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D 000	Initial Comments The Adult Care Licensure Section and the Davie County Department of Social Services conducted an annual survey on 5/4/15 and 5/5/15 with an exit conference via telephone on 5/6/15.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure 1 of 6 sampled staff (Staff C) was tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel file revealed: -Hire date of 4/9/15 as a Personal Care Aide (PCA). -No documentation of a TB test. Interview with the Administrator on 5/5/15 at 8:30 am revealed: -'I know I do not have her TB test, because she is	D 131		

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scheduled to go next week for it."
-It was the Administrator and Administrator Assistant's responsibility to assure that the TB test had been completed by the employee within 30 days of hire.
-There were no isolation precautions put in place until the TB test was completed within the 30 days of hire.
-New hires are required to go to their primary care physician, urgent care or the local health department for testing.
-Each new employee must pay for their own TB testing.
-Usually new employees obtained their TB test after 2 weeks of employment, which was when they received their first pay check.
-If an employee could not afford the TB test, they were terminated.

Telephone interview with Staff C on 5/5/15 at 10:35 am revealed:
-She was hired on 4/9/15 as a PCA.
-Her job duties were to provide care to the residents, which included bathing, feeding and caring for them.
-She was aware that she needed to get a TB test done.
-She had not had the money to pay for it over the past 3 weeks upon hire and did not inform the Administrator.
-She had an appointment to get the TB test done on 5/5/15.
-She had a prior TB test done approximately a year ago at another assisted living facility for prior employment.
-She had never tested positive for TB.

A completed TB test for Staff C, dated 5/5/15, was provided on 5/5/15, with results pending.

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D 131	Continued From page 2 On 05/05/15, the Director submitted a Plan of Protection as follows: -The Director and the Assistant Director will immediately check all staff records for TB testing. -The Director will assure all working staff will have TB testing administered within 24 hours. -The Assistant Administrator will be responsible for assuring all potential new hires will complete a one step TB skin test prior to hire. -The Director will monitor all new employees for TB testing and terminate if first step TB is not completed in the facility guideline of 2 weeks. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 20, 2015.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews the facility failed to ensure 4 of 8 staff sampled (Staff E, F, G, and Staff H) had no substantiated findings listed on the North Carolina Health Care Personal Registry (HCPR) prior to hire according to G.S. 131E-256.	D 137		

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D 137	Continued From page 3 The finding are: A. Review of Staff G's personnel record revealed: -Staff G was hired on 5/4/15 as a housekeeper. -No documentation of a HCPR check completed for Staff G. Interview on 5/5/15 at 7:45 am with Staff G revealed: -She started employment at the facility on 5/4/15 as a housekeeper. -She thought it was 4/28/15 when she applied for a position with the facility. -She was not aware if the facilty completed a HCPR check prior to her employment at the facility. Refer to interview on 5/4/15 at 4:00 pm with the Administrator. Refer to interview on 5/5/15 at 8:15 am with the Assistant Administrator. B. Review of Staff F's personnel records revealed: -Staff F was hired on 8/11/14 as a housekeeper. -No documentation of a HCPR check completed for Staff F. Staff F was not available for interview. Refer to interview on 5/4/15 at 4:00 pm with the Administrator. Refer to interview on 5/5/15 at 8:15 am with the Assistant Administrator. C. Review of Staff H's personnel records revealed: -Staff H was hired on10/10/13 as a dietary aide.	D 137		

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D 137	Continued From page 4 -No documentation of a HCPR check completed for Staff H. Interview on 5/5/15 at 8:10 am with Staff H revealed: -Staff H worked in the facility for over a year. -Staff H duties included serving and preparing meals for the residents. -Staff H was unaware if the facilty completed a HCPR check prior to employment. Refer to interview on 5/4/15 at 4:00 pm with the Administrator. Refer to interview on 5/5/15 at 8:15 am with the Assistant Administrator. D. Review of Staff E's personnel records revealed: -Staff E was hired on 7/28/08. -Staff E was employed as the Dietary Manager. -No documentation of a HCPR check completed for Staff E. Inteview on 5/5/15 at 7:50 am with Staff E revealed: -She was hired as a cook and advanced to the Dietary Manager. -She had been employed at the facility for 7 years. -She was not aware nor did she know what the HCPR was. Refer to interview on 5/4/15 at 4:00 pm with the Administrator. Refer to interview on 5/5/15 at 8:15 am with the Assistant Administrator. Interview on 5/4/15 at 4:00 pm with the	D 137		

