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	HAL055003	A. BUILDING: _____ B. WING _____	C 03/14/2019

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LAKEWOOD CARE CENTER	7981 OPTIMIST CLUB ROAD DENVER, NC 28037

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D 000	Initial Comments The Adult Care Licensure Section and the Lincoln County Department of Social Services conducted an annual survey on 03/13/19 to 03/14/19.	D 000		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a registered nurse completed on-site Licensed Health	D 280		

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Professional Support (LHPS) reviews and evaluations quarterly, including all tasks and a physical assessment for 3 of 6 sampled residents (#1, #2, and #9) including tasks for the collection and checking of finger stick blood sugar (#1), administration of medication by injection (#1), care of residents who are physically restrained (#2, #9), feeding techniques for residents with swallowing problems (#2), and administration of inhalation medication by inhalation machine (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 11/08/18 revealed:
-Diagnoses included dementia, diabetes, depression, and insomnia.
-There was a physician's order for Lantus (used to treat diabetes) inject 5 units at bedtime.
-There was a physician's order to check finger stick blood sugar (FSBS) once daily.

Review of Resident #1's physician's orders dated 03/08/19 revealed there was a physician's order to check FSBS twice daily before breakfast and dinner.

Interview with a medication aide (MA) on 03/13/19 at 4:30pm revealed Resident #1 received insulin daily and his FSBS was checked twice daily.

Review of Resident #1's current Licensed Health Professional Support (LHPS) review dated 10/22/18 revealed:
-Resident #1's LHPS tasks included collection and testing of finger stick blood samples.
-There was no documentation that the staff had been validated in collecting and testing of finger stick blood samples.

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D 280	Continued From page 2 Interview with a hospice nurse for Resident #1 on 03/15/19 at 11:55am revealed Resident #1 was admitted to hospice on 03/04/19. Refer to telephone interview with the facility's contracted LHPS registered nurse on 03/14/19 at 3:22pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm. Refer to interview with the Administrator on 03/14/19 at 5:00pm. 2. Review of Resident #9's current FL2 dated 09/26/18 revealed diagnoses included Alzheimer's disease, anxiety and primary insomnia. Review of Resident #9's Care Plan dated 05/17/18 revealed: -Resident #9 required extensive assistance with toileting, bathing, dressing, grooming, and personal hygiene. -Resident #9 required supervision with eating, ambulation, and transferring. -Resident #9 had a history of wandering. Review of Resident #9's Restraint Assessment Care Plan signed by a Nurse Practitioner from Hospice on 11/15/18 revealed: -There was a physician's order for full bed rails. -There was a physician's order for a safety belt and bed alarm for fall prevention when in bed and in wheelchair. -Medical symptoms that warranted the use of a restraint included confusion with a risk of falls, the risk of injury to self or others, and unable to make appropriate choices regarding safety.	D 280		

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-No alternatives to restraints were included in assessment.

Review of Resident #9's current Licensed Health Professional Support (LHPS) review dated 09/10/18 revealed:
-Resident #9's LHPS task included ambulation with assistive devices that required physical assistance.
-There was no documentation Resident #9 had an LHPS task for restraints.

Observation of Resident #9 sitting in her wheelchair in dining room on 03/14/19 at 11:50am revealed:
-Resident #9 had a gait belt around her body and the wheelchair.
-The gait belt was secured with a plastic clip behind the back of the wheelchair out of the reach of the resident.

Observation of Resident #9 in her room on 03/14/19 at 7:45am revealed:
-Resident #9 had a hospital bed with two full length bed rails with a fall mat located under the bed and a call button hanging on the wall at the bottom of the bed.
-Resident #9 was in the bed with the bed up against the wall to the left and the right bed rail was raised.
-Resident #9 was trying to get up out of the bed to the right and come over the top of the bed rail.
-The medication aide (MA) had to redirect Resident #9 to stay in the bed and not come over the top of the bed rail.
-After several minutes, the MA lowered the bed rail and had Resident #9 sit on the side of the bed to take her medications.

