STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 conducted an annual survey on 04/20/22 and 04/21/22.	D 000		
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 A2 VIOLATION Based on observations, interviews and record reviews the facility failed to provide appropriate supervision for 1 of 3 sampled residents (#3) who had 6 falls in a 4-month period, the most recent of which resulted in nasal bone fractures. The findings are: Review of the facility's Fall Policy revealed: -A pattern of unsteadiness and fall may indicate an emerging health concern for the resident. -All residents should be evaluated for fall risk and steps taken to reduce the risk. -Residents identified as at risk for falls should have interventions put in place to decrease the risk; Sample intergeneration listed in the policy included but not limited to mobility alarm, emergency pendant, pain medication, drug regimen review, assistive devices and supervised activities. -If the resident continued to fall with preventative approaches, the nature of the falls and the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 1	D 270		

intervention should be reviewed and modified where appropriate and may include additional support to supplement services provided by the facility.
-Any time a resident bumps their head, or reports to have bumped their head, the resident should see a medical provider within 24 hours for evaluation even if there is no apparent injury because there may be a serious injury requiring medical attention; Staff should not assess the seriousness of the injury.

Review of Resident #3's previous FL-2 dated 10/25/21 revealed:
-There was documentation for a memory care unit as the recommended level of care.
-Diagnoses included dementia and recurrent falls.
-She was constantly disoriented, semi-ambulatory and used a wheelchair for mobility.

Review of Resident #3's current FL-2 dated 04/21/22 revealed diagnoses included dementia and recurrent falls.

Review of Resident #3's current care plan dated 09/24/21 revealed:
-She required reminders because she was forgetful.
-She was sometimes disoriented.
-She required supervision from staff with ambulation.
-She required limited assistance from staff for eating and transferring.
-She required extensive assistance from staff for toileting, bathing, dressing and grooming.

Review of Resident #3's resident profile and care plan dated 09/27/21 revealed:
-She was able to communicate effectively and make needs known to staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 2	D 270		

-She occasionally had difficulty remembering and using information and required some reminders.
-She had 1-2 falls in the previous 90 days and required assistance with ambulation.

Review of Resident #3's Fall Assessment dated 10/01/21 revealed:
-There was documentation that incontinence was a problem and the intervention for this was documented as monitoring for changes and notifying the primary car provider (PCP) if she experienced issues.
-She used a wheelchair independently and the intervention for this was documented as "Rehab care to assess on move-in".
-There was documentation that she was on 4 or more medications, including antihypertensive, and the intervention was documented as monitoring her for changes and notifying the PCP of changes. (antihypertensive medications are used to decrease blood pressure)

Observation of Resident #3 on 04/20/22 at 8:27am revealed:
-She was sitting in a wheelchair in the activity room.
-There was a healing laceration over the bridge of her nose.
-There was yellow bruising around the laceration that extended under her eyes on each side.

Review of Resident #3's Resident Incident Report dated 01/09/22 revealed:
-She slid out of her wheelchair onto the floor at 2:00pm while in the activity room.
-She did not hit her head and there were no injuries noted at the time of fall.
-There were no interventions documented.

Review of Resident #3's progress note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 3	D 270		

01/09/22 revealed:
-She slid out of her wheelchair.
-There was no bruising or redness.
-Staff planned to monitor her throughout the shift.

Review of Resident #3's Resident Incident Report dated 02/09/22 revealed:
-She was found lying on the the floor of her bedroom at 4:00am.
-There were no injuries noted at the time of the incident.
-There was documentation on the 24 hour follow-up that she was seen by her PCP on 02/10/22 and a new wheelchair was ordered.

Review of Resident #3's record revealed and invoice from a local medical equipment company for a wheelchair dated 02/22/22.

Review of Resident #3's progress note dated 02/09/22 revealed she was found on the floor lying on her left side with no injury.

Review of Resident #3's Resident Incident Report dated 02/19/22 revealed:
-She was found lying on her side on the bathroom floor at 6:00am.
-There were no injuries noted at the time of the incident.
-There was documentation on a 24-hour follow-up report that an appointment was scheduled with her PCP to get an order for a hospital bed at the family's request dated 02/24/22.

Review of Resident #3's progress note dated 02/19/22 revealed staff found her lying on the floor on her left side.

