STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure four of six sampled employees assigned to perform duties in the special care unit completed six hours of orientation and had completed 20 hours of	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 468	Continued From page 1 training specific to the population being served within six months of employment. (Staff B, D, E, and F.) The findings are: 1. Review of the employee record for Staff B revealed: - Staff B, was hired on 4/30/08 as a medication aide/nursing assistant. - There were 12 hours of special care unit training documented between 2012 - 2014. - A total of 20 hours of special care training within 6 months of the special care unit opening was not documented. Interview with Staff B on 3/31/15 at 10:45 a.m. revealed: - She had been hired as a medication aide and nursing assistant. - Staff B on occasion filled in for staff not able to come to work in the special care unit. - That day she was going to work as a fill in on the evening shift and had done so since the special care opened a few years ago. - She had cross training for the assisted living and the special care unit but did not know exactly how much training was given. Refer to interview on 4/02/15 at 5 p.m. with the Director of Operations (DOO). 2. Review of the employee record for Staff D revealed: - Staff D, was hired on 12/26/08 as a medication aide (MA)/nursing assistant (PCA). - There were 5 hours of special care unit training documented in 2012. - There were 7 hours of special care unit training in 2014 plus one other hour not dated equaling only 13 hours total.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 468	Continued From page 2 Review of the Tuesday 3/31/15 and 4/01/15 staff work schedule revealed Staff D had worked the evening shift in the special care unit. Interview on 3/31/15 at 2:12 pm with Staff D revealed: - Staff D had been employed at the facility for 7 years. - Staff D worked in the Special Care Unit (SCU) on mainly 1st shift as a MA and also as a PCA. - Staff D received SCU training in dementia (did not specify types of training). Observation on 3/31/15 at 9:30 am of Staff D revealed Staff D was standing at the medication cart in SCU preparing a medication for a resident. Observation on 4/1/15 at 11:45 am revealed Staff D was assisting SCU residents coming into the dining room and being seated at the tables for lunch. Refer to interview on 4/02/15 at 5 p.m. with the Director of Operations (DOO). 3. Review of the employee record for Staff E revealed: - Staff E, was hired on 9/30/13 as a nursing assistant. - Five hours of special care unit training was documented in the employee's record. - The total of 20 hours of special care training within 6 months was not documented. Review of the Tuesday 4/01/15 staff work schedule revealed Staff E had worked the evening shift in the special care unit. Interview on 4/2/15 at 5:30 p.m. with the facility nurse revealed:	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 468	Continued From page 3 - Staff E had worked in the special care unit and had the training. - The nurse would look for further training. Observation on 4/1/15 at 4:15 pm of Staff E in the SCU revealed Staff E was assisting a resident in their room by providing personal care. Refer to interview on 4/02/15 at 5 p.m. with the Director of Operations (DOO). 4. Review of the employee record for Staff F revealed: - Staff F, was hired on 11/20/13 as a nursing assistant. - Six hours of special care unit training only was documented in the employee's record. - The total of 20 hours of special care training within 6 months was not documented. Review of the Daily Assignment Sheet revealed Staff F worked 4/01/15 and 4/02/15 in the special care unit as a nursing assistant on the night shift. Refer to interview on 4/02/15 at 5 p.m. with the Director of Operations (DOO). _____ Interview on 4/02/15 at 5 p.m. with the Director of Operations (DOO) revealed: - The Special Care Unit had been opened in 2013. - The DOO thought all the staff had their required training for the special care unit. - The business office was responsible for ensuring all staff qualifications were in the employee records. - The nurse taught the required special care unit training classes and any continuing education classes.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 468	Continued From page 4 - The nurse said some of the training class information was missing but they would continue to look for it. - A new system would have to be put in place to ensure all staff qualifications were completed and available	D 468		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 5 effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure half bedrails were used only after an assessment and care planning process had been completed and used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and only with a physician's written restraint order for four of four sampled residents. (#1, #2, #3, #4). The findings are: 1. Review of the current FL-2 dated 7/14/14 for Resident #4 revealed: - Diagnoses of Alzheimer's Dementia, history of hip fracture (Prior to admission.), history of deep vein thrombosis and coronary artery disease. - The current FL-2 listed the resident to be constantly disoriented, semi-ambulatory.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 6	D 482		

Review of Resident #4's current Assessment and Care Plan dated 10/23/14 revealed:
- The resident was total care.
- The resident was listed as constantly disoriented and semi-ambulatory.