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D 137	Continued From page 5 Administrator revealed: -She had been employed as the Administrator for 2 years. -She or the Assistant Administrator was responsible for completing the HCPR for new hires. -She was not aware housekeeping or dietary staff needed the HCPR check prior to hire. Interview on 5/5/15 at 8:15 am with the Assistant Administrator revealed: -She had been employed at the facility for 3 years. -She was aware the HCPR was to be checked on all employees prior to hire. -She was unaware staff's HCPR was not checked prior to hire. On 05/05/15, the Director submitted a Plan of Protection as follows: -The Administrator will check all dietary and housekeeping staff for findings on the HCPR immediately. -The Administrator will check all HCPR on all staff to ensure resident safety within 24 hours. -The Assistant Administrator will be responsible for completing the HCPR checks for all new hires prior to the employee working at the facility. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 20, 2015.	D 137		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F	D 484		

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D 484	Continued From page 6 .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained.	D 484		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment and care planning through a team process and attempted alternatives prior to the use of restraints for 3 of 3 sampled residents (Residents #1, #5, and #6) with bed rails and/or lap belts.

The findings are:

A. Review of Resident #1's current FL-2 dated 03/26/15 revealed:
-Diagnoses included Alzheimer's disease and osteoporosis.
-Documentation the resident was constantly disoriented, semi-ambulatory, and a wanderer.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 03/30/15.

Observation on 05/04/15 at 2:15 pm of Resident #1 revealed:
-The resident was lying in bed.
-One side of the bed was positioned against the wall and the other side had a 3/4-length bed rail in the up position.
-The resident's legs were in near-constant motion, repeatedly pulling the knees up toward the chest, then straightening.
-The resident did not make any major positional changes or attempt to get out of the bed.

Observations on 05/04/15 and 05/05/15 at various times of Resident #1 revealed:

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D 484	Continued From page 8 -The resident used her feet to propel herself throughout the facility in the wheelchair. -On every observation, the resident was sitting with her buttocks on the front half of the wheelchair seat with the lap belt in the axillary region and across the chest. Review of Resident #1's record revealed a "Consent For Physical Restraint Use" was signed by the resident's Power of Attorney (POA) and the facility Director on 03/30/15. Review of physician orders for Resident #1 revealed: -A "Physician's Evaluation and Orders" form dated 04/01/15 included orders for a "hospital bed" and a "wheelchair with seat belt". -A "Physician Restraint Order" dated 04/01/15 for "bedrails/wheelchair" to be used "while in bed/while in wheelchair". Review of Resident #1's current care plan revealed: -The care plan was completed by the Resident Care Coordinator (RCC) on 03/31/15 and signed by the physician on 04/01/15. -The care plan indicated the resident was ambulatory with aide or device (wheelchair) and required extensive assistance with ambulation/locomotion. -The care plan did not include any information regarding restraint use or the need for restraints. Review of a Restraint Assessment and Care Plan form for Resident #1 revealed there was one (undated) sheet for the assessment and a separate sheet for the care plan. Review of the Restraint Assessment form for Resident #1 revealed:	D 484		

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-The medical symptom that warranted the use of a physical restraint was "confusion with the risk of falls".
-The resident "came from another facility, can't walk may try to get up, may fall"
-"N/A" was written by the section for documenting alternatives that had been provided, with a resident response of "seat belt on wheelchair helps".

Review of the Restraint Care Plan form for Resident #1 revealed:
-The Restraint Care Plan form was signed by the POA and the facility Director on 03/30/15 and by the Nurse Practitioner (NP) on 04/01/15.
-The signature line for the Registered Nurse was blank.
-Bed rails and a seatbelt on wheelchair was listed as the least restrictive type of physical restraint that would provide safety.
-The section for documenting restraint alternatives was blank.
-The section for care to be provided to the resident during the time the resident was restrained was blank.

Interview on 05/05/15 at 9:15 am with the facility Director revealed:
-She initiated the restraint paperwork for Resident #1 on admission.
-She determined the resident needed the lap belt because she had a lap belt on her wheelchair when she was admitted to the facility and because she was at risk for falls because she tried to stand.
-She knew the resident was exit-seeking and tried to stand and was unable to because the previous facility reported that information to her.
-The Director observed bed rails on the resident's bed at the previous facility when she assessed

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the resident for admission to this facility.
-The bed rails were to "prevent (the resident) from falling from the bed".
-Restraint alternatives were not attempted prior to the application of Resident #1's restraints on admission to this facility.

