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
	HAL056001	A. BUILDING: _____ B. WING _____	R 03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Macon County DSS conducted an annual and follow-up survey on March 16 and 17, 2016.	D 000		
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 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.	D 485	D 485 Administrator will review current policies to ensure that they are effective. Updates will be made as appropriate, ie. time interval for restraint checks will be changed from 15 to 30 minutes. Using the electronic medical record, care coordinator for each restrained resident will ensure that checks and restraint releases are being performed per 10A NCAC 13F. 1501(d). Additionally, administrator will review electronic record weekly. With administrative oversight, Human-resource person will review restraint training and develop any needed changes to orientation and restraint training. Date of compliance will be May 2, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Approved by Brenda Boggs on 4/18/16

Brian Thumm | Administrator | 04/06/16

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D 485	Continued From page 1 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to perform 15 minute checks as ordered on 1 of 2 sampled residents (Resident #4) with an improperly positioned lap belt restraint. The findings are: Review of Resident #4's current FL-2 dated 5/21/15 revealed: -Diagnoses included dementia, glaucoma with blindness, agitation and vertigo. -The use of restraints with the additional comment of "soft belt while in wheelchair." Review of Resident #4's Resident Register revealed an admission date of 6/20/14. Review of Resident #4's Assessment and Care Plan dated 8/24/15 revealed: -"Disruptive Behavior/Socially Inappropriate" was checked. -"Non-ambulatory" was checked with the added comment in capital letters "WHEEL CHAIR WITH SOFT BELT DUE TO MULTIPLE FALLS." -The comment under the skin assessment in capital letters was "BRUISES EASILY." -The comment under the vision assessment in capital letters was "TOTAL BLIDNESS [sic] IN LEFT EYE ONLY BLURRED AND SHADOWS IN RIGHT." -"Daily incontinence" was checked for both bowel and bladder assessments. -"Always disoriented" was checked for orientation. -All activities of daily living for the resident was documented as totally dependent.	D 485		

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D 485	Continued From page 2 -Licensed Health Professional Support (LHPS) tasks documented in capital letters were " SOFT BELT RESTRAINT" and "WHEELCHAIR with seatbelt." -The Assessment and Care Plan was signed by the physician on 9/11/15. Review of a Consent for Restraint form for Resident #4 dated 9/26/14 revealed: -Documented potential risks which included "accidental injury from restraint" and "loss of independent mobility." -A signature from the Power of Attorney (POA). Review of a current LHPS note for Resident #4 dated 1/29/16 revealed: -"Resident cont [continues] to use the torso restraint when up. Staff monitors q 15 min[utes] and releases and exercises q 2h [hours]." -Staff competency was checked "yes" for the personal care task of "restraints." Review of a current physician's order for Physical Restraint form for Resident #4 dated 2/15/16 revealed: -Reason for restraint use was "fall and injury prevention." -Type of restraint to be used was "[brand name] torso support or blue soft belt." -Circumstance under which the restraint may be used was "torso support while resident is in her wheelchair" and "Blue soft belt while resident is in her recliner." -Time intervals at which the restraint was to be checked or loosened was "torso support check q [every] 15 [minutes] release Q 1 hr [hour]" and "Blue Belt check q 15 min release q 2 [symbol for hour]." -Documentation of an electronic physician's signature.	D 485		

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D 485	Continued From page 3 Review of a computer-printed personal care aide (PCA) report for Resident #4 titled "Admin History for [Resident's name] - TORSO RESTRAINT" for the period of 3/10/16 through 3/16/16 revealed: -A column labeled "Scheduled" with dates for the time period and either 7:00AM (for day shift) or 3:00PM (for evening shift). -Another column labeled "Administered" with a corresponding single date similar to that in the "Scheduled" column and a single time. -A column labeled "Caregiver" with PCA names. -No entries under the column headings of "Recorded Exception," "Notes" and "Witness." Review of a computer-printed PCA report for Resident #4 titled "Admin History for [Resident's name]- TORSO RESTRAINT REPOSITION" for the period of 3/10/16 through 3/16/16 revealed column headings, dates for the time period and information similar to the report Admin History for Torso Restraint. Review of computer-printed notes labeled "Charting Notes" for Resident #4 for the period of January 2016 through March 2016 revealed: -Eight separate entries, the most recent dated 2/28/16. -No narrative entries regarding the checking or releasing of a restraint. -One entry documented restraints as not needed on 2/3/16 at 10:38AM as the resident was in bed, with no other entries documenting restraint use. Review of an undated facility Physical Restraint Policy revealed: -"The use of either chemical or physical restraints must be carried out in such a way as to be compatible with both respect and comfort." -Examples of physical restraints included "lap	D 485		

