28/17 he had increased Resident #3's medication "while they waited to get her in somewhere." - He saw her on 1/4/17 "but made no changes" to Resident #3's medications. -On 1/9/17 he was notified about the residents fall but made no changes to her medications at that time. - He did not know staff had made no other attempts to continue to get her placed in a geri-psych unit. - "I don't know about that but in the meantime she is somewhat better than she was." - He agreed that she was sedated. - "At that time I did not feel like she was appropriate for placement." - "I was not concerned about it as much (following up on getting her placed) because she was sedated not restless." _____ The facility failed to locate a Geri-Psychiatric program placement for Resident #3 who required hospitalization for medication adjustment due to accelerating and variable agitated, aggressive and combative behaviors while in the facility's secure unit. These behaviors included twice threatening other residents and staff with a butter knife. The failure of the facility to meet these acute health care needs was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 1/13/17 that included:	D 273		

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D 273	Continued From page 25 - Initiate evaluation for medication and behavior review in a Geropsychiatry facility. - In the event Resident #3 becomes and displays severe agitation or aggression to self or others the resident will be sent to the Emergency room if staff unable to redirect. - Determine availability for in-house psych services. - Education of staff of redirection techniques and if ineffective send to the Emergency Room for safety per secured unit program director and Health and Wellness Director. - Health and Wellness Director and pharmacy conduct quarterly review for psychotropic use and possibility for reduction. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 4, 2017.	D 273		
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 residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. The findings are:	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE FOREST CITY	493 PINEY RIDGE ROAD FOREST CITY, NC 28043

(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
D912	Continued From page 26 A. Based on record reviews and interviews the facility failed to test 1 of 5 sampled residents (Resident #3) for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services. [Refer to Tag 234, 10A NCAC 13F .0703(A) Tuberculosis Test, Medical Exam and Immunization (Type B Violation)]. B. Based on observations, record reviews and interviews, the facility failed to provide appropriate supervision for 1 of 5 sampled residents (Resident #2) in accordance with the resident's assessed needs, care plan and current symptoms related to decline in condition and falls. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. C. Based on observations, record reviews and interviews, the facility failed to follow-up for 1 of 1 resident (Resident #3) requiring follow-up with a referral to a Gero-psychiatric unit for agitation and aggression. [Refer to Tag 246, 10A NCAC 13F .0902(B) Health Care (Type B Violation)].	D912		