Interview on 05/04/15 at 2:45 pm with a Personal Care Aide (PCA) revealed:
-Resident #1 had side rails up at all times when in the bed and a lap belt at all times when up in her wheelchair.
-When the resident was in the bed, she was able to turn herself over and scoot around in the bed.
-When the resident was up in the wheelchair, the staff checked her for incontinence "about every hour" and made sure her lap belt was "under her arms"
-On one occasion, the resident "got her arm through (the lap belt)" so the staff had to tighten the lap belt.

Interview on 05/04/15 at 3:05 pm with a second PCA revealed:
-The resident had a lap belt in place at all times when she was up in the wheelchair.
-The resident "likes to slide down in her chair, so she'd be in the floor without it (the lap belt)".
-On one occasion, the resident slid to the edge of the wheelchair seat and the lap belt was under her arms at the arm pits; the resident would have slid to the floor without the belt.

Telephone interview on 05/04/15 at 12:03 pm with Resident #1's POA revealed:
-He did not recall the facility staff asking him about restraints but they must have talked to him about them if he signed a consent for them.
-He preferred for the resident to have the restraints because she was elderly and had brittle

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bones.
-The bed rails were on the bed to "make it hard for her to get up".
-He observed the lap belt on the resident's first day in the facility and could have objected if he did not want it.
-If the resident was not restrained she may not know she can not stand by herself.
-The resident had "several" falls at the previous facility but had not had any falls at this facility.
-He was "very satisfied" with the care provided to the resident and preferred restraints to a fall.

Refer to interview on 05/05/15 at 9:15 am with the Director.

Refer to telephone interview on 05/05/15 at 1:10 pm with the Registered Nurse (RN).

B. Resident #5's current FI-2 dated 5/9/14 revealed:
-A copy of a new FL-2 that had not been signed by the primary care physician.
-Diagnoses included Advanced Dementia/Alzheimer's Type, chronic lymphocytic Leukemia, history of dysrhythmia, history of syncopal episodes, osteoarthritis, s/p heart catherization.
-Documentation the resident was constantly disoriented and ambulatory w/ assist.

Review of the Resident Register revealed that Resident #5 was admitted to the facility's Special Care Unit (SCU) on 7/31/12.

Review of a facsimile request sent to Resident #5's primary care physician revealed:
-On 9/27/12, a request was sent to the primary care physician's office for a lap belt for the resident's wheelchair.

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D 484	Continued From page 12 -Documentation on the request that the resident's Representative would like one too. -On 10/1/12, the primary care physician signed the order for the lap belt. Review of the Restraint Care Plan form completed on 4/6/13 revealed: -Documentation alternatives have failed, but no alternatives were listed. -Documentation the least restrictive type of physical restraint that would provide safety would be other: lap belt, wheelchair. -Documentation care to be provided to the resident during the time the resident was restrained would be personal care. -Signed by the Supervisor on 4/5/13, by the resident's Representative on 4/6/13, and by the Registered Nurse on 4/6/13 and the Physician signed on 5/16/13. Review of Resident #5's care plan revealed: -The care plan was completed by the Resident Care Coordinator (RCC) on 8/25/14 and signed by the physician on 8/26/14. -Documentation indicated the resident was ambulatory with an aide or device and the aide or device needed was a wheelchair with a lap belt. Review of the Restraint Care Plan form completed on 10/2/14 revealed: -Documentation alternatives have failed, but no alternatives were listed. -Documentation the least restrictive type of physical restraint that would provide safety would be other: lap belt. -Documentation care to be provided to the resident during the time the resident was restrained would be personal care. -Signed by the Supervisor on 10/2/14, by the resident's Representative on 10/2/14, the	D 484		