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D 485	Continued From page 4 belts (that the resident cannot remove)." -There was no mention of the time frequency required for checking or releasing restraints. Observation of Resident #4 on 3/16/16 at 11:10AM revealed: -The Resident was in her room, seated in a recliner with the seat back at an approximately 60 degree angle and her feet on the raised footrest. -The Resident was talking to herself. -A soft padded belt restraint was placed over her lap, the straps pulled behind the Resident at her hips and tied behind the back of the recliner. -The recliner was positioned at an approximately 45 degree angle to the doorframe with the seat back and restraint ties visible through the open door (the resident and position of the belt restraint was not visible while seated in the recliner when viewed from the hallway). Based on observation and asking simple screening questions, Resident #4 was determined to be unterviewable. Review of a manufacturer's Application Instruction Sheet for a soft belt restraint (the same as that observed applied to Resident #4) revealed: -"After applying a restrictive product, always monitor to make sure the patient is not able to slide down, or fall off the chair seat or mattress." -A picture of a person seated in a wheelchair with the soft belt restraint applied with the caption "Belt should be on lap in wheelchair." Observation of Resident #4 on 3/17/16 at 8:18AM revealed: -The Resident was in her room, seated in a recliner with the seat back at an approximately 60 degree angle, but the Resident had slid down the	D 485		

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D 485	Continued From page 5 chair seat with her feet and lower legs dangling over the edge of the raised footrest. -The Resident was talking to herself. -A soft padded belt restraint was placed over her breasts and upper chest, the straps pulled behind the Resident under her armpits and tied behind the back of the recliner. -The Resident was showing no signs of respiratory distress. -The recliner was positioned at an approximately 45 degree angle to the doorframe with the seat back and restraint ties visible through the open door (the resident and position of the belt restraint was not visible while seated in the recliner when viewed from the hallway). -No staff were in the immediate vicinity of the Resident's room. Based on observation and asking simple screening questions, Resident #4 was determined to be uninterviewable. A second observation of Resident #4 on 3/17/16 at 8:25AM revealed findings the same as that at 8:18AM. Observation of Resident #4's hallway on 3/17/16 at 8:25AM revealed: -Staff A, PCA, was assisting another resident at the end of the hallway near the nursing station. -The Memory Care Coordinator was attending to residents up and down the hallway. -Staff C, Medication Aide, was in the hallway at the medication cart performing a morning medication pass. A third observation of Resident #4 on 3/17/16 at 8:35AM revealed findings similar the same as that at 8:18AM.	D 485		

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D 485	Continued From page 6 A second observation of Resident #4's hallway on 3/17/16 at 8:37AM revealed: -Staff B, PCA, walked past Resident #4's room to enter another room at the end of the hallway by the emergency exit. -The Memory Care Coordinator was attending to residents up and down the hallway. -Staff C, Medication Aide, was in the hallway at the medication cart performing a morning medication pass. Interview of Staff B, PCA, on 3/17/16 at 8:40AM (in the hallway across from Resident #4's room) revealed: -Residents having lap belt restraints were checked every 15 minutes for correct belt placement and resident positioning. -The lap belt restraints were only removed for toileting and transfers. -She did not have an assignment to any residents in particular but cared for them all with the other PCAs. A fourth observation of Resident #4 on 3/17/16 at 8:44AM revealed findings the same as that at 8:18AM. A third observation of Resident #4's hallway on 3/17/16 at 8:45AM revealed: -The door to the laundry room door was open and Staff B, PCA, removing linens from the dryer. -Staff C, Medication Aide, was in the hallway at the medication cart performing a morning medication pass. A fifth observation of Resident #4 on 3/17/16 at 8:46AM revealed findings the same as that at 8:18AM. A fourth observation of Resident #4's hallway on	D 485		

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D 485	Continued From page 7 3/17/16 at 8:46AM revealed Staff B, PCA, walking past Resident #4's room with a stack of linens and entering another resident's room. A fifth observation of Resident #4's hallway on 3/17/16 at 8:48AM revealed Staff A, PCA, and the Memory Care Coordinator seated in the nursing office at computer screens. Interview with Staff A, PCA, on 3/17/16 at 8:55AM (in the hallway across from Resident #4's room) revealed: -There were three PCAs on the hallway that day but one had to go out on a transport with a resident, leaving two PCAs to care for the residents. -She did not have a specific resident assignment but with the other PCAs worked as a team to get resident care completed. A sixth observation of Resident #4 on 3/17/16 at 8:56AM revealed findings the same as that at 8:18AM. A seventh observation of Resident #4 on 3/17/16 at 9:00AM revealed findings the same as that at 8:18AM. Continuous observation of Resident #4's room from outside her room in the hallway on 3/17/16 from 8:18AM to 9:00AM revealed no staff entered her room during this time period. On 3/17/16 at 9:00AM Staff A, PCA, was asked to check on Resident #4. Interview with Staff A, PCA, on 3/17/16 at 9:00AM, inside Resident #4's room at her recliner revealed: -The lap belt restraint should not have been	D 485		