Review of Resident #3's physician orders dated 02/24/22 revealed an order for a hospital bed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 4 raised foot, head and side rails and to monitor frequently at night. Review of Resident #3's record revealed there was no clarification order of how frequently the resident was to be monitored and there was no documentation of increased supervision provided to the resident. Observation of Resident #3's bedroom on 04/21/22 at 12:58pm revealed there was no hospital bed. Review of Resident #3's Resident Incident Report dated 03/28/22 revealed: -She was found lying on her right side in her bedroom during rounds at 3:40am. -There were no injuries noted at the time of the incident. -There was documentation on the 24-hour follow-up report of no issues or concerns. -There was no documentation of interventions following the fall. Review of Resident #3's progress note dated 03/28/22 revealed staff found her lying on the floor on her right side. Review of Resident #3's Resident Incident Report dated 03/30/22 revealed: -She slid out her wheelchair while in the activity room at 1:45pm. -She hit her face on the floor; there was bleeding from the nose and a small scrape on the bridge of her nose. -She was not sent the hospital -There was documentation on the 24-hour follow-up report of no issues or concerns. -There was no documentation of interventions following the fall.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 5 Review of Resident #3's progress note dated 03/30/22 revealed: -She slid out of her wheelchair and hit her face and nose on the floor. -She was bleeding from her nose and had a scrape present on the bridge of her nose. Review of Resident #3's Resident Incident Report dated 04/16/22 revealed: -She fell forward out of her wheelchair while in the activity room at 10:30am. -She fell on her face and sustained a laceration to her nose. -She was sent to the local emergency room for evaluation. Review of Resident #3's progress note dated 04/16/22 revealed she returned from the local hospital at 1:20pm with a contusion of her right hip, laceration of the nose and nasal bone fractures. Review of Resident #3's emergency room (ER) documentation record from the local hospital dated 04/16/22 revealed: -She fell out of her wheelchair and hit her nose and was transported by emergency medical services (EMS) to the local hospital emergency room (ER). -She had a laceration over the bridge of her nose with swelling and tenderness; the laceration was repaired with a liquid adhesive closure. -There was an order for computerized tomography (CT) scan of her face and head ordered due to trauma and injury. -There was documentation the CT scan revealed nasal fractures with slight flattening and bucking and suspected fracture of the nasal septum. -There was an order for a right hip x-ray for	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 6	D 270		

trauma and injury.
-There was documentation there was no fracture noted of the hip.

Interview with a personal care aide (PCA) on 04/21/22 at 10:44am revealed:
-When she first started three years ago, Resident #3 was more independent and could walk but would fall a lot.
-Now, Resident #3 was total care and needed help with everything requiring redirection and reposition frequently because she would forget she was unable to get up and walk on her own.
-She could not recall when she reported her concerns regarding Resident #3 to a medication aide (MA), but all facility staff were aware that the resident was a high fall risk.
-Resident #3 was confused and was unable to put her arms in front herself to "catch herself" when she would fall.
-She was working on 04/16/22 when Resident #3 fell in the day room; she had just repositioned the resident in her wheelchair and turned her back to set up an activity when she heard the resident fall.
-When she turned around, Resident #3's face was on the floor and her nose was bloody.
-All facility staff were expected to provide safety checks to residents every two hours.
-The only intervention she was aware of that was put in place to prevent Resident #3 from falling was trying to keep her in the day room on day shift and not allow her to be in her bedroom where she would be alone, but she had never been instructed to provide Resident #3 with any increased supervision and did not check on her more often than every two hours if the resident was not in her direct line of sight.
-She was not sure if there were any orders or interventions in place for evening or night shift to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 7	D 270		

prevent Resident #3 from falling but knew the resident would try to get up on her own and would fall.

Telephone interview with a medication aide (MA) on 04/21/22 at 10:22am revealed:
-Resident #3 required a lot of care and the PCAs were responsible to provide that care as needed.
-During routine safety checks and rounds every two hours, it was not uncommon to find Resident #3 on the floor in her room on second or third shift.
-Resident #3 was known to fall often and when she did, it was her or any other MA's responsibility to notify the resident's PCP via fax and responsible party via phone.
-Resident #3 had not received any injuries with her falls when she was working.
-Resident #3 was a high fall risk because she would try to get up independently, was confused, forgetful, and disoriented, and thinks she can walk.
-To her knowledge, there were no fall intervention put into place by the facility to prevent future falls, she was not sure why.
-All staff were to provide safety checks to residents every two hours and no one at the facility had instructed her to provide any fall prevention interventions or increased supervision for Resident #3 any greater than every two hours.