Observation on 3/31/15 at 10:0 a.m. of Resident #4 revealed:
- The resident was asleep in the bed on her back.
- Bilateral half bedrails were in the up position.

Confidential interview revealed:
- The staff person provided total care which included bathing, dressing, feeding, turning, changing briefs and transfers for the resident.
- Resident #4 had not been moving much at all since January 2015.
- The facility might have the bedrails up on Resident #4's bed to keep her from falling out of the bed.
- No one not told the staff person to use the bedrails for the resident, but the staff pulled them up because they were on the bed.
- Staff pulled the bedrails up if they were in the down position to protect the resident.
- Staff said the resident had not had any serious injuries since admitted to the facility.

Interview on 3/31/15 at 11:15 a.m. with a medication aide revealed:
- Resident #4 required total care and had been on hospice care.
- The resident had bedrails for safety so she would not fall out of the bed.
- The MA was working in the facility when Resident #4 fell out of the bed with the bedrails in the down position.
- A new nursing assistant (NA) was in the room with the resident but had not pulled the bedrails to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 7	D 482		

the up position and the resident fell out of the bed.
- The resident went to the emergency room and came back with no serious injuries.
- The facility did not have any restraints because they were not allowed.

Review incidents with the half bedrails for Resident #4 were as follows:

Review of facility notes dated 1/02/14 (2014) for Resident #4 revealed:
- Resident #4 was calling for the aide.
- The resident was found by the aide with, "Resident neck stuck between rail and the bed mattress.
- The resident was talking and breathing.
- The aide got help.
- The resident was assessed and was found not to have any injuries.

Review of a faxed communication with the resident's physician dated 7/12/14 revealed:
- The resident's arm had been pressed up against the bed rail.
- Resident #4 sustained a left arm skin tear.

Review of an Accident/Incident report dated 1/22/15 for Resident #4 at 6:35 p.m. revealed:
- The supervisor documented Resident #4 was fed and left in a sitting position without the half bedrails in the up position.
- The resident obtained a skin tear and had hit her face.
- Emergency was called and the resident went to the hospital.

Review of a monthly Resident Assessment for Resident #4 dated 1/22/15 revealed:
- Resident #4 fell out of the bed after a meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 8	D 482		

when the bed rail was left in the down position.
- Emergency services were called and the resident was transferred to the hospital.
- The resident returned to the facility with an abrasion and no other injuries.

Review of facility nurse notes dated 1/23/15 for Resident #4 revealed:
- Resident #4 had a lot of movement that day.
- The resident was found rotated in the bed so the resident's legs were hanging over the side of the bed.
- There was no information if the bedrails were in the up or down position.

Observations on 4/01/15 at 12:15 p.m. of Resident #4 during the lunch meal in the resident's room revealed:
- Resident was awake and was moving and bending her legs up.
- A NA began to prepare the resident to eat lunch.
- The resident's bed was raised to a 75 degree angle and the bilateral half bed rails were in the up position.
- The resident turned her upper body to the right and faced the bed rail.
- The NA lowered the resident's head and repositioned the resident on her back.
- The NA raised the head of the bed again and the resident tried to turn to the right again.

