STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047012	A. BUILDING _____ B. WING _____	C 09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 the Hoke County Department of Social Services conducted an annual survey and a complaint investigation on 09/11/17 - 09/15/17. The Hoke County Department of Social Services initiated the complaint investigation on 09/01/2017.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the maintenance cart was stored in a locked area resulting in hazardous chemicals and multiple tools being unattended and accessible to residents. The findings are: Observation of the hallway near the dayroom on the middle hallway on 09/12/17 at 10:11 a.m. revealed: -The middle hallway started at the nurses' station on the assisted living side and led to the double door entrance to the special care unit (SCU). -There was a two shelf maintenance cart parked in the hallway near the dayroom that was	D 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Capps Clark — TITLE: Administrator — (X5) DATE: 11/09/2017.

REVIEWED Amended POC submitted on 12/1/17 & ACCEPTED — [illegible] 12/4/17

Date Survey Completed: September 15, 2017

AMENDED COPY

Provider's Plan of Correction

12/01/2017

Page 1 of 128

ID Prefix Tag D 056

10A NCAC 13F.0305 (f)(4) Physical Environment:

All locking areas on housekeeping and maintenance carts were checked to ensure properly locking storage for all chemicals and working tools were working properly. Two tool boxes were added to the cart for the maintenance man with locks. One will be for tools the other for any chemicals required to do his routine maintenance.

Staff members were trained on 11/10/2017 to include the regulations for environment. Also the requirements for the health department were included.

Staff will be trained on the regulations in section .0305 at time of hire and annually. Housekeeping Supervisor will be responsible for enforcing the regulations. Spot inspections will be completed to confirm compliance.

accepted FC

Complete Date: Training of current staff 11/15/2017

Page 3 of 128

ID Prefix Tag D 161

10A NCAC 13F.0504 (a) Competency Validation for LHPS Tasks:

As outlined during survey process, the LHPS check offs for staff are routine completed. The one worker found during survey was scheduled to be checked off on 9/20/2017. The posting for this meeting was attached to the staff bulletin board before survey. Please see the attendance sheets for LHPS Check offs since survey. Please note meetings are held only when staff need check offs completed. Also, the nurse was sick with flu for one week during November. The completed LHPS for the one employee is included in documents. The business

office director is responsible for identifying the employees who need to complete the LHPS Check offs. She has audited all the employees to ensure no other employee was missed. A complete listing to date of the audit is attached.

Accepted

LHPS Competency Validations will be scheduled biweekly with RN Consultant. The business office personnel will be responsible for maintaining list and posting training for new PCA Staff. Business office manger will be responsible for reviewing monthly that the aides have received competency validation and will report the results of that review to the administrator.

Complete Date: 11/10/2017

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ID Prefix Tag D 228

10A NCAC 13F .0702 (d) Discharge of Residents

Discharges that are required to be immediate due to the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health and safety of individuals in the facility will be documented within the resident chart and will follow state law and regulation. Safety issues that are due to resident to resident aggression will follow the established policy of the facility. A meeting will be held with the family members, POA, and/or guardian to discuss the circumstances that are being exhibited that are a danger to resident or other individuals within the facility. If physical assault occurs and confirmed, immediate discharge may be required to protect the other residents within the facility. Reports documenting the incident will be sent to primary care physician. The facility will make the local department of social services or the MCO/LME aware of the immediate discharge within 24 hours of the immediate discharge decision. If the immediate discharge is not effectuated within 48 hours the facility will request a meeting of the resident discharge team as defined by G.S. 131D. If the discharge cannot be effectuated within 72 hours the facility will contact the physician to determine if the physician has an objection and supports the continuing isolating the resident from interaction with

other residents. This would be re-evaluated weekly by facility staff and the physician.

All other discharges will follow the requirements specified in the regulation to include the 30-day written notice. Depending on the reason for discharge, if necessary, a new FL-2 or other documentation stating the physician determination for a different level of care will be secured for the residents chart. Discharges due to change in level of care that are needed will be as soon as possible after the notification of the doctor for the change. All important documents required will be forwarded to the facility of resident or family choice.

Complete Date: 11/10/2017

Page 10 of 128

ID Prefix Tag D 234

10A NCAC 13 F. 0703 (a) Tuberculosis Test, Medical Exam and Immunizations

Audit of the medical charts was completed on November 8, 2017 to identify any required TB skin test. Audit was completed and arrangements made for the test or chest x-rays to be completed.

All admissions will have the required one TB testing completed prior to admission. This documentation will include the date of test, the person name administering and reading the test, the location of the injection, the expiration of the TB solution, the lot number of the solution and the final results to include size of area if applicable for a positive result. During the admission process the required TB documentation will be secured by the business office and submitted to the RRC or SCU-C for review prior to actual admission.

The second TB testing required for the completion of the Two-Step process will be completed sometime from two weeks after the first to before one year has passed the first testing. The above documentation will be completed for the second TB test. The Resident Care Coordinator or the SCU-Coordinator will be responsible for reviewing any required TB test and report to the administrator those results monthly for a period of one year.

Complete Date: 11/10/2017

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ID Prefix Tag D 358

10A NCAC 13F.1004 (a) Medication Administration

Diabetic training was held on September 21, 2017 with the current medication administration staff. The 15 hour medication training class was held for all exiting employees on October 3- 10, 2017. Each medication aide was required to complete the checklists and test included in the state approved training course.

Facility has changed pharmacy's effective 9/7/2017. With this change the medication records were audited and corrections made with the Electronic MAR system. All records of resident with diabetes were checked by the new pharmacist to ensure the staff would be documenting all required information when administering insulin. It was discovered during the switch that the insulin had been entered as a "treatment" not a "medication". This distinction triggers built in programing within the electronic MAR system. This correction was completed on 9/7/2017.

Another part of the services provided by the new pharmacist is the request and the securing of narcotic refills. The pharmacy will establish a relationship with the individual physician to allow the pharmacy to request refill authorization that can be submitted with e-script. The pharmacist prefers to handle the narcotic refills in this manner to prevent a paper script from being lost or stolen. This process was put into place on September 7, 2017. As the prescriptions have required refills the pharmacy has established the relationship with the prescribing doctor.

accepted

The pharmacy has since completed a cart review and an additional medication review at the facility. The pharmacy's RN consultant completes random checks of the carts approximately every two weeks to see if staff has documented any medications as not being within the carts. Problems areas are investigated to see what needs to be done to resolve issue.

The RCC and the SCU-C will be responsible for ensuring the medications are administered correctly.

Complete Date: 10/12/2017

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ID Prefix Tag D 366 & Tag ID D 378

10A NCAC 13F.1004 (i) Medication Administration

10A NCAC 13F.1006 (b) Medication Storage

During the 15-hour medication aide training held October 3-10, 2017, the proper procedures for storing medications was reviewed.

The RCC and the SCU-C will be responsible for ensuring the medications are stored correctly and randomly checks to make sure security measures for stored medications are being met.

Complete Date: 10/12/2017

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ID Prefix Tag D 438

10A NCAC 13F.1205 Health Care Personnel Registry

The administration of the facility will follow the guideline outlined in the Health Care Personnel Registry with regards to the 24 hours report and the 5-day investigation reporting. The Administrator or the Business office personnel will be responsible for completing these reports Any report of rough handling or any other potential abuse allegation by family member or any one else will be reported within 24 hours of receiving such report to the HCPR even if the initial investigation indicates that no abuse occurred. Such findings will be included in the 5 day report when completed and sent to the HCPR.

Complete Date: 11/10/2017

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ID Prefix Tag D 980

GS 131D-25 Implementation

Current training in the facility with the upper management team will be completed to include the entire minimum standards and the 3-L policy. Weekly and monthly checklist will be implemented to ensure the staff is completing their assigned tasks. Conferences with other certified administrators have already been held. Recommendations by area administrators will be discussed and implemented when possible to improve the delivery of services.

Complete Date: 11/15/2017

COMPLETE
IN-SERVICE TRAINING REPORT
WITH PERSONNEL ATTENDING

Facility: OARC Department: SIC + Med Techs

Date: 09/19/17 Time: 2pm AM PM To: 3pm AM PM

Meeting area:

Number employees present: Number absent:

Summary of subject(s) covered: MANDATORY MEETING
Blood sugar, Sliding scale, Demerit Terms, narcotic count, being on time

Problems, comments, suggestions:

Conducted by: Signature Title

SIGNATURE OF PERSONNEL ATTENDING	TITLE	SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	SIC/MT		
[redacted]	MT/Aid		
[redacted]	MT		
[redacted]	DRS		
[redacted]	MT		
[redacted]	Sue		
[redacted]	SC/MT		
[redacted]	CNA/MT		
[redacted]	SIC/MT		
[redacted]	SIC		

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COMPLETE
IN-SERVICE TRAINING REPORT
WITH PERSONNEL ATTENDING

Facility: OPEN ARMS RETIREMENT CENTER Department: SIC + MED TECHS

Date: 09/21/2017 Time: AM PM To: AM PM

Meeting area: Class #1 (12:30pm - 2:00pm) Class #2 (2:00pm - 3:30pm)

Number employees present: Number absent:

Summary of subject(s) covered: Diabetes & Insulin Administration

Problems, comments, suggestions:

Conducted by: Signature Donna Price RN Title 9/21/2017

CLASS #1

SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	SIC/MT
[redacted]	SIC/MT
[redacted]	SIC/MT
[redacted]	PCA
[redacted]	SIC
[redacted]	MED TECH
[redacted]	MT
[redacted]	PCA
[redacted]	CNA/MT
[redacted]	STC/MT

CLASS #2

SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	DRS
[redacted]	PCA
[redacted]	CNA/MT
[redacted]	SIC
[redacted]	STC/MT

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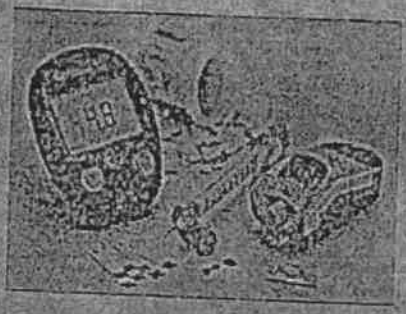
DIABETIC TRAINING



September 21st

(12:30-2:00pm)

[redacted]

(2:00pm-3:30pm)

[redacted]

[redacted]

Diabetes and Insulin Administration

Learning Objectives:

- ☐ Describe classifications of diabetes
- ☐ Describe the purpose of anti-diabetic agents
- ☐ Discuss normal vs abnormal blood sugar levels
- ☐ Discuss symptoms of hyper and hypoglycemia
- ☐ Discuss types of oral anti-diabetic agents
- ☐ Discuss the different types of insulin
- ☐ Describe what to do for low/high blood sugar
- ☐ Demonstrate how to properly administer subcutaneous insulin including sites, rotation of sites, reading insulin syringe, and using insulin pens
- ☐ Discuss insulin based on a sliding scale
- ☐ Discuss proper diabetic foot care
- ☐ Learn procedure for properly cleaning all equipment used for obtaining blood sugar levels
- ☐ Learn infection control practices pertaining to collecting blood sugars and administering insulin

Content Outline and Time Schedule:

- ☐ Describe classifications of diabetes – 15 minutes
- ☐ Describe the purpose of anti-diabetic agents – 10 minutes
- ☐ Discuss normal vs abnormal blood sugar levels – 10 minutes
- ☐ Discuss symptoms of hyper and hypoglycemia – 15 minutes
- ☐ Discuss types of oral anti-diabetic agents – 10 minutes
- ☐ Discuss the different types of insulin – 20 minutes
- ☐ Describe what to do for low/high blood sugar – 15 minutes
- ☐ Demonstrate how to properly administer subcutaneous insulin including sites, rotation of sites, reading insulin syringe, and using insulin pens – 25 minutes
- ☐ Discuss insulin based on a sliding scale – 20 minutes
- ☐ Discuss proper diabetic foot care – 10 minutes
- ☐ Learn procedure for properly cleaning all equipment used for obtaining blood sugar levels – 20 minutes
- ☐ Learn infection control practices pertaining to collecting blood sugars and administering insulin – 10 minutes

COMPLETE
IN-SERVICE TRAINING REPORT
WITH PERSONNEL ATTENDING

Facility: Opus Avons Retirement Center Department: Nursing

Date: 9/14/2017 Time: AM PM To: AM PM

Meeting area:

Number employees present: Number absent:

Summary of subject(s) covered: RESTRAINT TRAINING (Seatbelt refresher)

Problems, comments, suggestions:

Conducted by: Signature Title

SIGNATURE OF PERSONNEL ATTENDING	TITLE	SIGNATURE OF PERSONNEL ATTENDING	TITLE
Please See attached list of attendees - Thanks! [redacted]			

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COMPLETE
IN-SERVICE TRAINING REPORT
WITH PERSONNEL ATTENDING

Facility: OKRC

Department: All Nursing

Date: 09/20/17 Time: AM PM To: AM PM

Meeting area: Class #1 10AM-11AM Class #2 11AM-12pm Class #3 3pm-4pm
Class #4 9/21/2017 3:30pm-4:30pm

Number employees present: Number absent:

Summary of subject(s) covered: RESTRAINT TRAINING

Problems, comments, suggestions:

Conducted by: Signature [redacted] RN Title RN

#1
#2
#3

SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	PCA
[redacted]	SIC
[redacted]	PCA
[redacted]	PCA
[redacted]	SWC
[redacted]	DRS
[redacted]	SEC/MT
[redacted]	MT
[redacted]	CMMS
[redacted]	PCA
[redacted]	PCA MED TECH
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA

#3 Cont

SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	PCA
[redacted]	SEC/MT
[redacted]	PCA
[redacted]	PCA

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F #3 Cont

SIGNATURE OF PERSONNEL ATTENDING	TITLE	SIGNATURE OF PERSONNEL ATTENDING	TITLE
[redacted]	PCA		
[redacted]	Si CMT		
[redacted]	Si/MT		
[redacted]			
[redacted]	PCA		
[redacted]			
[redacted]	PCA		
[redacted]	Si/MT		
[redacted]	CNA I		

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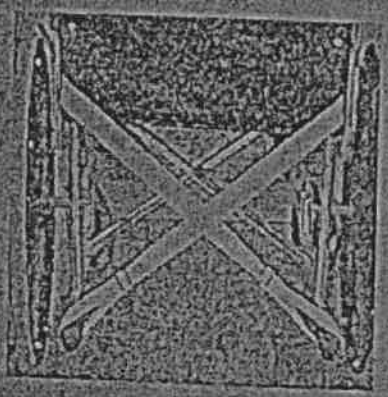
September 20th

Restraint Training for Everyone in the Nursing Department.

(Supervisors and Med Techs included)

You will have to attend one of these classes.
If not you will come off the schedule.

Class #1	10:00am-11:00am
Class #2	11:00am-12:00pm
Class #3	3:00-4:00pm



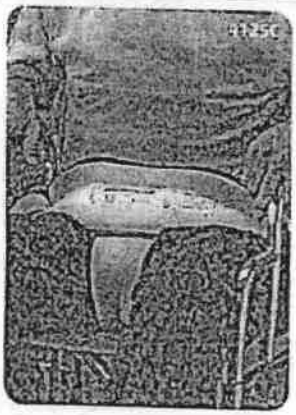
09/15/17

SOFT BELT

Applicable Products: REF 4125C

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: A pelvic holder to prevent sliding. For chair use only. **Rx ONLY**



POSEY SOFT BELT

REF 4125C Chair use only; 4½"W x 16½" (11 cm x 42 cm) belt pad w/6 foot (2 m) straps

INDICATIONS FOR USE:

- Patients assessed to be at risk of injury from a fall.
- Patients needing a positioning device for added safety while in a chair.
- Patients who have a tendency to slide down in a chair.

CONTRAINDICATIONS:

- **DO NOT** use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal.
- **DO NOT** use on patients with: ostomy, colostomy, or G-tubes; hernias, severe Cardio Obstructive Pulmonary Disease (COPD); or with post-surgery tubes, incisions, catheters, or monitoring lines. These could be disrupted by a restraint.

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur: if the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

APPLICATION INSTRUCTIONS:

WARNING Make sure patient wears proper undergarments to protect skin.

CAUTION Before use, check device for damage. Discard if you have any questions about patient safety.

1. Lay the device on the chair with the narrow side to the back of the chair.
2. Bring the ends of the connecting straps on the narrow end, down behind the chair, and secure out of the patient's reach (fig. 1).


FIG. 1

3. Position the patient as far back in the seat as possible, with the buttocks against the back of the chair.
4. Bring the wide part of the pelvic holder up between the patient's legs.
5. Bring the ends of the connecting straps on the wide end, down between the seat and wheelchair sides at a 45-degree angle (fig. 2).

FIG. 2

6. Criss-cross the straps and use quick-release ties to attach the straps to the opposite side kick spurs, out of the patient's reach (fig. 3).
7. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach.


FIG. 3

8. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is tilted or adjusted.

APPLICATION INSTRUCTIONS: (PLASTIC INCONTINENCE SHIELD):

1. Insert the pelvic straps through the shield starting at the widest part and pull the shield up until it rests on the foam pelvic piece.

WARNING

Heed these warnings to reduce the risk of serious injury or death:

- **Monitor skin conditions in the groin area frequently. If the patient slides down or forward, pelvic straps may damage the skin.**
- **There is a risk of chest compression or suffocation, if the patient's body weight is suspended off the chair seat. Use extreme caution with chair cushions. If a cushion dislodges, straps may loosen and allow the patient to slide off the seat (fig. 4).**
- **Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat and become suspended (fig. 4).**

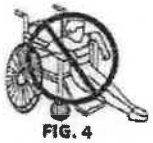


FIG. 4

- **STOP USE AT ONCE:** if the patient has a tendency to slide forward or down in the device; or is able to self-release.

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

Posey Company • 5635 Peck Road, Arcadia, CA 91006-0020 USA • www.posey.com
Phone: 1.800.447.6739 or 1.626.443.3143 • Fax: 1.800.767.3933 or 1.626.443.5014

EC REP MDSS GmbH Schiffgraben 41 D-30175 Hannover, Germany CE

192100 040609

Safety Information for the use of Posey Torso and Limb Restraining Products

Posey

⚠ WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death.

RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(5); Posey offers inservice training aids at no charge. Contact Posey online at: www.posey.com or call toll-free at 1.800.447.6739.

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's Individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.

NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:

- Aggressive or agitated patients; and
- Patients deemed at risk of aspirating their vomit. This includes patients in the supine position, or who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
- Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.

HOW TO TIE THE POSEY QUICK-RELEASE TIE

1. Wrap the strap once around a moveable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.
2. Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.
6. Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.

2. NEVER alter or repair this product. ALWAYS inspect before each use: Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook-and-loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

3. ALWAYS secure straps, to a movable part of the bed or chair frame, out of the patient's reach, using quick-release ties (see drawing below) or buckles. These allow easy release in the event of an accident or fire. Test to make sure straps cannot tighten, loosen, or slip and create excess slack. If this occurs, the patient may slide off the chair or bed, increasing the risk of serious injury or suffocation. Restraint release is an important part of facility fire and disaster drills. Straps can be cut with scissors in an emergency.
4. NEVER secure restraint strap to side rail.
5. NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.

6. NEVER expose this product to open flame, fire, smoking materials, or high heat sources. Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

7. NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.

LAUNDERING INSTRUCTIONS (If applicable):

- Fasten all buckles and locks to reduce risk of damage during wash and dry cycles. DO NOT put buckles or locks through extractors. For maximum life, launder in a laundry bag.
- Before laundering, zip up and turn the product inside out to protect zipper.
- Hook-and-loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the "hook" to the "loop" before laundering to help prevent lint buildup. As needed, use a stiff-bristle brush to remove lint from the "hook" side.
- These products, other than foam products, can be machine washed under CDC* guidelines for material soiled with blood or bodily fluid.

- For non-contaminated material, use lower temperature wash and dry cycles to extend product life.
- For foam products:

⚠ WARNING Test Zippers or hook-and-loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

*www.cdc.gov

SIZING TABLE FOR POSEY PRODUCTS

ALWAYS use the proper size product. Products that are too small or large may compromise patient comfort and could result in severe injury or death.

BINDING COLOR	SIZE	WEIGHT lbs (kg)	CHEST in. (cm)
White	X-Small	80-115 (27-52)	25-32 (64-81)
Red	Small	112-160 (51-73)	31-37 (79-94)
Green	Medium	135-203 (61-92)	35-40 (89-102)
Yellow	Large	160-225 (73-102)	38-44 (97-112)
Blue	X-Large	180-247 (82-112)	42-48 (107-122)
Black	XX-Large	220-275 (100-125)	46-55 (117-140)
Yellow/Black	XXX-Large	265-305 (120-139)	54-60 (137-152)
Blue/Black	XXXX-Large	295-340 (133-154)	58-64 (147-163)

• Posey Belts are not color-coded, but are sized according to this table. • Flame-retardant fabric is available on request. • Patient weight and size are a general indicator only. Consider individual physical characteristics to choose the right product for each patient. Refer to product label for specific sizing information.

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I9200B REV C 091518

LAP HUGGER

Applicable Products: NEW 6506, 6515, 6515L, 6515M, 6515N, 6515SL, 6515T

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: Vinyl covered foam cushion for wheelchairs or similar non-wheelchair applications. **Rx ONLY**

INDICATIONS FOR USE:

- Patients who have poor upper torso alignment and/or need a firm surface to rest their elbows on.
- Patients who require an anterior posture support.
- Patients who require a work area or eating area on their wheelchair or similar non-wheelchair applications.
- Product applications considered "self-release" or "assisted-release" must be specified by the ordering physician.

LATEX

CONTRAINDICATIONS:

- **DO NOT** use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal.
- **STOP USE AT ONCE:** if the patient has a tendency to slide forward or down in the device; or is able to self-release.
  NOTE: A restraint with a pelvic piece will reduce the risk of sliding, or of the patient pulling the device over his or her head. See Posey Catalog.
- **DO NOT** use on a patient who is unwilling or unable to follow instructions, and is at risk of a fall or re-injury from self-release.

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur if the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

POSEY LAP HUGGER

- NEW 6506 Tabletop Hugger
- NEW 6515T Lap Hugger
- NEW 6515N Lap Hugger
- NEW 6515 Lap Hugger
- NEW 6515M Lap Hugger
- NEW 6515SL Lap Hugger
- NEW 6515L Lap Hugger

POSEY LAP HUGGER PRODUCT OFFERING

Cat. #	Arm Style	Fits Wheelchair	Thickness	Color
6506	Full	16-18" (41-46 cm)	4" (10 cm)	Blue w/Window
6515T	Full	15-20" (41-51 cm)	2" (5 cm)	Blue
6515N	Full	16-20" (41-51 cm)	3" (8 cm)	Blue
6515	Full	16-20" (41-51 cm)	4" (10 cm)	Blue
6515M	Full	16-20" (41-51 cm)	4" (10 cm)	Mauve
6515SL	Full	20-24" (51-61 cm)	3" (8 cm)	Blue
6515L	Full	20-22" (51-56 cm)	4" (10 cm)	Blue

NOTE: This product is designed for use on full-length arm wheelchairs.

APPLICATION INSTRUCTIONS:

1. Position the patient in the wheelchair or chair.
2. Holding the Hugger horizontally with the squared notches facing toward you, place the Hugger flat on top of the armrests (fig. 1).
3. Compress each side of the Hugger, squeezing it under each armrest until the Hugger lies flat on the patient's/resident's lap (fig. 2).
4. Pull the Hugger forward until it is secure and the notches rest firmly in place against the wheelchair frame (fig. 3).

