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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up survey at your facility on 5/19/15-5/21/15.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 (Staff A) of 4 staff sampled had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff A's personnel record revealed: -She was hired as a personal care aide on 5/5/15. -Documentation the consent for a criminal background check had been completed on 5/5/15. -No documentation a criminal background check had been completed. Staff A was not available for interview. Interview with the Office Manager (OM) on 5/21/15 at 2:00 p.m. revealed: -She was aware Staff A's criminal background check had not been completed. -She was responsible for the completion of the criminal background checks for all staff. -Within two weeks after Staff A finished orientation, OM would complete criminal background check.	D 139		

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D 139	Continued From page 1 -No timeframe was given to complete the criminal background check for Staff A. -Staff A was hired on 5/5/15, but she did not start to work until 5/19/15. -She did not know that the criminal background checks for all staff should be completed, prior to hire. Interview with the Executive Director (ED) on 5/21/15 at 2:45 p.m. revealed: -She was not aware the criminal background check for Staff A had not been completed, prior to hire. -The Office Manager was responsible for the completion of the criminal background checks for all staff. -The OM should have completed Staff A's criminal background check, prior to hire. -The OM stated she thought that she had to wait 2 weeks after Staff A's orientation to complete the criminal background check. -The facility's monitoring plan in place for criminal background check for staff was for background checks to be completed, prior to hire. -The ED audited the criminal background checks for staff every 6 months.	D 139		
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	D 482		

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D 482	Continued From page 2 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 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 A2 VIOLATION	D 482		

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D 482	Continued From page 3 Based on observation, interviews and record reviews, the facility failed to assure that physical restraints were used only with a written order from a physician and used only after an assessment and care planning process had been completed for 2 of 2 sampled residents (#1 and #5), used to prevent resident from falling out of beds and chairs. The findings are: Review of Resident #1's current FL-2 dated 7/17/14 revealed: -Diagnoses included dementia, Parkinson's disease, cerebral atherosclerosis, chronic heart failure and arthritis. -Intermittently confused, ambulatory, continent of bowel and incontinent of bladder. Review of Resident #1's Resident Register revealed admission to the facility was on 7/7/14. Review of Resident #1's current care plan dated 1/5/15 revealed: -No documentation of an assessment of restraint use for Resident #1. -No documentation of a reclining chair or bedrails use. -Resident #1 was described as independent and ambulatory. Observation of Resident # 1 on 5/19/15 at 12:30pm revealed: -Resident was sitting in his room in a reclining chair with the chair tilted at a 30 degree angle with his feet raised upward. -The bed in the room had half bedrails. Based on observation and record review on 5/19/15 Resident #1 was not determined to be interviewable.	D 482		

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D 482	Continued From page 4 Interview with a Personal Care Aide (PCA) on 5/19/15 at 12:30pm revealed: -Resident #1 was required to have his chair leaned back whenever he was sitting in it to keep him from falling out of the chair. -The only time his chair did not have to be leaned back was at meals when he was sitting at the table, because the table would prevent him from falling out of the chair. -Resident #1 was not able to lower the chair to release himself. -When Resident #1 was in bed the bedrails must be placed in the up position, to prevent him from rolling out of bed. -Resident #1 was not able to remove the rails or climb out of bed around the rails. -The bed rails and recliner were not restraints, they were just needed to prevent Resident #1 from falling. Observation of Resident # 1 on 5/20/15 at 10:05am revealed: -Resident wasin bed lying on his side sleeping with both side rails up. Interview with a second PCA on 5/20/15 at 10:10am revealed: -Resident #1 was not able to pull himself up in bed and he is unable to move the side rails. -The side rails are always supposed to be up when Resident #1 was in bed, so that he does not fall out of bed. -She tried to check on him every 30 minutes and turn him every 2 hours. -She did not document when she checked or turned Resident #1. -She provided incontinent care 3 to 4 times per day. -She documented the incontinent care at the end	D 482		

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of her shift.
-She got Resident #1 out of bed for breakfast and lunch.
-She assists him in the recliner with the back tilted up, so that he did not fall.
-She assisted him at meal time and walked him around the courtyard outside and assisted him back to his room to lie down, because he had an open area on his bottom.
-When Resident #1 is in the chair she made sure he had pillows for comfort.
-She allowed him sit up in the chair for 30 minutes to an hour at a time.

