Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078038	A. BUILDING: _____ B. WING _____ JUL 9 2019 ADULT CARE LICENSURE SECTION RALEIGH	R 05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT CARE	600 MT. MORIAH ROAD LUMBERTON, NC 28360

(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 Licensue Section and Robeson County Department of Social Service conducted a follow up survey on May 21-May 22, 2019.	{D 000}		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (#2)received adequate care and services as evidenced by the resident being transported outside of the facility and being left without a means of returning into the facility resulting in the resident being sunburned. The findings are: Review of Resident #2's current FL-2 dated 02/08/19 revealed: -Diagnoses included Seizure disorder, Hypertension, Hypothyroid. -There was documentation the resident was intermittently disoriented. -There was documentation the resident was non-ambulatory. -There was documentation Resident #2 used a wheelchair. Review of Resident #2's assessment and care plan dated 02/11/19 revealed: -There was documentation Resident #2 was	D 338	Resident #2 was seen by her doctor the next morning about the sun spots on her left shoulder and was prescribed an Aloe Cream. Administrator had an intake meeting with all staff on 5-21 and 5-22 to go over the Plan of Correction. Administrator had a second intake meeting with all staff on 7-3-19 to go over the new permanent policy (Sun Safety Policy) changes. To ensure this doesn't reoccur again in the future, this new Sun Safety Policy explains where a resident should be when they are outside in the summer time to prevent sunburns, how often the resident should be checked on, and who is responsible for checking on that resident. Copies of these new policies are now posted in the staff office and Med Room 7-5-19	7-5-19

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

Tom Cl — Admin. Strator — 7-5-19

STATE FORM 6899 LL0W12 If continuation sheet 1 of 17

The Plan of Correction with addendum was reviewed and accepted on 07/15/19. Refer to the addendum on pages 2, 10 and 11 of this Statement of Deficiencies
S Simmons
07/15/19

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D 338	Continued From page 1 ambulatory with wheelchair. -There was documentation Resident #2 required supervision with eating, extensive assistance from staff with transferring, extensive assistance with toileting, ambulation/locomotion, bathing, dressing, and grooming/personal hygiene. Observation on 05/21/19 at 11:56 am of Resident #2 revealed: -She was in her room with no shirt on. -She had a sunburn with three blisters under the top layer of the skin about the size of a nickel or greater on her left shoulder and posterior neck. -She had six areas where the blisters had opened and were pink in color. -She had one blister that was draining. Observation on 05/22/19 at 10:45 am of Resident #2 revealed: -She was in her room sitting in her wheelchair. -She was able to able to pull the door handle down to open the door. -She was unable to maneuver the wheelchair out of the way of the door to open the door wide enough for her to exit her room without assistance. Observation on 05/22/19 at 4:06 pm of Resident #2 revealed: -She was in her room with her shirt slightly off her left shoulder revealing the sunburned area. -She had 2 blisters under the top layer of the skin about the size of a dime or smaller on her left shoulder and posterior neck. -She had 3 areas on her left shoulder where the skin had broken open and drying. -She had one area on her left shoulder that was coated in a white cream. Interviews with Resident #2 on 05/21/19 at 10:15	D 338	for a constant reminder. Administrator will monitor this new process weekly through the summer to ensure this is being done properly. We have also posted Sun Safety posters on all exit doors to remind staff and residents the importance of Sun Safety. I have included a copy of the new Sun Safety Policy and a copy of the Sun Safety poster in with this report. D338 Addendum per telephone with Ms. Seanward on 07/15/19. The administrator will monitor by physically observing & interviewing Residents randomely throughout the week. S Simmons 07/15/19	