Model #6506 Table Top Hugger With Window only:

5. To access the window area of model 6506, unzip the vinyl cover.

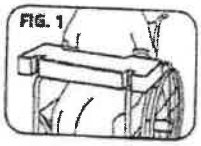
FIG. 1

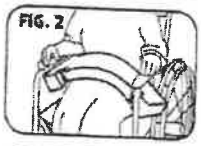
FIG. 2

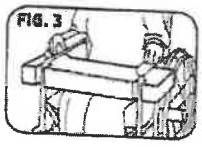
FIG. 3

WARNING This device should ALWAYS be snug, but not interfere with breathing or circulation. After application, slide an open hand (flat) between the device and patient to ensure proper fit. ALWAYS monitor a patient to make sure the patient is not able to slide down, under the device, and fall off the chair seat (fig. 4). If a patient's body weight becomes suspended off the chair, chest compression and suffocation could result. Restraints with a pelvic piece may be necessary to reduce sliding down.


FIG. 4

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

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19252 REV B 120809

Posey® Safety Information for the Use of Posey Wheelchair/Gerichair Lap Products

⚠ WARNING: ALWAYS Monitor patients per facility policy.
Improper application or use of any restraint may result in serious injury or death.

RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(6)). Posey offers inservice training aids at no charge. Contact Posey online at www.posey.com or call toll-free at 1.800.447.6739 (press 5).

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's Individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.

NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. **ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:**
   - Aggressive or agitated patients; and
   - Patients deemed at risk of aspirating their vomit. This includes patients who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
   - Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.

2. **This device should ALWAYS be snug, but not interfere with breathing or circulation. After application, slide an open hand (flat) between the device and patient to ensure proper fit. ALWAYS monitor a patient to make sure the patient is not able to slide down, under the device, and fall off the chair seat. If a patient's body weight becomes suspended off the chair, chest compression and suffocation could result. Restraints with a pelvic piece may be necessary to reduce sliding down.**

3. **NEVER alter or repair this product. ALWAYS Inspect before each use:** Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook and loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

4. **NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.**

5. **NEVER expose this product to open flame, fire, smoking materials, or high heat sources.** Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

6. **NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.**

CLEANING INSTRUCTIONS:

Vinyl Products:

- Wipe Clean with mild detergent. OSHA approved intermediate level disinfectants can be used per manufacturer instructions. DO NOT use phenol and benzyl based disinfectants.
- After cleaning, products MUST be rinsed with water to remove any residual chemicals.
- Make sure products are completely dry before use.

⚠ WARNING

Test Zippers and hook and loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

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9200C REV B 092412

SELF-RELEASING CHAIR BELT

Applicable Products: REF 4220

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: Self-Releasing Chair Belt. For wheelchair use only.

Rx ONLY

POSEY SELF-RELEASING CHAIR BELT

REF 4220 Self-Releasing Easy-Apply Belt, Rear Removable Buckle

INDICATIONS FOR USE:

- Patients needing a reminder to call for assistance before exiting a chair, and are able to follow instructions.
- Patients needing a positioning device for added safety while in a chair.

CAUTION This product is designed for self-release. If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician.

CONTRAINDICATIONS:

- **DO NOT** use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal.
- **DO NOT** use on patients with: ostomy, colostomy, or G-tubes; hernias, severe Cardio Obstructive Pulmonary Disease (COPD); or with post-surgery tubes, incisions or monitoring lines. These could be disrupted by a restraint.
- **DO NOT** use on a patient who is unwilling or unable to follow instructions, and is at risk of a fall or re-injury from self-release.

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur: if the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

APPLICATION INSTRUCTIONS (Repeat steps 1-5 on both sides):

CAUTION Before use, check device for damage. Discard if you have any questions about patient safety.

1. Remove the end of the nylon strap from the plastic slide buckle on the connecting strap.
2. Lay the lap belt across the chair seat.
3. Bring the ends of the connecting straps down at a 45-degree angle between the seat and wheelchair sides (fig. 1). Pull it through to the rear of the wheelchair and wrap the strap around the vertical bar located behind and under the seat (fig. 2).

FIG. 1

4. Thread the strap back through the slide buckle and remove any slack (fig. 3).

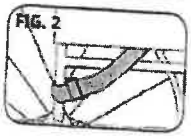
FIG. 2

5. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is tilted or adjusted. Make sure the slide buckle faces the inside of the wheelchair to keep the buckle out of the wheel spokes (fig. 4).

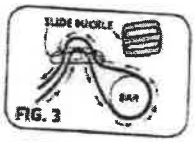

FIG. 3

6. Position the patient as far back in the seat as possible, with the buttocks against the back of the chair.
7. Connect the airline buckle so the belt is across the patient's lower lap. The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient.

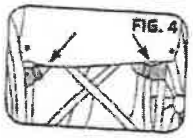
FIG. 4

WARNING

Heed these warnings to reduce the risk of serious injury or death:

- **There is a risk of chest compression or suffocation, if the patient's body weight is suspended off the chair seat. Use extreme caution with chair cushions. If a cushion dislodges, straps may loosen and allow the patient to slide off the seat (fig. 5).**
- **Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat and become suspended (fig. 5).**


FIG. 5

- STOP USE AT ONCE: if the patient is at risk to slide forward or down in the device.

  NOTE: A restraint with a pelvic piece will help to reduce the risk of sliding. See Posey Catalog.
- Before leaving the patient unattended, explain the purpose for the belt. Make sure the patient understands:
  - the need to call for assistance before exiting the chair; and
  - how to self-release in an emergency.

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

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19265 040809

Safety Information for the use of Posey Torso and Limb Restraining Products

Posey

⚠ WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death.

RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(5); Posey offers inservice training aids at no charge. Contact Posey online at www.posey.com or call toll-free at 1.800.447.6739.

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.

NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:

- Aggressive or agitated patients; and
- Patients deemed at risk of aspirating their vomit. This includes patients in the supine position, or who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
- Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.

HOW TO TIE THE POSEY QUICK-RELEASE TIE

1. Wrap the strap once around a movable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.
2. Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.
6. Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.

2. NEVER alter or repair this product. ALWAYS inspect before each use: Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook-and-loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

3. ALWAYS secure straps, to a movable part of the bed or chair frame, out of the patient's reach, using quick-release ties (see drawing below) or buckles. These allow easy release in the event of an accident or fire. Test to make sure straps cannot tighten, loosen, or slip and create excess slack. If this occurs, the patient may slide off the chair or bed, increasing the risk of serious injury or suffocation. Restraint release is an important part of facility fire and disaster drills. Straps can be cut with scissors in an emergency.
4. NEVER secure restraint strap to side rail.
5. NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.

6. NEVER expose this product to open flame, fire, smoking materials, or high heat sources. Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

7. NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.

LAUNDERING INSTRUCTIONS (if applicable):

- Fasten all buckles and locks to reduce risk of damage during wash and dry cycles. DO NOT put buckles or locks through extractors. For maximum life, launder in a laundry bag.
- Before laundering, zip up and turn the product inside out to protect zipper.
- Hook-and-loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the "hook" to the "loop" before laundering to help prevent lint buildup. As needed, use a stiff-bristle brush to remove lint from the "hook" side.
- These products, other than foam products, can be machine washed under CDC* guidelines for material soiled with blood or bodily fluid.

- For non-contaminated material, use lower temperature wash and dry cycles to extend product life.
- For foam products:

⚠ WARNING Test Zippers or hook-and-loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

*www.cdc.gov

SIZING TABLE FOR POSEY PRODUCTS

ALWAYS use the proper size product. Products that are too small or large may compromise patient comfort and could result in severe injury or death.

BINDING COLOR*	SIZE	WEIGHT lb. (kg)	CHEST in. (cm)
White	X-Small	60-115 (27-52)	25-32 (64-81)
Red	Small	112-160 (51-73)	31-37 (79-94)
Green	Medium	135-203 (61-92)	35-40 (89-102)
Yellow	Large	160-225 (73-102)	38-44 (97-112)
Blue	X-Large	180-247 (82-112)	42-48 (107-122)
Black	XX-Large	220-275 (100-125)	46-55 (117-140)
Yellow/Black	XXX-Large	265-305 (120-138)	54-60 (137-152)
Blue/Beige	XXXX-Large	295-340 (133-154)	58-64 (147-163)

* Posey Belts are not color-coded, but are sized according to this table. • Flame-retardant fabric is available on request. • Patient weight and size are a general indicator only. Consider individual physical characteristics to choose the right product for each patient. Refer to product label for specific sizing information.

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I920GB REV C 091516

SOFT BELT

Applicable Products: REF 4125, 4125L, 4125Q

APPLICATION INSTRUCTIONS

DESCRIPTION OF PRODUCT: Foam padded belt with cotton straps. For chair or hospital bed use.

Rx ONLY

INDICATIONS FOR USE:

- Patients assessed to be at risk of injury from a fall.
- Patients requiring a positioning device to assist medical treatment.
- Patients who need a supplemental restraint (5th point) of the thighs, pelvis, or chest, and who are already restrained at all four extremities.

CONTRAINDICATIONS:

- DO NOT use on a patient who is or becomes highly aggressive, combative, agitated, or suicidal, except as a 5th point restraint (see below).
- DO NOT use on patients with: ostomy, colostomy, or G-tubes; hernias, severe Cardio Obstructive Pulmonary Disease (COPD); or with post-surgery tubes, incisions or monitoring lines. These could be disrupted by a restraint.
- NEVER use a 5th point restraint on a patient:
  - With a pelvic fracture, supra-public catheter, ostomy, percutaneously placed feeding tube or recent incision.
  - With a history of cardiac or pulmonary disorders, or thoracic fractures.
  - To restrain head or neck.

ADVERSE REACTIONS

- Severe emotional, psychological, or physical problems may occur: If the applied device is uncomfortable; or if it severely limits movement. If symptoms of these problems ever appear for any reason, get help from a qualified medical authority and find a less restrictive, product or intervention.

POSEY SOFT BELT

REF 4125	Bed & chair; 4½"W x 16½" (11 cm x 42 cm) belt pad w/6 foot (2 m) straps
REF 4125Q	Bed & chair; 4½"W x 16½" (11 cm x 42 cm) belt pad, 6 foot (2 m) straps w/quick-release buckles
REF 4125L	Bed & chair; 4½"W x 30" (11 cm x 76 cm) belt pad w/8 foot (2.2/5 m) straps

APPLICATION INSTRUCTIONS:

WARNING Make sure patient wears proper undergarments to protect skin.

CAUTION Before use, check device for damage. Discard if you have any questions about patient safety.

APPLICATION INSTRUCTIONS: CHAIR

1. Position the patient as far back in the seat as possible, with the buttocks against the back of the chair.
2. Lay the lap belt across the patient's thighs with the foam facing in.
3. Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides (fig. 1). Criss-cross the straps behind the chair and draw them around the opposite side kick spurs.
4. Secure each connecting strap, out of the patient's reach, using a quick-release tie or buckle (figs. 2A and 2B). Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted.
5. The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient.

FIG. 1


FIG. 2A


FIG. 2B

APPLICATION INSTRUCTIONS: HOSPITAL BED

1. Bring the belt around the patient's waist with the foam pad facing in.
2. Criss-cross the straps behind the patient, and feed each strap through the positioning loops on the ends of the blue foam pad. The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient.
3. Secure each connecting strap around a movable part of the bed frame, at waist level, using a quick-release tie or buckle. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the bed is adjusted.

APPLICATION INSTRUCTIONS: 5TH POINT RESTRAINT

1. Bring the belt around the patient's waist, chest, or legs with the foam pad facing in. The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient.
2. Secure each connecting strap around a movable part of the bed frame, using quick-release ties or buckles. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the bed is adjusted.

NOTE: When using over the chest, the straps should go under the arms and attach at chest level, to a movable part of the bed frame. This will prevent the patient from sliding down and becoming entangled.

WARNING

Heed these warnings to reduce the risk of serious injury or death:

BED SAFETY

- ALWAYS use Hospital Bed Safety Workgroup (HBSW) (http://www.fda.gov/cdrh/beds/modguide.html) compliant side rails in the UP position and fill ALL gaps to reduce the risk of entrapment.

- Use side rail covers and gap protectors to help prevent the patient's body from going under, around, through or between the side rails. A failure to do so may result in serious injury or death if a patient becomes suspended or entrapped. Posey offers a full range of side rail pads and/or gap protectors to cover gaps.
- There is a risk of chest compression or suffocation if the patient's body weight is suspended off the mattress or chair seat. Use extreme caution with chair cushions. If a cushion dislodges, straps may loosen and allow the patient to slide off the seat (figs. 3, 4, and 5).
- Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat or mattress and become suspended or entrapped (figs. 3, 4, and 5).


FIG. 3

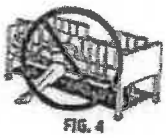
FIG. 4

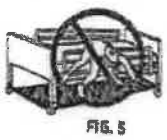
FIG. 5

- STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device; or is able to self-release.
  NOTE: A restraint with a pelvic piece will reduce the risk of sliding, or of the patient pulling the device over his or her head. See Posey Catalog.
- NEVER leave a patient requiring a 5th point restraint alone. One-on-one supervision is required in case of an emergency.

ADDITIONAL SAFETY AND LAUNDERING INSTRUCTIONS ON OTHER SIDE

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Safety Information for the use of Posey Torso and Limb Restraining Products

Posey

⚠ WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death.

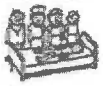
RX ONLY. NOT FOR HOME USE. Federal law (USA) restricts this device to sale by or on order of a physician. For use in a licensed healthcare facility only.

STAFF TRAINING: Staff must have on going training and be able to demonstrate competency to use this device in accord with: Posey instructions; your facility policies and state and federal regulations (Federal Register, Part IV, 42 CFR Part 482.13(e)(5) and (f)(6)); Posey offers inservice training aids at no charge. Contact Posey online at www.posey.com or call toll-free at 1.800.447.6739.

SELECTING THE RIGHT POSEY PRODUCT: Refer to the Posey catalog to help select the right device to meet individual patients' needs.

BEFORE APPLYING ANY RESTRAINT:

- Make a complete assessment of the patient to ensure restraint use is appropriate.
- Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment; or increase supervision.
- Use a restraint only when all other options have failed. Use the least restrictive device, for the shortest time, until you find a less restrictive alternative. Patients have the right to be free from restraint.
- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.
- A restraint must only be used in accord with the patient's Individualized Care Plan (ICP). The ICP is an assessment by an interdisciplinary team, which may include, but is not limited to: PT, OT, Nursing, the Physician, and Social Services. The ICP should include: restorative nursing; patient release; and pressure sore prevention.



NOTE: Just as patient behavior is not 100% predictable, no product is 100% foolproof. Patient safety requires regular reassessment and monitoring per facility policy. A product that worked in the past may be inappropriate if the patient's mental or physical health status changes. NEVER apply any product that you feel is unsafe. Consult with the proper medical authority if you have questions about patient safety.

⚠ ADDITIONAL WARNINGS:

1. ALWAYS monitor patient per facility policy. Be aware that constant monitoring may be required for:

- Aggressive or agitated patients; and
- Patients deemed at risk of aspirating their vomit. This includes patients in the supine position, or who are not able to sit up. If the patient vomits, he or she could aspirate the vomit and suffocate.
- Be prepared to intervene at the first sign of danger. Such patients require frequent review and evaluation of their physical and psychological status.

HOW TO TIE THE POSEY QUICK-RELEASE TIE

1. Wrap the strap once around a movable part of the bed frame leaving at least an 8" (20 cm) tail. Fold the loose end in half to create a loop and cross it over the other end.
2. Insert the folded strap where the straps cross over each other, as if tying a shoelace. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten. Test to make sure strap is secure and will not slide in any direction.
6. Repeat on other side. Practice quick-release ties to ensure the knot releases with one pull on the loose end of the strap.

2. NEVER alter or repair this product. ALWAYS inspect before each use: Check for broken stitches or parts; torn, cut or frayed material; or locks, buckles, or hook-and-loop fasteners that do not hold securely. DO NOT use soiled or damaged products. Doing so may result in serious injury or death. Dispose of damaged products per facility policy for BIOHAZARDOUS material.

3. ALWAYS secure straps, to a movable part of the bed or chair frame, out of the patient's reach, using quick-release ties (see drawing below) or buckles. These allow easy release in the event of an accident or fire. Test to make sure straps cannot tighten, loosen, or slip and create excess slack. If this occurs, the patient may slide off the chair or bed, increasing the risk of serious injury or suffocation. Restraint release is an important part of facility fire and disaster drills. Straps can be cut with scissors in an emergency.
4. NEVER secure restraint strap to side rail.
5. NEVER use Posey products on toilets, or on any chair or furniture that does not allow proper application as directed in the Application Instructions. DO NOT use at home.

6. NEVER expose this product to open flame, fire, smoking materials, or high heat sources. Some products may melt or ignite and burn. The facility smoking/no smoking policy should be strictly enforced.

7. NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash or sudden stop.

LAUNDERING INSTRUCTIONS (if applicable):

- Fasten all buckles and locks to reduce risk of damage during wash and dry cycles. DO NOT put buckles or locks through extractors. For maximum life, launder in a laundry bag.
- Before laundering, zip up and turn the product inside out to protect zipper.
- Hook-and-loop fasteners may collect lint after repeated use or laundering, reducing grip strength. Fasten the "hook" to the "loop" before laundering to help prevent lint buildup. As needed, use a stiff-bristle brush to remove lint from the "hook" side.
- These products, other than foam products, can be machine washed under CDC* guidelines for material soiled with blood or bodily fluid.

- For non-contaminated material, use lower temperature wash and dry cycles to extend product life.
- For foam products:

⚠WARNING: Test Zippers or hook-and-loop fasteners before each use. DISCARD device if it does not fasten securely.

STORAGE AND HANDLING:

- This device is designed for use in normal indoor environments.
- This device may be stored in ambient warehouse temperatures at normal humidity levels. Avoid excess moisture or high humidity that may damage product materials.

*www.cdc.gov

SIZING TABLE FOR POSEY PRODUCTS

ALWAYS use the proper size product. Products that are too small or large may compromise patient comfort and could result in severe injury or death.

BUCKLE COLOR	SIZE	WEIGHT lb. (kg.)	CHEST in. (cm)
White	X-Small	90-115 (27-52)	25-32 (64-81)
Red	Small	[illegible]	[illegible]
Green	Medium	135-203 (61-92)	35-40 (89-102)
Yellow	Large	[illegible]	[illegible]
Blue	X-Large	180-247 (82-112)	42-48 (107-122)
Black	XX-Large	[illegible]	[illegible]
Yellow/Black	XXX-Large	265-305 (120-138)	48-55 (122-140)
Blue/Black	XXXX-Large	[illegible]	54-60 (137-152)

• Posey Belts are not color-coded, but are sized according to this table. • Flame-retardant fabric is available on request. • Patient weight and size are a general indicator only. Consider individual physical characteristics to choose the right product for each patient. Refer to product label for specific sizing information.

Posey Company • 5635 Peck Road, Arcadia, CA 91006-0020 USA
Phone: 1.800.447.8739 • 1.626.443.3143 • Fax: 1.800.767.3933 • www.posey.com

EC REP MDSS GmbH Schiffgraben 41 D-30175 Hannover, Germany

CE

I82008 REV C 091516

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047012	A. BUILDING: _____ B. WING _____	C 09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 the Hoke County Department of Social Services conducted an annual survey and a complaint investigation on 09/11/17 - 09/15/17. The Hoke County Department of Social Services initiated the complaint investigation on 09/01/2017.	D 000		
D 058	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the maintenance cart was stored in a locked area resulting in hazardous chemicals and multiple tools being unattended and accessible to residents. The findings are: Observation of the hallway near the dayroom on the middle hallway on 09/12/17 at 10:11 a.m. revealed: -The middle hallway started at the nurses' station on the assisted living side and led to the double door entrance to the special care unit (SCU). -There was a two shelf maintenance cart parked in the hallway near the dayroom that was	D 058		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Capps Clark — TITLE: Administrator — (X6) DATE: 11/09/2017.

STATE FORM 6899 2Y2D11 If continuation sheet 1 of 28

11-29-17 TELEPHONE CALL to Facility's Administrator & discussed Plan of Correction submitted by the facility. The POC for all rules areas except .0401 Personal Care & Supervision, were ~~NOT~~ ~~Excepted~~ Accepted & Administrator to resubmit Plan of Correction by 11-29-17 - Jane Kinney, RN 11-29-17

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D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the maintenance cart was stored in a locked area resulting in hazardous chemicals and multiple tools being unattended and accessible to residents. The findings are: Observation of the hallway near the dayroom on the middle hallway on 09/12/17 at 10:11 a.m. revealed: -The middle hallway started at the nurses' station on the assisted living side and led to the double door entrance to the special care unit (SCU). -There was a two shelf maintenance cart parked in the hallway near the dayroom that was	D 056		

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D 056	Continued From page 1 unattended. -The doors to the day room were closed. -There were no staff or residents in the hallway on the middle hall. -There were several items on the top shelf of the maintenance cart including a notebook with a thermometer clipped to it, a metal sink stopper, a wrench, a white styrofoam cup, and two boxes. -The bottom shelf had multiple tools and maintenance supplies. -There was a can of electronics dust cleaner, a spray can of WD-40, a spray can of insect killer, and a spray can of baseboard stripper. -There was a white box with other chemicals, including glue. -There were two large tubes of caulking and a flashlight. -There were power tools, including an electric drill. -There were multiple tools including a hammer, a rubber mallet, wrench, pliers, and a small saw. Observation on 09/12/17 at 10:16 a.m. revealed: -A staff person rolled a laundry cart down the middle hall to the SCU. -The staff person walked by the maintenance cart and did not stop to secure the cart. Interview with the Director of Resident Services (DRS) on 09/12/17 at 10:20 a.m. revealed: -There were at least 7 residents on the assisted living side who were disoriented or confused as times. -Three of those resident wore wander guard bracelets. -There was one resident who asked frequently for scissors to cut off her wander guard bracelet. -She was not aware the maintenance cart was left unattended on the middle hall. -The maintenance cart was supposed to be	D 056		

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D 056	Continued From page 2 locked up when maintenance staff was not with the cart. -The maintenance staff must have left the cart in the hallway. -She did not know where the maintenance staff was located. -She would page him. Observation on 09/12/17 from 10:25 a.m. - 10:30 a.m. revealed: -The DRS paged the maintenance staff over the intercom system but he did not respond. -The DRS tried to find the maintenance staff by checking up and down the halls but she could not find him. -The DRS tried to put the maintenance cart in the maintenance closet but she did not have a key that would open the maintenance closet. -The DRS locked the maintenance cart in the central supply closet at 10:30 a.m. Interview with the maintenance staff on 09/12/17 at 3:57 p.m. revealed: -He left the maintenance cart in the middle hallway this morning while he was in training in the dayroom. -He left the maintenance cart in the hallway in case he was called out of training to do any repairs. -He was in training that morning on 09/12/17 from 9:00 a.m. to 12:00 noon. -They started the training back at 1:00 p.m. and they had just finished the training. -He usually kept the maintenance cart locked in the maintenance closet.	D 056		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks	D 161		

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D 161	Continued From page 3 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 7 non-licensed staff sampled (B) had been competency validated for licensed health professional support tasks including assistance with ambulation with assistive devices, transferring semi-ambulatory or non-ambulatory residents, feeding techniques for residents with swallowing problems, and care and use of physical restraints prior to the staff performing these tasks. The findings are: Review of Staff B's personnel file revealed: -She was hired as a personal care aide (PCA) on 08/01/17. -There was no licensed health professional support (LHPS) competency validation for Staff B. Observation of Staff B in the Special Care Unit (SCU) on 09/11/17 at 4:48 p.m. revealed: -Staff B was in the hallway outside of Resident #13's room.	D 161		