Interview with a third shift MA on 03/14/19 at

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4:09pm revealed:
-Resident #9 had a safety belt for her wheelchair because "she tries to stand up and walk with weak legs."
-Resident #9 had her right bed rail raised but got out of the bed over the bed rail during an incident on 03/13/19 at 4:00am.

Interview with a hospice nurse from Resident #9's primary care provider on 03/14/19 at 11:55am revealed:
-Resident #9 was usually up in her wheelchair with a safety belt on when she visited the resident.
-She did not know Resident #9 had full bed rails.

Attempted interview with Resident #9's guardian on 03/14/19 at 3:53pm was unsuccessful.

Refer to telephone interview with the facility's contracted LHPS registered nurse on 03/14/19 at 3:22pm.

Refer to interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm.

Refer to interview with the Administrator on 03/14/19 at 5:00pm.

3. Review of Resident #2's current FL2 dated 09/04/18 revealed:
-Diagnoses included traumatic brain injury due to motor vehicle accident, lung cancer, muscle weakness, spastic movements, bipolar disorder, seizure disorder, and dyslipidemia.
-The resident was non-ambulatory and required the use of a wheelchair.

Review of Resident #2's Care Plan dated 09/25/18 revealed:

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D 280	Continued From page 5 -The Licensed Health Professional Support (LHPS) review should be completed quarterly. -Resident #2 was documented as forgetful and needed reminders. -Resident #2 was totally dependent on staff for assistance with toileting and bathing. -Resident #2 required extensive staff assistance with ambulation/locomotion, dressing, grooming/personal hygiene, and transfers. -Resident #2 required limited staff assistance with eating. -Resident #2 was ambulatory with use of a wheelchair. a. Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 08/06/18 revealed: -Resident #2's LHPS tasks included care of residents who are physically restrained. -There was no documentation staff had been validated in restraints. Review of Resident #2's physician orders dated 10/31/18 revealed there was an order for a lap belt to be used when the resident was in the wheelchair. Review of Resident #2's physician orders dated 11/22/18 revealed there was an order to apply a lap belt per facility policy as needed for 2 hours on and 2 hours off due to recent falls out of wheelchair. Review of Resident #2's current LHPS review dated 03/13/19 revealed: -Resident #2's LHPS tasks included care of residents who were physically restrained. -There was no documentation staff had been validated in restraints.	D 280		

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Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 8:10am revealed:
-The LHPS reviews in the charts were the most current reviews.
-LHPS reviews were completed annually unless a significant change occurred for a resident.
-She did not know LHPS reviews were supposed to be completed quarterly.
-She and the LHPS nurse had completed a "few" LHPS reviews "last night."

Interview with Resident #2's hospice nurse on 03/14/19 at 10:10am revealed:
-She had taken over the care of Resident #2 in January of 2019.
-The restraint orders were already in place when she had taken over the care of Resident #2.
-Resident #2 had exhibited behaviors of falling forward out of her wheelchair in the past.
-A new medication had been introduced in the last couple weeks and the resident's behavior of falling forward out of the wheelchair had improved.

Refer to telephone interview with the facility's contracted LHPS nurse on 03/14/19 at 3:22pm.

Refer to interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm.

Refer to interview with the Administrator on 03/14/19 at 5:00pm.

b. Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 08/06/18 revealed:
-Resident #2's LHPS tasks included feeding techniques for residents with swallowing problems.
-There was no documentation staff had been

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validated in feeding techniques for residents with swallowing problems.

Review of Resident #2's physician orders dated 02/13/19 revealed there was an order for nectar thickened liquids.

Review of Resident #2's current LHPS review dated 03/13/19 revealed:
-Resident #2's LHPS tasks included feeding techniques for residents with swallowing problems.
-There was no documentation staff had been validated in feeding techniques for residents with swallowing problems.

Interview with Resident #2 on 03/13/19 at 10:42am revealed she was able to feed herself.