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D 338	Continued From page 2 am and at 11:56 am revealed: -She had pain in the left shoulder area. -Resident #2 was not able to communicate in complete details. -She was outside a few days ago (unable to state exact time/day/date) in the sun coloring in her wheelchair and she got sunburned. -She did not remember who assisted her to get outside or how long she was outside. -She saw the doctor this morning (05/21/19). -She could wear her shirt. -Her shoulder hurt. Interview with the Supervisor on 05/21/19 at 12:03pm revealed: -Resident #2 went outside on 05/20/19 and fell asleep sitting in her wheelchair around 1:00pm. -She was sitting at the picnic table located at the back of the facility in the sun. -She liked to color at the picnic table. -She went outside several times on 05/20/19. -The blisters were on her shoulder and neck this morning (05/21/19) when we got her dressed. -The primary care provider (PCP) was notified when she got to the facility the morning of 05/21/19. Observation on 05/21/19 at 12:30pm revealed the picnic tables located at the back of the facility were in full sunlight with no protective shade. Interview with another resident on 05/21/19 at 4:12 pm revealed: -She helped Resident #2 to the restroom. -Resident #2 hollered all day and night for no reason. -Resident #2 was on the front porch yesterday (05/20/19). -The resident declined further interview.	D 338		

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D 338	Continued From page 3 Interview with a second resident on 05/21/19 at 4:23 pm revealed: -Resident #2 was "a loud mother and yelled too much". -The staff helped Resident #2 outside when she went out. -Resident #2 called staff to come and get her when she was ready to go back in. -Resident #2 was outside a few days ago in the sun near a van in the parking lot. -She did not say how long Resident #2 was outside. -She thought this had occurred last Friday (05/17/19). Interview with a third resident on 05/21/19 at 4:35pm revealed: -Resident #2 was pushed outside in her wheelchair by staff and was left in the sun on 05/20/19. -Staff pushed her out the front door into the small parking lot past the porch on 05/20/19. -Staff told her to "yell all she wanted too". -It was hot that day. -Another resident pushed Resident #2 back inside after about 20 minutes because it was so hot. -He had never seen staff check on Resident #2 when she was outside. -Resident #2 hollered a lot. -Resident #2 could not push herself back inside once she was outside. -Resident #2 moved very slow. Interview with a fourth resident on 05/22/19 at 9:30 am revealed: -Resident #2 was able to ambulate inside of the facility without assistance. -Resident #2 was able to propel herself to the outside without assistance, but she probably	D 338		

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D 338	Continued From page 4 needed assistance to open the door. -Resident #2 usually asked to go outside and staffed pushed her outside. -Staff usually pushed Resident #2 on the front porch. -Resident #2 "hollers" all of the time. -He didn't know if staff pushed Resident #2 outside because she was "hollering." -He observed a medication aide push Resident #2 on to the porch one day at the end of last week, maybe Friday. -Resident #2 propelled herself to the small parking area located "just in front of the porch" and went to sleep. - Resident #2 was out in the sun twenty or thirty minutes until another resident pushed her back in the facility so she would not get sun burned. -He did not know if Resident #2 was sun burned on that day, but it was very hot outside. Confidential interview with a resident revealed: -The resident saw Resident #2 sitting in the sun yesterday (05/20/19) on the facility's front porch around 2:00pm. -Other residents that were sitting on the porch said staff had pushed Resident #2 in her wheelchair outside in the sun and left Resident #2. -The resident was concerned because it was very hot with the temperatures in the "90's" and Resident #2 could not propel her wheelchair on her own when she was outside. -The resident did not know how long Resident #2 had been sitting in her wheelchair in the sun but the resident pushed Resident #2 back under the porch in the shade because it was too hot outside. Confidential interview with a second resident revealed:	D 338		

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D 338	Continued From page 5 -Staff pushed Resident #2 outside in her wheelchair because she hollered a lot. -Resident #2 was pushed outside in the hot sun a few days ago by staff. -The resident did not know if staff monitored or checked on Resident #2 when she was outside. -The resident only saw staff push Resident #2 in and out of the back and front sitting areas of the facility and had never saw Resident #2 go out of the exit doors by herself. Interview with a personal care aide (PCA) on 05/21/19 at 9:51 am revealed: -There was no set time to check on residents. -They "just kept an eye on them". -She smoked and when she went out to smoke, she checked on the residents outside. -Residents also helped each other. -Resident #2's sun exposure was witnessed by other residents in the facility. -Resident #2 was put to bed later that day after sitting in the sun and no blisters were noted per staff. -Resident #2 was awakened the next morning for breakfast and during that time, the sunburn was noted by staff. -There were no previous issues in the past with Resident #2 experiencing sunburn. -Resident #2 was examined by the Primary Care Provider (PCP) and revealed: Stage II sunburn to left shoulder. -The PCP ordered Aloe skin cream to apply topically to affected area twice a day and as needed for sunburn. Interview with the cook on 05/22/19 at 9:48 revealed: -She had seen Resident #2 sitting at the picnic table out back on 05/20/19. -She stayed outside about fifteen or twenty	D 338		