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D 161	Continued From page 4 -Resident #13 was sitting in her wheelchair in the hallway. -Staff B wrapped the straps of a soft belt restraint around Resident #13's chest area and around the back of the wheelchair seat. -Staff B wrapped the straps around the resident 3 times and tied the straps in a knot behind the back of the wheelchair. -Staff B then pushed Resident #13 in the wheelchair down the hall to the dayroom. -Staff B was not assisted by any other staff during these tasks. Interview with Staff B on 09/11/17 at 5:00 p.m. revealed: -This was the first time she had used the soft belt restraint for Resident #13. -She put it on the resident because the resident did not have a seat belt in her wheelchair and she wanted to keep the resident from sliding out of the seat. -She had not been trained on how to use the soft belt restraint. Interview with the Special Care Unit Coordinator (SCUC) on 09/15/17 at 7:02 p.m. revealed: -New PCAs usually shadowed and worked with other staff for a couple of weeks after they were hired. -After the 2 weeks training with other staff, the SCUC would let the Registered Nurse (RN) Consultant or the Administrator know when the training was completed. -She was not aware Staff B had not been validated for LHPS tasks. -She was not aware the LHPS validation had to be completed prior to staff performing the tasks. -Staff B had been performing LHPS tasks independently since she finished the two weeks of training with other staff.	D 161		

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D 161	Continued From page 5 -Staff B would have completed her two weeks training sometime around the middle of 08/2017. -Staff B performed LHPS tasks independently including ambulation with assistive devices, transferring, feeding, and physical restraints. Interview with Staff B on 09/15/17 at 7:04 p.m. revealed: -She had worked at the facility as a PCA since August 2017. -She assisted residents with tasks such as ambulation with assistive devices, transferring, feeding, and physical restraints, including bedrails and seat belts. -She performed these tasks independently. -She had worked at another assisted living facility prior to this facility and she had performed these tasks prior to working at this facility. -She had not been observed or checked off by a RN to perform these tasks. -She was not sure when the facility's RN Consultant planned to check her off on the LHPS tasks. Interview with the Administrator's Assistant on 09/15/17 at 6:55 p.m. revealed: -She was responsible for the personnel files and staff qualifications. -Staff B started working as a PCA at the facility in August 2017. -New PCAs usually shadow / train with other staff about 2 weeks after hire. -Staff B had been working independently and performing LHPS tasks since she finished shadowing. -She had scheduled Staff B to have her LHPS validation done with the facility's RN Consultant on 09/20/17. -She was not aware the LHPS validation had to be done prior to staff performing the tasks.	D 161		

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D 161	Continued From page 6 -The RN Consultant came to the facility 2 days a week. -She would contact the RN Consultant about getting the LHPS validation done sooner for Staff B.	D 161		
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule: (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to obtain documentation by a medical provider giving reason for a resident discharge for 1 of 1 residents (#4) who was	D 228		

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D 228	Continued From page 7 discharged from the facility. The findings are: Review of Resident #4's FL-2 dated 7/11/17 revealed diagnoses included dementia, old cerebral infarct, expressive aphasia, chronic kidney disease, hypertension and seizures. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 8/05/16. Review of the office manager's notes revealed on 9/05/17 at 8:30am, a representative from a facility in another county stated she would be at the facility at 1:00pm to pick up Resident #4 and the resident was discharged on 9/05/17. Telephone interview with Resident #4's family member on 9/12/17 at 12:15pm revealed: -The Administrator and the Director of Resident Services (DRS) met with the family member in July 2017 (did not know the exact date) and informed her that Resident #4 had attacked a female resident. -Since that was the 3rd incident of attack on residents, Resident #4 "had to go". The Administrator could not keep him because other family members were calling her concerned about the safety of the other residents. -The DRS informed the family member the resident could not stay at the facility and the Administrator wanted him gone that night. -The following day, the Administrator started calling other facilities to find the resident somewhere to go. -The DRS or the Administrator contacted the family member almost daily for about 3-4 weeks until the local Department of Social Services	D 228		

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D 228	Continued From page 8 (DSS) got involved and informed the resident's family to take the resident out of the facility. -DSS informed the family that the resident had rights and the DSS staff would assist the family with finding a facility for the resident. -The family member accompanied the resident to a medical appointment to his primary physician and the physician did not tell the family he had ordered the resident discharge from the facility. -The physician did not inform the family the facility had contacted him about discharging the resident. -The facility never gave the resident a 30 day discharge notice. -The resident was discharged to a facility in another county on 9/5/17. Review of Resident #4's Resident Register revealed the Discharge notice form was not completed or signed by the Administrator or a staff from the facility. Telephone interview with Resident #4's physician on 9/13/17 at 10:15am revealed: -The facility did not inform him they could not provide care to meet the resident's needs and planned to discharge the resident. -He had not given an order to discharge the resident, but the resident had been transferred to another facility in another county. -There was documentation in the resident's record regarding a call from an Adult Protective Services staff on 7/17/17, who reported Resident #4 had assaulted a resident and would be removed from the facility Interview with the DRS on 9/13/17 at 4:15pm revealed: -After the resident attacked 3 residents, two in April 2017 and one in July 2017, the Administrator	D 228		

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D 228	Continued From page 9 talked to the family about taking the resident out of the facility immediately. -She contacted multiple facilities and sent the resident's FL-2 to those facilities, but he was difficult to place due to his behaviors. -The resident was discharged to an adult care facility in another county on 9/05/17. -She did not know if the resident's physician was contacted and a discharge order obtained. Interview with the Administrator on 9/15/17 at 11:10am revealed: -The Administrator did not complete a 30 day Notice of Discharge/Transfer because she felt the resident needed to be discharged immediately. -He was a danger to other residents and the facility could not provide appropriate care. -The resident was isolated to his room from 7/10/17 until he was discharged on 9/05/17. -The facility did not obtain a statement or order from the resident's physician for discharge because she did not think she needed an order from the physician. -The Administrator gave the family a verbal notice of immediate discharge in July 2017, but the resident was not discharged until 9/05/17. -The family was not informed of the resident's right to appeal the discharge because this was an emergency discharge.	D 228		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as	D 234		

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	HAL047012	A. BUILDING: _____ B. WING _____	C 09/15/2017

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D 234	Continued From page 10 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, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 5 residents sampled (#2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #3's current FL-2 dated 04/06/17 revealed diagnoses included malignant neoplasm of hypopharynx, Clostridium difficile colonization, Escherichia coli urinary tract infection, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, asthma, hypertension, osteoarthritis, congestive heart failure, anemia, irritable bowel syndrome, Parkinson's disease, depression, and systemic inflammatory response syndrome. Review of Resident #3's Resident Register revealed she was admitted to the facility on 05/12/16. Review of Resident #3's tuberculosis (TB) tests revealed: -There was one TB skin test placed on 09/28/16 and read as negative on 09/30/16. -There was a computer printed form from a skilled nursing facility with one TB skin test placed on 04/13/16 and documented as negative (0mm).	D 234		

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D 234	Continued From page 11 -There was no documentation on the form to indicate who placed or read the TB skin test or when it was read. -There was no electronic or written signature on the form. -There was no documentation of any other TB skin tests in the record. Interviews with the Director of Resident Services (DRS) on 09/14/17 at 5:30 p.m. and 09/15/17 at 12:37 p.m. revealed: -She was responsible for making sure TB skin tests were on file for residents living on the assisted living side of the facility. -She was not aware the TB skin test for Resident #3 was incomplete. -She would contact the skilled nursing facility to find out if they had more information on file for the TB skin test placed on 04/13/16. No further information was obtained by the facility by the end of the survey on 09/15/17. 2. Review of Resident #2's FL-2 dated 11/21/16 revealed diagnoses included dementia, hypertension, anxiety, osteoarthritis lower leg, lumbago, schizophrenia, delusional disorder, bipolar disorder, depression with psychotic disorder. Review of Resident #2's tuberculosis (TB) skin tests revealed: -There was a TB skin test placed on 02/09/10 and read as negative (0mm) on 02/11/10. -There was a second TB skin test placed on 08/23/10 and read as positive (20mm) on 08/25/10. -There was no documentation that a chest X-ray was done after the positive TB skin test on 08/25/10.	D 234		

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D 234	Continued From page 12 Interview with the Special Care Unit Coordinator (SCUC) on 09/14/17 at 5:00 p.m. -She did not work in the special care unit (SCU) in 2010 when Resident #2 was admitted. -She was not aware Resident #2 had a positive TB skin test. -She would contact the primary care provider to see if a chest x-ray had been done. Review of results of a chest x-ray dated 09/15/17 for Resident #2 revealed: -Resident #2 had a portable chest x-ray completed at the facility on 09/15/17. -Both lungs were clear with no evidence of TB. No documentation of a chest x-ray prior to 09/15/17 for Resident #2 was provided.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 6 residents (Resident #2, #11) in accordance with the resident's assessed needs	D 269		

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D 269	Continued From page 13 and care plan which resulted in Resident #2 not being transferred using the hoyer lift and Resident #11's fingernails not being cut. The findings are: 1.Review of Resident #2's FL-2 dated 11/21/16 revealed: -Diagnoses included dementia, hypertension, anxiety, osteoarthrosis lower leg, lumbago, schizophrenia, delusional disorder, bipolar disorder, depression with psychotic disorder. -Resident #2 was semi-ambulatory. Review of Resident #2's Care Plan dated 6/15/17 revealed: -The resident required an assistive device for all ambulation. -The resident required assistance with transferring. Review of note faxed to Resident#2's Primary Care Provider (PCP) dated 09/20/16 revealed: -Resident #2 had a decline in mobility. -The facility requested the use of the hoyer lift due to having to use 4-5 staff for transfers. Review of a prescription for Resident #2 dated 10/13/16 revealed an order for a hoyer lift. Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 08/10/17 revealed: -Staff should transfer Resident #2 with hoyer lift at all times. -Resident #2 was alert but confused at times. Review of an incident/accident report dated 08/28/17 revealed: -The Personal Care Aide (PCA) tried to assist Resident #2 on the shower chair.	D 269		

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D 269	Continued From page 14 -Resident #2 was assisted to the floor. -The PCA did not use the hoyer lift to transfer Resident #2. Interview with a PCA on 09/12/17 at 3:50 pm revealed: -It took three staff to transfer Resident #2 when the hoyer lift was not used. -Resident #2 was sometimes transferred from her chair to the bed without using the hoyer lift. -If Resident #2's bed was up high, Resident #2 was slid into the chair by the PCAs. -On 08/28/17, while being showered, Resident #2 was assisted to the floor to prevent a fall. -She was called to help assist another PCA to get Resident #2 off the floor. -Resident #2 had to be lifted off the floor by four PCAs in the shower room. -The hoyer lift was not being used to transfer Resident #2 during the incident on 08/28/17. Interview with a second PCA on 09/14/17 at 4:00 pm revealed: -Resident #2 was being transferred from the wheelchair to the shower chair, on 08/28/17, when she had to be assisted to the floor to prevent a fall. -Usually two people assisted with Resident #2. -Four PCAs had to lift Resident #2 off the floor during the incident. -The hoyer lift was not being used to transfer Resident #2. Interview with a third PCA on 09/15/17 at 7:15pm revealed: -Another PCA was giving Resident #2 a shower. -She was called to assist with lifting Resident #2 off the floor. -The PCA that was giving the shower never used the lift to transfer Resident #2.	D 269		

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D 269	Continued From page 15 - The hoyer lift was not being used when the incident happened. -The PCAs don't use the hoyer lift like they should. Interview with the Special Care Unit Coordinator (SCUC) on 09/14/17 at 4:20pm revealed: -Resident.#2 had been given a shower and was being transferred when she fell on 08/28/17. -Two other PCAs were called to help lift Resident #2 off the floor. -There was nothing in writing that instructed staff to use the hoyer lift on Resident #2 at all times. Interview with Resident #2's guardian on 09/14/17 at 5:40pm revealed: -Facility staff called the guardian on 08/28/17 and stated the PCAs were transferring the resident without using the hoyer lift, and Resident #2 had to be sat on the floor in the shower room to prevent Resident #2 from falling. -Resident #2 was ambulatory with a walker when she was admitted to the facility. -Resident #2 fell about two years ago at the facility. -Resident #2 was afraid of falling again. Observation on 09/12/17 at 12:45pm revealed: -Two PCAs assisted Resident #2 to bed to be changed. -The hoyer lift was used. -Resident #2 appeared to be uneasy as the lift was being pumped up. -The PCAs talked with Resident #2 throughout the entire process. -Resident #2 did not holler out while she was being transferred and changed. 2.Review of Resident #11's FL-2 dated 2/21/17	D 269		

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D 269	Continued From page 16 revealed: -Diagnoses included depression, contracture joint of the hand, posterior rhinorrhea, diabetic, hyperlipidemia, hypertension, history of cerebrovascular accident, chronic kidney disease stage 1, anxiety, constipation, seizures. -Resident #11 was admitted to the facility on 02/10/16. -Resident #11 required personal care assistance with bathing. Review of a Plan of Service Summary dated 11/22/16 revealed Resident #11's nail care was to be done on Thursdays on 2nd shift. Observation on 09/11/17 at 4:00 pm revealed: -Resident #11's nails were dirty on the right hand. -The nails on the contracted left hand were long and appeared to dig into the skin. Interview with the facility's Registered Nurse (RN) on 09/13/17 at 5:45 pm revealed: -The RN could trim diabetic residents' nails but the PCAs could not. - The RN was not sure if the PCAs could use a file or emery board on diabetic residents' nails. Interview with the Director of Resident Services (DRS) on 09/12/17 at 3:30 pm and on 09/15/17 at 11:00 am revealed: -The RN was responsible for keeping the diabetic residents' nails cut or trimmed. -The PCAs were to inform the RN whose nails needed to be cut or trimmed. -A Medication Aide (MA) at the facility had cut Resident #11's nails; she was not sure when. Interview with a MA on 09/15/17 at 1:00 pm revealed: -MAs were allowed to cut diabetic residents' nails.	D 269		

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D 269	Continued From page 17 -The MA had not been notified lately that Resident #11's nails needed trimming. -It had been a month since the MA trimmed Resident #11's fingernails. -The MA trimmed the nails on both of Resident 11's hands. Interview with the Administrator on 09/15/17 at 11:10 am revealed Resident #11 could do a few things with the" good hand" but could not use it to cut the nails on the contracted hand. Interview with Resident #11 on 09/11/17 at 4:15 pm and on 09/13/17 at 4:30 pm revealed: -Shower days were Tuesday, Thursday and Saturday on second shift. -The resident's fingernails on her contracted hand were hurting. -The nails on the contracted left-hand stuck into the palm of her hand. -Resident #11 was given a washcloth to put in her contracted hand to keep her nails from digging into her skin. -Resident #11 was not assisted by staff when putting the washcloth in her contracted hand. -Resident #11 was informed by staff that PCAs were not allowed to clip diabetic residents' nails. -The MAs said they don't have time to clips nails, because they were busy. -Resident #11 asked for pain pills to relieve the pain of her nails sticking into her skin. -The pain pills helped at times. The facility's failure to provide personal care resulted in one resident (#2) who required a 4 person assist to be lifted off the floor and having to be sat on the floor to prevent a fall; and another resident (#11) experiencing pain and increased risk for infection because of her fingernails not being cut. The noncompliance was	D 269		

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D 269	Continued From page 18 detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ Review of the facility's plan of protection dated 09/15/17 revealed: -PCS tasks will be reviewed with plan of service outlined by outside provider. -Required tasks will be put into accuflo system for reminder of tasks needed to be completed. -LHPS tasks will be reviewed with staff members -Personal care tasks will need to be monitored by PCA supervisors on each shift. -RCC and SCU coordinator will review tasks completed verses tasks ordered. -LHPS tasks list need to be reviewed with staff. -Schedule of PCA tasks need to be reviewed to ensure all residents are on schedules and all needs addressed. -Any training required will be completed by the RCC and SCU coordinator or RN Consultant to ensure staff knowledgeable of techniques required. -PCS tasks, documentation and reviews will be audited. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2017.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 19 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 2 of 5 residents sampled (#1 and #4) were met by failing to notify the health care provider of a resident (#1) who was experiencing withdrawal symptoms from not receiving scheduled pain medication and a resident (#4) who became totally dependent on staff, bedbound, drowsy and had multiple falls after receiving an antianxiety medication. The findings are: 1. Review of Resident #4's current FL-2 dated 7/11/17 revealed diagnoses included dementia, old cerebral infarct, expressive aphasia, chronic kidney disease, hypertension and seizures. Review of the office manager's notes revealed on 9/05/17 at 8:30am, a representative from a facility in another county stated she would be at the facility at 1:00pm to pick up Resident #4 and the resident was discharged on 9/05/17. a. Review of the facility's Incident/Accident Reports for Resident #4 revealed: -On 4/16/17 at 1:50pm, Resident #4 assaulted a resident and documentation revealed the physician was not notified. -On 4/21/17 at 9:15pm, Resident #4 assaulted a resident and documentation revealed the physician was not notified. Review of Resident #4's Nurse's Progress Notes dated 7/10/17 revealed: -"Around 4:40pm, another resident had reported that [Resident #4] was assaulting a female resident in the day room".	D 273		

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D 273	Continued From page 20 -"And now [Resident #4] is in the dining room arguing with the female resident. [Resident #4] was taunting the female resident, laughing at her, she was crying." -"I instructed [Resident #4] to please be quiet and would he please have a seat. He did, but he still was trying to argue with the female resident until I removed her out of the dining room". Interview with the Director of Resident Services (DRS) on 9/13/17 at 4:15pm revealed: -Resident #4 attacked 3 residents at 3 different times (2 times in April 2017 and 1 time in July 2017). -The resident was normally quiet and did not bother anyone. -He did not bother any of the residents from May 2017 until July 2017. -After the last incident in July 2017, the DRS talked to the resident who was emotional and crying, but unable to communicate his thoughts. -After each incident, the family was informed of the resident's behavior. The local police were notified after the last incident, but the resident's physician was not informed of any of the incidents. Interview with the 2nd shift supervisor on 9/13/17 at 4:00pm revealed: -She did not know if the DRS reported the 3 incidents of resident assaults to Resident #4's physician. -Resident #4 was transported to his physician's office on 7/11/17 after the last assault which occurred on 7/10/17. Review of documentation on a written report to Resident #4's physician from the facility dated 7/11/17 revealed, "Can you please see what you can do for this resident. He has hit 3	D 273		

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D 273	Continued From page 21 other residents on different occasions. He shows no signs of this behavior, but without any signs he will start hitting other residents with his fists." Review of the physician's reply and orders dated 7/11/17 (on the same form) revealed: - "I saw [Resident #4] today and he is stable." -"We are starting Klonopin (used to treat anxiety) 1mg 3 times a day for behavioral issues". Interview with Resident #4's physician on 9/13/17 at 10:15am revealed: -The facility only reported Resident #4 had hit other residents on 7/11/17. -The physician was not aware of previous incidents of Resident #4 hitting/attacking other residents. -He would have expected the facility to report any changes in residents' behavior which included abusive behaviors to rule out any physical/medical changes immediately. Interview with the Administrator on 9/13/17 at 5:55pm revealed: -During the first incident (no date provided), Resident #4 was trying to keep the female resident from going out the end door. -The incident in the day room occurred (no date provided) when Resident #4 "hauled off" and hit another resident in the chest. -After that incident, the family was notified, but could not come that day. The family was told something had to be done with Resident #4. b. Review of a physician's order for Resident #4 dated 7/11/17 revealed an order for Klonopin (used to treat anxiety) 1mg 3 times a day. Review of Resident #4's July 2017 medication	D 273		

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D 273	Continued From page 22 administration record (MAR) revealed: -On 7/11/17, there was no documentation the resident was administered Klonopin. -On 7/12/17, Klonopin 1mg was documented as administered at 8:00am and 8:00pm. The 2:00pm dose was not documented as administered -On 7/13/17, Klonopin 1mg was documented as administered at 8:00am, 2:00pm and 8:00pm. -On 7/14/17, Klonopin 1mg was documented as administered at 8:00am. The 2:00pm dose and the 8:00pm doses were not documented as administered. -On 7/15/17, Klonopin 1mg was documented as administered at 8:00am and 8:00pm. The 2:00pm dose and the 8:00pm dose was not documented as administered. -The Klonopin was documented as discontinued on 7/16/17. Review of an Incident/Accident Report for Resident #4 dated 7/16/17 revealed: -At 5:50pm, Resident #4 was found on the floor by staff. The resident stated he was trying to make it to the bathroom to vomit. However, he couldn't make it in time and the resident slid down in the vomit on the floor. - Range of motion was done by staff. -The family was notified, and there was no documentation that the physician was notified. Review of an Incident/Accident Report for Resident #4 dated 7/16/17 revealed: -At 10:50pm, Resident #4 was found on the floor. Range of motion was done by the staff. -The family was notified. The resident refused to go to the hospital and the physician was not notified. Review of an Incident/Accident Report for Resident #4 dated 7/17/17 revealed:	D 273		

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D 273	Continued From page 23 -At 5:18pm, the resident was observed by a staff lying on the floor complaining of left side pain. -Range of motion was done. The resident was transported to the hospital by emergency medical service. -The family could not be reached, and there was no documentation that the physician was notified. Review of an Incident/Accident Report for Resident #4 dated 7/17/17 revealed: -At 9:56pm, the resident was observed sitting on the floor but wasn't hurt. - Range of motion was done and the resident was able to move all limbs. - The resident was assisted to bed, and had no complaints. - There was no documentation that the physician was notified. Review of Resident #4's Nurses Progress Notes revealed: -On 7/18/17 at 5:30am, the resident was found on the floor on his right knee holding onto the air conditioning unit. At 6:00am, the resident was back in bed with his right leg hanging over the bed. -On 7/18/17 at 7:00pm, the resident was found on the floor, asked was he hurt, and he pointed to his chest and stomach. Asked if he wanted to go to the emergency room, he refused [to go to the emergency room]. -There was no documentation in the progress notes that the physician was notified of either fall on 7/18/17. Review of Emergency Department (ED) records for Resident #4 dated 7/18/17 revealed: -The resident was seen in the ED at 10:20am for accidental fall. -The resident was treated for an abrasion to the	D 273		

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D 273	Continued From page 24 skin (site not specified) and sent back to the facility. Interview with Resident #4's family member on 9/12/17 at 12:15pm revealed: -The family was informed by the Administrator and the DRS on 7/10/17 the resident had "hit" other residents (2 ladies in April 2017 and his roommate on 7/10/17) and they wanted him "to go". He had to leave the facility. -The family accompanied the resident to his physician's office on 7/11/17 and was informed by the physician that the facility had reported (today) the resident's behavior and requested medication to control his behavior. -The physician ordered a new medication which was started the next day. -The medication made the resident a "zombie"; he could not walk without assistance and required the use of a wheelchair and assistance with bathing, dressing and eating. -The resident was in bed and slept almost all day except when staff assisted him out of bed. -The resident was independent and did not require any assistance before starting the new medication. -After a week on the medication, the family talked to the DRS and requested the medication be stopped because it was "killing him". -The resident fell in his room several times in July 2017, even after the medication was stopped. - The resident vomited and was found on the floor by staff after he slipped down in the vomit. -She did not know if the facility reported the falls or vomit to the resident's physician. Confidential staff interview revealed: -The facility asked the physician to put the resident on medication to calm him after he hit a resident in July 2017.	D 273		

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D 273	Continued From page 25 -After the resident started the medication, he was in a "comatose state" almost immediately. -He was in the bed asleep during the day and looked like he was dead at times. - He did not respond when his name was called for 2-3 weeks. -The resident fell in his room at least 3 times and was only taken to the emergency room once for evaluation after a fall. -The family had talked to the DRS before the falls about sending the resident to the hospital to "get that medication out of his system" but she and the Administrator refused to send him out. -A supervisor refused to administer the medication because the resident was too sedated, but she did not call the physician. -The resident was taken off the medication after about a week, but it took 2-3 weeks before the resident was normal (ambulating, providing own personal care, awake and alert). Interview with a 2nd shift supervisor/medication aide (MA) on 9/13/17 at 4:00pm revealed: -Resident #4 became drowsy and difficult to wake up after starting Klonopin. -The resident had to be fed and the staff had to bathe and dress the resident. -The resident had to be assisted out of bed into a wheelchair because he was so drowsy. -The 2nd shift MA did not administer the Klonopin after the resident became drowsy. -The symptoms were reported to the DRS, but the MA did not know if the DRS reported the symptoms to the physician. -The Klonopin was stopped after about a week but the resident remained drowsy for about 2-3 weeks and had 3 or 4 falls in his room. -The resident was only sent to the emergency room 1 time after a fall. -She did not know if the resident's physician was	D 273		