Observation of Resident #2 during the lunch meal service on 03/13/19 from 12:17pm to 1:15pm revealed the resident was served commercially prepared nectar thickened tea and water with the meal.

Interview with the RCC on 03/14/19 at 8:10am revealed:
-The LHPS reviews in the charts were the most current reviews.
-LHPS reviews were completed annually unless a significant change occurred for a resident.
-She did not know LHPS reviews were supposed to be completed quarterly.
-She and the LHPS nurse had completed a "few" LHPS reviews "last night."

Refer to telephone interview with the facility's contracted LHPS nurse on 03/14/19 at 3:22pm.

Refer to interview with the Resident Care

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D 280	Continued From page 8 Coordinator (RCC) on 03/14/19 at 4:55pm. Refer to interview with the Administrator on 03/14/19 at 5:00pm. c. Review of Resident #2's physician order dated 01/03/19 revealed DuoNeb (used to treat airway narrowing) 0.5-3ml (2.5mg) 1 vial via nebulizer every 4 hours while awake at least three times daily. Review of Resident #2's current LHPS review dated 03/13/19 revealed: -Resident #2's LHPS tasks included care of residents with inhalation medication by machine. -There was no documentation staff had been validated in inhalation medications by machine. Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 8:10am revealed: -The LHPS reviews in the charts were the most current reviews. -LHPS reviews were completed annually unless a significant change occurred for a resident. -She did not know LHPS reviews were supposed to be completed quarterly. -She and the LHPS nurse had completed a "few" LHPS reviews "last night." Refer to telephone interview with the facility's contracted LHPS nurse on 03/14/19 at 3:22pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm. Refer to interview with the Administrator on 03/14/19 at 5:00pm. _____ Telephone interview with the facility's contracted	D 280		

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D 280	Continued From page 9 LHPS nurse on 03/14/19 at 3:22pm revealed: -He was responsible for completing the facility's LHPS reviews. -He thought the LHPS reviews were to be completed quarterly. -He relied on the RCC or the Facility Manager to call and let him know when an LHPS review was due for a resident. -He completed the LHPS reviews, but could not remember information about specific residents. -LHPS reviews he had completed would be filed in the resident record. Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm revealed: -She was responsible for calling the LHPS nurse when a resident's LHPS review was due. -She thought the LHPS reviews had to be updated annually unless the resident had a significant change in care. Interview with the Administrator on 03/14/19 at 5:00pm revealed: -She had thought the LHPS reviews were to be updated annually. -She did not know the LHPS reviews had to be updated quarterly. -The LHPS reviews would now be updated quarterly.	D 280		
D 384	10a NCAC 13F .1006 (h) Medication Storage 10a NCAC 13F .1006 Medication Storage (h) The facility may possess a stock of non-prescription medications or the following prescription legend medications for general or common use: (1) irrigation solutions in single unit quantities	D 384		

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D 384	Continued From page 10 exceeding 49 ml. and related diagnostic agents; (2) diagnostic agents; (3) vaccines; and (4) water for injection and normal saline for injection. Note: A prescribing practitioner's order is required for the administration of any medication as stated in Rule .1004(a) of this Section This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure stock prescription medications were legend medications by possessing 2 vials of Humalog insulin for common use. The findings are: Review of Resident #1's progress notes dated 11/29/18 revealed the resident's finger stick blood sugar (FSBS) was 499 and the resident was administered 10 units of "house insulin." Interview with a medication aide (MA) on 03/13/19 at 4:30pm revealed the facility had a standing order for insulin that could be used on any resident. Review of Assisted Living Facility Diabetic Blood Sugar Protocol from the facility's contracted provider revealed: -If resident's FSBS was 450 or higher, give 12 units of regular insulin (Humalog - used to treat diabetes) and repeat FSBS in one hour. -If resident's FSBS is still above 400, give an additional 6 units of regular insulin (Humalog). -Do not check the resident's FSBS anymore unless symptomatic.	D 384		

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-Only call the provider if the resident was symptomatic.
-Call 911 if the resident was not at baseline, lethargic, overly fatigued, not able to awake, or not responsive.