Interview with a third PCA on 5/20/15 at 10:20am revealed:
-The staff tried to keep Resident #1 on his right side because he has a decubitus on his left buttock.
-When he was in the chair the back of the chair need to be leaned back.
-Resident #1 was unable to get out of the chair when the back is tilted up.
-When he is in bed the resident is to be turned at least every 2 hours.
-She turns him more frequently due to the sore on his bottom.
-She provides incontinent care every 2 hours.
-She is supposed to complete her documentation during her last hour of work, she documents everything that happened throughout the day.
-There is an " hour book that one person will use to eyeball each resident every hour throughout the shift " .
-She had not been told by anyone at the facility that the bedrails or recliner for Resident #1 were a restraints.
-Interview with the Health Care Coordinator (HCC) on 5/20/15 at 11:30am revealed:
-Resident #1 had rolled out of bed onto the floor

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in the past.
-He has side rails on the bed to keep him from rolling out of bed and onto the floor again.
-Resident #1 cannot remove the side rails.

Interview with the Executive Director on 5/21/15 at 11:35am revealed:
-The bed rails for Resident #1 started out as an enabler, to assist resident with getting out of bed.
-She did not think the side rails were a restraint, because they were not full side rails.
-The reclining chair is needed for Resident #1 because he is contracted and cannot sit up straight.
-He automatically leans forward when sitting in a chair and would tip over onto the floor.
-She will contact the doctor to get an order for a restraint, because the recliner and side rails are in place for safety reasons.

Review of documentation notes in the resident's record revealed:
-On 2/20/15 A PCA was walking down the hall to do rounds, Resident #1 was heard "hollering for help " .
-When she walked into his room, Resident #1 was found hanging upside down on the bed with his head toward the ground and his thighs on the bedrail. Resident said he was okay, he was just trying to get up.
-Resident's head and neck were red from where he was upside down.
-There was a small knot on his head near the nape of the neck, no other obvious injuries.
-On 3/5/15 Resident #1 had a red area on his forehead due to leaning against the bedrails.

The PCA that discovered Resident #1 on 2/20/15 was not interviewable.

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Interview with the Executive Director on 5/21/15 at 9:25am revealed:
-She was informed that on 2/20/15, Resident #1 tried to climb over the bed rails and he got tangled up in the sheets was dangling from the bedrail.
-When that happened, Resident #1 was more ambulatory, but had a urinary tract infection at the time .
-At the time of the incident his bed rails were used for positioning.
-Resident #1 did not start declining to the point of needing bedrails as a restraint until mid- March.
-The PCA had documented on the 1 hour sheet that she had seen Resident #1 30 minutes prior to finding him dangling.
-Resident #1's doctor and family member were notified at the time of the incident.
-His family member did not want him sent to be sent out.

Interview with the HCC on 5/21/15 at 9:20am revealed:
-The incident with Resident #1 on 2/20/15 happened at 3:30 am.
-The Medication Aide (MA) notified her via text message at 4:00am on 2/20/15.
-The Medication Aide notified hospice at the time of the incident and was told to monitor Resident #1.
-" He was monitored very closely that night ".
-When she came into work on 2/20/15 at 8:00am, she got the incident report and assessed Resident #1 for injuries.
-The knot on his head had resolved by the time she assessed him.
-Resident #1 was seen by the Nurse Practitioner on 2/26/15.
-The HCC asked the PCA about the incident a couple of days later and she told her, she was

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walking down the hall and she heard someone say hello.
-She went to see who was saying hello and that's when she saw Resident #1 trying to get out of bed.
-The sheets were tangled around his legs and he was hanging upside down on the rail and sheet.
-After the incident happened the facility stopped using the bedrails, they started using a fall mat.
-Per facility policy when incidents happen during third shift families and physicians are not notified unless there is a serious emergency.
-Residents are not sent to ER/transported out just because they hit their head.

Interview with Resident #1's family member on 5/21/15 at 10:40am revealed:
-She received a telephone call from the facility the morning after the incident and informed her Resident #1 was trying to climb out of bed and got tangled up in the sheet.
-She was the person that advocated for Resident #1 to have the bed rails.
-He had been falling a lot even before he was admitted to the facility.
-She put a rail on the bed he had from home when he first entered the facility, to prevent him from falling.
-She had spoken with the Executive Director to see what could be done to keep Resident #1 from falling out of bed.
-In December 2014 he got a hospital bed from Hospice and she "pretty much insisted " on the use of bedrails whenever Resident #1 was in bed.
-She had witnessed the staff checking on him to make sure he was not rolling out of bed.