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D 273	Continued From page 26 informed of the falls or the side effects of the Klonopin. -The DRS was responsible for reporting resident changes to the medical providers. Interview with Resident #4's physician on 9/13/17 at 10:15am revealed: -The facility had not reported the multiple falls the resident had after starting Klonopin. -The facility did not report the resident had vomited while receiving the medication and was not treated for vomiting. -The facility had not reported the resident being sedated, or becoming dependent on staff for personal care immediately after starting the medication. -The facility informed the physician on 7/17/17 that the Klonopin had the resident very sedated, and the medication was discontinued. Interview with the DRS on 9/13/17 at 4:15pm revealed: -She contacted the resident's physician and reported the resident had assaulted other residents and needed to be started on medication to control his behaviors. -Resident #4 was started on Klonopin in July 2017 to control behavior issues and he was "zonked" out for about a week. -The resident was very sleepy/drowsy (stayed in the bed), and required total care, even with feeding. -After about 1 week on the medication, she contacted the resident's physician and the Klonopin was discontinued. In about 3-4 days, the resident started to get up and feed himself, but continued to require assistance with personal care. -Even though the symtoms started after a few doses of the Klonopin, she did not report any	D 273		

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D 273	Continued From page 27 symptoms to the physician before 7/17/17. -He had a few falls in his room while receiving the Klonopin, which included slipping in his vomit in his room. -She did not know if the resident's physician was informed of the falls and the vomiting. He was transferred to the emergency room after one fall. -The DSR was responsible for notifying the medical providers of resident changes. Interview with the Administrator on 9/13/17 at 5:55pm revealed: -During that time frame, when the resident was isolated in his room, the resident had two falls, and he was sent out to the emergency room one time (did not recall the date). -The physician was not contacted about isolating Resident #4. -The Administrator called the family and "told them what she was going to do." -She did not know if the family member conveyed to the physician about the resident being isolated. -The Administrator did not think it was a problem for Resident #4 to be isolated in his room because the door was open. -"I had no other choice. What was I supposed to do, just keep him in the general population and let him hurt people?" 2. Review of Resident #1's current FL-2 dated 7/17/17 revealed: -Diagnoses included fibromyalgia, peripheral neuropathy, multiple sclerosis, hypertension, anxiety and paranoia, seizure disorder and atrial fibrillation. -There was an order for Oxycodone 10mg, one tablet, every 6 hours (Oxycodone is an opioid pain medication used to treat moderate to severe pain and can be addictive. Abrupt discontinuation	D 273		

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D 273	Continued From page 28 of the medication could lead to symptoms such as restlessness, a runny nose, muscle aches, insomnia, irritability, and gastrointestinal complaints). Interview with Resident #1 on 9/11/17 at 11:45am revealed: -The resident had been at the facility since June 2016. -The resident had chronic and severe pain from neuropathy, fractures of his back, fibromyalgia and other problems. -The resident had been on Oxycodone for a few years and the medication controlled the severe pain. -The resident had been on Oxycodone 10mg every 6 hours for pain since admission to the facility in 2016. -The resident visited the physician at the pain clinic every other month and the physician always wrote 2 prescriptions for Oxycodone. One prescription was filled immediately and the other prescription was dated for the next month and filled on that date. -The resident received the Oxycodone every 6 hours until Sunday morning (9/10/17) with the last dose being administered at 12:15am. -The facility should have sent the prescription to the pharmacy to be filled on 9/9/17 (on a Saturday). -The Director of Resident Services (DRS) locked the prescription in her desk and the weekend staff did not fax the prescription to the pharmacy because they did not have access to the locked desk over the weekend. -The resident started having withdrawal symptoms Sunday evening (9/10/17) on 2nd shift and continued to have symptoms today. -The resident described the withdrawal symptoms as sleeplessness, irritation, runny diarrhea (back	D 273		

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D 273	Continued From page 29 and forth to the bathroom throughout the night and 4-5 times this morning), runny nose (nose bleeds when he blew his nose), burning eyes, a sinus headache, and severe lower back pain rated at 8 to 10 (10 being the highest level of pain on the pain scale) since Sunday. -The resident attempted to eat lunch today in the dining room but could not eat due to having diarrhea, headache, and lower back pain. -The resident "raised cane" with the staff on Sunday about Oxycodone not being available and the staff called the DRS at her home. -The resident informed the staff on Sunday and today of the withdrawal symptoms, but no one called the physician. Interview with a 2nd shift supervisor on 9/14/17 at 5:15pm revealed: -She worked on 9/9/17 and Resident #1 received his 6:00pm dose of Oxycodone. -On 9/10/17, the resident's Oxycodone was not available and the resident did not receive his 6:00pm dose of the medication. -The resident complained of "sinus infection", back pain and diarrhea Sunday but the medical provider was not informed. Interview with the DRS on 9/14/17 at 6:10pm revealed: -Resident #1 had a prescription for Oxycodone, dated 9/9/17, which was not sent to the facility pharmacy to be filled because the facility was in the process of changing pharmacies at the time the prescription was dated to be filled. -The Oxycodone was not available for 1 day (24 hours) but was filled on 9/11/17. -A staff called the DRS Sunday night (9/10/17) and informed her the resident was out of Oxycodone and was complaining of withdrawal symptoms.	D 273		

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D 273	Continued From page 30 -The resident's prescription was locked in her desk drawer and was not sent to the pharmacy until Monday (9/11/17). -She did not inform the resident's medical provider at the pain clinic or the resident's primary physician of the reported withdrawal symptoms from not receiving the ordered Oxycodone. Interview with the Administrator on 9/15/17 revealed: -She was not aware Resident #1 had not received his Oxycodone for more than 24 hours and had withdrawal symptoms. -The facility was changing pharmacies and the process started on 9/7/17. It took several days to complete the changeover; therefore the Oxycodone prescription was not filled on the prescription date (9/9/17). -She expected the supervisors or DRS to report medical changes, such as withdrawal symptoms, to the medical providers. Telephone interview with Resident #1's medical provider at a local pain clinic on 9/15/17 at 9:05am revealed: -Resident #1 was seen at the pain clinic every other month to evaluate pain and the effectiveness/problems with pain medication. -The resident had an order for Oxycodone 10mg, one tablet, every 6 hours to control chronic, severe back pain and 2 prescriptions (for 2 months) were always written each visit to assure the resident did not run out of medication. -If the resident missed more than 1 dose of the Oxycodone, the provider would expect him to experience withdrawal symptoms because the medication was short-acting. -The provider expected withdrawal symptoms including severe pain, diarrhea, and sinus problems.	D 273		

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D 273	Continued From page 31 -The facility should have reported the withdrawal symptoms to the provider because withdrawal symptoms from opioid pain medication could cause acute medical emergencies such as cardiac changes, high blood pressure, and severe diarrhea. _____ The facility failed to respond to the acute needs of Resident #4, experienced drowsiness, lethargy and dependency on staff for all care, resulting in multiple falls, after being prescribed an antianxiety medicaion upon the facility staff's request. The facility's failure resulted in serious neglect, which constitutes a Type A1 Violation. _____ Review of the facility's Plan of Protection dated 9/15/17 revealed: -The supervisors will complete routine resident checks throughout their shifts. -Any incidents, illnesses or unexplained sickness will be promptly addressed with primary health care providers. -Correspondence with the primary health care providers will be faxed to their office. -Any phone calls will be documented in the resident's record. -If necessary, the resident will be sent to the emergency department. -Policy need to be established to identify basic sickness triggers the Supervisors can use to determine the need for communication with primary physicians. -These triggers will be basic without assessment qualities to be sure they are within the scope of staff's knowledge. -Training need to be specific to supervisors in order for them to know steps to complete at time of a problem/incident/sickness arises with the resident. -General staff needs refresher to use their	D 273		

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D 273	Continued From page 32 "senses" in determining any problems that need to be reported to the supervisor for further or necessary care to be provided. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017.	D 273		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve milk to residents residing in the special care unit twice daily. The findings are: Review of the therapeutic spreadsheet diet menu for the lunch meal on 09/12/17 revealed 8 ounces of milk should be served for all diets except for calorie controlled diets and renal diets. Observation on 9/12/17 at 11:40 a.m. during the lunch meal in the special care unit (SCU)	D 299		

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D 299	Continued From page 33 revealed: -Nineteen residents were in the dining room during the lunch meal. -One resident was served a carton of milk. -Milk was not served or offered to the other residents. Review of the therapeutic spreadsheet diet menu for the supper meal on 09/12/17 revealed 8 ounces of milk should be served for all diets except for renal diet and only 4 ounces for some calorie controlled diets. Observation on 9/12/17 at 6:28 p.m. during the supper meal in the special care unit (SCU) revealed: -Nineteen residents were in the dining room during the lunch meal. -One resident was served a carton of milk. -Milk was not served or offered to the other residents. Interview with two personal care aides (PCAs) on 09/12/17 at 6:28 p.m. revealed: -They did not think the residents would drink milk if they put it on the table. -They thought the ice cream for dessert could take the place of milk. Interview with two residents in the SCU on 09/12/17 and 09/13/17 revealed the residents liked milk and they would drink some if they had it. Interview with the Special Care Unit Coordinator (SCUC) on 09/12/17 at 6:40 p.m. revealed: -Milk should at least be offered to all residents in the SCU. -She was not aware milk was not being offered to the residents.	D 299		

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D 299	Continued From page 34 Observation on 09/13/17 at 5:43 p.m. in the SCU dining room revealed: -There were 17 residents in the dining room eating supper. -One resident had milk. -The food cart did not have any milk on it. Interview with a PCA on 09/13/17 at 5:43 p.m. revealed: -One resident always got milk because he liked milk. -She thought there were 5 cartons of milk on the bottom of the food cart. -She asked another staff person in the kitchen to get some milk to pass out. Observation on 09/13/17 at 5:47 p.m. in the SCU dining room revealed: -A staff person in the kitchen brought some milk cartons from the kitchen into the dining room. -Staff offered cartons of milk to residents in the SCU dining room. -Two of the 17 residents had already finished their meals and had left the dining room. -Eight residents indicated they wanted milk and received it. -Five of the eight residents were observed drinking their milk. Interview with the Dietary Director on 09/13/17 at 4:40 p.m. revealed: -Milk should be put on the food cart and at least offered to all residents. -They never ran out of milk and they always had it on hand.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 35 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 5 residents sampled (#2, #5) including a resident with a no added salt / mechanical soft diet (#2) and a resident with an order for a no added salt / no concentrated sweets diet (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 11/21/16 revealed: -The resident's diagnoses included dementia, hypertension, osteoarthritis lower leg, anxiety, lumbago, schizophrenia, delusional disorder, bipolar disorder, and depression with psychosocial features. -The section for the diet order was blank. Review of a physician's order dated 08/17/17 for Resident #2 revealed an order for a no added salt (NAS) / mechanical soft (MS) diet. Review of the facility's diet list revealed Resident #2 was on a NAS/MS diet. Review of the therapeutic spreadsheet menu for lunch on 09/12/17 revealed: -There was a column labeled "Regular / NAS". -The lunch meal included: 3 ounces BBQ pork	D 310		

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D 310	Continued From page 36 tenderloin, ½ cup mashed red skin potatoes, ½ cup broccoli with cheese sauce, wheat dinner roll/bread, one packet of margarine, ½ fruit cup, 8 ounces milk, and 8 ounces beverage of choice. -The column for "Soft" diet was the same except for ground BBQ pork tenderloin. Review of the facility's diet manual revealed: -There was a description for regular ground or mechanical soft diets. -Foods that are difficult to chew are replaced with foods that have been altered into a form that can be easily chewed. -Foods from the Regular/NAS diet are mechanically altered, chopped, or ground. -Foods that may need to be modified include meats, poultry, raw vegetables, and other fibrous foods. Review of the substitution list for the lunch meal on 09/12/17 revealed the meal was being changed to baked chicken, mashed stewed potatoes, sweet green peas with pearl onions, dinner roll, fruit cobbler, milk and beverage of choice. Observation of Resident #2 on 09/12/17 at 11:40 a.m. revealed: -The resident was served 1 piece of baked chicken pulled away in large chunks from the bone. -The chicken meat was not ground. -The resident was served garden peas, stewed potatoes, soft roll, peach cobbler, pink lemonade, and water. -The resident ate all of her meal and did not have any problems eating chunks of chicken that should have been ground. Review of the therapeutic spreadsheet menu for	D 310		

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supper on 09/12/17 revealed:
-There was a column labeled "Regular / NAS".
-The supper meal included: 2 ounces seafood bake, 1 cup of spaghetti noodles, ½ cup vegetable blend, wheat dinner roll/bread, 1 packet of margarine, 2x3 square of yellow cake with chocolate frosting, 8 ounces milk, and 8 ounces beverage of choice.
-The column for "Soft" diet was the same as the Regular / NAS column.

Review of the substitution list for the supper meal on 09/12/17 revealed:
-The meal was being substituted because the residents would not eat the meal on the menu.
-The meal was being changed to tuna salad, crackers, lettuce, tomatoes, potato chips, cookies, milk and beverage of choice.

Observation of Resident #2 on 09/12/17 at 5:45 p.m. revealed:
-The resident was served 1 scoop of tuna salad, 1 leaf of lettuce, and 2 slices of tomato.
-The resident was served approximately 1 cup of plain potato chips and 4 saltine crackers.
-The resident was served a 4 ounce cup of no added sugar strawberry ice cream, unsweetened tea, and water.
-The resident ate all of her meal including the potato chips and saltine crackers without any problems.

Interview with a personal care aide (PCA) on 09/12/17 at 6:10 p.m. revealed she had not seen Resident #2 have any problems with swallowing her food, coughing or choking during meals.

Interview with the Special Care Unit Coordinator (SCUC) on 09/12/17 at 6:40 p.m. revealed:
-When Resident #2 ate fast, she would "cough a

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D 310	Continued From page 38 little". -She was not sure that Resident #2 should have gotten the potato chips and saltine crackers since she was on a mechanical soft diet. Interview with the Director of Resident Services (DRS) on 09/12/17 at 6:58 p.m. revealed potato chips were not mechanical soft and should not have been given to residents on mechanical soft diets. Interview with the Dietary Director on 09/13/17 at 4:40 p.m. revealed: -Meats should be ground for mechanical soft diets according to the menu. -He was unsure why Resident #2's chicken was not ground during the lunch meal on 09/12/17. -He thought the resident may have been served the wrong plate. -Residents on mechanical soft diets should have been served the mashed potatoes instead of potato chips for supper on 09/12/17. 2. Review of Resident #5's current FL-2 dated 01/27/17 revealed: -The resident's diagnoses included dementia with behavioral issues, diabetes type II, hypertension, hyperlipidemia, left extremity edema, osteoporosis, glaucoma, and urinary incontinence. -The resident was intermittently disoriented and required assistance with bathing and dressing. -There was an order for a no added salt (NAS) / no concentrated sweets (NCS) diet. Review of the facility's diet list revealed Resident #2 was on a NAS / NCS diet. Review of the therapeutic spreadsheet menu for lunch on 09/12/17 revealed:	D 310		

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D 310	Continued From page 39 -There was a column labeled "Regular / NAS". -The lunch meal included: 3 ounces BBQ pork tenderloin, ½ cup mashed red skin potatoes, ½ cup broccoli with cheese sauce, wheat dinner roll/bread, one packet of margarine, ½ fruit cup, 8 ounces milk, and 8 ounces beverage of choice. -The column for "NCS" diet was the same except for skim milk and diet beverage of choice. Review of the substitution list for the lunch meal on 09/12/17 revealed the meal was being changed to baked chicken, mashed stewed potatoes, sweet green peas with pearl onions, dinner roll, fruit cobbler, milk and beverage of choice. Observation of Resident #5 on 09/12/17 at 11:40 a.m. revealed: -The resident was served 1 piece of baked chicken pulled away in large chunks from the bone. -The resident was served garden peas, stewed potatoes, soft roll, peach cobbler, diet pink lemonade, and water. -The resident ate all of her chicken, potatoes, and peach cobbler. Interview with the Special Care Unit Coordinator (SCUC) on 09/12/17 at 6:40 p.m. revealed: -Diabetic residents were supposed to get different desserts than the other residents. -Resident #5 should not have gotten peach cobbler for dessert. Interview with the Director of Resident Services (DRS) on 09/12/17 at 6:58 p.m. revealed diabetic residents should get sugar free desserts. Interview with the Dietary Director on 09/13/17 at 4:40 p.m. revealed:	D 310		

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D 310	Continued From page 40 -The peach cobbler was made with brown sugar for the lunch meal on 09/12/17. -The aides should have served the sugar free ice cream or sugar free pudding available in the kitchen for the diabetics on NCS diets. -They have a diet list in the kitchen with the diets listed on it for each resident. -He did not know why Resident #5 got peach cobbler but she should not have gotten it. Observation of Resident #5 on 09/12/17 at 5:45 p.m. revealed the resident was served one 4 ounce cup of no sugar added strawberry ice cream for dessert with the supper meal. Review of Resident #5's August 2017 - September 2017 medication administration records (MARs) revealed: -The resident's blood sugar ranged from 82 - 407 from 08/01/17 - 08/31/17. -The resident's blood sugar ranged from 147 - 447 from 09/01/17 - 09/12/17. Based on observations, interviews, and record review, Resident #5 was not interviewable due to diagnoses of dementia.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

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D 338	Continued From page 41 TYPE A1 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure 2 of 4 sampled residents were free of physical abuse and neglect (#2 and #4); one resident (#2) was alledgedly abused by a personal care aide, who was observed jerking and mistreating the resident; and a second resident (#4), who was neglected by being isolated and not allowed to leave his room for almost two months. The findings are: 1. Review of Resident #4's FL-2 dated 7/11/17 revealed diagnoses included dementia, old cerebral infarct, expressive aphasia, chronic kidney disease, hypertension and seizures. Review of the office manager's notes revealed on 9/05/17 at 8:30am, a representative from a facility in another county stated she would be at the facility at 1:00pm to pick up Resident #4 and the resident was discharged on 9/05/17. Interview with Resident #4's family member on 9/12/17 at 12:15pm revealed: -Resident #4 had been living at the facility since August 2016 and never had any episodes of attacking or hitting other residents until April 2017. -In April 2017, the facility reported to the family member the resident hit a female resident and hit his roommate (did not know the exact dates of the incidents). The facility moved his roommate to another room across the hall from Resident #4. -The facility reported to the family member the resident attacked another female resident in July 2017 and the other residents were afraid of him. -On 7/10/17, after the 3rd incident, the	D 338		

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D 338	Continued From page 42 Administrator informed the family member that he "had to go". He could not stay at the facility because it was the third time he had hit other residents. The Administrator could not keep him because other residents were scared of him and families were complaining. -The Director of Resident Services (DRS) informed the family member that the Administrator informed the DRS the resident had to go the same night (7/10/17), because he could not stay at the facility. -The next day, the Administrator started contacting other facilities trying to find somewhere for the resident to go. -The Administrator informed the family member that a family member had to come to the facility to stay with the resident at night. -The resident was isolated in his room from 7/10/17 until he was discharged from the facility on 9/05/17 and not allowed to leave his room. The resident ate all of his meals in his room and only came out when a staff or family member accompanied him outside. -The resident was not allowed to go to the dining room or the TV room with other residents; he was isolated from everyone. -When the family member came to the facility, 2-3 times a week, the resident was always sitting in a chair or wheelchair looking out of the window. The family member never saw staff coming into his room to check on him. -When the family member took the resident outside, "staff would always ask me if I was going to stay with him because the Administrator informed the staff he could not be out of his room alone". -A staff told the family member the resident should not be isolated in his room, because it was not right. -The family member never talked to the	D 338		

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D 338	Continued From page 43 Administrator about Resident #4 being isolated/confined to his room. -The family member accompanied the resident to his primary physician on 7/11/17 because the facility had reported to the physician the resident needed to be on an antidepressant. -The resident was started on a medication the next day which he was administered 2-3 times a day for about a week. The medication caused him to be nonresponsive, limp, unable to walk, and had to be transferred in the wheelchair. -The family member asked the DRS to call the physician and stop the medication after the resident was administered the medication 5 or 6 days. -After the medication was stopped, the resident remained isolated in his room, was found several times on the floor and was taken to the emergency room one time (did not remember the dates). -The resident was found on the floor after he had vomited on the floor and slipped in the vomit. -The resident remained isolated in his room until he was discharged to another facility on 9/05/17. -If the resident walked out of his bedroom, the staff would take him back to his room. -Before Resident #4 was isolated in his room, he liked to sit in the TV room and watch TV; he participated in activities and always ate in the dining room with the other residents. -After the resident was isolated in his room, the staff on 2nd shift would accompany the resident outside every day. -The staff informed the family member other residents were afraid of Resident #4 because he had attacked 3 residents. Interview with Resident #4's former roommate on 9/13/17 at 11:50am revealed: -Resident #4 and he were roommates until the	D 338		

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D 338	Continued From page 44 resident shoved him against the bathroom door and hit him on his head on a Friday night in April 2017. He was taken to the emergency room for evaluation and moved to a room across from Resident #4. -Resident #4 hit another resident in April 2017 (in the hallway) and hit a resident in July 2017 in the TV room. -The resident was isolated in his room in July 2017. The staff would not let him come out and the other residents did not go into his room. -Resident #4 ate his meals in his room, did not sit in the TV room and did not eat in the dining room or come out to participate in activities. -The resident did walk out of his room a few times but the staff always took him back into his room. -Resident #4's wrists were seen tied to a chair with a rope for 2 days after he had walked outside of the facility without staff in July 2017 (did not remember the exact date). -The Administrator told me not to go in Resident #4's room. -He would always stop in front of Resident #4's room and speak to him but never went into his room. Interview with a 1st shift medication aide (MA) on 9/13/17 at 1:00pm revealed: -Resident #4 was isolated in his room since he assaulted the last resident in July 2017. -If the resident left his room or went outside, the staff took him back to his room immediately. -The MA did not know if there was an order isolate the resident to his room and from other residents. -The Administrator and the DRS instructed the staff to isolate the resident to his room. -The resident could not speak but made sounds to let you know what he wanted. He always wanted to go outside.	D 338		

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D 338	Continued From page 45 -The staff checked on him every 1-2 hours, brought his meals to the room and walked him outside at least 1 time every day on 1st shift. -After the resident was started on Klonopin (used to treat anxiety) in July 2017, the resident was in bed most of the time sleeping and the staff had to provide total care. -The resident fell in his room 2 or 3 times and slipped on the floor after vomiting one time. The resident was sent to the emergency room only one time after one of the falls (did not remember the date). -The MA was not aware of Resident #4 being restrained in a chair at any time. Interview with a 2nd shift personal care aide (PCA) on 9/13/17 at 3:40pm revealed: -She had been employed by the facility since 7/26/17. -Resident #4 was not a difficult resident, but he did not speak, only mumbled 1-2 words. -The resident was isolated in his room and the staff brought his meals to his room and assisted with his bath. -Whenever the resident walked out of his room, the staff would take him back to his room. -The resident was isolated in his room until he left the facility earlier this month, but was never restrained in a chair. Interview with the 2nd shift supervisor on 9/13/17 at 4:00pm revealed: -The Administrator ordered Resident #4 to be isolated to his room from July 2017 until he was discharged in September 2017, after the last incident occurred in July 2017 when he hit another resident. -The resident was drowsy and difficult to wake after starting Klonopin on 7/11/17, and required total care including feeding.	D 338		

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D 338	Continued From page 46 -The resident was isolated from all of the other residents and was not allowed to leave his room unless accompanied by staff or family. He could only go outside for short periods. -The staff checked on the resident about every 2 hours on 2nd shift. -There was no order in the resident's record to isolate the resident in his room. -The resident was never restained in a chair. Interview with the DRS on 9/13/17 at 4:15pm revealed: -The Administrator and the DRS made the decision to isolate Resident #4 from the other residents because the other residents were afraid of the resident after he had attacked 3 other residents and "we did not want another incident to occur so we made him stay in his room". -The resident's physician was not informed of their decision to isolate the resident to his room. -The resident's family was informed of the facility's plan to discharge the resident and isolate the resident to his room which was implemented from July 2017 (after the last attack on 7/10/17) until he was discharged on 9/05/17. -The resident was served all of his meals in his room and was not allowed to participate in any activities, eat meals in the dining room or sit in the TV room with the other resident population. -The resident always sat in a chair in his room near his window and watched TV when he was out of bed. -The resident's door remained opened at all times unless staff was providing care so the staff could check on him, but the resident was not allowed to walk out of his room unless the staff was taking him outside. -If the resident walked out of his room, the staff knew to escort him back inside his room. -Restraints had never been used to isolate the	D 338		

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D 338	Continued From page 47 resident to his room. -The resident was emotional after the last incident on 7/10/17. He started to cry when the DRS talked to him about the incident, but the resident could not talk; he only made noises and communicated with facial expressions. -The resident was ordered Klonopin on 7/11/17 and became "zonked out" for about a week and required total care from the staff until the medication was discontinued by the physician. -The resident then became more alert and was able to get out of bed and feed himself; but remained isolated in his room. -The resident had several falls in his room and was found on the floor by staff. The resident was sent to the emergency room after only one fall. -One fall occurred when he vomited on the floor and slipped in his vomit, but was not sent to the emergency room. -There was not an order to isolate Resident #4 to his room. Telephone interview with Resident #4's primary physician on 9/13/17 at 10:15pm revealed: -He was not aware of the resident being isolated in his room and there was no documentation from the facility informing the physician of the need to isolate the resident to his room. -He did not give the facility orders to isolate the resident to his room or from the other residents. -He expected the facility to report resident changes, which included abusive behaviors or medication problems. Interview with the Administrator on 9/14/17 at 6:00pm revealed: -Resident #4 was isolated in his room after he had attacked a 3rd resident in 3 months. -He was not allowed to eat in the dining room, participate in activities or socialize with any of the	D 338		

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D 338	Continued From page 48 residents because she did not want him to harm any more residents. -The resident was not allowed to go to the dining room because other residents were afraid of him. -"We could either subject all the residents to him or protect the residents." -The resident's physician was not informed of the resident's isolation and the facility did not obtain an order for the resident's isolation to his room because she did not need an order to protect the other residents from harm. -The resident was isolated in his room until his discharge on 09/05/17. -The staff was allowed to accompany the resident outside of the facility and sit with him outside. -Restraints were never used to isolate the resident to his room. -"I don't feel like we neglected him." 2. Review of Resident #2's FL-2 dated 11/21/16 revealed: -Diagnoses included dementia, hypertension, anxiety, osteoarthrosis lower leg, lumbago, schizophrenia, delusional disorder, bipolar disorder, depression with psychotic disorder. -Resident #2 was semi-ambulatory. Review of Resident #2's Care Plan dated 6/15/17 revealed: -The resident required an assistive device for all ambulation. -The resident required assistance with transferring. Review of Resident #2's Licensed Health Professional Support (LHPS) assessment dated 08/10/17 revealed: -Staff should transfer Resident #2 with a hoyer lift at all times. -Resident #2 was alert but confused at times.	D 338		

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D 338	Continued From page 49	D 338		

Review of an Incident/Accident report dated 08/31/17 revealed:
- The PCA (Staff E) was lifting Resident #2 by herself with the hoyer lift and that requires two people.
- Resident #2 was hollering during the process.
- The PCA (Staff E) was pulling on Resident #2's arm.