Observation of the facility's medication storage refrigerator on 03/14/19 at 4:30pm revealed 2 unopened vials of Humalog insulin dispensed to the facility on 12/17/18 and 01/14/19 with no resident's name on label.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/14/19 at 10:51am revealed:
-The pharmacy had dispensed a vial of Humalog insulin to the facility on 07/24/18, 12/17/19, and 01/14/19.
-The pharmacy dispensed the insulin to the facility from a signed physician order written on 07/24/18 with directions to "use per standing order."
-There was no resident's name documented on the order.
-The order was to be used by any resident in the facility.
-She did not know if the facility staff had received training to administer the insulin or how to know if a resident needed the insulin.

Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 10:07am revealed:
-The MAs only administered the "house insulin" for an emergency.
-They had used the protocol since they had contracted with their current provider approximately 2 years ago.
-The protocol could be used on anyone with an order to check FSBS.
-The protocol was not signed by a licensed

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D 384	Continued From page 12 physician. -The facility provides MAs with an hour of annual diabetic training during the annual 6 hour medication administration training. Interview with the Facility Manager on 03/14/19 at 11:47am revealed: -The Diabetic Protocol was used on all diabetics in the facility. -The facility had used the protocol since they contracted with their current provider. -The facility covered the cost of the insulin because the order was a standing order. Interview with the facility's contracted Nurse Practitioner on 03/14/19 at 7:40am revealed it was okay for the facility to use the Diabetic Protocol on all diabetics in the facility. Interview with the Administrator on 03/14/19 at 5:05 pm revealed she thought it was okay to have insulin on their standing orders since the licensed provider had given the facility the protocol.	D 384		
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;	D 482		

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D 482	Continued From page 13 (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION	D 482		

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D 482	Continued From page 14 Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were applied correctly according to the manufacturer's instructions for 3 of 3 sampled residents (Resident #2, #3, and #9). The findings are: 1. Review of Resident #9's current FL2 dated 09/26/18 revealed diagnoses included Alzheimer's disease, anxiety and primary insomnia. Review of Resident #9's Restraint Assessment Care Plan signed by a Nurse Practitioner from Hospice on 11/15/18 revealed: -There was a physician's order for a safety belt and bed alarm for fall prevention when in bed and in wheelchair. -Resident #9's safety belt should be released every 2 hours and should be checked every 30 minutes when out of wheelchair and out of bed. -Medical symptoms that warranted the use of a restraint included confusion with a risk of falls, the risk of injury to self or others, and unable to make appropriate choices regarding safety. -No alternatives to restraints were included in assessment. -Resident #9's guardian had given consent for the use of restraints. Review of Resident #9's record revealed there was no signed physician's order, care plan, or assessment to renew the safety belt after the current order dated 11/15/18. Review of Resident #9's Hospice nursing visit summary note dated 02/21/19 revealed Resident #9 should be using a lap belt in wheelchair for	D 482		

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safety but was not signed by a licensed physician.

Interview with a third shift MA on 03/14/19 at 4:09pm revealed Resident #9 had a safety belt for her wheelchair because "she tries to stand up and walk with weak legs."

Observation of Resident #9 sitting in her wheelchair in dining room on 03/14/19 at 11:50am revealed:
-Resident #9 had a gait belt around her body and the wheelchair.
-The gait belt was secured with a plastic clip behind the back of the wheelchair out of the reach of the resident.

Interview with a first shift personal care aide (PCA) on 03/14/19 at 11:40am revealed:
-She was responsible for checking on each resident with a restraint every 2 hours.
-She knew Resident #9 had a safety belt to wear while she was in her wheelchair.
-She removed the safety belt from Resident #9 every 2 hours and stood the resident up and then put her back in the wheelchair with the safety belt.

