STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl060158	A. BUILDING: _____ B. WING _____	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT STONEHAVEN 2	6001 BISMARK PLACE CHARLOTTE, NC 28211

(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
C 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on 09/23/22 and 09/26/22.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician's orders for 2 of 3 sampled residents (Resident #1 and #3) related to an order for monthly weights (#1) and an order to apply a left wrist brace every night (#3). The findings are: 1. Review of Resident #1's current FL2 dated 09/08/22 revealed: -Diagnoses include dementia and history of COVID pneumonia. -There was an order for monthly weights. Review of Resident #1's record revealed: -The order for monthly weights originated on 03/01/22. -Resident #1 was referred to hospice on 07/19/22 due to malnutrition, physical decline and failure to	C 249	Item 1: a. We will be re-in-service staff on monthly weights and vitals b. Weights and vitals will be completed between the 1st and 6th of each month and documented. The RCC will check on the 7th of the month to ensure that they are done and documented. Item 2: a. Inservice all Med Administrators on proper documentation, follow through and communication. b. RCC will be responsible for making sure all orders are charted and up to date monthly. Nurse and Manager will also check Monthly.	10/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lev Saks — TITLE: Administrator — (X6) DATE: 12/02/2022

Reviewed and acknowledged LSB 12-02-2022

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C 249	Continued From page 1 thrive. Review of Resident #1's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for a monthly weight. -There was no documentation of a monthly weight in August 2022. Review of Resident #1's Monthly Vital Signs Record revealed: -There was documentation Resident #1's weight in January 2022 was 110 pounds. -There was no documentation of a weight in March, April, May or June 2022. -There was a weight entry of 93.3 pounds documented on 07/01/22 but was crossed out and documented as 08/01/22. -There was documentation Resident #1 weighed 91.9 pounds on 09/04/22. Interview with the Resident Care Coordinator (RCC) on 09/26/22 at 9:34am revealed: -Monthly weights were obtained on all residents between the 1st and the 6th of each month regardless of an order. -Each resident had a Monthly Vital Signs Record and their monthly weight was documented on it. -Resident #1 had a physician's order for monthly weights so there was also an entry on the eMAR where Resident #1's weight was documented. -It must be an oversight if the weight was not documented on the eMAR or the Monthly Vital Signs Record because she thought they were taken each month. -The Medication Aide (MA) working at the beginning of the month was responsible for obtaining Resident #1's weight. Interview with the facility's Manager on 09/26/22	C 249		

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C 249	Continued From page 2 at 9:34am revealed: -Weights were to be documented on the Monthly Vital Signs Record and also on the eMAR if there was a physician's order for weights. -Weights were scheduled to be obtained between the 1st and the 6th of each month. -The RCC was responsible for ensuring weights were obtained. -She thought weights were being taken and documented on Resident #1. Interview with a MA on 09/26/22 at 11:41am revealed: -Weights were scheduled to be obtained between the 1st and the 6th of each month. -The MA working at the beginning of the month was responsible for obtaining Resident #1's weight. 2. Review of Resident #3's current FL2 dated 11/18/21 revealed diagnoses included dementia and osteoarthritis. Review of Resident #3's physician's orders dated 08/01/22 revealed there was an order for a left wrist brace apply nightly at bedtime. Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry to wear a left wrist brace at night at 8:00pm. -There was documentation Resident #3's wrist brace was applied on 08/02/22, 08/05/22, 08/14/22, 08/19/22, 08/22/22, 08/27/22, and 08/28/22. -There was no documentation Resident #3's wrist brace applied on 08/01/22, 08/03/22, 08/04/22, 08/06/22, 08/07/22, 08/09/22 through 08/13/22, 08/15/22 through 08/18/22, 08/20/22, 08/21/22,	C 249		