Interview with a second MA on 04/21/22 at 10:31am revealed:
-Resident #3 required total care assistance to include toileting, dressing, and eating.
-Resident #3 could not walk or stand independently and would forget that she required assistance to get up and stand or walk.
-Staff tried to monitor Resident #3 on day shift by keeping her in common areas and in staff's line of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 8	D 270		

sight.
-Safety checks were completed on all residents every two hours but here was no process in place to provide Resident #3 with any increased supervision, she did not know why.
-She was in the day room on 04/16/22 (mid-morning) passing out coffee and snacks with a PCA when Resident #3 fell forward out of her wheelchair hitting her face and nose on the floor as she was walking toward the resident.
-She called EMS and sent Resident #3 to the ER for that fall but did not recall if she was working when other falls occurred.
-Falling was not a new issue for Resident #3 because she frequently tried to get up on her own.
-If a resident fell, it was the MA's responsibility to call the resident's responsible party, notify the Special Care Coordinator (SCC), fill out an Incident Report, document a progress note in the computer, fax a notification of the fall to the PCP, write the incident in the staff communication book, and call 911 for medical attention if necessary.
-Other than trying to keep the resident in the day room during the day she was not aware of any other interventions put into place to prevent future falls for Resident #3.
-It was all of the staff's responsibility to complete safety checks every two hours and she had not received any instructions or orders to provide Resident #3 with increased supervision.

Telephone interview with a third MA on 04/21/22 at 11:04am revealed:
-Resident #3 was total care and required assistance with all activities of daily living except for eating.
-Resident #3 required much more additional assistance than most residents and it sometimes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 9	D 270		

took up to three staff members to provide her the care that she needed at one time.
-She was not sure why Resident #3 had frequent falls but knew the resident was known for "scooting" out of her wheelchair and would forget she could not stand independently.
-She started working at the facility and had noticed that Resident #3 had declined from being able to walk independently with a walker to no longer being able to pull herself up and being in a wheelchair.
-She was working during two of Resident #3's falls, one in which the resident fell out of her bed without injury, and another when she fell out of the wheelchair and hit the bridge of her nose.
-She reported the falls to the SCC and thought the SCC was looking into transferring Resident #3 to a facility for an increased level of care but did not know for sure.
-The resident had received a new wheelchair about one month ago and was supposed to get a hospital bed but the had not arrived, and she was not sure why.
-The resident had received physical therapy (PT) at one point, she could recall when, but it had not helped her, and she was still falling.
-She tried to keep a close eye on Resident #3 but had never been instructed to provide increased supervision or safety checks to the resident outside of the standard expectation of every two hours.

Interview with the Special Care Coordinator (SCC) on 04/21/22 at 1:12pm revealed:
-Resident #3 had a hospital bed with side rails ordered along with increased monitoring but she had not received the hospital bed yet due to insurance issues.
-Increased monitoring meant that the staff should monitor the resident more frequently than the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 10	D 270		

normal expectation of every two hours.
-She did not clarify the order of what increased monitoring meant from the PCP because she assumed it meant every hour.
-She had communicated the expectation of increased monitoring to some of the staff on night shift, she could not recall exactly when, and had expected them to pass the information on to the rest of the staff by word of mouth each shift.
-There was no other process in place to ensure Resident #3 received increased supervision because she just trusted the staff to provide increased supervision because they knew the resident was a fall risk.
-There was no way for her to know if the increased monitoring had taken place because there was not a place for staff to document if they had provided increased supervision and she did not want to add more documentation to the staff's plate if she did not have to because every two hours safety checks did not have to be documented either since staff just knew to do it.
-Ensuring a process of increased supervision for Resident #3 was her responsibility and it "just fell through the cracks".