Interview with the nursing assistant feeding the resident on 4/01/15 at 12:15 p.m. revealed:
- Resident # 4 was unable to move out of the bed on her own.
- She could not walk or stand by herself now.
- The resident could turn partially to the side as she had done prior to the lunch meal.
- The bedrails were for safety so she would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 9 fall out of the bed. Interview on 4/01/15 at 3:30 p.m. with the facility nurse Resident Care Coordinator (RCC) revealed: - The hospice nurse got the resident a hospital bed that came with the bed rails. - She would look for the orders. - She said the resident had needed bedrails since about the end of December 2014 or the beginning of January 2015 due to decline in activity and condition. - The resident had fallen one time when the rails were lowered in January of 2015. - The facility did not have any bedrail restraints. - The RCC thought the half bedrails were not restraints. - She thought only full bedrails were restraints. - The bedrails for Resident #4 were for "...safety". - No assessment or care plan nor use of alternatives had been completed for the bilateral half bedrails used to keep Resident #4 from falling out of the bed. - There was not a specific restraint order for the bilateral half bedrails to be used as a restraint. - The RCC said she and the registered nurse would assess all residents with half bed rails as soon as possible. Interview with the facility registered nurse on 4//02/15 11 a.m. revealed: - The bed rails on Resident #4's bed were used for safety. - She was not aware that half bed rails were possible restraints. - She and the facility nurse would assess all bed rails to determine if they were enablers or restraints and get orders as needed. - She was more aware of the restraint	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 10	D 482		

requirements for Resident #4 now.
- The facility would now ensure alternatives, a team assessment and care plan, restraint orders while in restraints, as well as restraint consent with family, responsible party and/or resident would be completed.

Review of the most recent Licensed Health Professional Support Review dated 3/18/15 for Resident #4 revealed:
- The resident required feeding and transfers.
- There was no information related to the use of bedrails as restraints.

Interveiw on 4/02/15 at 3 p.m. with the Resident #4's physician revealed:
- The physician knew the resident had the half bedrails on her bed.
- The resident previously used them to position in the bed.
- At this point in the resident's stage of complete dementia, the bed rails should be used for her protection.

No assessment, orders or consent for the use of the bedrails for Resident #4 was provided by the end of the survey.

Refer to interview with the facility's registered nurse on 4/02/15 11 a.m.

Refer to interview on 4/2/15 at 5 p.m. with the DOO.

Refer to the facility's Restraint Policy of 4/02/15.

Refer to the facility's Plan of Protection dated 4/2/15.

2. Review of Resident #2's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 11 11/19/14 revealed: - The resident's diagnoses included dementia, chronic obstructive pulmonary disease, peripheral vascular disease, and left groin pain. - The resident used continuous O2 at 2L/min. via nasal cannula and required nebulizer treatments. Review of Resident #2's current Assessment and Care Plan dated 3/17/15 revealed: - The resident was hearing impaired, constantly disoriented, forgetful, and used a wheel chair without a lap belt for mobility and needed assistance with transferring. Observation on 3/31/15 at 10:05 a.m. of Resident #2 revealed: - The resident was seated in a wheel chair in the Special Care Unit's (SCU) TV lounge area. - The resident was using O2 via nasal cannula attached to an oxygen tank at the back of his wheelchair. - The resident was non-verbal and was watching an activity in progress. Observation on 3/31/15 at 10:15 am of Resident #2's room revealed: - The resident had a hospital bed with 1/2 bedrails attached. - The bed was situated with the left side next to the wall. Record review for Resident #2 revealed: - A physician order sheet dated 3/17/15 for "hospital bed with 1/2 siderails and alternating pressure pad". - No documentation that an assessment was done or a care planning process had been completed by the facility for the use of restraints for the resident. - No documentation that alternatives had been	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 12	D 482		

used by the facility prior to the use of restraints for the resident.
- No documentation by Resident #2's Power of Attorney (POA) giving permission for the use of restraints.

Interview on 4/2/15 at 3:30 pm with the SCU 2nd shift Medication Aide (MA) revealed:
- Resident #2 could roll in bed and the bedrails would prevent him from falling on the floor.
- The bed rails were used every time the resident was in bed.
- The MA had not seen the resident trying to get out of bed with the bed rails up; he would wait for staff to put them down.
- The MA did not know if there was a physician's order or assessment in his chart for the use of bedrails.
- The MA did know the use of bedrails was a restraint for the resident.
- To use a restraint, a doctor's order was needed.
- Staff made 20 minute checks on residents with bedrails per SCU policy.

Interview on 4/2/15 at 4:03 pm with Resident #2's POA revealed:
- The resident had the hospital bed with 1/2 bedrails for 2 years.
- The bed rails may be pulled up when he sleeps.
- The POA did not know if there was a physician's order written for the use of the bedrails.