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D 338	Continued From page 6 minutes. -She did not see her outside on 05/21/19. -It was hard for Resident #2 to open the door, so someone had to let her out and push her back in. Telephone interview with a medication aide on 05/22/19 at 4:10 p.m. revealed: -Resident #2 was usually on the inside of the facility when he worked. -Resident #2 ambulated well in her wheelchair. -Resident #2 could propel herself outside and she was able to open doors. -He was informed by staff when he arrived at work on 05/20/19 Resident #2 went to sleep in the sun and her shoulders got sunburned. -He was not sure when she received the sunburn. Interview with Resident #2's power of attorney (POA) on 05/21/19 at 3:58 pm revealed: -He was satisfied with the services at the facility. -Other family members were satisfied as well, when they went to visit. -If any issues arose, the staff would notify him. -The last time, he was notified by staff, was last year when Resident #2 fell out of her wheelchair and broke her arm. -He was not aware of the sunburn on Resident #2's shoulder. Interview with Resident #2's Primary Care Provider (PCP) on 05/21/19 at 3:58 pm revealed: -She was aware of Resident #2's sunburn. -She saw Resident #2 today (05/21/19). -She ordered aloe vera cream for Resident #2's sunburn. -She said that the sunburn was recent since it was blistered. Interview with the Patient Health Coordinator on 05/22/19 at 2:36pm revealed:	D 338		

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D 338	Continued From page 7 -Resident #2 was physically able to get herself in and out of the building. - "She could do what she wanted to do when she wanted to do it." -There was no set time to check on Resident #2 when she was outside -She told other residents when she was ready to come in if it was before the staff went to get her. -She liked to go outside and color. A second interview with Resident #2's PCP on 05/22/19 at 3:40pm revealed: -Resident #2 had stage 2 sunburn on her left shoulder and neck. -It would take one to two weeks for the sunburn to heal. -She had heard Resident #2 expressing her wants and needs. -The resident was "fair skin" and would be sensitive to the sun. -She would expect for the resident to be kept out of the sun when outside with no more direct sun exposure than 5 to 10 minute intervals in the direct sunlight so the resident's skin would not burn. -She would order sunscreen for the resident. -This was the first time Resident #2 had ever had a sunburn. The facility failed to assure Resident #2 received adequate care and service when outside on the grounds of the facility and unable to maneuver her wheelchair back into the facility during the high sun of the day resulting in a Stage II sunburn. The facility's noncompliance was detrimental to the health, welfare and safety of the resident and constitutes a Type B Violation. A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on	D 338		

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D 338	Continued From page 8 05/22/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 338		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep	D 482	All documentation was prepped by PHC during the State Review and was in the folder waiting on the doctor to sign off on it before the survey was completed. I, the Administrator, sat down with the PHC and went over the requirements needed for obtaining an order for bedrails for safety, bedrails as a restraint, and the difference between the two. To ensure this doesn't happen again and that everything is obtained in the future, we developed an INITIAL RESTRAINT CHECKLIST for the PHC to use in the future to ensure that all parts are done and that all information is obtained for each part. The rule itself was added to the bottom of this	

