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THE GARDENS OF TRENT	2915 BRUNSWICK AVENUE NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure section conducted an Annual Survey on 04/04/22 through 04/06/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide referral and follow-up for 1 of 6 sampled residents (#6) with multiple aggressive behaviors towards property and other residents. The findings are: Review of Resident #6's current FL-2 dated 03/02/22 revealed: -Diagnoses included unspecified dementia without behavioral disturbance and Parkinson's disease. -The recommended level of care was documented as special care memory unit. -He was intermittently disoriented. -He was ambulatory and wandered. -There were no other behaviors documented on the FL-2. Review of Resident #6's care plan dated 08/27/21 revealed there was no documentation of aggressive behaviors or behavioral disturbances. Review of Resident #6's psychiatric assessment note dated 11/09/21 revealed:	D 273		

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-Staff reported Resident #6 had increased confusion, wandering, and anxiousness.
-The findings included worsening anxiety, progressing dementia with behaviors, and worsening adjustment disorder.
-Depakote was prescribed.(Depakote is a medication used to treat mood disorders.)

Review of Resident #6's psychology note dated 11/17/21 revealed:
-Resident #6 had delusions and "increasingly risky behaviors".
-He was physically aggressive with staff.
-He had delusions that other residents were his wife (who did not live in the facility).
-Staff reported increased anxiety and confusion.
-Resident #6 became agitated if he heard a female resident in distress and would become physically aggressive with staff because he thought staff was hurting his wife.
-Resident #6 received Ativan three times a day. (Ativan is a medication used to treat anxiety.)
-Resident #6 would continue to benefit from staff monitoring and supporting him.

Review of Resident #6's psychology note dated 12/08/21 revealed he continued to become physically aggressive towards staff when he mistook other residents for his wife and thought staff was hurting her.

Review of Resident #6's psychiatric provider note dated 12/13/21 revealed:
-Staff reported Resident #6 had hallucinations and agitation.
-Ativan had been discontinued 11/17/21.
-Provider prescribed Abilify once a day. (Abilify is medication used to treat psychosis.)

Review of Resident #6's psychology note dated

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12/16/21 revealed he needed close supervision and monitoring of his behaviors but did not specify how often he should be monitored.

Review of Resident #6's psychiatric provider note dated 01/10/22 revealed his dementia with behaviors was progressing and his adjustment disorder was worsening.

Review of Resident #6's progress notes dated 01/16/22 revealed he was sent to the emergency room (ER) due to acute mental status change and behaviors.

Review of Resident #6's Accident/Incident report dated 01/16/22 revealed:
-He went through plastic and pushed staff at 6:46pm.
-He was agitated.
-He did not sustain and injury but was sent to the local emergency room.
-There were instructions to monitor his status for seventy-two hours and chart progress notes daily from 01/16/22 through 01/19/22.

Review of Resident #6's fifteen-minute check sheets dated 01/17/22 through 01/20/22 revealed:
-There was documentation of Resident #6's location in the facility every 15 minutes beginning at 5:45am on 01/17/22 and ending at 6:45am on 01/20/22.
-There were two columns on the sheet; one for time and another for "status".
-Resident #6's location was documented in the column with the heading "status".
-There was no documentation of behavior or activity during the checks.

Review of Resident #6's progress notes dated

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D 273	Continued From page 3 01/23/22 revealed he was sent to the ER due to behaviors. Resident #6's Accident/Incident report for 01/23/22 was requested on 04/06/22 at 10:05 am and was not provided. Resident #6's fifteen-minute check sheet following the 01/23/22 incident was requested on 04/06/22 at 10:05 am and was not provided Review of Resident #6's primary care physician (PCP) note dated 01/26/22 revealed: -Resident #6 had episodes of agitation and aggression. -He was increasingly aggressive and agitated when asked to do things by staff. -She prescribed Seroquel once a day. (Seroquel is a medication used to treat psychosis and behaviors.) Review of Resident #6's progress notes dated 01/28/22 revealed: -Resident #6 was combative and verbally expressed he wanted to kill a fellow resident and staff member. -Emergency medical services (EMS) and the police were called but the resident was not transported to the hospital. Resident #6's Accident/Incident report for 01/28/22 was requested on 04/06/22 at 10:05 am and was not provided. Resident #6's fifteen-minute check sheet following the 01/28/22 incident was requested on 04/06/22 at 10:05 am and was not provided. Review of Resident #6's progress notes dated 01/31/22 revealed:	D 273		

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-Resident #6 was combative, damaging property, and "busting windows."
-Resident #6 was sent to the hospital ER.

Review of Resident #6's Accident/Incident report dated 01/31/22 revealed:
-He busted the window in the dining room at 1:00am.
-He did not sustain any injury but was sent to the local emergency room.