Observation on 4/2/15 at 4:20pm of Resident #2 revealed:
- The resident was in his room lying in bed resting.
- The bed rails were in the lowered position.

Review of the most current Licensed Health Professional Support Review (LHPS) for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 13 #2 dated 3/18/15 revealed: - The resident had 1/2 bedrails on his hospital bed. - There was no documentation related to the 1/2 bedrails as restraints. Interview on 4/2/15 at 1:35 pm with Resident #2's primary care physician's (PCP) nurse revealed: - The resident was last seen in the office on 3/23/15 for a follow-up after an x-ray. - There was no documentation in the resident's records for the use of bedrails. Continued interview at 4:45 p.m. with Resident #2's PCP's nurse revealed: - There was no assessment or order in Resident #2's patient records for the use of bed rails. - Per the physician, the facility needed to call the physician to do the process for the use of bed rails for (Resident #2). Continued interview on 4/2/15 at 7:25 p.m. with the DOO revealed: - Resident #2 had a hospital bed with ½ bed rails upon admission. - The DOO did not think ½ bed rails were restraints, only full rails. - The DOO did not go through the restraints process for the use of the ½ rails for Resident #2. - We "will have to start from scratch and consider that bed rails and lap belts can be restraints." - The DOO stated he "will have to follow the restraint guidelines and the facility policy." Refer to interview with the facility's registered nurse on 4/02/15 11 a.m. Refer to interview on 4/2/15 at 5 p.m. with the DOO.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 14 Refer to the facility's Restraint Policy of 4/02/15. Refer to the facility's Plan of Protection dated 4/2/15. 3. Review of Resident #3's current FL-2 dated 2/05/15 revealed: - Diagnoses of Alzheimer's Dementia, dizziness, vertigo, depression, and hypertension. - The resident was listed as a fall risk, constantly disoriented and semi-ambulatory. Review of Resident #3's Assessment and Care Plan dated 1/26/15 included the resident was always disoriented and required total care for activities of daily living. Observation on 3/31/15 at 10:05 a.m. of Resident #3's bedroom revealed - The resident was not in the bedroom. - The resident's bed was observed to have a half bedrails in the down position. Observations on 3/31/15 at 11:15 a.m., 4/01/15 at 8:45 a.m. and 4/02/14 at 3:20 p.m. revealed Resident #3 was always in the wheelchair with a seat belt attached. Review of the Record for Resident #3 revealed: - A Restraint Assessment and Care Plan for the seatbelt was completed with orders and consent. - There was no information related to the half bed rails as a restraint/enabler. Review of the record for Resident #3 did not reveal any other documentation in relation to the half bedrails. Interview on 4/01/15 at 3:45 p.m. with the facility nurse revealed:	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 15 - The resident had declined from her previous status recently. - Previously the half bedrails on her bed were used to provide the resident assistance for pulling up in the bed. - Resident #3 could possibly roll off of the bed now. - She could move her body and would slide down in the wheel chair. - The resdient could move her legs over the side of the bed but was too week to sit up on her own. - The resident could not stand and walk. - A wheelchair was used for the resident. - Resident #3 would not be able to call out for help if caught up in the bedrails. - The facility did not have any bedrail restraints. - The nurse thought the half bedrails were not restraints. - She thought only full bedrails were restraints. - No assessment or care plan nor use of alternatives had been completed for the bilateral half bedrails used to keep the resident from falling out of the bed. - There was not a specific restraint order for the bilateral half bedrails to be used as a restraint. - The nurse said she and the registered nurse would assess all residents with half bed rails. Review of a Licensed Health Professional Support Review (LHPS) dated 3/18/15 for Resident #3 revealed: - The resident required transfers, feeding techniques physical restraint - seatbelt. - The resident had poor trunk control and poor safety awareness. - No information was documented related to the bilateral half bedrails for safety. Interview on 4/02/15 at 12:30 p.m. with a nursing assistant (NA) revealed:	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 16	D 482		

- She bathed Resident #3 and she would transfer and dress the resident.
- The resident could move her legs some and could slide in the wheelchair.
- The resident could not stand on own and walk.
- The bedrails were on the bed and she would use them if the resident went back to bed for safety.
- The NA was not aware of any injuries from falls or the bedrail for Resident #3.