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D 484	Continued From page 13 Registered Nurse signature space was blank, and the Physician signed on 11/6/14. Record review revealed there was no documentation in the resident's record in regards to a restraint assessment. Observation of Resident #5 on 5/4/15 at 9:30 am revealed: -The resident's family member was visiting with her and was taking her on a walk in her wheelchair. -She was up in her wheelchair with her lap belt on and leaning slightly forward in her wheelchair. Observation of Resident #5 on 5/4/15 at 12:15 pm revealed the resident was in the dining room eating lunch sitting in a wheelchair with her lap belt on. Observation on 5/4/15 at 2:45 pm of Resident #5 revealed the resident was in her recliner, and did not have a lap belt on at that time. Observation on 5/4/15 at 3:30 pm of Resident #5 revealed she was lying down in her bed with no bed rails on her bed. Interview on 5/5/15 at 10:15 am and 10:30 am with 2 Personal Care Aides (PCAs) revealed: -Both PCAs released the lap belt every 2 hours for toileting, bathing, before and after lunch time. -Both PCAs stated they were around the residents most of the time in the SCU so they were constantly checking on them. Interview with Resident Care Coordinator on 5/5/15 at 2:45 pm revealed: -Resident #5 has had no recent falls. When she was first admitted she was falling out of her	D 484		

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wheelchair. She was trying to walk, but her "mind was so bad" that she had not been able to walk for some time.

Interview with the resident's Representative on 5/4/15 at 9:15 am revealed:
-There had been signs posted in the facility for care plan meetings, but he had not been able to attend them because the meetings were scheduled during the day
-He visited the resident twice daily, in the mornings and in the evenings before staff put the resident in bed.
-The facility had requested the lap belt because the resident had fallen, and tended to lean forward while in the wheelchair.
-The facility had talked to him about getting the lap belt because the resident leaned forward while in the wheelchair, would try to stand unassisted, and the resident could not do things for herself.
-He was pleased with the care provided by the facility staff and had no concerns.

Refer to interview on 05/05/15 at 9:15 am with the Director.

Refer to telephone interview on 05/05/15 at 1:10 pm with the Registered Nurse (RN).

C. Review of Resident #6's current FL-2 dated 04/26/15 revealed:
-Diagnoses included cellulitis of the right leg, hypertension, depression, peripheral vascular disease, back pain, macular degeneration, and cerebral vascular accident.
-Documentation the resident was intermittently confused.

Review of the Resident Register revealed

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D 484	Continued From page 15 Resident #6 was admitted to the facility on 02/11/10. Observation on 05/05/15 at 9:00 am of Resident #6 revealed: -The resident was in a wheelchair with a black lap belt loosely placed on the lower waist area. -The resident was calmly sitting in the wheelchair eating breakfast. Review of Resident #6's record revealed a "Consent for Physical Restraint Use" was signed by the resident's Power of Attorney (POA) and the facility Director on 10/24/12. Review of physician orders revealed: -A "Physician's Evaluation and Orders" form dated 10/24/12 included orders for a "lap belt". -A "Physician Restraint Order" dated 10/24/12 for "lap belt" to be used "while in wheelchair". Review of Resident #6's current Care Plan revealed: -The Care Plan was completed by the Resident Care Coordinator (RCC) on 10/17/14 and signed by the physician on 11/06/14. -The Care Plan indicated the resident was ambulatory with aide or device (wheelchair) and required assistance with ambulation and eating. -The Care Plan did not include any information regarding restraint use or the need for restraints. Review of the Restraint Assessment for Resident #6 revealed: -The medical symptom that warranted the use of a physical restraint was "confusion with falls". -Check marks were written by the section for documenting alternatives that had been provided, with no responses written next to the alternatives.	D 484		

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D 484	Continued From page 16 Review of the Restraint Care Plan form for Resident #6 revealed: -The Restraint Care Plan form was signed by the POA and the facility Director on 10/12/14 and by the physician on 11/06/14. -The signature line for the Registered Nurse was blank. -Lap belt was listed as the least restrictive type of physical restraint that would provide safety. -The section for documenting restraint alternatives was blank. -The section for care to be provided to the resident during the time the resident was restrained was blank. Based on observation, record review, and staff interviews, it was determined Resident #6 was not interviewable. Interview with a Personal Care Aide on 05/05/15 at 12:15 pm revealed: -She checked on residents with lap belts every hour. -As a PCA, she would unclip the belt for a short time and clip it back. -As a PCA, she was not aware of the facility care planning process for restraints. Interview with Resident #6's POA on 05/05/15 at 3:50 pm revealed: -He signed the consent every couple of years. -He did not remember how long Resident #6 had been using the lap belt. -He remembered that the seat belt was placed due to frequent falls out of the wheelchair when Resident #6 leaned over. -He said, "they forget to put the seat belt on her and she has falls out of the wheelchair. You get what you pay for I guess."	D 484		