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D 482	Continued From page 9 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 bed rails were used only after an assessment and care planning process had been completed through a team process for 1 of 3 residents sampled (#2) included a resident with bed rails who had a history of falls. The findings are: Review of Resident #2's current FL-2 dated 02/08/19 revealed: -Diagnoses included Seizure disorder, Hypertension, Hypothyroidism. -There was documentation the resident was intermittently disoriented. -There was documentation the resident was	D 482	New INITIAL RESTRAINT CHECKLIST for quick reference if needed. I have included a copy of this new form in with this report. PHC will use this checklist every time a restraint is needed. PHC will notify Administrator if any restraint has been ordered so he can review the process when completed. Administrator will also check monthly to see if anyone had any changes that resulted in the need for a hospital bed, rails, or restraints. 7-5-19 D 482 addendum per telephone with Mr Seanlan on 7/15/19. The administrator sat down with the PHC on 06/19/19. The administrator will monitor for any changes monthly by performing Chart audits. The administrator will monitor for physical restraints randomly. He will provide ongoing	

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D 482	Continued From page 10 non-ambulatory. -There was documentation Resident #2 used a wheelchair. Review of Resident #2's assessment and care plan dated 02/11/19 revealed: -There was documentation Resident #2 was ambulatory with wheelchair. -There was documentation Resident #2 required supervision with eating, extensive assistance from staff with transferring, extensive assistance with toileting, ambulation/locomotion, bathing, dressing, and grooming/personal hygiene. -There was no documentation regarding the use of bed rails by Resident #2. Review of Resident #2's record revealed there was no consent for the bedrails. Review of Resident #2's Licensed Health Professional Support (LHPS) Review dated 03/01/19 revealed there was no assessment for the use of bedrails. Interview with a representative from the durable medical equipment provider on 05/22/19 at 3:17 pm revealed: -Their company delivered a semi-electric hospital bed with mattress and rails to Resident #2 on 02/11/19. -The documentation provided to them by Resident #2's PCP noted the resident would benefit from a hospital bed due to the patient required frequent changes in body position which was not feasible with an ordinary bed. -The documentation also noted the resident had limited mobility and could not independently make changes in position. Observation of Resident #2 on 05/21/19 at 2:14	D 482	Education with staff one on one as indicated. A Simmons 07/15/19	

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D 482	Continued From page 11 pm revealed: -Resident #2 was in her bed, lying on her right side with her face towards the wall. -Resident #2 did not respond when her name was called. -The bedrails were in the up position. Observation and interview of Resident #2 on 05/21/19 at 3:09 pm revealed: -Resident #2 was in her bed, lying on her right side with her face towards the wall. -Resident #2 responded when her name was called. -Resident #2 was not sure why her bed had rails. -Resident #2 could not demonstrate how she used the rails. -She had a new bed and she liked it. -When asked about falls, she only remembered falling out of her wheelchair and broke her arm. -She did not remember when it happened (unable to state exact time/day/date), but said she was outside when she fell. -Resident #2 was not able to communicate in complete details.	D 482		
	Interview with a personal care aide (PCA) on 05/22/19 at 9:51 am revealed: -Resident #2 could "scoot down" to the end of the bed to try and get her remote control. -Resident #2 wore adult briefs for incontinence and would need to be changed. -She was able to change Resident #2 by herself with Resident #2 using the side rails for help in turning and repositioning. -There was no set time to check on the residents. -Resident #2 was checked every 2 hours when they made "rounds". Interview with a Medication Aide (MA) on 05/22/19 at 12:29 pm revealed:			