Interveiw on 4/02/15 at 3 p.m. with the Resident #4's physician revealed:
- The physician knew the resident had the half rails on her bed.
- She previously used them to position in the bed.
- At this point in the resident's stage of complete dementia, the bed rails should be used for her protection.

No assessment, orders or consent for the use of the bedrails for Resident #3 was provided by the end of the survey.

Refer to interview with the facility's registered nurse on 4/02/15 11 a.m.

Refer to interview on 4/2/15 at 5 p.m. with the DOO.

Refer to the facility's Restraint Policy of 4/02/15.

Refer to the facility's Plan of Protection dated 4/2/15.

4. Review of Resident #1's current FL-2 dated 11/19/14 revealed:
- The resident's diagnoses included Alzheimer's dementia, anemia, sepsis, and atrial fibrillation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 17	D 482		

- The resident was constantly disoriented, non-ambulatory, required total care, and was a falls risk.

Review of Resident #1's current Assessment and Care Plan dated 1/24/14 revealed:
- The resident required total care with 2-person assistance.
- The was no documentation for the use of bedrails or a lap belt alarm.

Observation on 3/31/15 at 9:40 a.m. of Resident #1 revealed:
- The resident was seated in a high backed wheel chair in the Special Care Unit's (SCU) TV lounge area.
- The resident's head was supported at the back by a neck pillow and he was wearing a lap belt alarm which was secured in the front.
- The resident's eyes were open, but he did not respond when spoken to.

Observation on 3/31/14 at 4:30 p.m. of Resident #1 revealed:
- The resident was sleeping in a reclining lounge chair in the TV section of the dining room.
- A chair alarm was attached to the chair and the resident's clothing.

Observation on 3/31/15 at 9:45 a.m. of Resident #1's room revealed the
resident had a hospital bed with 1/2 length bedrails.

Record review for Resident #1 revealed:
- No documentation that an assessment was done or a care planning process had been completed by the facility for the use of restraints for Resident #1.
- No documentation that alternatives had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 18	D 482		

used by the facility prior to the use of restraints for Resident #1.
- No written physician's order for the use of restraints for Resident #1.
- No documentation by the Power of Attorney (POA) giving permission for the use of restraints after a physician's order for Resident #1.

Further review revealed a facility Hold Harmless Waiver for Restraints signed by Resident #1's POA on 9/4/14.

Interview on 4/2/15 at 3:40 pm with the SCU 2nd shift Medication Aide (MA) revealed:
- The MA did not know how long Resident #1 had used bedrails; they were used to keep him from rolling out of bed.
- The resident also had a seat belt alarm and chair alarm.
- The MA had not observed the resident trying to get out of bed and could not put the bedrails down by himself; he waited for staff to get him out of bed.
- The MA heard the resident's seat belt alarm several times when the resident bent over to reach for items on the floor.
- The resident could release the seat belt.
- The MA had watched him sometimes playing with the release on the seat belt alarm.
- The MA saw an order for one of Resident #1's alarms in his chart, but was not sure for which one.
- The MA had not seen an assessment or order for the resident for the use of restraints.

Observation on 4/2/15 at 4:00 p.m. of Resident #1 revealed:
- The resident was lying in bed with the ½ bed rails pulled up.
- The resident was positioned on his right side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 19	D 482		

facing the bedrails with his knees bent and lying at the bottom half of the mattress.
- The resident's left leg was crossed over the right with his left foot and lower leg dangling off the bed.
- The resident's face was 2 inches away from the side of the mattress and the bars at the curved end of the bedrails.