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C 249	Continued From page 3 08/23/22 through 08/26/22, and 08/29/22 through 08/31/22 with documentation resident refused. Review of Resident #3's September 2022 eMAR revealed: -There was an entry to wear a left wrist brace at night at 8:00pm. -There was documentation Resident #3's wrist brace was applied on 09/02/22, 09/07/22 through 09/12/22, 09/17/22 through 09/19/22, and 09/21/22. -There was no documentation Resident #3's wrist brace was applied on 09/01/22, 09/03/22 through 09/06/22, 09/13/22 through 09/16/22, 09/20/22, and 09/22/22 with documentation resident refused. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 09/23/22 at 3:45pm revealed: -She did not know Resident #3 had a left wrist brace ordered. -She could not find a wrist brace for Resident #3. -She thought the order was for a call button device and she could not find the wrist band attachment to attach the call button to Resident #3's wrist. -She thought it was a mistake some of the night shift MA's documented the brace as applied to Resident #3's left wrist. -The MA's that documented the brace as not applied and reason was documented as refused should have documented the brace was unavailable for Resident #3 instead. -She was responsible to clarify physician's orders. Interview with the Manager on 09/26/22 at 12:45pm revealed: -The call button device was not a left wrist brace that was ordered for Resident #3.	C 249		

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C 249	Continued From page 4 -She thought the order for Resident #3's wrist brace was an old physician's order. -The RCC was responsible for reviewing and clarifying all physician's orders if needed. Attempted telephone interview with Resident #3's responsible person on 09/26/22 at 12:27pm was unsuccessful.	C 249		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 2 of 3 sampled residents (Resident #1 and #3) with physician's orders for a pureed diet (#1) and a finger foods diet (#3). The findings are: Review of Resident #1's current FL2 dated 09/08/22 revealed: -Diagnoses included dementia and history of COVID pneumonia. -There was an order for a pureed diet. Observations in the kitchen during initial tour on 09/23/22 at 11:49am revealed: -There was a piece of paper hanging on the	C 270	a. Groove menu was notified to add puree to therapeutic diet menu. b. in home resident diet list has been updated and placed where all staff can see. c. therapeutic diet extensions sheet will be posted along with weekly menu. a. Finger food added to therapeutic diet list. b. RCC will ensure correct diet list is posted c. staff will be in serviced on correct use of finger foods.	10/31/2022

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C 270	Continued From page 5 refrigerator that documented Resident #1's diet as pureed. -A puree diet menu was not posted in the kitchen. Observations in the dining room on 09/23/22 at 9:03am and 12:30pm and on 09/26/22 at 8:30am revealed all food served to Resident #1 was pureed. Interview with a Medication Aide (MA) on 09/26/22 at 9:17am revealed: -The facility did not have a pureed menu. -She knew how to puree Resident #1's food because she was trained by a previous employer. -She used the regular menu as guidance and pureed all food served to Resident #1. Interview with the Resident Care Coordinator (RCC) on 09/26/22 at 9:25am revealed: -The facility did not have a pureed menu. -She knew how to puree food but she never had any official training at the facility. -She used the regular menu as guidance and pureed all food served to Resident #1. -The facility never needed anything other than a regular menu until Resident #1 was ordered a pureed diet in August 2022. Interview with the facility's Manager on 09/26/22 at 12:30pm revealed: -The facility should have a therapeutic diet menu to match the residents diet orders. -The RCC told her about Resident #1's order for a pureed diet in August 2022. -She thought the RCC was printing and posting the pureed menu each week when she printed the regular menu. -The RCC had access to a computer program that generated all menu extension but the Manager was unaware a pureed menu was not	C 270		

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C 270	Continued From page 6	C 270		

one of the menu extensions included with the program.
-She should have confirmed a pureed menu was available after the order was received.

2. Review of Resident #3's current FL2 dated 11/18/21 revealed diagnoses included dementia, protein-calorie malnutrition, and glaucoma with blindness.

Review of Resident #3's care plan dated 07/22/22 revealed:
-Diet type was documented as a finger food diet.
-Resident #3 required extensive assistance from staff to eat.

Review of Resident #3's physician's order dated 08/01/22 revealed an order for a finger foods diet.