Interview with Staff E, personal care aide (PCA) on 09/12/17 at 3:50 pm revealed:
-Two PCAs usually assisted with changing and transferring Resident #2, but it was only Staff E in the resident's room that day (08/31/17).
-Staff E tried to get Resident #2 up. Resident #2 was hollering and holding onto the bed rails. Resident #2 did not want to be turned. Staff E tried to pry Resident #2's hands off the bed rail.
-Resident #2's family member came into the room and appeared to be mad. The family member told Staff E, "I'm about tired of you. There should be another aide in here with you". The Special Care Unit Coordinator (SCUC) came into the room and told the PCA to leave the room.
-Staff E was written up and was moved to the assisted living (AL) side of the facility to work.

Review of the facility's Investigation Notes dated 08/31/17 revealed:
-Staff E was trying to open Resident #2's hand and loosen the resident's hold on the bedrails.
-Staff E was written up and moved from the back hall to the front hall to work.
-Staff E was taken off the schedule for one day.

Review of a verbal statement from the SCUC dated 8/31/17 revealed:
-Resident #2's family member approached the SCUC and was very upset.
-The family member stated to the SCUC that

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D 338	Continued From page 50 Staff E was being rough with Resident #2. -Staff E reported to the SCUC that she was trying to get Resident #2 out of bed and the resident kept gripping the bed rails and was resisting. -Staff E tried to get Resident #2's hands loose from the bed. Interview with Resident #2's family member on 09/12/17 at 4:24pm and on 09/14/17 at 5:40pm revealed: - Immediately upon entering the special care unit (SCU) the family member could hear Resident #2 hollering. -Staff E was unaware the family member had opened Resident #2's room door and was observing. -Staff E was pulling on Resident #2's arms. -Staff E was observed picking up Resident #2 legs and dropping them down on the bed. - Staff E was told to leave Resident #2 alone. -The family member told the SCUC that she (family member) observed Staff E jerking and mistreating Resident #2. -The SCUC made Staff E leave the room, and another PCA finished the care for Resident #2. -Staff E was moved to another hall in the facility to work. -The Administrator was informed that Staff E abused Resident #2 by the family member. -The Administrator informed the family member she was not aware of the incident and would take care of it. Interviews with the SCUC on 09/12/17 at 4:00 pm and on 09/14/17 at 10:10am revealed: -The SCUC was told by the family member that Staff E was jerking, mistreating and abusing Resident #2. -When the SCUC went into Resident #2's room, Staff E was trying to get the resident out of the	D 338		

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D 338	Continued From page 51 bed. Staff E was trying to remove the resident's hands from the rail. -Staff E had not called another PCA in to help her get Resident #2 up with the hoyer lift. -The SCUC called another PCA into Resident #2's room to assist the resident. -The SCUC told the Administrator that Staff E did not have two people in the resident's room with the hoyer lift. -Staff E was removed from the room, and was written up. Interview with the facility's Registered Nurse (RN) on 09/13/17 at 12:10 pm revealed: -The PCAs had been trained to step away from the residents when they became difficult and give the residents time to get themselves together. -The PCAs should use a soft voice and explain to the residents what they would be doing. -The PCAs were not taught during personal care training to pry away or jerk residents' extremities if the residents were gripping or holding onto the bed rails. Observation on 09/12/17 at 12:45pm revealed: -Two PCAs assisted Resident #2 to bed to be changed. -The hoyer lift was used. -Resident #2 appeared to be uneasy as the lift was being pumped up. -The PCAs talked with Resident #2 throughout the entire process. -Resident #2 did not holler out while she was being transferred and changed. Interview with the Administrator on 09/12/17 at 6:00 pm and on 09/13/17 at 6:00 pm revealed: -The Administrator was not immediately made aware of what happened. -The family member told the Administrator that	D 338		

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D 338	Continued From page 52 Resident #2 had been abused shortly after 4:00pm on the day of the incident. -The family member reported that the incident had "just happened." -It happened within 15 minutes of the family member arriving to the facility. -Staff E was changing Resident #2, and Staff E knew she was supposed to have two staff when using the hoyer lift. -Resident #2 was hollering when the family member entered the SCU. -The family member informed the SCUC what happened. -The SCUC removed Staff E from the room. -Staff E tried to loosen Resident #2's grip on the bed rails. -Staff E did not understand what she had done wrong. -Staff E was written up and taken off the schedule for one day. -Staff E was moved from the SCU to the AL side of the building permanently. -A 24-hour report nor a 5 day report was completed, but the Administrator investigated the allegation and determined there were no further action required. The facility failed to assure residents were free from abuse and neglect as evidenced by Resident #4 being confined to his room by staff and the Administrator, isolating the resident from other residents and all activities from 7/11/17 until discharge from the facility on 9/05/17; and Resident #2 being pulled and jerked while in bed by a personal care aide. The facility's failure to assure residents resulted in serious abuse and serious neglect, which constitutes a Type A1 Violation. Review of the facility's Plan of Protection dated	D 338		

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D 338	Continued From page 53 9/14/15 revealed: -The facility will hold training with the supervisors and staff about identifying changes in residents. -The supervisor will check on residents to see what might be a problem that needs attention such as primary physician being notified or transferred to emergency room. -Any new orders and instructions will be adhered to in future care of resident identified with changes. -Re-education of 24-48 hour follow-up notes will be held. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#8, #9) observed during the medication passes	D 358		

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D 358	Continued From page 54 including errors with a medication used to control phosphorus levels (#9), a combination inhaler for breathing problems and a steroid nasal spray for allergies (#8); and 4 of 6 residents (#1, #3, #5, #10) sampled for record review including errors with missed doses of a narcotic pain medication (#1), errors with missed doses of a heart / blood pressure medication and glaucoma eye drops (#3), errors with sliding scale insulin (#5, #10), and errors with a Vitamin D supplement (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 7/17/17 revealed: -Diagnoses included Fibromyalgia, peripheral neuropathy, multiple sclerosis, hypertension, anxiety and paranoia, seizure disorder and atrial fibrillation. -There was an order for Oxycodone 10mg, one tablet, every 6 hours (Oxycodone is an opioid pain medication used to treat moderate to severe pain and can be addictive. Abrupt discontinuation could lead to symptoms such as restlessness, a runt nose, muscle aches, insomnia, irritability, and gastrointestinal complaints). Interview with Resident #1 on 9/11/17 at 11:45am revealed: -The resident had lived at the facility since June 2016. -The resident had chronic and severe pain from neuropathy, fractures of his back, fibromyalgia and other problems. -The resident had been on oxycodone 10mg every 6 hours for pain since admission to the facility in 2016. -The resident visited the physician at the pain clinic every other month and the physician always wrote 2 prescriptions for Oxycodone. One	D 358		

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D 358	Continued From page 55 prescription was filled immediately and the other prescription was dated for the next month and was filled on that date. -The facility should have sent the prescription to the pharmacy to be filled on 9/9/17 (on a Saturday). -The Director of Resident Services (DRS) locked the prescription in her desk, and the weekend staff did not have access to the prescription and did not fax the prescription to the pharmacy. -The resident received Oxycodone every 6 hours until Sunday morning (9/10/17) with the last dose being administered at 12:15am. -The resident started having withdrawal symptoms Sunday evening (9/10/17) on 2nd shift and continued to have symptoms today. -The resident described the withdrawal symptoms as sleeplessness, irritation, runny diarrhea (back and forth to the bathroom throughout the night and 4-5 times this morning); runny nose (nose bleeds when he blew his nose); burning eyes; a sinus headache and severe lower back pain rated at 8 to 10 since Sunday. -The resident "raised cane" with the staff on Sunday about Oxycodone not being available and the staff called the DRS at her home. Review of Resident #1's medication administration record for September 2017 revealed: -On 9/9/17, Oxycodone 10mg was documented as administered at 12:00am, 6:00am, 12:00pm and 6:00pm. -On 9/10/17, Oxycodone 10mg was documented as administered at 12:00am. The resident did not receive Oxycodone at 6:00am, 12:00pm, or 6:00pm. -On 9/11/17, the resident did not receive Oxycodone at 6:00am.	D 358		

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D 358	Continued From page 56 Interview with a 2nd shift supervisor on 9/14/17 at 5:15pm revealed: -She worked on 9/9/17 (2nd shift) and Resident #1 received his 6:00pm dose Oxycodone. -On 9/10/17, the resident's Oxycodone was not available and the resident did not receive his 6:00pm dose of the medication. -The resident complained of "sinus infection", back pain and diarrhea Sunday but the medical provider was not informed. Interview with the DRS on 9/14/17 at 6:10pm revealed: -Resident #1 had a prescription for Oxycodone, dated 9/9/17, which was not sent to the facility pharmacy to be filled because the facility was in the process of changing pharmacies at the time the prescription was dated to be filled. -The Oxycodone was not available for 1 day (24 hours) but was filled on 9/11/17. -A staff called her Sunday night and informed her the resident was out of Oxycodone and was complaining of withdrawal symptoms. -The resident's prescription was locked in her desk drawer and was not sent to the pharmacy until Monday (9/11/17). -The resident received a dose of Oxycodone on 9/11/17 at 12noon. -She did not inform the resident's medical provider at the pain clinic or the resident's primary physician of the withdrawal symptoms from not receiving the ordered Oxycodone. Interview with Resident #1's medical provider at a local pain clinic on 9/15/17 at 9:05am revealed: -Resident #1 was seen at the pain clinic every other month to evaluate pain and effectiveness/problems with pain medication. -The resident had an order for Oxycodone 10mg, one tablet, every 6 hours to control his chronic	D 358		

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D 358	Continued From page 57 severe back pain and 2 prescriptions (for 2 months) were always written each visit to assure the resident did not give out of medication. -If the resident missed more than 1 dose of Oxycodone, the medical provider would expect him to experience withdrawal symptoms due to the medication being short-acting. -Expected withdrawal symptoms included severe pain, diarrhea, and sinus problems. -The facility should have reported the withdrawal symptoms to the medical provider because withdrawal symptoms from opioid pain medication could cause acute medical emergencies such as cardiac changes, high blood pressure, and severe diarrhea. -The medical provider expected the facility to send each Oxycodone prescription to the pharmacy to be filled on the date documented on the prescription to prevent the resident from missing any doses of the pain medication. Interview with the Administrator on 9/15/17 revealed: -She was not aware Resident #1 did not receive Oxycodone for more than 24 hours and had withdrawal symptoms. -The facility was changing pharmacies and the process started on 9/7/17; it took several days to complete the changeover. Therefore, the Oxycodone prescription was not filled on the prescription date (9/9/17). -She expected the supervisors or the DRS to report medical changes such as withdrawal symptoms to the medical providers. 2. Review of Resident #5's current FL-2 dated 01/27/17 revealed: -The resident's diagnoses included dementia with behavioral issues, diabetes type II, hypertension,	D 358		

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D 358	Continued From page 58 hyperlipidemia, left extremity edema, osteoporosis, glaucoma, and urinary incontinence. -The resident was intermittently disoriented. A. Review of physician's orders for Resident #5 revealed: -There was an order dated 02/08/17 for fingerstick blood sugars (FSBS) to be checked 3 times a day. -There was an order dated 02/10/17 for Novolog Flexpen according to the following sliding scale: 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than (>) 400 = 12 units. (Novolog is rapid-acting insulin used to lower blood sugar.) Review of Resident #5's July 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Novolog Flexpen sliding scale insulin to be administered 3 times a day at 7:00 a.m., 12:00 p.m., and 7:00 p.m. -The FSBS was 165 on 07/22/17 at 7:00 a.m. and would have required 2 units of insulin but 4 units were documented as administered. -The FSBS was 172 on 07/09/17 at 12:00 p.m. and would have required 2 units of insulin but 1 unit was documented as administered. -The entry for 7:00 a.m. and 12:00 p.m. had rows for the site, amount, FSBS and staff initials to be documented. -The entry for 7:00 p.m. did not have a row for the amount of insulin to be documented. -The FSBS ranged from 163 - 380 on 24 occasions at 7:00 p.m. from 07/01/17 - 07/31/17 and would have required Novolog sliding scale insulin but no amounts were documented on those 24 occasions. -A site of administration was documented but	D 358		

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D 358	Continued From page 59 without the amount documented, it could not be determined if the correct amount of insulin was administered on those 24 occasions. -The FSBS ranged from 82 - 407 from 07/01/17 - 07/31/17. Review of Resident #5's August 2017 MAR revealed: -There was a computer printed entry for Novolog Flexpen sliding scale insulin to be administered 3 times a day at 7:00 a.m., 12:00 p.m., and 7:00 p.m. -The FSBS was 231 on 08/02/17 at 7:00 a.m. and would have required 4 units of insulin but 6 units were documented as administered. -The FSBS was 154 on 08/03/17 at 7:00 a.m. and would have required 2 units of insulin but "0" units were documented as administered. -The FSBS was 178 on 08/11/17 at 7:00 a.m. and would have required 2 units of insulin but "0" units were documented as administered. -The FSBS was 156 on 08/17/17 at 7:00 a.m. and would have required 2 units of insulin but "0" units were documented as administered. -The FSBS was 159 on 08/29/17 at 7:00 a.m. and would have required 2 units of insulin but "0" units were documented as administered. -The FSBS was 182 on 08/15/17 at 12:00 p.m. and would have required 2 units but none was documented as administered because it was "within range". -The FSBS was 269 on 08/17/17 at 12:00 p.m. and would have required 6 units but 8 units were documented as administered. -The entry for 7:00 p.m. did not have a row for the amount of insulin to be documented. -The FSBS ranged from 178 - 407 on 31 of 31 days at 7:00 p.m. from 08/01/17 - 08/31/17 and would have required Novolog sliding scale insulin but no amounts were documented on those 31	D 358		

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D 358	Continued From page 60 occasions. -A site of administration was documented but without the amount documented, it could not be determined if the correct amount of insulin was administered on those 31 occasions. -The FSBS ranged from 82 - 407 from 08/01/17 - 08/31/17. Review of Resident #5's September 2017 MAR from the previous primary pharmacy revealed: -Documentation for this electronic MAR (e-MAR) was from 09/01/17 - 09/06/17. -There was a computer printed entry for Novolog Flexpen sliding scale insulin to be administered 3 times a day at 7:00 a.m., 12:00 p.m., and 7:00 p.m. -The FSBS was 267 on 09/03/17 at 7:00 a.m. and would have required 6 units of insulin but no amount was documented as administered. -The entry for 7:00 p.m. did not have a row for the amount of insulin to be documented. -The FSBS ranged from 167- 341 on 6 of 6 days at 7:00 p.m. from 09/01/17 - 09/06/17 and would have required Novolog sliding scale insulin but no amounts were documented on those 6 occasions. -A site of administration was documented but without the amount documented, it could not be determined if the correct amount of insulin was administered on those 6 occasions. -The FSBS ranged from 147 - 400 from 09/01/17 - 09/06/17. Review of Resident #5's September 2017 MAR from the current primary pharmacy revealed: -Documentation for this e-MAR started on 09/07/17. -There was a computer printed entry for Novolog Flexpen sliding scale insulin to be administered 3 times a day at 7:15 a.m., 11:15 a.m., and 5:15 p.m.	D 358		

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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 358	Continued From page 61 -The FSBS was 400 on 09/07/17 and 09/09/17 at 7:15 a.m. and would have required 10 units of insulin but 12 units were documented as administered both times. -The FSBS was 447 on 09/12/17 at 7:15 a.m. and would have required 12 units of insulin but "0" units were documented. -The FSBS was 155 on 09/09/17 at 11:15 a.m. and would have required 2 units of insulin but 1 unit was documented as administered. -The FSBS ranged from 155 - 447 from 09/07/17 - 09/12/17. Interview with a medication aide (MA) on 09/14/17 at 1:50 p.m. revealed: -She thought the amount administered always popped up on the e-MAR and the MAs would have to enter the amount of sliding scale insulin they gave. -The amount should be printed on the MARs. -There was no other forms or documents it would be documented on to her knowledge. -She did not know why the wrong amount of insulin was documented on the MARs for the sliding scale insulin. -The MAs were supposed to administer the Novolog according to the scale on the MARs. Interview with the Special Care Unit Coordinator (SCUC) on 09/14/17 at 6:00 p.m. revealed: -The MAs should administer the correct amount of insulin based on the sliding scale and document it on the e-MARs. -There was not currently a system to check the MARs for accuracy and to check to see if medications such as sliding scale insulin were administered as ordered. -She was not aware the amount of sliding scale insulin for Resident #5's 7:00 p.m. dose was not documented on the MARs.	D 358		

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	HAL047012	A. BUILDING: _____ B. WING _____	C 09/15/2017

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D 358	Continued From page 62 -No one had reported any problems with the MARs to her. -The facility just switched to a different primary pharmacy last week. -She would check with the e-MAR system to see if there was a way to print the amount of sliding scale administered for the 7:00 p.m. doses on the previous e-MARs. Interview with the facility's Registered Nurse (RN) Consultant on 09/14/17 at 6:30 p.m. revealed: -The MAs had been trained to administer sliding scale insulin according to the scale ordered. -She was not aware the amounts of sliding scale insulin administered for Resident #5 were not documented for the 7:00 p.m. doses. -She would check to see if there was a different way to print the information from the e-MARs. Interview with the SCUC on 09/15/17 at 2:25 p.m. revealed she had spoken with someone from the e-MAR vendor and they were checking on the sliding scale insulin documentation for Resident #5 but she had not heard back from them. Based on observations, interviews, and record review, Resident #5 was not interviewable due to diagnoses of dementia. Attempted telephone interview with Resident #5's primary care provider on 09/15/17 was unsuccessful. B. Review of Resident #5's current FL-2 dated 01/27/17 revealed there was an order for Vitamin D 2000 units take 2 tablets once daily. (Vitamin D is a supplement used to treat Vitamin D deficiency.) Review of Resident #5's July 2017 - September	D 358		

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D 358	Continued From page 63 2017 medication administration records (MARs) revealed: -There was a computer printed entry for Vitamin D 2000 units take 2 tablets (= 4000 units) daily. -Vitamin D 2000 units, 2 tablets were documented as administered daily at 8:00 a.m. from 07/01/17 - 09/14/17. Observation of Resident #5's medications on hand on 09/14/17 revealed: -There was one supply of Vitamin D 2000 units that was dispensed by the previous pharmacy on 08/29/17. -Sixty tablets were dispensed on 08/29/17. -Ten of the 60 tablets had been punched from the card. -The date "8/31" was handwritten along with staff initials beside the #60 bubble on the card that was empty. -There was no other supply of Vitamin D on hand. Interview with a medication aide (MA) on 09/14/17 at 1:50 p.m. revealed: -The MAs write the date and initial on the bubble card when they first start using the supply in each card. -The "8/31" on the Vitamin D pack meant the first dose was punched from the card on 08/31/17. -She administered 2 Vitamin D tablets to Resident #5 from this same Vitamin D pack this morning, 09/14/17. -There was no other supplies of Vitamin D tablets on hand for Resident #5. -They had not received any Vitamin D from the new pharmacy that started servicing the facility last week. -She did not know why only 10 Vitamin D tablets had been used for Resident #5 since 08/31/17 when 2 should be administered daily. (15 doses would have been required since 08/31/17 or a	D 358		

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D 358	Continued From page 64 total of 30 tablets.) Interview with the Special Care Unit Coordinator (SCUC) on 09/14/17 revealed: -The MAs had been trained to administer the medications according to the orders. -The MAs usually date and initial the bubble packs when they punch the first tablet from the card. -The facility just changed to a new primary pharmacy last week. -The Vitamin D supply on hand for Resident #5 was from the previous primary pharmacy. -She thought the previous primary pharmacy had gone out of business. -She would try to get a dispensing record from the previous pharmacy. Telephone interview with a pharmacist at the facility's current primary pharmacy on 09/14/17 at 5:10 p.m. revealed: -They just started servicing the facility last week. -They had not dispensed any Vitamin D for Resident #5. Pharmacy dispensing records for Resident #5's Vitamin D were requested but not provided by the end of the survey on 09/15/17. Review of Resident #5's labwork in the record revealed no Vitamin D levels were available for review. Based on observations, interviews, and record review, Resident #5 was not interviewable due to diagnoses of dementia. 3. Review of Resident #10's current FL-2 dated 04/05/17 revealed: -The resident's diagnoses included type 2	D 358		