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D 484	Continued From page 17 Refer to Director interview on 05/05/15 at 9:15 am. Refer to Registered Nurse (RN) interview on 05/05/15 at 1:10 pm. _____ Interview on 05/05/15 at 9:15 am with the Director revealed: -When a resident required a restraint, it was discussed with the resident's family and written consent obtained. -The facility did not conduct team meetings for restraint assessments and care planning. -The assessment and care planning was completed by herself or the Resident Care Coordinator (RCC); the Registered Nurse was not involved in the assessment and care planning for restraints. -The Director was not aware of the regulation for a team process, including an RN and the POA, for restraint assessment and care planning. -The Director was not aware she needed to have documentation of restraint alternatives tried prior to the application of a restraint. Interview on 05/05/15 at 1:10 pm with the Registered Nurse (RN) revealed: -She had been "helping (the facility) out" for 1 and 1/2 years. -She was not involved in restraint assessment or care planning and was unaware regulations required RN participation. _____ On 05/05/15, the Director submitted a Plan of Protection as follows: -The Director or designee, with a Registered Nurse, would conduct an immediate audit/assessment of all residents with restraints currently in place to ensure all requirements of NCAC 13F .1501 are met and documented in	D 484		

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D 484	Continued From page 18 each resident's record. -All staff involved in the application or monitoring of restraints would be inserviced prior to their next scheduled shift regarding the procedure for the application and monitoring of restraints. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 20, 2015.	D 484		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint	D 485		

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and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.
(6) The restraint order shall be kept in the resident's record.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure a complete and accurate physician's order was obtained prior to the use of restraints and updated every three months for 3 of 3 sampled residents (Residents #1, #5, and #6) with bed rails and/or seatbelts.

The findings are:

A. Review of Resident #6's current FL-2 dated 04/26/15 revealed:
-Diagnoses included cellulitis of the right leg, hypertension, depression, peripheral vascular disease, back pain, macular degeneration, and cerebral vascular accident.
-Documentation the resident was intermittently confused.

Observation on 05/05/15 at 9:00 am of Resident #6 revealed:
-The resident was in a wheel chair with a black lap belt loosely placed on the lower waist area.
-The resident was calmly sitting in the chair eating breakfast.

Review of the "Physician's Evaluation and Orders" form for Resident #6 dated 02/12/12 revealed:
-An order for a lap belt, while in wheelchair due to

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confusion with a risk of falls.
-An order for time intervals included checked, loosened and removed every 2 hours.

Record review revealed no documentation of a physician's order for the lap belt since 2/12/12.

Review of the "Consent for Physical Restraint Use" form for Resident #6 dated 01/30/12 revealed:
-The consent of a lap belt due to confusion with risk of falls.
-Form was signed by Resident #6's primary contact person.

Review of Resident #6's Restraint Use and Monitoring form revealed:
-Missing approximately 6 dates of documentation in the month of April 2015.
-Month of May 2015 documentation was complete.

Based on observation, record review and staff interviews, it was determined Resident #6 was not interviewable.

Interview with a Personal Care Aide on 05/05/15 at 12:15 pm revealed:
-She checked on residents with lap belts every hour.
-As a PCA, she would unclip the belt for a short time and clip it back
-As a PCA, she was not aware of the facility care planning process for restraints.

Interview with Resident #6's Power of Attorney (POA) on 05/05/15 at 3:50 pm revealed:
-He signed the consent every couple of years.
-He did not remember how long Resident #6 had been using the lap belt.

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-He remembered that the seat belt was placed due to frequent falls out of the wheelchair when Resident #6 leaned over.
-He said, "they forget to put the seat belt on her and she has falls out of the wheelchair. You get what you pay for I guess."

Refer to Director interview on 05/05/15 at 9:15 am.

Refer to Registered Nurse (RN) interview on 05/05/15 at 1:10 pm.

B. Resident #5's current FI-2 dated 5/9/14 revealed:
-A copy of a new FL-2 that had not been signed by the primary care physician.
-Diagnoses included Advanced Dementia/Alzheimer's Type, chronic lymphocytic Leukemia, history of dysrhythmia, history of syncopal episodes, osteoarthritis, s/p heart catherization.
-Documentation the resident was constantly disoriented and ambulatory w/ assist.