Interview with a second shift MA on 03/14/19 at 2:41pm revealed:
-The PCAs were responsible for "working with the restraints and checking to make sure the restraint is on correctly."
-Resident #9 "tries to stand up while in wheelchair so she has a safety belt."

Telephone interview with a representative from Resident #9's durable medication equipment supplier on 03/14/19 at 11:15am revealed a gait belt was used to assist a residing in walking, standing, and transferring and should not be used as a restraint to hold someone in a wheelchair.

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D 482	Continued From page 16 Interview with a Hospice nurse from Resident #9's primary care provider on 03/14/19 at 11:55am revealed: -She started working with the facility about a month ago. -She was in the facility 3 to 4 times each week. -Resident #9 was usually up in her wheelchair with a safety belt on when she visited the resident. -She did not know the facility was using a gait belt as the safety belt on the wheelchair. -A gait belt should only be used to transfer resident. Interview with the Facility Manager on 03/14/19 at 2:45pm revealed: -Hospice supplied all the equipment they ordered for a resident. -She assumed if Hospice supplied the equipment then it was "okay" to use. Interview with the Administrator on 03/14/19 at 5:05pm revealed: -Gait belts should only be used for transferring residents. -She thought the belts they were using were okay because Hospice had supplied the belts to use on the wheelchairs. Attempted interview with Resident #9's guardian on 03/14/19 at 3:53pm was unsuccessful. Refer to the review of the facility's physical restraint policy. 2. Review of Resident #3's current FL2 dated 01/10/19 revealed: -Diagnoses included Alzheimer's disease, dementia with behavioral disturbances, major	D 482		

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depressive disorder, and anxiety disorder.
-He was a wanderer and constantly confused.
-He was semi-ambulatory and used a wheelchair with restraint belt.
-There was a physician's order for a wheelchair with restraint belt.

Review of Resident #3's Care plan dated 09/25/18 revealed:
-He required extensive assistance and was totally dependent with toileting, bathing, dressing, grooming, and transferring.
-He required extensive assistance with ambulation.

Review of Resident #3's Restraint Assessment Care Plan signed by the Hospice Nurse Practitioner dated 03/01/18 revealed:
-There was an order for a wheelchair seat belt when Resident #3 was in the wheelchair, and remove when not in the wheelchair.
-Medical symptoms that warranted the use of a restraint was confusion with the risk of falls.

Review of the consent to use restraints dated 03/01/18 revealed:
-Resident #3's guardian had not signed the consent for use of restraints.
-The consent had documented "left message" with the guardian on 02/23/18 at 3:10pm.

Observation of Resident #3 on 03/13/19 at 10:08am revealed:
-He was awake and lying in bed with the bed pushed up against the wall and the side rail pulled up.
-A wheelchair was next to the bed with a gait belt laid over the wheelchair.

Observation of Resident #3 on 03/14/19 at

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D 482	Continued From page 18 9:15am revealed he was in his wheelchair with a gait belt fastened around his waist, through the arms of the wheelchair, and buckled at the back of the wheelchair. Interview with a first shift personal care aide (PCA) on 03/14/19 at 9:20am revealed: -Resident #3 "used to be restrained in the wheelchair with a quick release belt, but it was too small and it would cut into him so we started using a gait belt instead". -The gait belt was removed every 2 hours for personal care needs of Resident #3 and then reapplied. -Resident #3 had to be restrained due to multiple falls out of the wheelchair. Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 9:57am revealed: -Resident #3 had an order for the use of a gait belt as a restraint in the wheelchair for safety since 03/08/18. -Resident #3 had unhooked the quick release on the lap belt originally ordered and fell out of his wheelchair multiple times. Telephone interview with a representative from Resident #3's durable medication equipment supplier on 03/14/19 at 11:15am revealed a gait belt was used to assist a residing in walking, standing, and transferring and should not be used as a restraint to hold someone in a wheelchair. Interview with the Hospice nurse on 03/14/19 at 11:55am revealed: -Resident #3's previous Hospice nurse reported to her that Resident #3 was changed to a gait belt because he had unbuckled his quick release safety belt and fell out of his wheelchair several times.	D 482		

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-She had not personally seen Resident #3 trying to get out of the wheelchair or undo his gait belt.
-Resident #3's health had declined and "he could probably be changed back to a lap belt".
-Hospice reviewed the residents condition every 60 days to determine if restraints were needed.