Interview with a Medication Aide on 5/21/15 at 11:00am revealed:
-She was working the night of 2/19/15 when

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Resident #1 was attempted to get out of bed.
-One of the PCAs told her she was walking down the hall when she found Resident #1 hanging over his bed.
-When she saw Resident #1 he was on the bed slumped over holding onto the bedrails on the side of the bed.
-She was called to the room where she proceeded to get his vital signs, notify hospice and she texted the HCC.
-She could not remember what time it was when the incident took place, she just remembers it was 30 minutes after her one hour check.
-She did not send Resident #1 out, or notify his family that night, because the situation did not seem that urgent.
-She monitored Resident #1 the remainder of the night.
-The next time she worked on the hallway with Resident #1 he had the bedrails up.
-She completed an incident report and had the PCA complete documentation of the incident.
-She passed on information concerning the incident to the Medication Aide the next morning, so that they could " keep an eye on him ".

Interview with Resident #1 ' s Healthcare Provider on 5/21/15 at 11:20am revealed:
-Resident #1 has bedrails to keep him from falling out of bed.
-The facility had "always " used the bedrails for Resident #1 to prevent him from falling out of bed.
-Resident #1 started receiving Hospice services in December of 2014 and they ordered a hospital bed for him.
-Resident #1 thinks he can get up by himself and walk.
-Staff had discussed other alternatives with her such as frequent checks, and moving his bed

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closer to the wall. They always try the least restrictive measures.
-Resident #1 had not at any time been able to move the bedrails himself.
-The recliner that he uses at the facility is also in place to prevent him from falling when he is in the chair.

Review of the facility policy on physical restraints and alternatives revealed:
-Bedrails may not be used to prevent a resident from rising voluntarily from his/her bed.
-Bedrails may be used if they are half rails to provide assist to the resident to get in and out of the bed.

Interview with the Executive Director on 5/21/15 at 2:15pm revealed:
-She had obtained orders for the restraints using bedrails and reclining chairs to prevent falls on 5/21/15.
-She was working with the owner to change the facility's policy on restraints.

Review of physician orders for Resident #1 dated 5/21/15 revealed:
-Restraint orders for half bedrails and the use of a reclining chair.
-Resident #1 was to be monitored by staff every 30 minutes while in bed with bedrails or in reclining chair.
-Resident to be released for 10 minutes every 2 hours and Resident to be toileted during that time.
-Resident to be transported in reclining chair and the chair is to be in a reclining position to keep Resident from falling.
-A removable tray may be used with the reclining chair, the tray is to be removed for 10 minutes every 2 hours and resident to be toileted.

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D 482	Continued From page 11 -Was valid for 90 days. 2. Review of Resident #5's current FL-2 dated 7/30/14 revealed: -Diagnoses included Alzheimer's disease and gastroesophageal reflux disease (GERD). -Resident #5 was constantly disoriented. -Resident #5 was ambulatory with limited ability. Review of Resident #5's current care plan dated 7/31/14 revealed: -No documentation of an assessment of restraint use for Resident #5. -No documentation of a reclining chair or full-length siderails use. -Resident #5 was ambulatory but required supervision. -Resident was always disoriented and had a significant memory loss. Observations on 5/19/15 at 11:00 a.m. and 2:45 p.m. revealed: -Resident #5 was lying in her bed with full-length siderails pulled up on both sides of the bed. -Resident #5 was able to move her legs and arms. Observations on 5/20/15 at 9:30 a.m. and 2:00 p.m. revealed: -Resident #5 was lying in her bed with full-length siderails pulled up on both sides of the bed. -Resident #5 was able to move her legs and arms. Observation on 5/20/15 at 10:45 a.m. revealed Resident #5 was sitting in a reclining chair in her room with feet reclined. Observation on 5/21/15 at 10:00 a.m. revealed:	D 482		

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-Resident #5 was lying in her bed with full-length siderails pulled up on both sides of the bed.
-Resident #5 was able to move her legs and arms.

Observation on 5/21/15 at 10:15 a.m. revealed Resident #5 was sitting in a reclining chair in her room with feet reclined.

Review of the physician's restraint order for Resident #5 dated 5/21/15 revealed:
-"Full bed rail to any side of resident's bed is not directly adjacent to a stationary wall. Bed rails are to be used to prevent injury to the resident as a result of rolling out of bed/attempting to stand without assistance and are to be placed at all times while resident is in bed."
-The reclining chair is to be in a reclining position/removable tray in place at all times. The restraint is necessary reduce falls risk and prevent injury to the resident.

Based on observation and record review on 5/19/15, Resident #5 was not interviewable.

Confidential interviews with 8 of 8 staff members revealed:
-Resident #5's siderails were pulled up on both sides of the bed when the resident was in the bed.
-Siderails were used to prevent Resident #5 from falling out of the bed.
-Resident #5 could not push the siderails down.
-Resident #5 could not use the siderails for positioning or support.
-The reclining chair was reclined to prevent Resident #5 from falling out of the chair.
-Resident #5 could not use the release knob on the reclining chair.
-Resident #5 could move her legs and arms.