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D 358	Continued From page 65 diabetes, Alzheimer's disease, altered mental status, dementia, hypertension, migraines, Vitamin D deficiency, hypercholesterolemia, osteoarthritis, chronic lymphedema, and hiatal hernia, -There was an order for fingerstick blood sugars (FSBS) once daily rotating times. -There was an order for Novolog Flexpen with daily FSBS followed by sliding scale: 0 - 200 = 0 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 999 = 0 units, call physician. (Novolog is rapid-acting insulin used to lower blood sugar.) Review of Resident #10's September 2017 medication administration record (MAR) from the previous pharmacy revealed: -Documentation for this electronic MAR (e-MAR) was from 09/01/17 - 09/06/17. -There was a computer printed entry to check FSBS daily rotating times and it was scheduled for rotating times of 7:00 a.m. 12:00 p.m., 5:30 p.m., and 8:30 p.m. -The FSBS was 152 on 09/01/17 at 5:30 p.m., 102 on 09/02/17 at 7:00 a.m., 229 on 09/03/17 at 8:30 p.m., 167 on 09/04/17 at 12:00 p.m., 174 on 09/05/17 at 5:30 p.m., and 150 on 09/06/17 at 7:00 a.m. -There was a computer printed entry for Novolog Flexpen, FSBS daily followed by sliding scale: 0 - 200 = 0 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 999 = 0 units, call physician. -Novolog was scheduled for 7:30 a.m., 12:00 p.m., 5:30 p.m., and 8:30 p.m. -There was an "X" in each block for all 4 scheduled times for 09/01/17 - 09/02/17 and 09/03/17 - 09/06/17 with no FSBS documented and no Novolog documented as administered on those days.	D 358		

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D 358	Continued From page 66 -The FSBS was documented 4 times on 09/03/17: 144 at 7:30 a.m., 77 at 12:00 p.m., 215 at 5:30 p.m., and 229 at 8:30 p.m. -Novolog was documented as administered twice on 09/03/17 with 4 units each at 5:30 p.m. and 8:30 p.m. instead of alternating daily as ordered. -The resident's FSBS ranged from 77 - 229 from 09/01/17 - 09/06/17. Review of Resident #10's September 2017 MAR from the current pharmacy revealed: -Documentation for this e-MAR started on 09/07/17. -There was a computer printed entry for Novolog Flexpen, check FSBS 4 times daily and sliding scale: 0 - 200 = 0 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 999 = 0 units, call physician. -Novolog sliding scale insulin was scheduled for 7:15 a.m., 11:15 a.m., 5:15 p.m., and 8:30 p.m. -The resident's FSBS was checked 4 times a day from 09/07/17 - 09/12/17 (11:15 a.m.) instead of once daily rotating times as ordered. -Novolog sliding scale insulin was documented as administered twice on 09/08/17 at 5:15 p.m. and 8:30 p.m. -Novolog sliding scale insulin was documented as administered twice on 09/10/17 at 11:15 a.m. and 5:15 p.m. -The resident's FSBS ranged from 102 - 256 from 09/07/17 - 09/12/17. Review of Resident #10's physician's orders revealed there was no order to check FSBS 4 times a day or to administer Novolog sliding scale insulin 4 times a day. Interview with the Special Care Unit Coordinator (SCUC) on 09/12/17 at 1:30 p.m. revealed: -The facility had just changed to a new primary	D 358		

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D 358	Continued From page 67 pharmacy last week. -She was not aware of any order changes for Resident #10's FSBS or Novolog sliding scale insulin. -Resident #10's FSBS and Novolog sliding scale insulin were supposed to be done once daily rotating to a different time each day. -She was not aware the order was not entered correctly on the e-MARs. -She thought the new pharmacy entered the orders on the e-MARs. -She had not checked the e-MARs since the new pharmacy took over last week. -She would recheck the orders and notify Resident #10's primary care provider (PCP). Interview with the SCUC on 09/13/17 at 4:11 p.m. revealed: -Resident #10's PCP faxed a response today (09/13/17) and wanted the resident's FSBS and sliding scale insulin done once daily alternating times as ordered previously. -She thought the order was entered incorrectly on the new September 2017 MARs by the new pharmacy. -Facility staff did not catch the error when they approved the orders on the e-MARs. Review of a physician's order for Resident #10 signed on 09/13/17 revealed the PCP wanted Resident #10's FSBS checked once daily with rotating times followed by sliding scale insulin instead of 4 times daily. Based on observation, interview, and record review, Resident #10 was not interviewable due to diagnoses of Alzheimer's disease and dementia. Attempted telephone interview with Resident	D 358		

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D 358	Continued From page 68 #10's PCP on 09/15/17 was unsuccessful. 4. Review of Resident #3's current FL-2 dated 04/06/17 revealed diagnoses included malignant neoplasm of hypopharynx, Clostridium difficile colonization, Escherichia coli urinary tract infection, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, asthma, hypertension, osteoarthritis, congestive heart failure, anemia, irritable bowel syndrome, Parkinson's disease, depression, and systemic inflammatory response syndrome. A. Review of Resident #3's current FL-2 dated 04/06/17 revealed there was an order for Carvedilol 3.125mg twice daily. (Carvedilol is used to treat heart problems and high blood pressure.) Review of Resident #3's July 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Carvedilol 3.125mg 1 tablet 2 times a day. -Carvedilol was scheduled to be administered at 10:00 a.m. and 10:00 p.m. -Carvedilol was documented as administered twice daily from 07/01/17 - 07/29/17 (10:00 a.m.). -Carvedilol was not documented as administered on 07/29/17 at 10:00 p.m. due to being "on order". -Carvedilol was documented as administered on 07/30/17 and 07/31/17. -The resident's monthly blood pressure was 100/55 and pulse was 76 on 07/16/17. Review of Resident #3's August 2017 MAR revealed: -There was a computer printed entry for Carvedilol 3.125mg 1 tablet 2 times a day. -Carvedilol was scheduled to be administered at	D 358		

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D 358	Continued From page 69 10:00 a.m. and 10:00 p.m. -Carvedilol was not documented as administered twice daily from 08/01/17 - 08/25/17 (10:00 a.m.) due to the medication being "on order". -Carvedilol was documented as administered from 08/25/17 (10:00 p.m.) - 08/31/17. -The resident's monthly blood pressure was 136/72 and pulse was 65 on 08/16/17. Review of progress notes for Resident #3 revealed: -There was no documentation of the attempts to obtain the Carvedilol or contact the physician in 07/2017 when the medication ran out. -08/09/17: The medication aide (MA) called the pharmacy about refill on resident's Carvedilol. Pharmacist stated there was no refill, "will notify physician". -08/15/17: Noted Carvedilol still not here, call pharmacy, note waiting to hear from physician, refill request has been sent to him. -08/21/17: Note Carvedilol still not in, notified pharmacy, continue to wait on hearing from the physician. Physician has been notified several times (did not specify if pharmacy or facility notified the physician several times.) Telephone interview with a pharmacist at the retail pharmacy used by Resident #3 on 09/15/17 at 4:40 p.m. revealed: -It appeared there were no refills on the Carvedilol in 07/2017. -The pharmacy usually sent refill requests via fax or online requests to physicians' offices. -If the pharmacy was unable to dispense a medication due to no refills, they would make a note for the facility and put in the basket for when the facility picked up medications. -The pharmacy may also tell the facility to contact the physician for refills.	D 358		

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D 358	Continued From page 70 -The pharmacy did not document these communications. -He was unsure if anyone from the facility contacted them about refills for Resident #3's Carvedilol. -Prior authorization for insurance was not required for Resident #3's Carvedilol. -He was unsure why there was a delay in getting refills for the Carvedilol. Review of pharmacy dispensing records for Resident #3 dated 03/01/17 - 09/15/17 revealed: -Sixty Carvedilol 3.125 tablets were dispensed on 03/13/17. -Sixty Carvedilol 3.125 tablets were dispensed on 04/12/17. -Sixty Carvedilol 3.125 tablets were dispensed on 05/12/17. -Sixty Carvedilol 3.125 tablets were dispensed on 06/23/17. -No Carvedilol was dispensed in 07/2017. -Sixty Carvedilol 3.125 tablets were dispensed on 08/22/17. Observation of medications on hand on 09/15/17 revealed: -There was one supply of Carvedilol 3.125mg tablets dispensed on 08/22/17. -There was 19 of 60 tablets remaining on hand. Interview with the Director of Resident Services (DRS) on 09/15/17 at 12:38 p.m. revealed: -She was aware Resident #3's Carvedilol was unavailable for a few weeks at the end of 07/2017 and into 08/2017. -Resident #3 used a local retail pharmacy and the facility was responsible for calling the pharmacy for refills when needed. -The facility should contact the pharmacy when there was about one week's supply left on hand.	D 358		

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D 358	Continued From page 71 -The facility would pick up Resident #3's medications from the local pharmacy when they were ready. -If refills were needed, the pharmacy usually contacted the primary care provider (PCP). -If a medication did not come in, the MA should contact the PCP and document in the progress notes. -The facility was waiting on the pharmacy to get refills for the Carvedilol. -The MAs contacted the pharmacy about the Carvedilol but they did not contact the PCP when there was a delay in getting the refills. -She did not know if the PCP was aware the resident missed any doses of Carvedilol. Telephone interview with Resident #3's family member on 09/15/17 at 1:50 p.m. revealed: -She was very concerned about some of Resident #3's medications being unavailable recently. -There had been some instances when the resident was out of medications for several weeks. -The facility ran out of Carvedilol, a heart medication the resident had been taking for a couple of years. -The resident had episodes of tachycardia a couple of years ago and was put on the Carvedilol. -The resident no longer saw a cardiologist but she still needed the Carvedilol. -The resident's medications came from a local retail pharmacy and the facility was supposed to order and pick up the resident's medications. -There was a new pharmacist and she thought there may have been a breakdown of communication between the pharmacy and the PCP's office -The facility did not let the PCP know that the	D 358		

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D 358	Continued From page 72 resident needed refills and was out of the Carvedilol. -She contacted the PCP about the Carvedilol (could not recall date). -She spoke with the facility's Administrator about the Carvedilol being unavailable. -The Administrator told the family member that the facility was working on a system to help with this problem. Interview with Resident #3 on 09/15/17 at 6:28 p.m. revealed: -The facility ran out of some of her medications in the past and recently. -She could not recall if they had run out of her Carvedilol. -She had heart issues and sometimes got short of breath when walking down the hall. Attempted telephone interview with Resident #3's PCP during the survey on 09/15/17 was unsuccessful. B. Review of a physician's order dated 08/09/17 for Resident #3 revealed there was an order to restart Latanoprost 0.005% 1 drop in each eye at bedtime. (Latanoprost eye drops are used to treat glaucoma.) Review of Resident #3's August 2017 medication administration record (MAR) revealed there was an entry for Latanoprost instill 1 drop in both eyes at bedtime and it was documented as administered at 10:00 p.m. from 08/10/17 - 08/31/17. Review of Resident #3's September 2017 MAR revealed: -There was an entry for Latanoprost instill 1 drop in both eyes at bedtime and it was documented	D 358		

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D 358	Continued From page 73 as administered at 10:00 p.m. from 09/01/17 - 09/06/17. -Latanoprost was not documented as administered on 09/07/17, 09/08/17, or 09/11/17 due to "waiting on pharmacy". Telephone interview with a pharmacist at the retail pharmacy used by Resident #3 on 09/15/17 at 4:40 p.m. revealed: -It appeared there were no refills on the Latanoprost in 09/2017. -The pharmacy usually sent refill requests via fax or online requests to physicians' offices. -If the pharmacy was unable to dispense a medication due to no refills, they would make a note for the facility and put in the basket. -The pharmacy may also tell the facility to contact the physician for refills. -The pharmacy did not document those communications. -He was unsure if anyone from the facility contacted them about refills for Resident #3's Latanoprost. Review of pharmacy dispensing records for Resident #3 dated 03/01/17 - 09/15/17 revealed: -One 2.5ml bottle of Latanoprost eye drops was dispensed on 03/06/17. -One 2.5ml bottle of Latanoprost eye drops was dispensed on 04/07/17. -No Latanoprost was dispensed in 05/2017, 06/2017, 07/2017, or 08/2017. -One 2.5ml bottle of Latanoprost eye drops was dispensed on 09/12/17. Observation of Resident #3's medications on hand on 09/15/17 revealed there was one 2.5ml bottle of Latanoprost 0.005% eye drops dispensed on 09/12/17.	D 358		

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D 358	Continued From page 74 Interview with the Director of Resident Services (DRS) on 09/15/17 at 12:38 p.m. revealed: -She was not aware Resident #3's Latanoprost eye drops were recently unavailable. -Resident #3 used a local retail pharmacy and the facility was responsible for calling the pharmacy for refills when needed. -The facility should contact the pharmacy when there was about one week's supply left on hand. -The facility would pick up Resident #3's medications from the local pharmacy when they were ready. -If refills were needed the pharmacy usually contacted the physician. -If a medication did not come in, the MA should contact the physician and document in the progress notes. -She did not know if the physician was aware the Resident missed any doses of Latanoprost. Telephone interview with Resident #3's family member on 09/15/17 at 1:50 p.m. revealed: -She was very concerned about some of Resident #3's medications being unavailable recently. -There had been some instances when the resident was out of medications for several weeks. -The facility recently ran out of Latanoprost, an eye drop for glaucoma. -Resident #3 needed the eye drop because she had glaucoma and macular degeneration. -Resident #3 was no longer able to read and had blurry vision. -The resident's medications came from a local retail pharmacy and the facility was supposed to order and pick up the resident's medications. -She did not know why there was a delay in getting Resident #3's eye drops. -She spoke with the facility's Administrator about	D 358		

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D 358	Continued From page 75 the resident's medications being unavailable. -The Administrator told the family member that the facility was working on a system to help with this problem. Interview with Resident #3 on 09/15/17 at 6:28 p.m. revealed: -The facility ran out of some of her medications in the past and recently. -They recently ran out of her eye drops. -She was not sure how many days she did not receive the eye drops. -She did not notice any difference with her eyes when she did not receive the eye drops. -She had poor vision and could not see well. Attempted telephone interview with Resident #3's eye doctor on 09/15/17 was unsuccessful. 5. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 10:00 a.m. and 11:00 a.m. medication passes on 09/12/17 and 09/13/17. A. Review of Resident #9's current FL-2 dated 06/14/17 revealed: -Diagnoses included pneumonia, muscle weakness, intracerebral hemorrhage, and systemic inflammatory response syndrome. -There was an order for Renvela 800mg 2 tablets with meals. (Renvela lowers phosphate levels in kidney disease requiring dialysis.) Observation of the medication pass on 09/13/17 at 10:20 a.m. revealed: -Resident #9 was in the dining room eating lunch before she left to go to dialysis. -The medication aide (MA) administered two Renvela 800mg tablets to the resident.	D 358		

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D 358	Continued From page 76 Review of Resident #9's labwork from the dialysis center revealed: -The resident's phosphorus was 6.1 (high) on 07/12/17. (Reference range for phosphorus levels is 3.0 - 5.5 mg/dL.) -The resident's phosphorus was 5.2 on 07/31/17. -The resident's phosphorus was 5.0 on 08/08/17. -There were no phosphorus levels for 09/2017 in the record. Review of an order by the Physician's Assistant (PA) at the dialysis center for Resident #9 dated 09/04/17 revealed: -There was an order to stop Renvela 800mg for now due to low phosphorus. -There was a fax stamped date of 09/06/17 for receipt at the top of the page. Review of Resident #9's September 2017 medication administration records (MARs) revealed: -There was a computer printed entry for Renvela 800mg take 2 tablets 3 times a day with each meal. -Renvela was scheduled to be administered at 7:00 a.m., 11:00 a.m., and 5:00 p.m. -Renvela was documented as administered from 09/01/17 - 09/13/17 (11:00 a.m. dose). -The stop order for Renvela dated 09/04/17 was not included on the MARs and the administration of Renvela continued after the order to stop it. Telephone interview with the Administrator of the dialysis center on 09/13/17 at 12:12 p.m. revealed: -Resident #9's phosphorus level was drawn on 09/01/17 and it was 2.9 (low). -The PA wrote an order last week to stop the Renvela and the order was faxed to the facility.	D 358		

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D 358	Continued From page 77 -She was not sure what day it was faxed to the facility. -The PA then decided to decrease the Renvela to 1 tablet 3 times a day. -She was unsure if an order to decrease the Renvela was faxed to the facility. -She would contact the PA about the Renvela. Interview with the Director of Resident Services (DRS) on 09/13/17 at 12:32 p.m. revealed: -She was not aware of the order dated 09/04/17 to stop the Renvela. -It appeared the order was faxed to the facility on 09/06/17 based on the fax stamped date at the top of the page. -The MA / Supervisor on duty was responsible for faxing any new orders to the pharmacy when received and stapling a fax confirmation sheet to the order. -The pharmacy then inputs the orders into the electronic MAR system. -The order to stop Renvela was not faxed to the pharmacy since there was no fax confirmation sheet stapled to it. -It appeared the order was filed in the resident's record and not implemented. -The facility did not receive an order last week to decrease Renvela. -The Renvela should have been discontinued based on the order the facility received on 09/06/17. -She would write a medication error report and notify the dialysis center. Review of a medication error report for Resident #9 dated 09/13/17 revealed: -The DRS notified the dialysis center that Renvela continued to be administered to the resident after it was discontinued from 09/06/17 - 09/13/17. -The facility received the order via fax on	D 358		

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D 358	Continued From page 78 09/06/17 and the order was overlooked and filed in the resident's record. -The error was discovered on 09/13/17. -The DRS asked for advisement on what should be done by the facility. Telephone interview with the PA at Resident #9's dialysis center on 09/13/17 at 2:10 p.m. revealed: -She wrote an order last week to stop the Renvela because the resident's phosphorus was low. -She later discussed the Renvela with the dietician at the dialysis center and they decided to decrease the Renvela to 1 tablet 3 times a day. -She thought the dietician discussed it with the resident. -She did not fax an order to the facility because she thought the dietician had taken care of it. -She would have expected the facility to stop administering the Renvela based on the stop order faxed last week. -She was going to send an order for the facility to hold the Renvela now and have the resident's labwork rechecked at dialysis on Friday, 09/15/17. -She would decide after the labwork whether the Renvela should be restarted. Review of orders from the PA at the dialysis center dated 09/13/17 in response to the medication error report for Resident #9 revealed: -Please advise staff at the facility to discontinue Renvela. -Please obtain a repeat phosphorus level when the resident arrives to dialysis on Friday, 09/15/17. Interview with Resident #9 on 09/15/17 at 6:10 p.m. revealed: -She went to dialysis today, 09/15/17.	D 358		

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D 358	Continued From page 79 -She was unsure if they checked any labwork at dialysis. -She was not sure about her medications, including the Renvela. B. Review of Resident #8's current FL-2 dated 04/11/17 revealed diagnoses included brain cancer, seizure disorder, diabetes, cellulitis of the ankle, and frequent falls. a. Review of Resident #8's current FL-2 revealed there was an order for Symbicort 160/4.5mcg, inhale 2 puffs twice a day. (Symbicort is a combination inhaler with a steroid and long-acting bronchodilator used to treat and prevent breathing problems in lung disease.) Review of the September 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Symbicort 160/4.5mcg inhale 2 puffs twice daily. -Symbicort was scheduled to be administered at 10:00 a.m. and 10:00 p.m. Observation of the 10:00 a.m. medication pass on 09/13/17 revealed: -The medication aide (MA) administered Symbicort to Resident #8. -The MA administered 2 quick puffs in a row at 10:08 a.m. without allowing at least 1 minute between the puffs. -The MA waited about 5 seconds between the 2 puffs of medication. -The MA did not instruct the resident to hold breath in after each puff for approximately 10 seconds to allow the medication to reach the lungs. -Some medication vapors came back out of the resident's mouth.	D 358		

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D 358	Continued From page 80 Interview with the MA on 09/13/17 at 1:35 p.m. revealed: -She was trained a long time ago on proper technique for inhalers. -She could not remember how long she should wait between the puffs. -She was unsure how long the resident should hold in her breath with each the puff. Interview with Resident #8 on 09/13/17 at 4:20 p.m. revealed: -The MAs usually gave her 2 to 3 puffs of the inhaler back to back without waiting between the puffs. -The inhaler did not help with her breathing problems. Interview with the Director of Resident Services (DRS) on 09/13/17 at 1:45 p.m. revealed: -The MAs had been trained on proper technique for administering inhalers. -The MAs should wait at least 1 minute between puffs. Interview with the facility's Registered Nurse (RN) Consultant on 09/13/17 at 1:50 p.m. revealed: -The MAs had been trained on proper inhaler technique. -The MAs should wait 1 to 3 minutes between puffs. b. Review of physician's orders dated 07/06/17 for Resident #8 revealed an order for Flonase 50mcg Nasal Spray, 2 sprays in each nostril once daily. (Flonase is a steroidal nasal spray used to treat nasal symptoms of seasonal or year-round allergies.) Review of the September 2017 medication administration record (MAR) revealed:	D 358		

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D 358	Continued From page 81 -There was a computer printed entry for Flonase 50mcg Nasal Spray, use 2 sprays in each nostril once daily. -Flonase was scheduled to be administered at 10:00 a.m. Observation of the 10:00 a.m. medication pass on 09/13/17 revealed: -The medication aide (MA) administered Flonase to Resident #8 while the resident's head was tilted back. -The Flonase bottle was not upright when the MA sprayed it into the resident's nostrils. -The MA administered 4 sprays in the left nostril and 3 sprays in the right nostril instead of 2 sprays in each nostril as ordered. Interview with the MA on 09/13/17 at 1:35 p.m. revealed: -She was aware only 2 sprays of Flonase should be administered in each nostril. -She did not hear the Flonase come out of the bottle after the first spray so she gave more sprays to make sure the medication came out of the bottle. -She was trained a long time ago on proper technique for nasal sprays. -She was aware the resident should have her head upright and not tilted back when administering the nasal spray. -The resident usually tilted her head back for the nasal spray. Observation of Resident #8's Flonase Nasal Spray in the medication cart on 09/13/17 at 1:35 p.m. revealed the bottle was over half full of medication. Interview with Resident #8 on 09/13/17 at 4:20 p.m. revealed:	D 358		

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D 358	Continued From page 82 -She thought she usually got about 1 spray in each nostril of the Flonase but she was not sure. -She sometimes had a little blood come from her nose when she blew her nose. -She had a headache today (09/13/17) after she got her nasal spray. -She did not usually have a headache. Interview with the Director of Resident Services (DRS) on 09/13/17 at 1:45 p.m. revealed: -The MAs had been trained on proper technique for administering nasal sprays. -The MAs should make sure the resident's head was upright when administering nasal sprays. -The MAs should administer the amount of sprays ordered by the physician. Interview with the facility's Registered Nurse (RN) Consultant on 09/13/17 at 1:50 p.m. revealed: -The MAs had been trained on proper technique for nasal sprays. -The MAs should make sure the resident was sitting up straight and their head should not be leaned back when administering nasal sprays. The facility failed to assure that medications were administered as ordered including a resident (#1), who experienced pain and withdrawal symptoms from missing doses of a narcotic pain medication and experienced pain and withdrawal symptoms; a resident (#10), who received rapid-acting insulin more frequently than it was ordered; a resident (#5), who received the incorrect dose of sliding scale insulin; a resident (#3), who did not receive a heart / blood pressure medication and glaucoma eye drops as ordered due to the medications being unavailable; and a resident (#9), who had a diagnoses of end stage renal disease and continued to receive a medication used to control phosphorus levels in dialysis after	D 358		