Interview with the Facility Manager on 03/14/19 at 2:45pm revealed:
-Hospice supplied all the equipment they ordered for a resident.
-The facility was not responsible for equipment not available to the resident.
-She assumed if Hospice supplied the equipment then it was "okay" to use.

Interview with the RCC on 03/14/19 at 3:10pm revealed:
-Resident #3 had a gait belt to restrain him in the wheelchair.
-A wheelchair lap belt was previously used on Resident #3 to restrain him in the wheelchair, but he would "unhook it and has fallen multiple times out of the wheelchair."
-She did not know that a gait belt was not an approved substitution for a wheelchair lap belt.
-She planned on ordering a cushion belt to use on residents' with an order for restraints in wheelchairs.
-She will have the Hospice nurse complete staff training on use and application of the cushion belt when it is ordered.

Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 03/14/19 at 3:22pm revealed:
-Gait belts were not an appropriate device to use as a restraint.
-"I didn't even know they were using gait belts to restrain."

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-When on site he would go around the facility with the RCC or Facility Manager when seeing residents to do their LHPS Evaluations.
-He relied on the RCC and Facility Manager knowledge of the residents and their care needs when doing LHPS Evaluations.
-He did some teaching on restraint use with new employees.

Interview with the Administrator on 03/14/19 at 5:05pm revealed:
-Gait belts should only be used for transferring residents.
-She thought the belts they were using were okay because Hospice had supplied the belts to use on the wheelchairs.

Attempted telephone interview with Resident #3's guardian on 03/13/19 at 8:45am was unsuccessful.

Refer to the review of the facility's physical restraint policy.

3. Review of Resident #2's current FL2 dated 09/04/18 revealed:
-Diagnoses included traumatic brain injury due to motor vehicle accident, lung cancer, muscle weakness, spastic movements, bipolar disorder, seizure disorder, and dyslipidemia.
-The resident was intermittently disoriented and incontinent of bladder and bowel.
-The resident was non-ambulatory and required the use of a wheelchair.

Review of Resident #2's record revealed the resident had been in the care of Hospice since 04/23/18.

Review of Resident #2's Care Plan dated

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D 482	Continued From page 21 09/25/18 revealed: -Resident #2 was documented as forgetful and needed reminders. -Resident #2 was totally dependent on staff for assistance with toileting and bathing. -Resident #2 required extensive staff assistance with ambulation/locomotion, dressing, grooming/personal hygiene, and transfers. Review of Resident #2's Restraint Assessment and Care Plan dated 10/31/18 revealed: -There was an order for a lap belt to be used when the resident was in the wheelchair. -Resident #2's lap belt was ordered to be released every 2 hours and checked every 30 minutes. -The medical symptom which warranted the use of a restraint was due to the risk of injury to self or others. -There was documentation of the alternatives tried prior to use of restraints including frequent monitoring, pain management, toileting schedule, redirection, and ambulation assistance. -Resident #2 had given verbal consent for the use of restraints. Review of Resident #2's Hospice Nurse Practitioner's order dated 11/22/18 revealed apply lap belt per facility policy when needed 2 hours on and 2 hours off due to recent falls out of wheelchair. Interview with a personal care aide (PCA) on 03/14/19 at 8:25am and 10:03am revealed: -She routinely provided personal care to Resident #2. -The staff applied the lap belt restraint when Resident #2 was "trying to throw herself in the floor" from her wheelchair. -Resident #2's behavior had improved lately and	D 482		

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the lap belt had not needed to be used.
-The lap belt was applied around Resident #2's midsection and was secured at the back of the wheelchair.
-The lap belt was easy to loosen and get off the resident.
-The PCA assigned to Resident #2 was responsible to check Resident #2 every 30 minutes while the resident wore the lap belt restraint.
-The PCA assigned to Resident #2 was responsible to release Resident #2 every 2 hours to provide incontinent care to the resident.