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(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 -The facility was restraint free. Interview with the Health Care Coordinator (HCC) on 5/20/15 at 11:00 a.m. revealed: -She was aware Resident #5 had a hospital bed with full siderails after her hip fracture on 9/18/14. -Resident #5 was non-ambulatory after she fractured her hip on 9/18/14. -Staff pulled up Resident #5's siderails when resident was in bed to prevent resident from falling out of the bed. -Resident #5 could not push the siderails down. -Resident #5 could not use the siderails for positioning or support. -She was also aware staff reclined Resident #5 when she was sitting in the reclining chair to prevent falls. -Resident #5 could not use the release knob on the reclining chair. -She did not consider full-length siderails in up position or reclining chair in a reclining position as a restraint for a Hospice patient. -The facility was restraint free -She was made aware that anything that restricted a resident's movement was a restraint. -She notified Resident #5's physician on 5/20/15 (no time) that the resident needed a restraint order for full-length siderails and for reclining chair in a reclining position. Telephone interview with Resident #5's family member on 5/21/15 at 8:45 a.m. revealed: -He was aware Resident #5 had a hospital bed with siderails. -The siderails were needed to prevent Resident #5 from falling out of the bed. -He was okay with the siderails being pulled up when Resident #5 was in the bed. -He did not think Resident #5 could not push the siderails down.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096041	A. BUILDING: _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

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D 482	Continued From page 14 -He also did not think Resident #5 could use the siderails for positioning or support. -He did not know if Resident #5 had a reclining chair. Interview with Resident #5's physician on 5/21/15 at 10:30 a.m. revealed: -She was notified on 5/20/15 that Resident #5 needed a restraint order for full siderails in an up-position and reclining chair in a reclining position. -She was aware that full-length siderails were being used to prevent Resident #5 from rolling out of bed. -Resident #5 could not push the siderails down due to her dementia. -Resident #5 could not use the siderails for positioning or support due to her dementia. -She was also aware a reclining chair in a reclining position was being used to prevent Resident #5 from falling out of the chair. -Resident #5 could not use the release knob on the reclining chair due to her dementia. -Resident #5 could move her legs and arms. -Resident #5 was non-ambulatory. Interview with the Executive Director (ED) on 5/21/15 at 2:27 p.m. revealed: -She was aware that Resident #5 had a hospital bed with full siderails after her hip fracture on 9/18/14. -Resident #5 was non-ambulatory after her hip fracture on 9/18/14. -The siderails were pulled up when Resident #5 was in bed to prevent her from slipping out of bed. -Resident #5 could not push the siderails down. -Resident #5 could not use the siderails for positioning or support. -She was aware that staff reclined Resident #5 in	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096041	A. BUILDING: _____ B. WING _____	05/21/2015

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D 482	Continued From page 15 the reclining chair to prevent her from slipping out of the chair. -Resident #5 could not use the release knob on the reclining chair. - Because Resident #5 was a Hospice patient and in declining health, she did not consider full-length siderails in an up position or reclining chair in a reclining position as a restraint. -The facility was restraint-free. -She was made aware that anything that restricted a resident's movement was a restraint. _____ The plan of protection received from the Executive Director on 5/20/15 revealed: The Executive Director and Health Care Coordinator will: 1. Obtain order clarification to include restraint type, time period of use, and intervals to be checked, loosened and removed. 2. Obtain written consent from family/power of attorney. 3. Exhaust all alternatives prior to restraint use such as fall mats on the floor beside beds, specialized wheelchairs, diversion techniques and behavior modification. 4. Initiate resident restraint use record. 5. Immediate initiation of staff training/education regarding restraint use, documentation requirements and facility protocols regarding resident safety and monitoring of restraints. 1. Monthly quality assurance review by RN/Healthcare Coordinator. 2. Quarterly quality assurance review by Executive Director and Management team. 3. Posted list for expiration date of restraint orders. 4. Initial training for all staff regarding restraint use and procedures with quarterly in services to	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 482	Continued From page 16 continue education regarding resident safety while using restrains. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 20, 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, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to use of physical restraints. The findings are: Based on observation, interviews and record reviews, the facility failed to assure that physical restraints were used only with a written order from a physician and used only after an assessment and care planning process had been completed for 2 of 2 sampled residents (#1 and #5), used to prevent resident from falling out of beds and chairs.[Refer to tag 0482 10A NCAC 13F .1501 Use of Physical Restraints and Alternatives (Type A2 Violation)].	D912		