Review of the Resident Register revealed that Resident #5 was admitted to the facility's Special Care Unit (SCU) on 7/31/12.

Review of a facsimile request sent to Resident #5's primary care physician revealed:
-On 9/27/12, a request was sent to the primary care physician's office for a lap belt for the resident's wheelchair.
-Documentation on the request that the resident's Representative would like one too.
-On 10/1/12, the primary care physician signed the order for the lap belt.

Record review revealed no physician's orders

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D 485	Continued From page 22 after 10/1/12 for the lap belt. Review of the Restraint Care Plan form completed on 4/6/13 revealed: -Documentation alternatives have failed, but no alternatives were listed. -Documentation the least restrictive type of physical restraint that would provide safety would be other: lap belt, wheelchair. -Documentation care to be provided to the resident during the time the resident was restrained would be personal care. -Signed by the Supervisor on 4/5/13, by the resident's Representative on 4/6/13, and by the Registered Nurse on 4/6/13 and the Physician signed on 5/16/13. Review of Resident #5's care plan revealed: -The care plan was completed by the Resident Care Coordinator (RCC) on 8/25/14 and signed by the physician on 8/26/14. -Documentation indicated the resident was ambulatory with an aide or device and the aide or device needed was a wheelchair with a lap belt. Review of the Restraint Care Plan form completed on 10/2/14 revealed: -Documentation alternatives have failed, but no alternatives were listed. -Documentation the least restrictive type of physical restraint that would provide safety would be other: lap belt. -Documentation care to be provided to the resident during the time the resident was restrained would be personal care. -Signed by the Supervisor on 10/2/14, by the resident's Representative on 10/2/14, the Registered Nurse signature space was blank, and the Physician signed on 11/6/14.	D 485		

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Observation of Resident #5 on 5/4/15 at 9:30 am revealed:
-The resident's family member was visiting with her and was taking her on a walk in her wheelchair.
-She was up in her wheelchair with her lap belt on and leaning slightly forward in her wheelchair.

Observation of Resident #5 on 5/4/15 at 12:15 pm revealed the resident was in the dining room eating lunch sitting in a wheelchair with her lap belt on.

Observation on 5/4/15 at 2:45 pm of Resident #5 revealed the resident was in her recliner, and did not have a lap belt on at that time.

Observation on 5/4/15 at 3:30 pm of Resident #5 revealed she was lying down in her bed with no bed rails on her bed.

Interview on 5/5/15 at 10:15 am and 10:30 am with 2 Personal Care Aides (PCAs) revealed:
-Both PCAs released the lap belt every 2 hours for toileting, bathing, before and after lunch time.
-Both PCAs stated they were around the residents most of the time in the SCU so they were constantly checking on them.

Interview with Resident Care Coordinator on 5/5/15 at 2:45 pm revealed:
-Resident # 5 has had no recent falls. When she was first admitted she was falling out of her wheelchair. She was trying to walk, but her "mind was so bad" that she had not been able to walk for some time.

Interview with Resident #5's Representative on 5/4/15 at 9:15 am revealed:
-There had been signs posted in the facility for

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care plan meetings, but he had not been able to attend them because the meetings were scheduled during the day.
-He visited the resident twice daily, in the mornings and in the evenings before staff put the resident in bed.
-The facility had requested the lap belt because the resident had fallen, and tended to lean forward while in the wheelchair.
-The facility had talked to him about getting the lap belt, because the resident leaned forward while in the wheelchair, would try to stand unassisted, and the resident could not do things for herself.
-He was pleased with the care provided by the facility staff and had no concerns.

Refer to Director interview on 05/05/15 at 9:15 am.

Refer to Registered Nurse (RN) interview on 05/05/15 at 1:10 pm.

C. Review of Resident #1's current FL-2 dated 03/26/15 revealed:
-Diagnoses included Alzheimer's disease and osteoporosis.
-Documentation the resident was constantly disoriented, semi-ambulatory, and a wanderer.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 03/30/15.

Observation on 05/04/15 at 2:15 pm of Resident #1 revealed:
-The resident was lying in bed.
-One side of the bed was positioned against the wall and the other side had a 3/4-length bed rail in the up position.