Observation of Resident #2's device identified by the PCA as a lap belt restraint on 03/14/19 at 10:04am revealed the device was a gait belt.

According to the Occupational Safety and Health Administration (OSHA), gait belts are used to transfer cooperative residents who are partially dependent with some weight-bearing capacity and to support residents during ambulation.

Telephone interview with a representative from Resident #2's durable medication equipment supplier on 03/14/19 at 11:15am revealed a gait belt was used to assist a resident in walking, standing, and transferring and should not be used as a restraint to hold someone in a wheelchair.

Interview with Resident #2's Hospice nurse on 03/14/19 at 10:10am revealed:
-She had taken over the care of Resident #2 in January of 2019.
-The restraint orders were already in place when she took over the care of Resident #2.
-Resident #2 had exhibited behaviors of falling forward out of her wheelchair in the past.
-A new medication had been introduced in the

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last couple weeks and the resident's behavior of falling forward out of the wheelchair had improved.
-The lap restraint being used on Resident #2 did appear to be a gait belt.
-A gait belt was intended to be used in transfers and ambulation.
-Gait belts were not safe to be used as a restraint.
-She would immediately find an appropriate alternative lap belt restraint device for Resident #2.

Interview with Resident #2's Hospice nurse on 03/14/19 at 11:55am revealed she and the Nurse Practitioner had decided to discontinue use of the lap belt restraint for Resident #2, because it was no longer needed.

Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 03/14/19 at 3:22pm revealed:
-Gait belts were not an appropriate device to use as a restraint.
-"I didn't even know they were using gait belts to restrain."
-He did some teaching on restraint use with new employees.

Interview with the Administrator on 03/14/19 at 5:00pm revealed:
-Hospice had been responsible for ordering restraints for Resident #2.
-Hospice had ordered the gait belt from their durable medical equipment supplier to be used as a lap belt restraint for the resident while in a wheelchair.

Interview with the Administrator on 03/14/19 at 5:05pm revealed:

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D 482	Continued From page 24 -Gait belts should only be used for transferring residents. -She thought the belts they were using were okay because Hospice had supplied the belts to use on the wheelchairs. Refer to the review of the facility's physical restraint policy. Review of the facility's physical restraint policy revealed: -Physical restraints will be used only if all other alternatives have been tried and have been unsuccessful. -Alternatives shall be documented in the resident's medical chart. -The facility should then complete an assessment, develop a care plan and have the support of the physician, Registered Nurse (RN), resident representative, and the supervisor. -The resident may refuse the use of any form of restraint, but the representative may consent if the resident is not capable of making a sound decision. -The restraint must be applied correctly and resident must be checked and cared for according to the care plan specifications. -Staff must be trained and validated as competent to perform applications of restraints per RN. -A log documenting time the restraint was applied, care given, etc., shall be used by resident's caregiver. The failure of the facility to assure restraints were used only after physician orders for physical restraints were updated quarterly and restraints were applied correctly in according to the	D 482		

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D 482	Continued From page 25 manufacturer's instructions was detrimental to the health, safety, and welfare of three sampled residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2019.	D 482		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.	D 485		

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D 485	Continued From page 26 (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician orders for physical restraints were updated quarterly for 2 of 3 sampled residents (Resident #2 and #9) with orders for lapbelt restraints, 1 of 1 sampled resident with an order for full bed rails (Resident #9). The findings are: 1. Review of Resident #9's current FL2 dated 09/26/18 revealed diagnoses included Alzheimer's disease, anxiety and primary insomnia. a. Review of Resident #9's Restraint Assessment Care Plan signed by a Nurse Practitioner from Hospice on 11/15/18 revealed: -There was a physician's order for full bed rails. -Medical symptoms that warranted the use of a restraint included confusion with a risk of falls, the risk of injury to self or others, and unable to make appropriate choices regarding safety. -No alternatives to restraints were included in assessment. -Resident #9's guardian had given consent for the use of restraints.	D 485		

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Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:53pm revealed she did not know the physician's order for restraints had to be updated quarterly.