Interview on 4/2/15 at 12:25 p.m. with Resident #1's POA revealed:
- The resident was admitted to Assisted Living (AL) before going to the SCU.
- The resident had changed a lot in the past year and had been very active.
- the Resident Care Coordinator (RCC) and the Director of Operations (DOO), the hospital bed with ½ bedrails, the chair alarm, and the seat belt alarm were ordered by the POA in September 2014 for the resident in the SCU.
- The POA assumed staff used the bed rails to prevent the resident from falling when trying to get out of bed.
- The POA assumed from the RCC and the DOO that Resident #1's physician was consulted about the bed rails and chair alarm; they told the POA that they would take care of everything.
- The POA did not have any idea if there was a physician's order for the bedrails and alarms.

Review of the most current Licensed Health Professional Support Review (LHPS) for Resident #1 dated 3/18/15 revealed:
- The resident required assistance with feeding, transferring, and personal care.
- The resident had a chair alarm.
- There was no documentation related to the use of bedrails.

Interview on 4/2/15 at 1:35 p.m. with Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 20 #1's primary care physician (PCP) revealed: - The PCP "had no concept of (Resident #1's) abilities, he had a fractured hip". - The PCP had not done an assessment or made an order for the bedrails, chair alarm or lap belt. - He "will work with the facility to get done what we need to do". Interview on 4/2/15 at 7:15 p.m. with the Director of Operations (DOO) revealed: - Resident #1 came from a skilled facility and had bedrails and a seat belt there. - When he was admitted to this facility and a hospital bed was ordered, ½ bedrails were requested. - The DOO did not consider ½ bedrails to be a restraint and did not get an assessment, try alternatives, or get a physician order to use them for Resident #1. Refer to interview with the facility's registered nurse on 4/02/15 11 a.m. Refer to interview on 4/2/15 at 5 p.m. with the DOO. Refer to the facility's Restraint Policy of 4/02/15. Refer to the facility's Plan of Protection dated 4/2/15. _____ Review of the facility's Restraints Policy Revised: 4/02/15 revealed: - "It is the policy of the facility to insure that alternative(s) are tried before the use of physical restraints. - If alternatives to physical restraints have failed, the lease restrictive restraint will be used.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 21 - A restraint will only be applied after an order is obtained, resident/representative has given consent, and a restraint assessment and care plan are completed by the collaborative team. - Documentation will be completed on a restraint oversight form to reflect time of application and duration of the restraint, release of the restraint and removal of the restraint per the order. - All orders and assessments will be updated every 90 days." Interview with the facility's registered nurse on 4/02/15 at 11 a.m. revealed: - She was not aware that half bed rails were possible restraints. - The bedrails were used for safety or as enablers. - She and the facility nurse/Resident Care Coordinator (RCC) would assess all bed rails to determine if they were enablers or restraints and get orders as needed. - She was aware of the complete restraint requirement now and would ensure alternatives, a team assessment and decision would be made, a restraint consent with family, responsible party and/or resident would be completed. Interview on 4/02/15 at 5 p.m. with the Director of Operations revealed: - He was not aware the half bedrails were possibly restraints. - He thought only full bedrails were restraints and the facility did not have any of those at this time. - The RCC and the facility's nurse would assess the residents' bed rails. _____ Review of the facility's Plan of Protection dated 4/2/15 revealed: - All residents with restraints will be assesed for	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 482	Continued From page 22 proper use and documentation to assure restraints are being used in lest restrictive manner. - On 4/02/15 the RCC/ Licensed Practical Nurse and the facility's Registered Nurse completed assessments, physician's orders and consents for residents with restraints. - Documentation was completed on residents who use siderails as enablers. - Staff will check residents and document care while in restraints by physician's orders. - Update of resident condition assessments for residents with restraints will be completed every three months. - Monitoring of staff use and care with residents in restraints will be monitored weekly for one month and then monthly to ensure proper use, documentation and care to ensure resident safety. - Training on use and care of residents with restraints will be implemented. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2015.	D 482		
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 observation, interveiw and record review, the facility failed to assure each resident	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 23 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to the use of physical restraints. The findings are: Based on observation, interview and record review, the facility failed to assure half bedrails were used only after an assessment and care planning process had been completed and used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and only with a physician's written restraint order for four of four sampled residents.(#1, #2, #3, #4). [Refer to Tag D 0482, 10A NCAC 13F .1501 Use of Restraints and Alternatives (Type B Violation).]	D912		