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D 482	Continued From page 12 -Side rails were used so that Resident #2 could not get out of bed. -He put the bed rails up because he did not want the resident to fall. -Resident #2 was able to pull herself over in the bed a little using bed rails during personal care such as when he changed her adult brief or linen, but not much. -The bed rails helped when he changed Resident #2. -He wasn't instructed on any specific rules or use of the bed rails, he just noticed one day Resident #2 had a new bed. -He did not remember when Resident #2 received her new bed. -Other staff told him the bed rails were for Resident # 2's protection and to keep her from falling out of bed. -Resident #2 was in the bed when he left this morning (05/22/19) and her rails were up. -When he worked first shift, he kept Resident #2 in the living room area to keep an eye on her. -No fall mats or other devices had been used prior to bed rails. -Resident #2 had fallen out of bed in the past. -She slid out of bed twice in February with no injuries. -Resident #2 fell out of bed a couple times last summer but didn't remember exactly when. -He checked on Resident #2 every two hours during the night shift. -Staff checked every two hours to ensure residents were breathing and if they needed any adult incontinence brief or linen to be changed. -Resident #2 used the call bell when assistance was needed but also hollered sometimes. -The facility did not utilize restraints. Interview with the Patient Health Coordinator (PHC) on 05/21/19 at 3:38 pm revealed:	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078038	A. BUILDING: _____ B. WING _____	R 05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT CARE	600 MT. MORIAH ROAD LUMBERTON, NC 28360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 13 -She did not remember the exact date of the bed and bed rails order. - Resident #2's previous PCP had ordered the bed rails. -The Administrator had provided the survey team with a signed physician's order for Resident #2's bed with bed rails when the survey team was unable to locate the order in Resident #2's record. A second interview with the PHC on 05/22/19 at 2:36 pm revealed: -Resident #2's hospital bed came with bed rails. -That was the way the order was written. -Staff had been using them for fall precautions. -Resident #2 slid herself off a single bed in February 2019; she was not injured. -There were no instructions on how to place the bed rails. -Resident #2 could hold on to the bed rail to help turn herself. -Resident #2 could not lift her bodyweight over the rails. -There were no orders for restraints. -The bed rails were only used for fall precautions. -The facility was restraint free. -Resident #2 did not have a care plan for bed rails. -The bed rails were put up when Resident #2 was in bed. -She had never complained about the bed rails being up. Interview with a third personal care aide (PCA) on 05/22/19 at 2:41 pm revealed: -She "assumed" the bed rails were to keep Resident #2 from rolling off the bed. -Staff always assisted Resident #2 when needed. -She knew to check on Resident #2 when she hollered or pulled her call light. -The PCA did not consider bed rails a restraint.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078038	A. BUILDING: _____ B. WING _____	R 05/22/2019

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D 482	Continued From page 14 -Restraints were not utilized in the facility. Interview with Resident #2's current Primary Care Provider (PCP) on 05/22/19 at 3:40 pm revealed: -Resident #2 used the bed rails for repositioning and for fall precautions. -She sent an order for the bed the same day it was ordered and resent to staff the same day. -The order was written on 04/30/19 and resent it to the supervisor in charge (SIC). -She was unsure if any other less restrictive devices had been used prior to bed rails on the new bed. -The bed rails should be up when Resident #2 was in the bed for fall precautions. -Resident #2 should be monitored every two hours. -She did not say why the resident should be monitored every two hours. Interview with Administrator on 05/22/19 at 4:29 pm revealed: -The facility did not have a restraint policy. -The facility used the rails for Resident #2 for repositioning, not as a restraint. -He was aware if they had restraints they would have to have an order, care plan, assessment, and a consent from the Power of Attorney (POA). -A bed rail is considered a restraint. -The facility did not consider the rails to be a restraint. -The PCP had been notified on 05/21/19 that an order, care plan, assessment, and a consent was needed for Resident #2's bed rails. Attempted interview on 05/22/19 at 10:26 am with Resident #2's previous PCP, who ordered the bed and bed rails, was unsuccessful. The facility failed to assure physical restraints	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 482	Continued From page 15 were used only after an assessment and care planning process had been completed through a team process and only with a written order from the primary care provider for Resident #2 who had been observed scooting to the bottom of the bed which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 05/22/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 482		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure each resident received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to physical restraints and resident rights.	{D912}	This is a Tag resident rights violation that goes with the other violation. Please see those Pages for details (7-5-19)	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 16 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure bed rails were used only after an assessment and care planning process had been completed through a team process for 1 of 3 residents sampled (#2) included a resident with bed rails who had a history of falls. [Refer to Tag 482 10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (#2)received adequate care and services as evidenced by the resident being transported outside of the facility and being left without a means of returning into the facility resulting in the resident being sunburned. [Refer to Tag 911, G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)].	{D912}		