Interview with the Administrator on 03/14/19 at 5:05pm revealed she did not know the physician's order for restraints must be updated quarterly.

b. Review of Resident #9's Restraint Assessment Care Plan signed by a Nurse Practitioner from Hospice on 11/15/18 revealed:
-There was a physician's order for a safety belt and bed alarm for fall prevention when in bed and in wheelchair.
-Resident #9's safety belt should be released every 2 hours and should be checked every 30 minutes when out of wheelchair and out of bed.
-Medical symptoms that warranted the use of a restraint included confusion with a risk of falls, the risk of injury to self or others, and unable to make appropriate choices regarding safety.
-No alternatives to restraints were included in assessment.
-Resident #9's guardian had given consent for the use of restraints.

Review of Resident #9's Hospice nursing visit summary note dated 02/21/19 revealed Resident #9 should be using a lap belt in wheelchair for safety but was not signed by a licensed physician.

Interview with a third shift MA on 03/14/19 at 4:09pm revealed Resident #9 had a safety belt for her wheelchair because "she tries to stand up and walk with weak legs."

Interview with the RCC on 03/14/19 at 4:53pm revealed she did not know the physician's order for restraints had to be updated quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055003	A. BUILDING: _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	7981 OPTIMIST CLUB ROAD DENVER, NC 28037

(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 485	Continued From page 28 Interview with the Administrator on 03/14/19 at 5:05pm revealed she did not know the physician's order for restraints must be updated quarterly. 2. Review of Resident #2's current FL2 dated 09/04/18 revealed: -Diagnoses included traumatic brain injury due to motor vehicle accident, lung cancer, muscle weakness, spastic movements, bipolar disorder, seizure disorder, and dyslipidemia. -The resident was intermittently disoriented and incontinent of bladder and bowel. -The resident was non-ambulatory and required the use of a wheelchair. Review of Resident #2's record revealed the resident had been in the care of Hospice since 04/23/18. Review of Resident #2's Restraint Assessment and Care Plan dated 10/31/18 revealed: -There was an order for a lap belt to be used when the resident was in the wheelchair. -Resident #2's lap belt was ordered to be released every 2 hours and checked every 30 minutes. -The medical symptom which warranted the use of a restraint was due to the risk of injury to self or others. -There was documentation of the alternatives tried prior to use of restraints including frequent monitoring, pain management, toileting schedule, redirection, and ambulation assistance. -Resident #2 had given verbal consent for the use of restraints. Review of Resident #2's record revealed there were no signed physician orders to renew the lap belt restraint after 11/22/18.	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 485	Continued From page 29 Interview with Resident #2's Hospice nurse on 03/14/19 at 10:10am revealed: -She had taken over the care of Resident #2 in January of 2019. -The restraint orders were already in place when she took over the care of Resident #2. Interview with Resident #2's Hospice nurse on 03/14/19 at 11:55am revealed she and the Nurse Practitioner had decided to discontinue use of the lap belt restraint for Resident #2, because it was no longer needed. Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 4:55pm revealed: -She was responsible for obtaining and maintaining restraint assessments, care plans, and restraint orders for residents. -She was not aware physician orders for restraints were required to be updated quarterly. -Resident #2's restraint orders had not been updated since November 2018. Interview with the Administrator on 03/14/19 at 5:00pm revealed: -She and her staff had thought physician orders for restraints were supposed to be updated quarterly. -She and her staff would now ensure physician orders for restraints were updated quarterly.	D 485		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 30 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical restraints. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were applied correctly according to the manufacturer's instructions for 3 of 3 sampled residents (Resident #2, #3, and #9).[Refer to Tag 482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type B Violation)].	D912		