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D 485	Continued From page 25 -The resident's legs were in near-constant motion, repeatedly pulling the knees up toward the chest, then straightening. -The resident did not make any major positional changes or attempt to get out of the bed. Observations on 05/04/15 and 05/05/15 at various times of Resident #1 revealed: -The resident used her feet to propel herself throughout the facility in the wheelchair. -On every observation, the resident was sitting with her buttocks on the front half of the wheelchair seat with the seat belt in the axillary region and across the chest. Review of a "Physician's Evaluation and Orders" form dated 04/01/15 revealed: -An order for a "hospital bed" and a "wheelchair with seat belt". -No further information regarding restraints. Review of a "Physician Restraint Order" dated 04/01/15 revealed: -"Type Of Restraint To Be Used: Bedrails/wheelchair". -"Time Period Restraint Is To Be Used: While in bed/While in wheelchair". -"Time Intervals The Restraint Must Be: Checked every two hours, Loosened every two hours, Removed every two hours". Review of Resident #1's record revealed there had been no Restraint Use And Monitoring form initiated for the resident since admission to the facility on 3/30/15. Refer to interview on 05/05/15 at 9:15 am with the Director. Refer to interviews on 05/04/15 and 05/05/15 at	D 485		

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D 485	Continued From page 26 various times with 5 Personal Care Aides. Interview on 05/05/15 at 9:15 am with the facility Director revealed: -Staff routinely checked and removed restraints every 2 hours. -She was not aware regulations required restraints to be checked at least every 30 minutes, but staff documented on a "Restraint Use And Monitoring" form, which was sectioned into 30-minute blocks of time. Interviews on 05/04/15 and 05/05/15 at various times with 5 Personal Care Aides (PCAs) revealed: -4 of 5 PCAs stated restraints were required to be removed every two hours and were removed during incontinent/toileting rounds. -1 of 5 PCAs stated staff were supposed to check restraints every hour and remove them every two hours when incontinent care was provided. -One PCA stated she signed all the blocks (on the monitoring form) at the end of her shift for a couple of days, but quit documenting on the form because she was not sure if she was doing it correctly. The PCA further stated she did not seek out restrained residents every 30 minutes to check a restraint because she "cant--got work to do". -One PCA stated she signed all the blocks of the monitoring form at the end of her shift. When she signed the blocks, she was signing that the restraint was on, not necessarily that she had seen or checked the restraint at that time. On 05/05/15, the Director submitted a Plan of Protection as follows: -The Director or designee, with a Registered Nurse, would conduct an immediate audit/assessment of all residents with restraints	D 485		

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	HAL030003	A. BUILDING: _____ B. WING _____	05/06/2015

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D 485	Continued From page 27 currently in place to ensure all requirements of NCAC 13F .1501 are met and documented in each resident's record. -The audit will ensure the physician's order includes care to be provided during the use of the restraint as well as time intervals to be checked and released, but no longer than 30 minutes for checks and every 2 hours for releases. -All staff involved in the application or monitoring of restraints would be inserviced prior to their next scheduled shift regarding the procedure for the application and monitoring of restraints. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 20, 2015.	D 485		
D 487	10A NCAC 13F .1501 (f) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, B and C) had received physical restraint training and validated on restraint use by a registered nurse.	D 487		

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D 487	Continued From page 28 The findings are: A. Review of Staff A's personnel records revealed: -Staff A was hired on 1/23/06 as a Personal Care Aide (PCA) and a Medication Aide (MA). -Staff A's restraint training was documented on the Licensed Health Professional Support (LHPS) on 2/24/10 as "policy given out-see previous task". -Staff A's previous task were documented as "geri chair, hospital bed with rails, check every 2 hours and record on flow sheet." -Staff A had an additonal LHPS task evaluation dated 3/10/06 which included restraint training on geri chairs and lap pillows, not applicable (NA) was documented for waist belt restraints, vest restraints, pelvic restraints and wrist restraints. -Staff A's restraint training was signed and dated 2/24/10 by a registered nurse. -No further documentation on the use of restraints was documented on the LHPS. Staff A was not available for interview. Refer to interview on 5/5/15 at 1:10 pm with the facility contract Nurse. Refer to interview on 5/5/15 at 2:30 pm with a Personal Care Aide (PCA). Refer to interview on 5/5/15 at 2:45 pm with the Director. B. Review of Staff B's personnel record revealed: -Staff B was hired on 1/31/08 as a Medication Aide (MA) and Supervisor in Charge (SIC). -Restraint training documented on the Licensed Health Professional Support (LHPS), "restraints already done, alternative care such as book, baby	D 487		

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D 487	Continued From page 29	D 487		

dolls, TV, observe closely".
-Staff B's LHPS task documented, "geri chair with table, hospital bed with side rails, check every 2 hours and document on flow sheet."
-Staff B's restraint training was signed and dated 3/4/10 by a Registered Nurse.
-No further documentation on the use of restraints was documented on the LHPS.