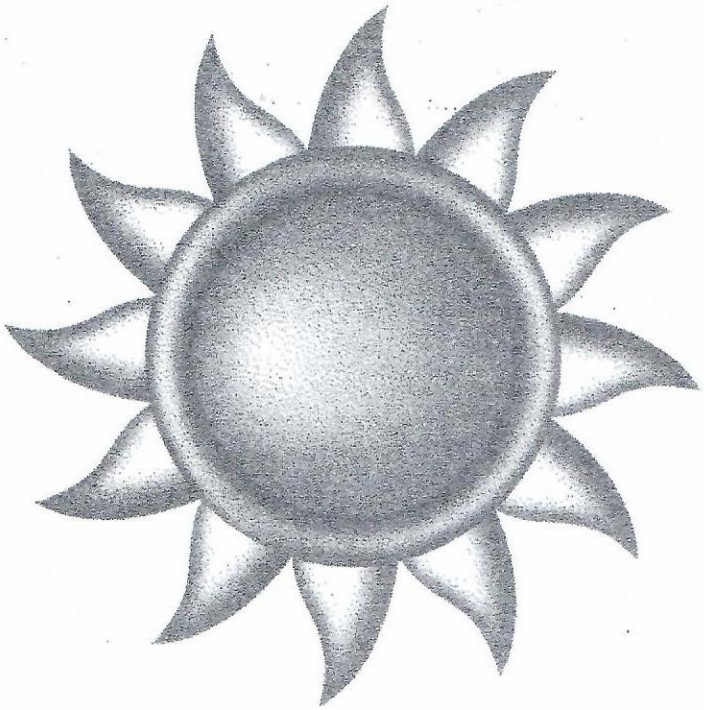
Sun Safety Policy

All Semi-ambulatory and Non-Ambulatory residents that go outside or request to go outside need to be protected by the following rules and facts.

1. **Where can they go?** They can go anywhere there is shade to protect them from the Sun directly. The front and back porches are the best places to have them enjoy the outside without fear of the sun.

2. **How often are they checked on?** These residents will be checked every 10 minutes while they are outside in the shade.

3. **Who is responsible to bring them back in?** Everyone is responsible for checking to see how long a resident has been outside if they come across a resident outside and don't know how long they had been out there. But ultimately, it's the responsibility of the Staff member that took them outside to check on them every 10 minutes and bring them back in when the resident is ready to go in or the staff member believes it is time for that resident to go in due to sun safety.



Limit Sun Exposure in the Summer Time to 10 minutes at a time!!!

Thank You,

[redacted]

INITIAL RESTRAINT CHECKLIST

1. RESTRAINT ORDER

(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. RESTRAINT ASSESSMENT

(A) medical symptoms that warrant the use of a restraint;
(B) how the medical symptoms affect the resident;
(C) when the medical symptoms were first observed;
(D) how often the symptoms occur;
(E) alternatives that have been provided and the resident's response; and
(F) the least restrictive type of physical restraint that would provide safety.

3. RESTRAINT CARE PLAN

(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
(B) the type of restraint to be used; and
(C) care to be provided to the resident during the time the resident is restrained.

4. RESTRAINT TEAM (WORKS TOGETHER TO DO #2 ASSESSMENT & #3 CARE PLAN

(A) A STAFF MEMBER (SIC OR PCA)
(B) A NURSE OR DOCTOR
(C) RESIDENT
(D) RESIDENT'S POA (IF THEY HAVE ONE)

SECTION .1501 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13F .1501 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;

(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;

(3) the least restrictive restraint that would provide safety;

(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.

(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;

(6) applied correctly according to the manufacturer's instructions and the physician's order; and

(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.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:

(A) medical symptoms that warrant the use of a restraint;

(B) how the medical symptoms affect the resident;

(C) when the medical symptoms were first observed;

(D) how often the symptoms occur;

(E) alternatives that have been provided and the resident's response; and

(F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:

(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;

(B) the type of restraint to be used; and

(C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:

(A) the medical need for the restraint;

(B) the type of restraint to be used;

(C) the period of time the restraint is to be used; and

(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.

(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.

(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.

(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.

(6) The restraint order shall be kept in the resident's record.