Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081010	A. BUILDING: _____ B. WING _____	C 02/11/2016

RECEIVED MAR 11 2016 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON CARE CENTER	125 HENDERSON CIRCLE FOREST CITY, NC 28043

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D 000	Initial Comments The Adult Care Licensure Section and Rutherford County Department of Social Services conducted an annual survey and a complaint investigation on February 11-12, 2016. The complaint investigation was initiated by the Rutherford County Department of Social Services on February 08, 2016.	D 000		2/11/16
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	D 482	★ ALL BEDRAILS HAVE BEEN REMOVED ON AT LEAST ONE SIDE OF BED AND ON BOTH SIDES ON OTHERS FOR THE RESIDENTS WHOM DO NOT HAVE DR'S ORDER WITH OUT DIGNOSIS. ★ ORDERS ALONG WITH DIGNOSIS HAVE BEEN OBTAINED FOR RESIDENTS IN NEED OF BED RAILS. 2/12/16 ★ ALL RESIDENTS WITHOUT DRS ORDERS HAVE BEEN REMOVED FROM GERI CHAIRS AND HAVE BEEN GIVEN WHEELCHAIRS. 2/11/16	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ADMINISTRATOR 3/10/16

Reviewed and accepted with revisions (Pg. 8)
RWilson RN 3/14/16.

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D 482	Continued From page 1 (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 Based on observations, record review and interviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed and a physician order obtained for bed rails and a geri-chair with a table top for 1 of 2 sampled residents with physical restraints resulting in Resident #5 falling out of the bed over the bed rails. The findings are: Review of Resident #5's current FL2 dated 12/03/15 revealed a diagnosis of fall. Further review of Resident #5's record revealed: -There was no physician's order for restraints. -There was no assessment and care planning of	D 482	★ ALL RESIDENTS WHOM NEED GERI CHAIR, WE HAVE CONTACTED MD AND OBTAINED ORDERS W/ DIGNOSIS.	2/12/16

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D 482	Continued From page 2 the resident's need for restraints. -Diagnoses included cerebral vascular accident (CVA), long term anticoagulation therapy with Warfarin and aspirin, hemiplegia with left sided weakness, aphasia, and dysarthria. Review of Resident #5's Resident Register revealed: -An admission date of 04/07/15. -The resident required assistance with dressing, bathing, ambulation, getting in and out of bed, and toileting. -The resident's memory was adequate. -The resident had a wheelchair. Review of an Assessment and Care Plan for Resident #5 dated 04/07/15 revealed: -The resident required the use of a wheelchair or walker for ambulation. -The resident's upper extremities and memory were adequate, and speech was normal. -The resident was totally dependent for toileting, eating, dressing, grooming, and transferring. -The resident required extensive assistance with ambulation. -Documentation was absent for the use of restraints. Interview with Resident #5's family member on 02/11/16 at 10:25am revealed: -The resident had fallen out of the bed in the facility on two separate occasions when the bed rails were in use. -The first fall occurred around August 2015 and the other was in December 2015. -The resident had no other falls at this facility. Review of an Accident and Incident Report for Resident #5 dated 09/07/15 at 3:45pm revealed: -The resident was found sitting on the floor by the	D 482 ★	RESIDENT #5 DR'S ORDER'S WITH DIGNOSIS HAVE BEEN OBTAINED. FROM RESIDENT #5's MD.	2/12/16

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D 482	Continued From page 3 Medication Aide (MA). -The resident had a "pump knot on right side of forehead and right side found red area and bruised" and would be observed for the next 48 hours. Review of an Emergency Department record for Resident #5 dated 09/07/15 at 7:46pm revealed: -"Patient fell beside bed at 'nursing home' [facility] and hit face and right flank area." -"Ecchymosis (bruising) right lower flank area." -Diagnoses included hematoma right forehead, hematoma right flank, and Warfarin anticoagulation. -Computed tomography (CT) scan of the head revealed right frontal/periorbital soft tissue swelling. Review of the facility's second shift Nurse's Note sheet dated 12/02/15 revealed Resident #5 was at the hospital because the resident "climbed over the bed rails" and fell in the floor. Review of an Emergency Department record for Resident #5 dated 12/02/15 at 7:35pm revealed: -"Fell over bedrail out of bed." -"Has a hematoma over right forehead." -Diagnoses included head injury secondary to fall, right forehead hematoma, and intracerebral hemorrhage of the right occipital lobe with Warfarin anticoagulation. -CT scan of the head revealed a focal acute parenchymal hemorrhage within the right occipital lobe and right periorbital soft tissue hematoma. -The resident was transferred to another hospital for neurosurgery consultation. Review of a hospital clinical Discharge Summary for Resident #5 dated 12/03/15 at 10:57am revealed:	D 482		