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D 358	Continued From page 83 the medication was discontinued. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm and serious neglect to the residents and constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 09/15/17 revealed: -A new pharmacy has been hired to service facility. -The Director of Resident Services (DRS) and Special Care Unit Coordinator (SCUC) will review medication administration records (MARs) / treatment administration records (TARs). -DRS and SCUC will print the MARs/TARs out and sign off they have been reviewed. -This process will be used for 3 months to ensure orders are entered properly and transition to new pharmacy has been completed. -The first review will be completed by 09/30/17 for October 2017 MARs. -Likewise, these reviews will follow for October 2017 and November 2017. -A chart review schedule will be created to have each chart reviewed monthly versus the MARs/TARs. -With new pharmacy, a chart review and cart review were completed 09/05/17 - 09/07/17. -Recommendations from pharmacy were received on 09/14/17. -These recommendations will be reviewed and the quality improvement committee will be enlisted to complete a plan to routinely spot check carts, MARs, TARs, and other documentation for discrepancies. -The pharmacy will be utilized to complete quality checks of medication aides (MAs). -Non-compliance / repeat non-compliance will dictate MA removal from cart with retraining or discharge.	D 358		

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D 358	Continued From page 84 -Extra or repeat training will need to be completed for insulin administration with a concentration on sliding scales. -Inhaler, eye drops, and other medications without oral route of administration will be reviewed with current MAs. -Basic skills and requirements about medication storage, ordering, disposal, and refusals / medication outs will be reviewed. -The policy with regards to these areas will be reviewed and updated if necessary. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure Medication Aides (MA) observed residents (#3, #6 and #7) swallow medications once administered before signing off on the Medication Administration Record (MAR) resulting in medications being spilled/dropped by residents. The findings are:	D 366		

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D 366	Continued From page 85 1. Review of Resident #3's current FL-2 dated 04/16/17 revealed: -Diagnoses included Parkinson's disease, Osteoarthritis and Irritable Bowel Syndrome. -The resident was intermittently disoriented. -The resident's vision was listed under the Functional Limitation section as limited. Review of Resident #3's Resident Register dated 05/12/16 revealed: -The resident had glaucoma and macular degeneration. -The resident wore glasses. -The resident had difficulty seeing small print. -The resident was forgetful and needed reminders. Observation in Resident #3's room on 09/11/17 at 12:00pm revealed: -There was a plastic medication cup with pink liquid residue, a 6 ounce plastic cup with approximately 2 ounces of a clear liquid and an empty paper medication cup on a table beside her chair. -On the floor beside the table was 3 white capsules, a yellow tablet, a white tablet and a brownish red tablet. Interview with Resident #3 on 09/11/17 at 12:02pm revealed: -She had been in the bathroom when the medication aide (MA) came in with her medications this morning. -The MA had left her medications on the table by her chair for her to take after she finished in the bathroom. -She was not sure of the time the MA left the medications but knew it was after breakfast. -Resident #3 had dropped her medications from	D 366		

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D 366	Continued From page 86 the paper cup while trying to take them. -The resident had taken the pink liquid without problem. -The resident did not recall if the MA administered the eye drops this morning. -She thought she had drank the Miralax mixture. -The resident was unsure of how many medications were in the paper cup and how many she had dropped. -She had not told the MA she had dropped her medicine because the MA had not been back since she left the medication. -The resident was unsure of how often MAs left her medication for her to take by herself. Interview with Resident #3 on 09/15/17 at 6:28 p.m. revealed: -The resident had poor vision. -"I can't see good". Review of Resident #3's September 2017 medication administration record (MAR) revealed: -The resident's morning medications were scheduled at 8:30am and 10:00am. -At 8:30am, the resident was to receive Pepto Bismol (used to treat diarrhea, heartburn and/or nausea) 1 teaspoon with meals. -At 10:00am, the resident was to receive Align (a probiotic supplement) 1 capsule; Sinemet 25/100 (used to treat Parkinson's disease) 1 tablet; Coreg 3.125mg (used to treat hypertension) 1 tablet; Senokot-S (a laxative) 1 tablet on Monday, Wednesday and Friday; Miralax powder (a laxative) 17 grams in 8 ounces of water; Systane Ultra drops (used to relieve dry, irritated eyes) 1 drop in each eye; Trusopt 2% drops (used to treat Glaucoma) 1 drop in each eye; Hydrochlorothiazide 12.5mg (used to treat hypertension) 1 capsule; Claritin 10mg (used to	D 366		

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	HAL047012	A. BUILDING: _____ B. WING _____	C 09/15/2017

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D 366	Continued From page 87 treat allergies) 1 tablet and Premarin 0.625mg (a hormone replacement). -All morning medications were documented as administered for 09/11/17. Observation of Resident #3's medication on hand 09/11/17 at 1:00pm revealed: -The 3 capsules found on the floor resembled Hydrochlorothiazide 12.5 mg that was on hand for Resident #3. -The brownish red tablet found resembled Senokot-S that was on hand for Resident #3. -The yellow tablet found on the floor resembled Sinemet 25/100 that was on hand for Resident #3. -The white tablet found on the floor resembled Coreg 3.125mg that was on hand for Resident #3. Interview with the first shift MA on 09/11/17 at 12:55pm revealed: -She never left medications in residents' rooms for them to take later. -If a resident refused the medications or was in the bathroom, she would return later to attempt administration. -Once the resident took the medication, the MA would document administration on the MAR. -After being shown the dropped medications, the MA said she left Resident #3's medication this morning because the resident was coming out of the bathroom and would take them momentarily. -The MA acknowledged that leaving medications for a resident to take later was not the facility policy. -The MA had not administered the Trusopt 2% eye drops nor the Systane Ultra eye drops at 10:00am as documented. -The remaining clear liquid on the resident's table was water "because Miralax becomes cloudy	D 366		

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D 366	Continued From page 88 after it sits". Interview with the Director of Resident Services on 09/11/17 at 1:15 p.m. revealed: -The MAs had been trained to actually observe residents take their medications, -The MAs should not document their initials on the MARs until they actually observe a resident take their medications. -The MA should have waited and observed Resident #3 take her medications that morning (09/11/17) during the medication pass. -She was not aware the MA had not administered the two eye drops to Resident #3 that morning either. -The MA should not have documented the eye drops as being administered on the MAR. -She would complete a medication error report and notify Resident #3's primary care provider of the medication errors. Review of a faxed physician's order sheet from Resident #3's primary care provider (PCP) on 09/11/17 at 3:05pm revealed: -The PCP was notified of the missed medications. -The PCP ordered "resume routine medication schedule". Refer to interview with a 1st shift MA on 9/13/17 at 1:00pm. Refer to interview with a 2nd shift MA on 9/13/17 at 4:00pm. Refer to Interview with the Administrator on 09/11/17 at 6:15 p.m. 2. Review of Resident #6's FL-2 dated 4/21/17 revealed:	D 366		

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D 366	Continued From page 89 - Diagnoses included history of cerebrovascular accident (CVA), hyperlipidemia, history of bilateral pulmonary embolism and history of deep vein thrombosis (DVT). -Medication orders included Docusate 100mg 2 times a day (used to treat constipation), Lisinopril 10mg one time a day (used to treat high blood pressure), Metoprolol Tart 25mg 2 times a day (used to treat high blood pressure) and Simvastatin 40mg at bedtime (used to treat high cholesterol). Observation on 9/11/17 at 12:25pm revealed 4 empty, clear, plastic medication cups stacked inside the top drawer in Resident #6's bedside table. Interview with Resident #6 on 9/11/17 revealed: -The Medication Aides (MA) brought his medication (pills) in his room in the plastic medication cups and watched him take the medications. -At times, the MAs would set the cups on the bedside table and walk over to his roommate to check on him or walk out of the room. -When the medication was left on the table, he would always take the medication and sometimes place the cup in the bedside table drawer. -The MAs did not leave the medication on his bedside table often, only when they were busy at times. -The resident did not know the MAs name, stating his eyesight was not too good. Review of Resident #6's medication administration record (MAR) for September 2017 revealed all medications were documented as administered by the MAs. Refer to interview with a 1st shift MA on 9/13/17	D 366		

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D 366	Continued From page 90 at 1:00pm. Refer to interview with a 2nd shift MA on 9/13/17 at 4:00pm. Refer to Interview with the Administrator on 09/11/17 at 6:15 p.m. 3. Review of Resident #7's FL-2 dated 01/17/17 revealed: -Diagnoses included hypertension, anxiety, chronic obstruction pulmonary disease (COPD), depression, thyroid nodule, and chronic back pain. -Medication orders included Aspirin 81mg every day (used as a blood thinner), Azor 5/20mg every day (used to treat high blood pressure), Breo-Ellipta 100/25mcg 1 puff every day (used to treat COPD), Linzess 290 mcg every other day (used to treat irritable bowel syndromw with constipation), Meloxicam 15mg every day (used to treat relieve pain), Omeprazole 20mg every day (used to gastroesophageal reflux), Potassium ER 20meq every day (used to treat low potassium), Pravastatin 20mg every day with supper (used to treat high cholesterol), Spiriva Handihaler inhale 1 cap every day (used to treat COPD), Venlafaxine HCL Er 75mg every day (used to treat depression) and Diphenhydramine 25mg every 6 hours as needed for itching. Review of a physician's order for Resident #7 dated 7/6/17 revealed an order for Belsomra 10mg at bedtime as needed for sleep. Interview with Resident #7 on 9/11/17 at 12:55pm revealed: -The MAs brought medications to her room in plastic medication cups and watched her take her medications.	D 366		

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D 366	Continued From page 91 -The resident's sleep aide was ordered for bedtime if she needed it. -If the MAs bought her sleep aide to take at bedtime,around 8:00pm -9:00pm, and she was not in her room or in the bathroom, the medication was left on her bedside table in the plastic cup and the resident would take the pill before going to bed. -At times if the MAs brought the sleep aide and the resident was in her room and not ready to take the pill, the resident would place the cup with the pill in the bedside drawer and take the pill when she was ready for bed. -The resident refused to give names of MAs. Confidential resident interview revealed: - The MAs usually brought medications in a cup and stayed in the room until the medications were taken by the resident. -At times, if the resident was in the bedroom, the MAs would leave the cup with the medications on the bedside table and tell the resident the medication was on the table. -The resident would take the medication when out of the bathroom. Refer to interview with a 1st shift MA on 9/13/17 at 1:00pm. Refer to interview with a 2nd shift MA on 9/13/17 at 4:00pm. Refer to Interview with the Administrator on 09/11/17 at 6:15 p.m. _____ Interview with a 1st shift MA on 9/13/17 at 1:00pm revealed: -The MA did not leave medications with the resident or on the bedside table.	D 366		

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D 366	Continued From page 92 -The MA always observed the resident s take the medication before leaving and if the resident did not take the medication, she would take the medication out of the room. Interview with a 2nd shift MA on 9/13/17 at 4:00pm revealed: -The MA did not leave medications with residents or on the bedside table. -The MA always observed the residents take the medication before leaving the resident's room. -If the resident did not take the medication, she would take the medication out of the room. She would not leave the medication in the room. Interview with the Administrator on 09/11/17 at 6:15 p.m. revealed: -The MAs had been trained to actually observe the residents take their medications. -The MAs should not document medications as administered unless they actually observe the resident take the medications.	D 366		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the medication cart on Jordan	D 378		

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D 378	Continued From page 93 Hall was locked on 3 occasions when the medication cart was not under the immediate or direct physical supervision of the medication aide. The findings are: Observation on 09/11/17 at 10:13 a.m. on Jordan Hall on the assisted living side revealed: -There was a medication cart parked about midway down the hall. -The push-button lock on the medication cart was sticking out and the cart was not locked. -There was no medication aide (MA) in sight on the hallway. Interview and observation of the Administrator on 09/11/17 at 10:16 a.m. revealed: -She was unaware the medication cart on Jordan Hall was unlocked. -She did not know where the MA was located. Observation on 09/11/17 at 10:16 a.m. revealed: -The Administrator walked down Jordan Hall toward the nurses' station to search for the MA. -The MA came walking from Townsend Hall toward the nurses' station and Jordan Hall. -The MA had a water pitcher in her hand. -The Administrator told the MA the medication cart was unlocked and "state" was in the building. Observation on 09/11/17 at 10:17 a.m. revealed the MA walked to the mediation cart on Jordan Hall and pushed in the push-button lock on the cart. Observation on 09/14/17 at 4:23 p.m. on Jordan Hall on the assisted living side revealed: -There was a medication cart parked about midway down the hall. -The push-button lock on the medication cart was	D 378		

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D 378	Continued From page 94 sticking out and the cart was not locked. -There was no MA in sight on the hallway. -Two residents walked by the unlocked medication cart. -A visitor pushed another resident in a geri-chair by the unlocked medication cart. Observation on 09/14/17 from 4:26 p.m. - 4:29 p.m. revealed: -The MA walked from the nurses' station area to a resident's room on the Jordan Hall. -At 4:28 p.m., the MA came out of the resident's room and was walking down Jordan Hall when she noticed the medication cart was unlocked. -The MA locked the medication cart. -A second MA came back to the medication cart at 4:29 p.m. Interview with the MA on 09/14/17 at 4:28 p.m. revealed: -They were in the process of training a new MA. -She did not realize the medication cart was unlocked. -It should have been locked. Interview with the Director of Resident Services (DRS) on 09/14/17 at 4:37 p.m. revealed: -The MAs had been trained to keep the medication carts locked when they were not in sight of the carts. -She was not aware the medication cart on Jordan Hall had been left unlocked again. Observation on 09/15/17 at 5:18 p.m. on Jordan Hall on the assisted living side revealed: -There was a medication cart parked about midway down the hall. -There was a resident in a geri-chair in the hallway and the back of the geri-chair was touching the medication cart.	D 378		

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D 378	Continued From page 95 -The push-button lock on the medication cart was sticking out and the cart was not locked. -There was no MA in sight on the hallway. -A resident wearing a wander guard bracelet on her ankle walked by the unlocked medication cart and stopped at the cart to talk to the resident in the geri-chair. -A visitor walked up to the resident in the geri-chair at the medication cart and started talking to the resident in the geri-chair. Interview with the DRS on 09/15/17 at 5:21 p.m. revealed: -She was not aware the medication cart on Jordan Hall was unlocked. -It was supposed to be locked. -She did not know the location of the MA assigned to that cart. -She would lock the cart. Observation on 09/15/17 at 5:22 p.m. revealed the DRS locked the medication cart on Jordan Hall. Observation on 09/15/17 at 5:25 p.m. revealed: -The DRS found the MA on the back hall in the Special Care Unit (SCU). -The MA walked back to Jordan Hall from the SCU.	D 378		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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D 438	Continued From page 96	D 438		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 1of 1 sampled residents (#2) by a staff (Staff E) to the Health Care Personnel Registry (HCPR).

The findings are:

1.Review of Resident #2's FL-2 dated 11/21/16 revealed diagnoses included dementia, hypertension, anxiety, osteoarthrosis lower leg, lumbago, schizophrenia, delusional disorder, bipolar disorder, depression with psychotic disorder.

Review of an Incident/Accident report dated 08/31/17 revealed:
- Staff E was lifting Resident #2 by herself with the hoyer lift that required two staff.
- Resident #2 was hollering during the process.
- Staff E was pulling on Resident #2's arm.

Interview with Staff E, personal care aide (PCA). on 09/12/17 at 3:50 pm revealed:
-Two PCAs usually assisted with changing and transferring Resident #2 but it was only Staff E on that day (08/31/17).
-Staff E tried to get Resident #2 up. Resident #2 was hollering and holding onto the bed rails. Resident #2 did not want to be turned. Staff E tried to pry Resident #2's hands off the bed rail.
-Resident #2's family member came into the room and appeared to be mThe family member

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D 438	Continued From page 97 told Staff E, "I'm about tired of you. There should be another aide in here with you." -The Special Care Unit Coordinator (SCUC) came into the room and told Staff E to leave the room. -Staff E was written up, and was moved to the assisted living side of the facility to work. Review of Investigation Notes dated 08/31/17 revealed: -Staff E was trying to open Resident #2's hand and loosen the resident's hold on the bedrails. -Staff E was written up. -Staff E was moved from the back hall to the front hall to work. -Staff E was taken off the schedule for one day. Review of a verbal statement from the SCUC dated 8/31/17 revealed: -Resident #2's family member approached the SCUC and was very upset. -The family member stated that Staff E was being rough with Resident #2. -Staff E was trying to get Resident #2 out of bed and the resident kept gripping the bed rails and was resisting. -Staff E tried to get Resident #2's hands loose from the bed. Interview with the Administrator on 09/12/17 at 6:00 pm and on 09/13/17 at 6:00 pm revealed: -The Administrator was not immediately made aware of what happened. -The family member told the Administrator that Resident #2 had been abused shortly after 4:00pm on the day of the incident. -The family member reported that the the incident had "just happened." -It all happened within 15 minutes of the family member arriving to the facility.	D 438		

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D 438	Continued From page 98 -Staff E was changing Resident #2, and Staff E knew she was supposed to have two staff when using the hoyer lift. -The SCUC removed Staff E from the room. -Staff E was written up and taken off the schedule for one day. -Staff E was moved from the SCU to the AL side of the building permanently. -A 24-hour report nor a 5 day report was completed, but the Administrator investigated the allegation and determined there were no further action required. -The Administrator was concerned that if the report was sent to HCPR, the allegation would remain on Staff E's HCPR report. -The Administrator was very careful with those reports because she knew the ramifications, and she wanted to make sure the information she had was accurate. -The Administrator was responsible for investigating allegations of abuse; completing 24 hour/5 day reports; and sending the reports to HCPR. Review of a HCPR 24 hour report revealed: -The report was completed and faxed to HCPR on 9/13/17. -The incident date was 8/31/17 and the allegation was made by a family member, who alleged that Resident #2 was being treated rough by a staff. -The accused staff was Staff E. Review of a 5 day report revealed the report was completed on 9/13/17 and faxed to HCPR on 9/13/17. The failure of the facility to report an allegation of abuse and the results of their investigation of a resident (#2) by a staff member (Staff E) to the N. C. Health Care Personnel Registry resulted in an	D 438		

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D 438	Continued From page 99 alleged perpetrator of abuse being allowed to continue to work, putting Resident #2 and other residents at risk for further abuse. This failure resulted in residents being at substanital risk for harm, which constitutes a Type A2 Violation. _____ Review of the Facility's Plan of Protection dated 9/14/17 revealed: -Depending on the allegation, employee will be reassigned, suspended, or discharged. -A 24 hour report will be completed. -Part of internal investigation includes interviews with staff, family and any possible witnesses. -Internal investigation completed and 5 day report completed. -If further action required with employee, then it's taken care of. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT TO EXCEED OCTOBER 15, 2017.	D 438		
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	D 482		

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D 482	Continued From page 100 (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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used after an assessment and	D 482		

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D 482	Continued From page 101 care planning process had been completed as required for 3 of 3 residents sampled with restraints (#2, #5, #13); and failed to assure physical restraints were applied correctly for 1 of 3 residents sampled with restraints (#13) who had a soft belt pelvic restraint. The findings are: 1. Review of Resident #13's current FL-2 dated 02/20/17 revealed: -Diagnoses included Alzheimer's dementia, hypertension, osteoarthritis of the hip, iron deficiency, Vitamin D deficiency, and Vitamin B12 deficiency. -The resident was intermittently disoriented and wandered. -The resident required assistance with bathing and dressing. -The section for restraints was blank. Review of Resident #13's Resident Register revealed the resident was admitted to the facility on 05/10/17. Review of Resident #13's current resident care plan dated 06/28/17 revealed: -The resident was not oriented to person, time, or place. -The resident could not take direction, follow instructions, or communicate wants/needs. -The resident could tell her likes and dislikes at times. -The resident got aggressive with staff at times. -The resident wandered at times. -There was no documentation related to the use of any physical restraints. -The resident required extensive to total assistance with bathing and grooming. -The resident required extensive assistance with	D 482		

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D 482	Continued From page 102 toileting and dressing. -The resident required limited assistance with ambulation, transferring, and eating. Review of Resident #13's Licensed Health Professional Support (LHPS) review dated 05/17/17 revealed: -LHPS tasks included ambulation with assistive device, transferring, and physical restraints. -The resident used a wheelchair for locomotion but could ambulate with a cane for short distances. -Staff assisted with the use of the wheelchair for long distances. -Staff provided assistance with transfers. -The resident had a couple of falls with no lasting injuries. -The resident required the use of half bedrails to help prevent falls/injury. -The resident needed a seat belt in the wheelchair to help prevent falls/injury when she was out of bed. Review of Resident #13's LHPS review dated 08/10/17 revealed: -LHPS tasks included ambulation with assistive device, transferring, and physical restraints. -The resident required extensive assistance from staff with locomotion with wheelchair and transferring. -The resident required the use of half bedrails to help prevent falls/injury. -The resident needed a seat belt in the wheelchair to help prevent falls/injury when she was out of bed. Review of incident/accident reports for Resident #13 revealed: -05/17/17: The resident fell out of bed and had injury to left elbow and hip. The resident was	D 482		

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D 482	Continued From page 103 sent to the emergency room (ER). -06/11/17: The resident became combative and swung at staff and rolled on the floor. The resident had skin tear on top of nose. The family did not want resident sent to ER. -06/22/17: The resident was found on floor in day room. It appeared the resident got out of wheelchair and fell on floor. The resident was sent to ER for evaluation. -06/28/17: It appeared the resident got up from wheelchair and fell on the floor. The resident complained of abdominal pain and was sent to the ER. -07/02/17: The resident was observed lying on the floor on her left side. The resident had a bump and skin tear on left forehead and skin tear on left elbow. The resident was sent to the ER. -07/04/17: The resident undone seat belt and fell onto the floor. The resident had a skin tear on her right elbow and was sent to the ER. -07/12/17: The resident slid out of wheelchair because of "loosen seat belt". No injuries were noted. Review of physician's orders for Resident #13 revealed: -There was an order request dated 05/17/17 to get a hospital bed with rails for safety precautions. -There was a second request dated 06/14/17 that family requested a hospital bed because the resident had problems falling out of bed. -The primary care provider (PCP) signed an order on 06/14/17 for hospital bed with rails for safety. Review of a physical restraint assessment and care plan form for Resident #13 dated 06/21/17 revealed: -It was attached to an order dated 06/21/17 for ½ bedrails.	D 482		

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D 482	Continued From page 104 -The section for the restraint currently being used was blank. -Alternatives to restraints being used were bowel and bladder training every 2 hours and snacks 3 times a day. -Alternatives attempted to avoid restraint use included toileting, assist with snacks and meals as needed, activities, and family visits. -The medical symptoms for the restraint were risk for falls and number of falls "up"; weak and unsteady gait; continues to get up on her own; and due to cognitive impairment unable to call for assistance. -The symptoms were first noted upon admission and daily. -The form was signed by the family and the Special Care Unit Coordinator (SCUC). -There was no documentation a Registered Nurse (RN) participated in the assessment and care plan process for the restraint. -The section for the RN Consultant to sign was blank. Review of physician's orders for Resident #13 revealed: -There was an order request dated 06/26/17 to get a light weight wheelchair with seat belt to prevent falls. -There was an order for physical restraint electronically signed by the PCP on 06/26/17 for a seat belt. -There was an order for home medical equipment electronically signed by the PCP on 06/28/17 for a standard wheelchair with back and seat cushions and seat belt. -There was fax confirmation to the DME Company on 06/28/17. Review of a physical restraint assessment and care plan form for Resident #13 dated 06/27/17	D 482		

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D 482	Continued From page 105 revealed: -It was attached to a consent form for the use of a seat belt signed by the family on 06/28/17. -The section for the restraint currently being used was blank. -Alternatives to restraints being used were bowel and bladder training every 2 hours and fluid will be offered (how often was not specified). -Alternatives attempted to avoid restraint use included toileting, assist with snacks and meals as needed, activities, and family visits. -The medical symptoms for the restraint were weak and unsteady gait and she continued to get up on her own. -The symptoms were first noted upon admission and daily. -The form was signed by the family and the SCUC. -There was no documentation a RN participated in the assessment and care plan process for the restraint. -The section for the RN Consultant to sign was blank. Review of a physical restraint assessment and care plan forms for Resident #13 dated 08/28/17 revealed: -It was attached to a consent form for the use of a pelvic support restraint signed by the family on 08/28/17. -The section for the restraint currently being used was blank. -Alternatives to restraints being used were bowel and bladder training every 2 hours and fluid will be offered (how often was not specified). -Alternatives attempted to avoid restraint use included toileting, assist with snacks and meals as needed, activities, and family visits. -The medical symptoms for the restraint were weak and unsteady gait and the resident	D 482		