Interview with the Administrator on 04/21/22 at 1:39pm revealed:
-She expected all orders to be clarified and implemented as ordered by the PCP.
-She expected all residents to receive safety checks every two hours and increased supervision (more often than every two hours) as needed as defined by the resident's PCP assessment and orders.
-It was the SCC's responsibility to clarify orders and implement increased supervision for Resident #3 due to her falls.
-Resident #3 had been at the facility for a couple of years and had experienced a significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 11	D 270		

number of falls as her disease process progressed.
-She expected staff to be notified of orders and interventions and for there to be a process in place to communicate and carry out those orders as expected.
-She was responsible for tracking resident falls to ensure the resident received 24-hour follow-up and new orders, but she did not track trends to consider other interventions to put into place.
-She was not sure why no other interventions had been put into place for Resident #3.
-The facility could have requested a chair alarm or fall mat to help prevent injury, but there was no process in place to implement increased supervision and she did not know why.
-She expected supervision changed as ordered by Resident #3's PCP orders and she did not expect documentation of supervision because the policy only required charting by exception and the facility staff should know to do it.
-She trusted staff to ensure residents were checked on, expected increased supervision with the needs to be of resident reflected in their care plans, and expected a private sitter for any resident's who required 1:1 supervision and it would have been the SCC's responsibility to identify those needs and implement the interventions as needed for Resident #3.

Interview with Resident #3's PCP on 04/21/22 at 12:40pm revealed:
-She had been notified by facility staff of Resident #3's falls.
-PT had been attempted.
-She was told the facility was unable to provide the resident with restraints as requested and due to this she requested an increased level of care to a skilled nursing facility who could provide restraints to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 12 -One of the resident's more recent falls resulted in a fracture of the resident's nasal bridge bone and a contusion (deep bruise) to her hip. -Staff were rarely able to answer questions she asked about Resident #3 when they brought her in for appointments which made it difficult to provide orders and guide the resident's care. -Because Resident #3 had recurrent falls, she would have expected the facility to provide the resident with increased or constant supervision and possibly provide side rails to her bed, a chair alarm, and a call button for the resident to be able to call for help, and would have ordered those interventions if the facilty had given her a clear picture of the resident's needs. -She expected the facility to provide care to meet the resident's needs to prevent further falls or injuries. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable. Attempted interview with Resident #3's guardian on 04/21/22 at 11:16am was unsuccessful. _____ The facility failed to provide increased supervision for Resident #3 who sustained 6 falls in a 4-month period which resulted in her being transported to the hospital for injuries including nasal bone fractures and a hip contusion. This failure resulted in substantial risk of serious physical harm which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S.131D on 04/21/22 for this violation. CORRECTION DATE FOR THE TYPE A2	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 270	Continued From page 13 VIOLATION SHALL NOT EXCEED MAY 21, 2022.	D 270		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provided feeding assistance to ensure dignity and respect to 1 of 2 sampled residents (#2) related to not assisting the resident continuously throughout the meal with the use of eating utensils. The findings are: Review of Resident #2's current FL-2 dated 09/06/21 revealed: -Her level of care was in the special care unit (SCU) and she was intermittently disoriented. -Diagnoses included dementia and intermittent tachycardia. -There was an order for a mechanical soft diet (soft, chopped, or pureed foods ordered for feeding or swallowing difficulties). Review of Resident #2's Resident Register dated 09/11/21 revealed: -The resident was forgetful and required reminders.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 14 -The resident required food that was easily chewed. Review of Resident #2 current care plan and assessment dated 09/06/21 revealed: -The resident was always disoriented with significant memory loss and required reminders and redirection. -The resident required supervision with eating. Review of Resident #2's resident profile and care plan dated 02/07/22 revealed: -The resident was on a mechanical soft diet and required assistance in determining food preferences. -The resident had issues with chewing, could feed herself, and needing reminded and queuing to eat. Observation of Resident #2 at the breakfast meal service on 04/21/22 from 8:30am to 9:28am revealed: -Resident #2 was escorted to the table, seated, and served breakfast consisting of approximately 1 cup of oatmeal in a bowl, 1 cup of applesauce in a bowl covered in plastic wrap, 1.5 cups of scrambled eggs, 1 piece of toast, and 12 ounces of water which corresponded to the menu for a mechanical soft diet as ordered at 8:30am. -There were two personal care aide (PCA) and the facility nurse in the dining hall assisting residents; Resident #2 was not offered any assistance in getting set up to eat upon being served. -The resident stared at her plate for two minutes, attempted to remove the plastic wrap from the applesauce bowl, then stuck her finger through the plastic wrap and began dipping her finger in the applesauce and licking it trying to eat; there were three staff members in the room but they	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 15	D 312		