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D 482	Continued From page 4 -Diagnosis of facial hematoma. -Repeat CT scan of the head was negative for acute bleed. Interview with Staff A (Medication Aide) on 02/10/16 at 10:25am revealed: -Bed rails were used for Resident #5 when the resident was in bed to keep the resident from getting up and falling. -Staff A had been trained on and voiced proper procedures for physical restraint use. Interview with Staff E (Medication Aide) on 02/10/16 at 2:40pm and 02/11/16 at 3:45pm, respectively revealed: -Bed rails were used for Resident #5 because "[The resident] does try to get out of bed." -Resident #5 could ambulate with the use of a walker and assistance/supervision from staff. -A tab alarm was used when Resident #5 was in bed to alert staff if/when the resident tried to get up without calling for help. -Staff E had been trained on and voiced proper procedures for physical restraint use. Interview with Assistant Administrator A on 02/11/16 at 2:45pm revealed: -Resident #5's fall on 09/07/15 was unwitnessed by staff. -Resident #5 fell out of the bed over the bed rails on 12/02/15 and fell face first onto the floor. -There was no Accident and Incident Report completed for the 12/02/15 fall. -Resident #5's family was notified of both falls. -There was no physician order for restraints in the chart for Resident #5. -No assessment and care planning was done prior to the use of restraints or alternatives. -She was unsure of the date when the bed rails were first implemented for Resident #5.	D 482 *	ALL RESIDENTS WHOM HAVE FALLEN AND HIT THEIR HEAD HAVE AND WILL CONTINUE TO BE SENT IMMEDIANTLY TO ER, FOR FUTHURE EVALUATION.	2/12/16

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D 482	Continued From page 5 -They implemented the tab alarm after the fall on 12/02/15. -Resident #5 had no other falls since the tab alarm had been implemented on 12/03/15. -"We try to keep [the resident] up in the chair, but [the resident] prefers to be in the bed." -"Eighty-five percent of the time [the resident] is up front in the common area of the building or in the living room." -Resident #5 "has not tried to get out of the bed since the 12/02/15 fall." Observation on 02/11/16 at 3:36pm revealed Resident #5's tab alarm had sounded, 2 staff members (Staff C and E) ran into Resident #5's room and found the resident sitting up in bed with both legs hanging off of the end of the bed between the foot board and the bed rail. Review of the facility's policy on restraints revealed: -The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to ones body and includes bed rails when used to keep the resident from voluntarily getting out of bed as opposed to enhancing the mobility of the resident while in bed. -The Administrator shall ensure that each resident with medical symptoms that warrant the use of physical restraints is assessed and a care plan is developed. -The assessment and care planning shall be completed prior to the resident being restrained, except in emergency situations. -The assessment and care planning shall be completed through a team process. -The team must consist of, but is not limited to	D 482		

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D 482	Continued From page 6 the following: the supervisor, or a personal care aide (PCA), a Registered Nurse, and the resident's representative. -Physical restraints shall be applied only by staff who have received training and who have been validated for competency by a Registered Nurse on the proper use of restraints. -Training and competency validation on restraints shall occur before staff members apply restraints. -The administrator shall assure that training is provided to all staff responsible for caring for residents with medical symptoms that warrant restraints. Review of 3 random staff qualification records revealed all had received training in the use of physical restraints. The facility provided a Plan of Protection on February 11, 2016 that included: -Bed rails were removed from Resident #5's bed. -An assessment would be conducted as soon as possible and a physican order would be obtained as warranted. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2016.	D 482		
D915	G.S. 131D-21(5) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.	D915		

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D915	Continued From page 7 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 2 sampled residents were free from physical restraints with no clear and indicated medical symptoms. The findings are: Based on observations, record review and interviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed and a physician order obtained for bed rails and a geri-chair with a table top for 1 of 2 sampled residents with physical restraints resulting in Resident #5 falling out of the bed over the bed rails. [Refer to Tag D482, 10A NCAC 13F .1501 Use of Physical Restraints and Alternatives (Type A2 Violation.)]	D915	* ALL RESIDENTS WILL BE ASSESSED ~~AND~~ ON ADMISSION AND AS ANY CHANGES IN THEIR STATUS, ALONG W/ DOCUMENTATION 3/16/16 Addendum per Telephone conversation with Assistant Administrator: - Assistant Administrator will monitor all residents with restraints monthly and make changes as needed. - Completion date for POC will be March 10, 2016.	2/15/16

3/16/16 Reviewed + accepted with revisions — [illegible]

[illegible] RN ACLS