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D 482	Continued From page 106 continued to get up on her own. -The symptoms were first noted upon admission and daily. -The form was signed by the family and the SCUC. -There was no documentation a RN participated in the assessment and care plan process for the restraint. -The section for the RN Consultant to sign was blank. Review of physician's orders for Resident #13 revealed: -There was an order signed by the PCP on 09/06/17 for a pelvic support restraint. -There was an order signed by the PCP on 09/06/17 for ½ bed rails. -There was an order signed by the PCP on 09/07/17 for a standard wheelchair with seat cushion and seat belt. -There was a faxed stamp with 09/07/17 handwritten below it. Observation of Resident #13 in the Special Care Unit (SCU) on 09/11/17 at 4:48 p.m. revealed: -A personal care aide (PCA) was in the hallway outside of Resident #13's room. -Resident #13 was sitting in her wheelchair in the hallway. -The PCA wrapped the straps of a soft belt restraint around Resident #13's chest area and around the back of the wheelchair seat. -The PCA wrapped the straps around the resident 3 times and tied the straps in a knot behind the back of the wheelchair. -The PCA then pushed Resident #13 in the wheelchair down the hall to the dayroom. Interview with the PCA on 09/11/17 at 5:00 p.m. revealed:	D 482		

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D 482	Continued From page 107 -This was the first time she had used the soft belt restraint for Resident #13. -She put it on the resident because the resident did not have a seat belt in her wheelchair and she wanted to keep the resident from sliding out of the seat. -She had not been trained on how to use the soft belt restraint. -She planned to ask the SCUC how to use the soft belt but she had not asked yet. Interview with the SCUC on 09/11/17 at 5:02 p.m. revealed: -The soft belt for Resident #13 was a pelvic restraint. -The resident had just gotten it in the "last week or two". -She was not sure how to apply the soft belt restraint. -She had not been trained on how to apply it. -The durable medical equipment (DME) Company delivered the soft belt to the facility but they did not teach or train staff on how to use it. -There should be instructions with the box but she would have to find it. -She would reposition the soft belt because it was supposed to be around the pelvic area, not the chest area. Observation on 09/11/17 at 5:02 p.m. revealed: -The SCUC untied the straps and positioned the soft belt around the resident's pelvic area. -She pulled the straps between each side of the seat, criss-crossed the straps behind the back of the wheelchair, and wrapped the straps around both anti-tip bars multiple times. -She then tied the ends of the straps together in a knot in the center at the bottom of the wheelchair. Interview with the medication aide (MA) on	D 482		

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D 482	Continued From page 108 09/11/17 at 5:20 p.m. revealed: -She had training about a year ago on restraints when she worked at a hospital. -She had not applied the soft belt restraint to Resident #13 before because it was fairly new. -The soft belt restraint did not look like it was currently applied correctly to the resident. -It should be tied in a manner where you can pull the strap one time to release it in case of an emergency. -She would try to reapply the soft belt restraint. Observation on 09/11/17 at 5:20 p.m. revealed: -The MA untied the knot on the soft belt restraint for Resident #13. -The MA reapplied the soft belt restraint and made loops in the straps so they could be released in one pull. Observation of Resident #13 on 09/12/17 at 9:53 a.m. revealed: -The resident was lying in bed with 1 bedrail in the up position. -The other side of the bed was pushed against the wall and the bedrail was in the down position. -The resident mumbled when spoken to. Interview with the SCUC on 09/12/17 at 10:10 a.m. revealed: -Resident #13 started sliding out of chair and falling when she was admitted to the facility. -The resident's family wanted the resident to get a new wheelchair with a seat belt. -She did not know why the DME Company sent a soft belt. -She called the DME Company today, 09/12/17, and she was waiting to hear back from them. -The order was supposed to be for a seat belt. -She did not know why "pelvic support" was circled on the order.	D 482		

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D 482	Continued From page 109 Interview with a technician from the DME Company on 09/12/17 at 11:35 a.m. revealed: -He was currently at the facility to bring a new seat belt with press-button release for Resident #13. -He was going to install the new seat belt today, 09/12/17. -He was not sure about the soft belt restraint for Resident #13. -He brought supplies based on orders the company received. Interview with the SCUC on 09/12/17 at 11:40 a.m. revealed: -She did not realize the soft belt restraint did not have the piece in the crotch like the facility had used in the past for a former resident. -She did not open the box when the DME technician delivered it. -After she saw the soft belt restraint, she got an order based on what was delivered to the facility. Observation of Resident #13 on 09/12/17 at 12:20 p.m. revealed: -Resident #13 was pushed down the hall by staff in a wheelchair to the dining room. -The resident was wearing the new seat belt. Interview with the facility's RN Consultant on 09/13/17 at 9:20 a.m. revealed: -There was a former resident at the facility that had a pelvic restraint with a piece in the crotch. -She had trained facility staff on how to apply that type of pelvic restraint. -She was not aware Resident #13 had a soft belt restraint until either yesterday (09/12/17) or the day before (09/11/17) when she was notified by the Administrator. -She usually worked at the facility every	D 482		

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D 482	Continued From page 110 Wednesday and Thursday. -No one had notified her when they received the soft belt restraint for Resident #13. -The SCUC or Director of Resident Services (DRS) should notify her when the facility got an order for restraints so she could make sure everyone was trained on how to properly apply and use the restraint. -She had not trained staff on how to use a soft belt restraint because no one at the facility had one previously to her knowledge. -The soft belt restraint should be tied in 1 pull knots that can be easily released with one pull. -She had trained staff on bedrails, lap buddies, geri-chairs with trays, geri-tent, and seat belts. -The seat belt should be applied snuggly up against the resident's waist/pelvic area and the seat belt should not be loose. Interview with the SCUC on 09/13/17 at 11:35 a.m. revealed: -She faxed the order for wheelchair with seat belt to the DME Company on 06/28/17. -She called the DME Company back later to find out why the equipment had not been delivered to the facility. -She did not document the call and she could not recall when she called. -In the meanwhile, they used an old wheelchair with a seat belt that the family had brought for Resident #13. -The equipment was delivered to the facility on 08/25/17. -They received the wheelchair and the soft belt restraint instead of a seat belt. -After they received the soft belt, she thought it was a pelvic restraint so she got an order from the PCP for the pelvic support restraint. Telephone interview with a representative from	D 482		

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D 482	Continued From page 111 the DME Company on 09/13/17 at 1:40 p.m. revealed: -They received an initial referral via fax for Resident #13 on 06/28/17 for wheelchair, basic cushions, and seat belt. -They received an order for a physical restraint, a seat belt, (dated 06/26/17) for Resident #13 on 06/28/17. -They delivered a wheelchair, seat belt, and cushions on 08/28/17. -He was not sure why there was a two month delay in getting the equipment to the facility. -They received a second detailed order for a standard wheelchair, seat cushion, and seat belt on 09/08/17 that was signed by the physician on 09/07/17. -They did not deliver another wheelchair but they delivered a soft belt restraint on 09/08/17. -He was not sure why a soft belt was sent to the facility. -They did not receive an order dated 09/06/17 for a pelvic support restraint. -It appeared they pulled the wrong item when they delivered the soft belt restraint. -Another employee with the DME company spoke with the facility's SCUC and brought a seat belt to the facility on 09/12/17. Observation of Resident #13 on 09/13/17 at 4:37 p.m. revealed: -Resident #13 was sitting in the special care unit day room in a wheelchair. -The resident was wearing a seat belt. -The seat belt was loose and sagging down toward the top of the resident's legs. Observation of Resident #13 on 09/15/17 at 2:29 p.m. revealed: -The resident was lying in bed with 1 bedrail in the up position.	D 482		

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D 482	Continued From page 112 -The other side of the bed was pushed against the wall and the bedrail was in the down position. Telephone interview with Resident #13's family member on 09/14/17 at 3:57 p.m. revealed: -Resident #13 had some falls from the bed and the wheelchair. -He was aware Resident #13 had a hospital bed with rails and he signed off so they could use the bedrails. -The resident walked with a cane when she was first admitted but eventually the resident either could not or did not want to walk so she was put in a wheelchair. -The resident started leaning over and falling out of the wheelchair. -There was an older wheelchair with a seat belt the resident used and he had signed off so they could use it. -After the resident's insurance changed, they got a new wheelchair. -The DME Company recommended a soft belt because the resident was sliding out from under the seatbelt. -It was his understanding the soft belt restraint would come up between the legs and go around the waist. -He thought the facility was going to use the soft belt restraint. Interview with the DRS and the SCUC on 09/14/17 at 5:55 p.m. revealed: -They were responsible for getting orders for restraints. -They were responsible for the assessment and care planning process for physical restraints. -They were not aware a RN was supposed to be part of the assessment and care planning team process for restraints. -They would have the facility's RN Consultant	D 482		

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D 482	Continued From page 113 take part in the team process for restraints. Review of physician's orders for Resident #13 revealed: -There was a fax cover sheet dated 09/12/17 with the facility requesting the PCP to sign and date a restraint order and fax back to the facility. -The attached restraint order form had "seat belt" circled. -The order had not been signed by the PCP. -There was a fax confirmation to the PCP dated 09/12/17. Attempted telephone interviews with Resident #13's primary care provider on 09/14/17 and 09/15/17 were unsuccessful. 2. Review of Resident #5's current FL-2 dated 01/27/17 revealed: -Diagnoses included dementia with behavioral issues, diabetes type II, hypertension, hyperlipidemia, left extremity edema, osteoporosis, glaucoma, and urinary incontinence. -The resident was intermittently disoriented. -The resident was non-ambulatory. -The resident required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. - The section for restraints was marked and indicated "bedrails". Observation of Resident #5 on 09/12/17 at 9:59 a.m. revealed: -The resident was sitting in her wheelchair in the day room of the special care unit. -The resident was asleep and her body was leaning to the right in the wheelchair.	D 482		

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D 482	Continued From page 114 Review of a physical restraints conference form dated 01/17/14 for Resident #5 revealed: -The restraint being used was bedrails / hospital bed with rails. -There was no documentation of an assessment and care planning process being completed including a registered nurse (RN). -There was a consent form signed by the resident's responsible party. Review of a physician's restraint order dated 05/06/14 for Resident #5 revealed: -There was an order for bedrails. -The medical need for the restraint included: anytime resident was left unattended and their safety might be jeopardized; the resident was unable to be in charge of her well-being due to their mental or physical condition; and there was a history of falls or the resident was known to wander. -The resident was to be checked every 30 minutes and released every 2 hours. Review of Resident #5's current annual assessment and care plan dated 06/05/17 revealed: -The resident required supervision with eating. -The resident required extensive assistance with bathing, dressing, and grooming. -The resident required total assistance with toileting, ambulation, and transferring. -The resident used physical restraints daily. -The type of restraint or specific information regarding the use of the restraint was not included. Review of Resident #5's quarterly resident profile and screening assessments for the Special Care Unit (SCU) dated 01/23/17, 04/14/17, and 07/01/17 revealed:	D 482		

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D 482	Continued From page 115 -The resident required total care with toileting, bathing, and dressing. -The resident did not walk and staff assisted with ambulation with wheelchair. -The resident was low risk for falls. -The resident as constantly disoriented. -The restraint section had "bedrails" listed. -The assessment dated 07/01/17 noted the staff made sure bedrails were up while in bed. Review of Resident #5's Licensed Health Professional Support (LHPS) reviews dated 05/17/17 and 08/10/17 revealed: -LHPS tasks included ambulation with assistive device, collecting and testing fingerstick blood sugars, medication through injections, transferring, and physical restraints. -The resident required the use of a wheelchair for mobility. -Staff must wheel her and transfer her at all times. -Bedrails were used when in bed to promote safety and to prevent falls. -The resident had potential for falls/injury. -The nurse noted to follow facility protocol / physician's orders for residents with physical restraints. Review of current physician's orders for physical restraint for Resident #5 revealed there were orders for bedrails signed by the physician on 03/16/17, 06/14/17, 06/21/17, and 09/08/17. Interview with the Director of Resident Services (DRS) on 09/14/17 at 1:30 p.m. revealed: -When she did the assessment and care plan process for Resident #5 in 2014, the facility did not have a Registered Nurse (RN) Consultant. -The DRS and the resident's family member participated in the care plan meeting for	D 482		

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D 482	Continued From page 116 restraints. -She did the restraint and care plan process for Resident #5 because the resident resided on the assisted living side of the facility until January 2017. -Staff put the bedrails up when Resident #5 was lying in bed for safety. -Resident #5 was not a frequent faller but was at risk for falls. -She would do a new assessment and care plan process for Resident #5 and have the facility's RN Consultant participate and sign off. Observation of Resident #5 on 09/15/17 at 2:20 p.m. revealed the resident was lying in bed asleep with both bedrails in the up position on each side of the bed. Based on observation, interviews, and record review, Resident #5 was not interviewable due to diagnoses of dementia. Review of a physical restraints care plan form dated 09/14/17 for Resident #5 revealed: -The restraint currently being used was bedrails. -The alternatives to restraints currently being used and projected goals included: bowel and bladder training every 2 hours; snacks at 10:00 a.m., 3:00 p.m., and 8:00 p.m.; and fluids will be offered every 2 hours. -The facility was currently using the least restrictive type of restraint available. -Care to be provided while resident was restrained included: bowel and bladder assistance to be offered every 2 hours; snacks to be served at 10:00 a.m., 3:00 p.m., and 7:00 p.m.; and 6 ounces of fluids to be offered every 2 hours. -The medical symptom that warranted the restraint was dementia.	D 482		

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D 482	Continued From page 117 -The resident thought she could get up out of bed and walk to the bathroom by herself. -The medical symptom was first observed upon admission and daily. -Alternatives attempted included taking the resident to the bathroom and changing her every 2 hours. -The alternatives were tried until the resident could not stand up in the bathroom anymore. -The resident had no response to the alternatives. -The signatures of the restraint team included the Director of Resident Services (DRS) and the Registered Nurse (RN) Consultant and they dated it 09/14/17. -The Special Care Unit Coordinator and the resident/responsible party signature lines were blank. 3.Review of Resident #2's FL-2 dated 11/21/16 revealed: -Diagnoses included dementia, hypertension, anxiety, osteoarthrosis lower leg, lumbago, schizophrenia, delusional disorder, bipolar disorder, depression with psychotic disorder. Interview with a PCA on 09/15/17 at 11:15 am revealed: -The bedrails are always put up when Resident #2 is in bed. -Resident's bedrails are put up when the resident is in the bed to prevent falls. Review of physician order for physical restraint dated 07/11/17 revealed: -There was a medical need for a physical restraint. -The type of restraint to be used are bed rails. -The restraint is to be used any time Resident #2 is left unattended and safety might be jeopardized.	D 482		

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D 482	Continued From page 118 -Resident's #1's PCP signed the three-month order on 07/11/17. Review of letter sent to the guardian dated 07/28/15 revealed: -The guardian would be able to attend the conference to discuss physical restraints. -The conference is scheduled for 08/14/15 Review of consent form for physical restraints use revealed: -The guardian consented to the use of bed rails restraints for fall prevention. -The guardian signed the consent form on 08/14/15 -The SCUC signed the consent form. Review of physical restraint assessment revealed: -Medical symptoms that warrant the use of physical restraint included the prevention of falls, weak and unsteady gate, inability to stand independently. -Resident #2 continues to try and get up on her own due to cognitive impairment. -Conference with POA was on 08/14/15. -The SCUC signed the form, but did not date it. -The facility RN signed the form and dated it 08/27/2015 Review of care plan for resident using physical restraints revealed: -The SCUC signed the care plan but did not date it. -The facility RN did not sign the care plan. The facility failed to include a registered nurse in the assessment and care planning process prior to using physical restraints on 3 of 3 residents including bedrails, a seat belt, and a soft pelvic	D 482		

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D 482	Continued From page 119 belt on Resident #13 and bedrails for Resident #2 and Resident #5. The facility failed to assure restraints for Resident #13 were applied correctly according to the manufacturer's instructions including a soft pelvic restraint and a seat belt. The failure of the facility to apply restraints correctly to Resident #13 who had a history of falls with injuries was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 09/15/17 revealed: -The facility will review all restraint orders currently in the facility. -Correct documentation required to include Registered Nurse (RN), family, and staff will be completed with assessment and care planning completed for each restraint. -Once restraints order, training needs to be scheduled to address restraints in the facility by staff. -The Licensed Health Professional Support (LHPS) check off process on new hires will include the restraint training. -The facility will complete a restraint audit. -The facility will complete assessment, care plan, meeting, and order from doctor. -The facility will assure personal care services (PCS) documentation is updated with restraints ordered. -The facility will follow care plan / assessment in daily care process. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2017.	D 482		

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D912	Continued From page 120	D912		
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, 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 rules and regulations as related to the use of physical restraints and alternatives. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used after an assessment and care planning process had been completed as required for 3 of 3 residents sampled with restraints (#2, #5, #13); and failed to assure physical restraints were applied correctly for 1 of 3 residents sampled with restraints (#13) who had a soft belt pelvic restraint. [Refer to Tag D482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 121 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure residents were free from abuse and neglect as related to resident rights, personal care and supervision, health care, health care personnel registry, and medication administration. The findings are: 1. Based on observations, interviews and record reviews the facility failed to ensure 2 of 4 sampled residents were free of physical abuse and neglect (#2 and #4); one resident (#2) was alledgedly abused by a personal care aide, who was observed jerking and mistreating the resident; and a second resident (#4), who was neglected by being isolated and not allowed to leave his room for almost two months. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 6 residents (Resident #2, #11) in accordance with the resident's assessed needs and care plan which resulted in Resident #2 not being transferred using the hoyer lift and Resident #11's fingernails not being cut. [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 2 of 5 residents sampled (#1 and #4) were met by failing to notify the health care provider of a resident (#1) who was experiencing withdrawal symptoms from not receiving scheduled pain medication and a resident (#4)	D914		

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D914	Continued From page 122 who became totally dependent on staff, bedbound, drowsy and had multiple falls after receiving an antianxiety medication. [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 4. Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 1 of 1 sampled residents (Resident #2) by a staff (Staff E) to the Health Care Personnel Registry (HCPR). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#8, #9) observed during the medication passes including errors with a medication used to control phosphorus levels (#9), a combination inhaler for breathing problems and a steroid nasal spray for allergies (#8); and 4 of 6 residents (#1, #3, #5, #10) sampled for record review including errors with missed doses of a narcotic pain medication (#1), errors missed doses of a heart / blood pressure medication and glaucoma eye drops (#3), errors with sliding scale insulin (#5, #10), and errors with a Vitamin D supplement (#5). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of	D980		

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D980	Continued From page 123 residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to notify the physician of her decision to isolate a resident to his room where the resident experienced multiple falls as a result of becoming lethargic and drowsy from an antianxiety medication requested by facility staff from the resident's physician; failed to report a known allegation of resident abuse and the facility's investigation to the Health Care Personnel Registry, and allowing the alleged perpetrator to continue to work in the facility as a personal care aide; and failed to assure the overall management, operations, and policies and procedures of the facility were implemented to maintain each residents' right to be free of abuse and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care, health care, resident rights, medication administration, reporting to the Health Care Personnel Registry, physical environment, competancy validation for LHPS tasks, discharge of residents, tuberculosis test for residents, medication administration and medication storage, all of which are the responsibility of the Administrator. The findings are: 1. Based on observations, interviews and record reviews the facility failed to ensure 2 of 4 sampled residents were free of physical abuse and neglect (#2 and #4); one resident (#2) was alledgedly abused by a personal care aide, who was	D980		

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D980	Continued From page 124 observed jerking and mistreating the resident; and a second resident (#4), who was neglected by being isolated and not allowed to leave his room for almost two months. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 6 residents (Resident #2, #11) in accordance with the resident's assessed needs and care plan which resulted in Resident #2 not being transferred using the hoyer lift and Resident #11's fingernails not being cut. [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 2 of 5 residents sampled (#1 and #4) were met by failing to notify the health care provider of a resident (#1) who was experiencing withdrawal symptoms from not receiving scheduled pain medication and a resident (#4) who became totally dependent on staff, bedbound, drowsy and had multiple falls after receiving an antianxiety medication. [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 4. Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 1 of 1 sampled residents (Resident #2) by a staff (Staff E) to the Health Care Personnel Registry (HCPR). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to administer	D980		

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D980	Continued From page 125 medications as ordered for 2 of 7 residents (#8, #9) observed during the medication passes including errors with a medication used to control phosphorus levels (#9), a combination inhaler for breathing problems and a steroid nasal spray for allergies (#8); and 4 of 6 residents (#1, #3, #5, #10) sampled for record review including errors with missed doses of a narcotic pain medication (#1), errors missed doses of a heart / blood pressure medication and glaucoma eye drops (#3), errors with sliding scale insulin (#5, #10), and errors with a Vitamin D supplement (#5). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).] 6. Based on observations and interviews, the facility failed to assure the maintenance cart was stored in a locked area resulting in hazardous chemicals and multiple tools being unattended and accessible to residents. [Refer to Tag D056 10A NCAC 13F. 0305(f)(4) Physical Environment]. 7. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 7 non-licensed staff sampled (B) had been competency validated for licensed health professional support tasks including assistance with ambulation with assistive devices, transferring semi-ambulatory or non-ambulatory residents, feeding techniques for residents with swallowing problems, and care and use of physical restraints prior to the staff performing these tasks. [Refer to Tag D161 10A NCAC 13F. 0504(a) Competency Validation for Licensed Health Professional Support Tasks]. 8. Based on interviews and record review, the facility failed to obtain documentation by a medical provider giving reason for a resident	D980		

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D980	Continued From page 126 discharge for 1 of 1 residents (#4) who was discharged from the facility. [Refer to Tag D228 10A NCAC 13F. 0702(d) Discharge of Residents]. 9. Based on record reviews and interviews, the facility failed to assure 2 of 5 residents sampled (#2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D234 10A NCAC 13F. 0703(a) Tuberculosis Test, Medical Examination and Immunizations]. 10. Based on observations, interviews and record reviews, the facility failed to assure Medication Aides (MA) observed residents (#3, #6 and #7) swallow medications once administered before signing off on the Medication Administration Record (MAR) resulting in medications being spilled/dropped by residents. [Refer to Tag D366 10A NCAC 13F. 1004(i) Medication Administration]. 11. Based on observations and interviews, the facility failed to assure the medication cart on Jordan Hall was locked on 3 occasions when the medication cart was not under the immediate or direct physical supervision of the medication aide. [Refer to Tag D378 10A NCAC 13F. 1006(b) Medication Storage]. _____ The Administrator failed to manage the overall operations of the facility and failed to assure the policies of the facility were implemented as related to two residents' health care needs not being met resulting in a resident (#4) having multiple falls due to lethargy and drowsiness after receiving an antianxiety medication requested by the facility from the physician; two residents' rights were maintained without hinderance related	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047012	A. BUILDING: _____ B. WING _____	C 09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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
D980	Continued From page 127 to one resident (#4) being confined and isolated to his room by staff where the resident was not able to engage in activites or dining with the other residents, and a second resident (#2), who was abused by a staff; an incident of abuse not being reported to the Health Care Personnel Registry by the facility upon being notified that the incident had occurred; multiple medication administration errors observed on the medication pass and four residents not receiving medications as ordered, including a narcotic pain medication, insulin, heart/blood pressure medication, and eye drops for glaucoma; not providing personal care to two residents in accordance to the residents' assessed needs, including a resident (#2), who required a hoyer lift fortransfer and experienced a fall when staff failed to utilize the lift, and a second resident (#11), who had not received nail care and the fingernails were causing pain to the resident's skin as a result of the resident's hand being contracted; and discharging a resident #4) without docoumentation from a physician the reason for discharge. The Administrator's failure resulted in serious neglect and physical harm to the residents, which constitutes a Type A1 Violation. _____ A Plan of Protection was requested on 10/09/17. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017.	D980		