were not watching her or sitting at her table.
-At 8:35am the dietary manager recognized the resident was trying to eat her applesauce with her finger through plastic wrap while serving other residents their plates.
-The dietary manager removed the plastic wrap from the bowl of applesauce and walked away.
-At 8:37am, the resident had still not received any assistance and continued to stick her fingers in the applesauce and oatmeal then licking them; she did attempt to bite a half piece of toast but dropped the portion she was unable to bit in her lap.
-At 8:40am, the facility nurse cleaned up and removed the resident's dishes sitting next to Resident #2 but did not recognize the resident was eating applesauce and oatmeal with her fingers, offered no assistance, and walked away.
-At 8:45am, the resident had a confused look on her face as she stared blankly at her plate; she attempted to pick up the bowl of applesauce and put it to her mouth but was unable and dropped it back on the plate.
-Staff continued to walk around the dining room assisting other residents, offering second helpings, and cleaning up dirty place settings, but they did not assist Resident #2 as she tried to pick up scrambled eggs dropping about 50% of the eggs back on the plate or table and ingesting the other 50% of each bite.
-At 8:50am, the resident attempted to pick up the applesauce bowl again but was unsuccessful, then began to eat the applesauce with her finger.
-At 8:58am, a PCA recognized that the resident was struggling to eat, picked the food she dropped out of the resident's lap setting it to the side, placed a fork in the resident's hand, then walked away; the resident dipped the wrong end of the fork into the applesauce and licked it then placed the fork back down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 16	D 312		

-At 9:01am, the resident attempted to drink out of an empty cup sitting at her place setting then began dipping and licking her fingers in the oatmeal again.
-At 9:02am, the facility nurse came to the table, wiped the resident's fingers with a napkin, offered the resident some water, then removed the remaining applesauce and fork from the table.
-At 9:03am, the resident attempted to eat her oatmeal with her spoon, had difficulty scooping and picking up the bites of oatmeal, but when successful, repeatedly dropped bites of the oatmeal on the plate or table before making it to her mouth.
-At 9:09am, the oatmeal cup tipped over and the resident began trying to pick up the oatmeal and eat it with her fingers; she was successful about 60% of her attempts.
-At 9:16am, the resident was eating her scrambled eggs with her fingers/hands, tried to use the spoon, but knocked the food off the plate and was unable to pick up bites of eggs with the spoon.
-From 9:12am to 9:15am, the resident sat in the dining room alone with no other residents or staff attempting to continue to eat her breakfast unsupervised.
-At 9:19am, the facility nurse sat down at the table with the resident and encouraged her to eat, wiped her fingers with a napkin (the resident had food and debris under her finger nails), and assisted the resident to hold a fork to eat her eggs walking away from the resident by 9:20am.
-From 9:20am to 9:26am, the resident sat in the dining room alone unattended again continuing to eat her eggs with her hands from the plate, the table, and her lap.
-At 9:26am, the facility nurse came back and began removing the resident's silverware leaving the table again by 9:27am without assisting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 17	D 312		

resident any further.
-At 9:28am, the facility nurse returned, offered the resident a bite of eggs while standing over her with a fork, the resident declined, so the nurse wiped the resident's fingers, picked up the remaining food in the resident's lap, and wheeled her out of the dining room into the activity room.
-The resident ingested 80% of her oatmeal, 80% of her applesauce, 80% of her eggs, 50% of the toast, and 20% of the water.

Review of Resident #2's record revealed there was no documentation that the resident was unable to use eating utensils, struggled to eat, ate with her hands, or that her PCP was made aware.

Interview with a PCA on 04/21/22 at 9:46am revealed:
-All facility staff were trained to watch how residents ate but there was no process that she was aware of to identify specific residents who required feeding assistance.
-Staff were to allow residents to eat with their fingers, even if they were missing their mouth and required redirection to allow them to maintain their dignity.
-The only time staff would intervene was to offer silverware on occasion or if a resident was just playing with the food and not trying to eat at all.

Interview with a second PCA on 04/21/22 at 9:54am revealed:
-Staff were trained to allow residents to maintain as much independence as possible before intervening to assist them with eating.
-Resident #2 required redirection and assistance with eating because she sometimes would get confused and forget to eat well and had slowly been declining.
-Resident #2 would sometimes use eating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 18	D 312		

utensils, but normally ate with her hands and fingers.
-Staff were trained to watch residents eat and report any decline in their ability to do so.
-It was the medication aides (MAs) or the SCC responsibility to reach out to the resident's PCP to intervene and adapt as needed and they were aware.
-She was not aware of any specific orders for feeding assistance for Resident #2, but the resident could consume her food and eat well most days.