Refer to interview on 5/5/15 at 1:10 pm with the facility contract Nurse.

Refer to interview on 5/5/15 at 2:30 pm with a Personal Care Aide (PCA).

Refer to interview on 5/5/15 at 2:45 pm with the Director.

C. Review of Staff C's personnel records revealed:
-Hire date of 4/9/15 as a Personal Care Aide (PCA).
-Restraint training documented on the LHPS, "must have MD order, Check every 2 hours, bed alarms, Geri chairs, side rails, and lap buddy are all restraints."
-Documented on LHPS restraint task training, " alternative, read to the patient,ambulation with the patient, folding wash clothes, coloring, must check restraints every 2 hours and document.
-No further documentation on the use of restraints was documented on the LHPS.

Refer to interview on 5/5/15 at 1:10 pm with the facility contract Nurse.

Refer to interview on 5/5/15 at 2:30 pm with a Personal Care Aide (PCA).

Refer to interview on 5/5/15 at 2:45 pm with the

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D 487	Continued From page 30 Director. Interview on 5/5/15 at 1:10 pm with the facility contract Nurse revealed: -She was employed by the facility for 18 months. -She completed the LHPS task for all new employees for the facility. -She was in the facility 2 or 3 times weekly. -She reviewed with the new employees the restraints policy and reviewed the different types of restraints the facility used. -She had never taught a restraint class in the facility. -She never gotten the new employees to do a return demonstration in applying the restraints during the LHPS task check off. -She informed the new employees to check the residents in restraints every 2 hours. -She was not aware restraints were to be checked every 30 minutes. -She said this was her first position as a facility LHPS nurse. Interview on 5/5/15 at 2:30 pm with a Personal Care Aide (PCA) revealed: -She was employed at the facility for 1 month. -She had given personal care to the residents which included releasing lap belts for toileting residents. -She received no training on restraints from the facility, but had training on restraints at a facility where she was previous employed. -She stated, " I check the residents who are in restraints every hour and release the restraint every 2 hours." Interview on 5/5/15 at 2:45 pm with the Director revealed: -She was responsible for calling the facility contract Nurse to complete the LHPS tasks	D 487		

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D 487	Continued From page 31 check off for all new hires. -She caledl the Nurse after an employee had completed the 3 day orientation in the facility. -She was unaware what or how the Nurse was conducting the 1 on 1 LHPS evaluation. -She said when the nurse completed the training she gave the signed LHPS task evaluation to her Assistant Director for filing in the staff personnel record.	D 487		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding the use of physical restraints, tuberculosis testing, and other staff qualifications. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment and care planning through a team process and attempted alternatives prior to the use of restraints for 3 of 3 sampled residents (Residents #1, #5, and #6) with bed rails and/or seat belts. [Refer to Tag 484, 10A NCAC 13F .1501(c) (Type B Violation).]	D912		

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D912	Continued From page 32 B. Based on observations, interviews, and record reviews, the facility failed to ensure a complete and accurate physician's order was obtained prior to the use of restraints and updated every three months for 3 of 3 sampled residents (Residents #1, #5, and #6) with bed rails and/or lap belts. [Refer to Tag 485, 10A NCAC 13F .1501(d) (Type B Violation).] C. Based on interviews, and record reviews the facility failed to ensure 4 of 8 staff sampled (Staff E, F, G, and H) had no substantiated findings listed on the North Carolina Health Care Personal Registry (HCPR) prior to hire according to G.S. 131E-256.[Refer to Tag 0137, 10A NCAC 13F .0407 (a)(5) (Type B Violation).] D. Based on interview and record review, the facility failed to assure 1 of 6 staff (C) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 0131, 10A NCAC 13F.0406 (a) (Type B Violation).]	D912		