Review of Resident #6's fifteen-minute check sheets dated 01/31/22 through 02/02/22 revealed:
-There was documentation of Resident #6's location in the facility every 15 minutes beginning a 12:00pm on 01/31/22 and ending at 6:45am on 02/02/22.
-There were two columns on the sheet; one for time and another for "status".
-Resident #6's location was documented in the column with the heading "status".
-There was no documentation of behavior or activity during the checks.

Interview with a Medication Aide (MA) on 04/06/22 at 3:17pm revealed:
-She was on duty when Resident #6 broke the window.
-There were no warning signs that the resident was upset prior to him breaking the window. He had an explosive outburst.
-After breaking the window, Resident #6 sat down in the dining room and talked about missing his wife and wanting to go home.
-She redirected him by changing the conversation to another topic and Resident #6 sat quietly without incident.
-Resident #6 displayed no aggression before or after breaking the window.

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D 273	Continued From page 5 -She was not aware of any interventions that were put into place after the incident. Observation of Resident #6 on 04/04/22 at 9:54am revealed: -He was sitting on the edge of the bed in resident room #21 with his eyes closed. -Resident room #21 belonged to another resident of the facility. -There were no residents or staff in the room with Resident #6. Review of Resident #6's psychology progress note dated 02/02/22 revealed psychology services were discontinued due to his poor response to therapeutic interventions and poor prognosis. Review of Resident #6's physician orders dated 02/09/22 revealed the psychiatric provider prescribed haloperidol and increased the dosage of Abilify. (Haloperidol is a medication used to treat psychosis.) Review of Resident #6's psychiatric progress note dated 02/28/22 revealed: -Staff reported Resident #6 had hallucinations and agitation. -The provider completed a psychiatric history form for a possible admission to a geriatric psychiatric facility. Interview with a personal care aide (PCA) on 04/04/22 at 9:50am revealed: -There were two residents on the West side of the facility that required increased supervision. -Resident #6 was not one of the residents mentioned by the PCA as requiring increased supervision. -Increased supervision meant that they needed	D 273		

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increased rounding, more than every two hours to ensure their safety.

Interview with a second PCA on 04/06/22 at 2:10pm revealed:
-She witnessed one instance about 3 months ago when Resident #6 took utensils during a meal in the dining room and attempted to get the door open.
-When a staff member approached Resident #6, he became upset and was only able to be calmed by a male housekeeper.
-There was no formal training from the facility about how to handle Resident #6's behaviors.

Interview with a second medication aide (MA) on 04/06/22 at 8:10am revealed:
-Resident #6 was calm when he was first admitted and then became violent.
-Resident #6 would be very calm and then have aggressive outburst.
-Resident #6 was supposed to be discharged on 03/01/22 because of his aggressive behaviors.
-Resident #6 could sometimes be talked down when he became aggressive and sometimes he could not be talked down.
-Resident #6 tried to get through the plastic barrier that divided the resident hall to create the COVID-19 isolation wing and "manhandled" one of the aides to get past her into the isolation area .
-Resident #6 had become aggressive aggressive with a resident that was no longer at the facility;Resident #6 had the resident on the floor hitting him but thought the resident had provoked him.
-Resident #6 went into a female resident's room a couple of months prior which lead to Resident #6 being sent to the local emergency room because he was upset and threatening believing the

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female resident was his wife.
-Prior to the window being broken, Resident #6 had gotten another resident's cane and was swinging it in the air.
-She could not recall the dates of these incidents.
-She did not remember a meeting to identify triggers or interventions following any aggressive incident.
-Staff would conduct increased monitoring for seventy-two hours after incidents if he was sent to the emergency room but was not aware of any other interventions put into place for Resident #6.
-She did not remember being trained on how to deal with aggressive residents but knew to remove the other residents during aggressive incidents from a previous job.

Telephone interview with Resident #6's family member on 04/06/22 at 12:30pm revealed:
-He was concerned that Resident #6 did not receive the attention that he needed.
-He was not aware of any interventions put into place to help Resident #6 other than to change his medications.
-He had a meeting with the administrator to discuss Resident #6's discharge from the facility after the window was broken but he did not remember what date the meeting occurred.
-He received a discharge notice for Resident #6 due to his behaviors during the meeting with the administrator but had not found a facility to move him to.