Interview with a MA on 04/21/22 at 9:40am revealed:
-Staff identified residents who needed feeding supervision and assistance by watching all the residents during a meal service.
-To her knowledge, there were no residents that required 1:1 feeding assistance.
-If there was a resident who ate with their fingers, staff should try to intervene and encourage the use of eating utensils.
-She expected staff to assist residents as trained by sitting on the resident's dominant side at eye level, using eating utensils, and allowing the resident to take as much time as needed to eat.

Interview with the facility nurse on 04/21/22 at 9:32am revealed:
-The staff knew which residents needed feeding supervision and assistance, but unless a resident was completely unable to feed themselves, the staff would not sit down 1:1 to assist and feed the resident.
-The staff did not sit down with residents who required feeding supervision and assistance because they wanted the residents to be able to maintain their independence.
-When she attempted to assist Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 19	D 312		

during the breakfast meal service that day, 04/21/22, the resident was unable to consume food using her fork when it was offered to her, so she allowed the resident to consume her food using her fingers to allow the resident to maintain her independence.

Interview with the Special Care Coordinator (SCC) on 04/21/22 at 10:04am revealed:
-PCAs were expected to be in the dining room during meal services to watch residents eat; they were to stand back as much as possible and allow residents to be as independent as possible.
-If a resident was unable to eat the PCAs were expected to intervene.
-Resident #2 required feeding assistance and supervision; she liked to eat with her hands, does well doing so, and has not lost weight.
-She was not aware that Resident #2 was attempting to eat foods on her mechanical soft diet such as applesauce with her fingers.
-She would have expected staff to intervene and assist Resident #2 as needed but would have expected staff to be as "hands off" as possible.

Interview with the Administrator on 04/21/22 at 1:39pm revealed:
-She expected staff to provide residents with supervision while eating and provide reminders, cueing, and assistance as necessary.
-A resident's care plan should reflect a need for eating assistance, but she did not expect staff to provide 1:1 feeding assistance to maintain resident's independence.
-The staff had been trained to observe residents and to provide queuing and redirection but not to sit and feed a resident out of dignity and respect.
-When staff recognized that Resident #2 was having difficulty eating, they should have reached out to the resident's PCP with the concerns for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 312	Continued From page 20 notification and evaluation. -She was unaware Resident #2 was having difficulty eating and the facility could have requested an evaluation from physical therapy (PT), speech, and occupational therapy (OT) to try and address her needs and possibly provide her with specialized utensils to assist her in eating. Interview with Resident #2's primary care provider (PCP) on 04/21/22 at 12:40pm revealed: -She expected all residents to be supervised during meals and for Resident #2 to be assisted with eating using eating utensils at every meal out of dignity and respect. -If the facility wanted to help the resident maintain her dignity, respect, and independence, she would expect a staff member to sit with the resident 1:1 to provide coaching, redirection, encouragement, and assistance as needed to eat in a manner the resident would have eaten prior to the cognitive decline from her diagnosis. -It was undignified to allow the resident to eat with her fingers or to struggle to get food to her mouth. -The resident was not cognitively able to choose to eat with her fingers over silverware due to confusion and inability on how to use eating utensils. -The resident was on a therapeutic diet that required eating utensils to eat the consistency of the food she needed, and it was inappropriate to allow her to eat her food with her fingers.	D 312		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 464	Continued From page 21	D 464		

.0801 and 13F .0802 of this Subchapter, the facility shall assure the following:
(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.
(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a Special Care Unit (SCU) resident profile and care plan was completed quarterly for 3 of 3 sampled residents (#1, #2, #3) as required to guide resident care.

The findings are:

1.Review of Resident 1's current FL-2 dated 04/01/22 revealed:
-Diagnoses included dementia, diabetes, high blood pressure, osteoarthritis and depression.
-She was intermittently disoriented.
-She was semi-ambulatory and used a wheelchair or walker to assist with mobility.
-A Special Care Unit was the recommended level of care.
-There was documentation Resident #1 was admitted on 05/20/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 464	Continued From page 22 Review of Resident #1's Resident Registered signed and dated on 05/23/19 revealed there was no admission date documented. Review of Resident #1's current care plan and assessment dated 04/02/21 revealed: -She required limited staff assistance with toileting, ambulation, bathing, dressing and grooming. -She required supervision from staff for transfer. Review of Resident #1's record revealed there was not a more recent resident profile and care plan present. Refer to interview with the Special Care Coordinator on 04/21/22 at 1:12pm. Refer to interview with the Administrator on 04/21/22 at 1:39pm. 2. Review of Resident #2's current FL-2 dated 09/06/21 revealed: -The resident was admitted to the facility on 09/15/20. -Her level of care was in the special care unit (SCU) and she was intermittently disoriented. -Diagnoses included dementia and intermittent tachycardia. -There was an order for a mechanical soft diet (soft, chopped, or pureed foods ordered for feeding or swallowing difficulties). Review of Resident #2's Resident Register dated 09/11/20 revealed: -The resident was forgetful and required reminders. -The resident required food that was easily chewed.	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 464	Continued From page 23 Review of Resident #2 current care plan and assessment dated 09/06/21 revealed: -The resident was always disoriented with significant memory loss and required reminders and redirection. -The resident required supervision with eating. Review of Resident #2's resident profile and care plan dated 02/07/22 revealed: -The resident was on a mechanical soft diet and required assistance in determining food preferences. -The resident had issues with chewing, could feed herself, and needing reminded and queuing to eat. Review of Resident #2's record revealed there was another six-month care plan dated 10/27/21, but there were no quarterly resident profile and care plan assessments present. Refer to interview with the Special Care Coordinator on 04/21/22 at 1:12pm. Refer to interview with the Administrator on 04/21/22 at 1:39pm. 3. Review of Resident #3's current FL-2 dated 04/21/22 revealed: -Diagnoses included dementia, incontinence and recurrent falls. -There was documentation for a skilled nursing facility as the recommended level of care. -She was constantly disoriented, semi-ambulatory and used a wheelchair for mobility. -She was admitted on 10/10/19. Review of Resident #3's previous FL-2 dated 10/25/21 revealed:	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 464	Continued From page 24	D 464		

-There was documentation for a memory care unit as the recommended level of care.
-Diagnoses included dementia, incontinence and recurrent falls.
-She was constantly disoriented, semi-ambulatory and used a wheelchair for mobility.

Review of Resident #3's Resident Register dated 10/10/19 revealed:
-She required assistance with ambulation.
-She required orientation to time and place.
-There was no admission date documented.

Review of Resident #3's current care plan and assessment dated 09/24/21 revealed:
-Diagnoses included dementia and she required reminders because she was forgetful.
-She was sometimes disoriented.
-She required supervision from staff with ambulation.
-She required limited assistance from staff for eating and transferring.
-She required extensive assistance from staff for toileting, bathing, dressing and grooming.

Review of Resident #3's resident profile and care plan dated 09/27/21 revealed:
-She was able to communicate effectively and make needs known to staff.
-She occasional had difficulty remembering and using information and required some reminders.
-She had 1-2 falls in the previous 90 days and required assistance with ambulation.

Review of Resident #3's record revealed there was another six-month care plan dated 04/06/21, but there were no quarterly resident profiles and care plan assessments present.

Refer to interview with the Special Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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 464	Continued From page 25 Coordinator on 04/21/22 at 1:12pm. Refer to interview with the Administrator on 04/21/22 at 1:39pm. _____ Interview with the Special Care Coordinator on 04/21/22 at 1:12pm revealed: -It was her responsibility to ensure quarterly resident profile and care plans had been completed, but she had not done them because she was unaware that it was a requirement until being made aware that day, 04/21/22. -If she had been aware that quarterly resident profile and care plans needed to be done, she would have done them. -It was important for residents to have accurate and up to date resident profile and care plans as required because it was a resource to the staff on how to guide care for the residents. Interview with the Administrator on 04/21/22 at 1:39pm revealed: -She was aware quarterly resident profile and care plans were to be completed on residents in the SCU but was not aware they were not being done. -It was the SCC's responsibility to ensure quarterly resident profile and care plans were completed and she expected the rule to be followed to ensure staff knew how to provide the proper care to each resident. -She was not aware the SCC did not know to complete quarterly resident profile and care plans and should have learned to do it in her initial training as the SCC.	D 464		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMOI	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
D912	Continued From page 26 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 are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews and record reviews the facility failed to provide appropriate supervision for 1 of 3 sampled residents (#3) who had 6 falls in a 4-month period, the most recent of which resulted in nasal bone fractures.[Refer to tag D270 10A NCAC 13F .0901(b) (Type A2 Violation)].	D912		