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D 485	Continued From page 8 across the Resident's breasts but across her abdomen. -The resident was "not in a good position" in the recliner and another staff member would be required to assist with repositioning Resident #4. Interviews with Staff A, PCA; Staff B, PCA and Staff C, Medication Aide on 3/17/16 at 9:00AM, inside Resident #4's room at her recliner revealed: -Staff A, PCA had checked on the Resident "20 to 30 minutes ago." -Staff B, PCA had checked on the Resident "20 to 30 minutes ago." -Staff C, Medication Aide had last checked on Resident #4 at 7:30AM but since that time had been passing medications on the floor. -Staff A, PCA stated staff were expected to check lap belt restraints for tightness and positioning every 15 minutes with a release of the device to help the resident to the bathroom every 2 hours. Review of Physical Restraint training sheets, signed by registered nurses revealed: -Staff A PCA completed training on 8/23/15. -Staff B PCA completed training on 8/23/15. -Objectives of the training included "negative outcomes from using physical restraints," "correct application of physical restraints" and "monitoring and caring for residents who are restrained ...." Review of LHPS skill checkoff sheets revealed: -Staff A PCA completed the checkoff sheet on 3/16/16. -Staff B PCA completed the checkoff sheet on 3/8/16. -Skills checked off included "Care of residents who are physically restrained."	D 485		

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D 485	Continued From page 9 Interview with the Memory Care Coordinator on 3/17/16 at 9:05AM revealed: -She expected staff to do a 15 minute check for restraint placement and resident positioning, and a 2 hour release of the device. -Challenges with Resident #4 included the size of her room which limited placement of her recliner and required consideration of her roommate. -Resident #4 was known to wiggle in her chair resulting in position changes, sometimes with the lap belt restraint sliding up to her chest. -Resident #4 had been known to sometimes get an arm out from under the belt when it was across her chest. -Staff documented restraint checks in the computer record at the end of their shift, which per the LHPS nurse was acceptable. Telephone interview with the POA on 3/17/16 at 10:00AM revealed: -Resident #4 wore a "band" around her waist when in a wheelchair or recliner due to her leaning over too far when seated. -The resident was a "wiggle worm" and known to move around and change her position. -A family member requested the restraint be used to prevent Resident #4 falling out of the wheelchair or recliner. -Sometimes Resident #4 would "scoot" down the chair but staff were good to go into her room, check on her and move the device if necessary. -"Staff are constantly coming by [Resident #4's room]" and during shift changes to check on Resident #4. Interview with the Administrator on 3/17/16 at 11:50Am revealed: -He expected staff to examine restraints on residents every 15 minutes and to release them every 2 hours.	D 485		

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D 485	Continued From page 10 -The use of restraints meant meeting a higher standard and "this needs to be done right." A Plan of Protection was received from the facility on 3/17/16 as follows: -All staff, direct care and support, were immediately informed of the severity of the issue through staff meetings, with information regarding the proper appearance of a properly applied lap restraint. -Staff had been instructed to position client's wheelchairs to face outward into the hall to facility care aide monitoring. -When a lap restraint is found to be incorrectly applied staff are required to tell the supervisor for immediate remediation. -To ensure compliance with 15 minutes checks a task would be added to the electronic charting system that would automatically alert staff to the correct time the check was due. -A copy of the manufacturer's lap belt restraint instructions with proper placement and application would be made available to care aides. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2016.	D 485		
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.	D912	D912 Administrator will oversee implementation of new restraint management procedures to ensure that residents receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations, particularly in this instance, as related to restraint monitoring. All procedures will be completed by May 2, 2016	

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D912	Continued From page 11 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations relate to the use of physical restraints and alternatives. The findings are: Based on observations, record reviews and interviews, the facility failed to perform 15 minute checks as ordered on 1 of 2 sampled residents (Resident #4) with an improperly positioned lap belt restraint [Refer to Tag 912, 10A NCAC 13F .1501(d), Use of Physical Restraints and Alternatives (Type B Violation)].	D912		