Telephone interview with Resident #6's psychologist on 04/06/22 at 2:08pm revealed:
-She relied on staff to describe what behaviors Resident #6 displayed.
-Staff reported to her that Resident #6 became more agitated and delusional in the evening.
-Resident #6 would become aggressive at times

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D 273	Continued From page 8 with staff when he had delusions and thought the staff were hurting his wife. Telephone interview with Resident #6's psychiatric provider on 04/06/22 at 2:13pm revealed: -She relied on staff to report Resident #6's behaviors to her. -She began adjusting his medications when staff reported increased displays of anxiety and agitation. -She was not aware of the extent of the behaviors displayed by Resident #6 until 02/28/22 when she completed additional paperwork for potential admission to a mental health hospital. -She was not aware of the incident with the butter knife. -She was not aware of the incident with the broken window for a least a week after the incident. -She was not consulted for possible interventions that could be used to help Resident #6. -Resident #6 needed to be monitored more closely, that if residents were monitored at least every two hours, he needed to be monitored at least every hour. -Interventions she would recommend included move Resident #6 into a calm place, as he did better away from other people, especially in his room reading. -The facility staff could have the resident call his family because that calmed him. Interview with the lead MA on 04/06/22 at 12:38pm revealed: -Resident #6 got very confused in the evenings and went into other resident rooms. -She was not aware Resident #6 had been aggressive towards other residents. -There was an incident where Resident #6	D 273		

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pushed a staff member when she was trying to prevent him from entering the Covid-19 unit.
-Staff were unable to calm Resident #6 on the evening he broke the window and was sent to the local ER.
-There had been medication changes, a psychiatric referral and looked at discharge for Resident #6.
-She did not remember any meeting to identify triggers or prevention of behaviors for Resident #6.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 9:03am revealed:
-She was responsible for pre-admission assessments and thought Resident #6 was "higher functioning" when he was admitted to the facility.
-She was not aware Resident #6 had aggressive behaviors prior to his admission to the facility.
-Resident #6 got agitated sometimes because his wife was in another facility and he wanted to see her.
-She never witnessed Resident #6 become aggressive and believed staff exaggerated his behaviors.
-Resident #6 was "slinging chairs' when he broke out the window and had slung chairs once before.
-Resident #6 would sometimes get "irate', has moved dressers into the hallway and dressed in a female resident's clothes.
-There did not seem to be any identifiable triggers and behaviors came on suddenly.
-They had increased supervision by moving Resident #6's room closer to the medication room, obtained psychiatric services and contacted his family as interventions for aggressive behaviors.
-Behaviors had improved since medications had been added but he continued to go into other

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resident rooms.
-She did not remember staff reporting Resident #6 had been aggressive with them or another resident.
-Staff were trained on behaviors and dementia upon hire.
-There had been a 30-day discharge notice given to Resident #6's family but she was not sure if it was for financial or behavioral reasons.
-Resident #6's behaviors had improved since the addition of a medication and he was more suitable for the environment.

Interview with Resident #6's PCP on 04/06/22 at 10:15am revealed:
-Resident #6 would get agitated after talking with his family member.
-Resident #6 continued to have aggressive episodes after breaking the window in the dining room.
-Discharge to another facility had been discussed but his behaviors improved after a medication was added.

Interview with the Executive Director (ED) on 04/06/22 from 10:05am to 10:40am revealed:
-Residents were monitored every 2 hours unless there was an identified need to increase frequency such as falls or behaviors.
-Increased monitoring following aggression were dependant upon severity of the incident.
-She was not aware of Resident #6 being aggressive with other residents and had not heard of any altercation with another resident.
-She was aware Resident #6 had been verbally aggressive toward staff but was not aware he had attempted any physical harm.

Second interview with the ED on 04/06/22 from 1:10pm to 1:39pm revealed:

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D 273	Continued From page 11 -Behavior reports were an internal document and part of the quality program for the facility. -After the resident had an incident when he was upset about the COVID-19 unit barrier, they moved his room closer to the front of the hallway. -When Resident #6 got upset,sometimes calling his family would calm him down and other times it would not. -He was intermittently disoriented. -No other interventions were done after 01/26/22, including after the incidents on 01/28/22 and 01/31/22, because the PCP had changed his medication at that time and wanted to allow time for the medication to be effective. -Resident #6 was scheduled to be discharged to a geriatric mental health facility out of state but the move "fell through" and she believed it was financial reasons. -Resident #6 was given a 30-day discharge notice because the facility could not handle his behaviors. _____ The facility failed to provide notification to the psychiatric provider for Resident #6 who had aggressive behaviors which resulted in an altercation with another resident and a window being broken out in the common dining room. This failure was detrimental to the health, safety, and welfare of the residents constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on April 28, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 21, 2022.	D 273		

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D912	Continued From page 12	D912		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Health Care. The findings are: Based on observations, interviews and record reviews, the facility failed to provide referral and follow-up for 1 of 6 sampled residents (#6) with multiple aggressive behaviors towards property and other residents.. [Refer to tag D273 10A NCAC 13F .0902(b) Health Care.]	D912		