Observations in the kitchen during initial tour on 09/23/22 at 11:49am revealed:
-There was a piece of paper hanging on the refrigerator that documented Resident #3's diet as regular/cut up
-There was not a finger food menu posted in the kitchen.

Observation of the breakfast meal service on 09/23/22 at 9:10am revealed:
-Resident #3 was sitting at the dining room table holding a fried egg in her hand while taking small bites of the egg.
-There was a whole biscuit, 2 pieces of uncut bacon, watermelon pieces in a small bowl, and an unopened yogurt setting on the table in front of Resident #3.

Interview with the hospice registered nurse (RN) on 09/23/22 at 12:05pm revealed:
-Resident #3 was blind and could not see to

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C 270	Continued From page 7 navigate a fork to eat with. -Resident #3 took about an hour to eat her meals because she chewed one bite of food for long periods of time. Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:45pm revealed: -Resident #3 was legally blind and could not use a fork to feed herself. -Resident #3's food was not cut into pieces because staff would cut the food when they fed her. -The food served to Resident #3 could be considered finger foods. -The yogurt cup served to Resident #3 was not a finger food. Interview the Manager on 09/26/22 at 12:30pm revealed: -The facility should have a therapeutic diet menu to match the residents diet order -She thought the RCC was printing and posting the menu extensions each week when she printed the regular menu. -The RCC had access to a computer program that generated all menu extension but the Manager was unaware a finger foods menu was not one of the menu extensions included with the program. -She should have confirmed a finger foods menu was available after the order was received. -The RCC was responsible for contacting the primary care provider (PCP) to clarify the therapeutic diet order if a therapeutic diet menu was unavailable. Telephone interview with Resident #3's PCP on 09/26/22 at 1:18pm revealed: -Resident #3 was not able to use silverware so she ordered her a finger foods diet.	C 270		

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C 270	Continued From page 8 -She expected staff to either serve Resident #3 finger foods to eat or assist Resident #3 with her meals. Attempted telephone interview with Resident #3's responsible person on 09/26/22 at 12:27pm was unsuccessful.	C 270		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #3) related to medications used to treat anemia, vaginal dryness caused by the body making less estrogen, and a medication used to treat elevated blood pressures. The findings are: Review of Resident #3's current FL2 dated 11/18/21 revealed diagnoses included dementia, hypertension and anemia. a. Review of Resident #3's physician's orders dated 08/01/22 revealed cyanocobalamin (a	C 330	1. a. Staff will be in serviced on documentation to include refusal and availability of medications. b. B12 and vaginal cream has been discontinued by doctor after discussion with family. c. Cart audit will be conducted twice a month. Once by the 3rd shift med tech and on the 16th by the RCC. RCC will document the review and any findings. 2. a. Amlodipine has been dc'd by hospice nurse as of 10/19/2022 b. cart audits will be conducted twice a month. Once by the 3rd shift med tech and on the 16th by the RCC. RCC will document the review and any findings.	10/20/22

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C 330	Continued From page 9 medication used to treat a vitamin B12 deficiency caused by anemia) 1,000 mcg/ml give injection monthly administered by the hospice registered nurse (RN). Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for cyanocobalamin 1,000mcg/ml give 1 injection monthly administered by the hospice RN. -There was documentation on 08/25/22 cyanocobalamin was not administered due to withheld per orders and a note "waiting for nurse to administer". Review of Resident #3's September 2022 eMAR revealed: -There was an entry for cyanocobalamin 1,000mcg/ml give 1 injection monthly administered by the hospice RN. -There was no documentation cyanocobalamin was administered from 09/01/22 through 09/23/22. Observation of Resident #3's medications on hand on 09/23/22 at 3:45pm revealed there was no cyanocobalamin available for administration. Interview with the RCC/MA on 09/23/22 at 3:45pm revealed: -Resident #3's cyanocobalamin refill had not been dispensed by the facility's contracted pharmacy for September's dose. -She was responsible for medication cart audits making sure all medications were available for administration. -She was responsible for requesting a refill for the cyanocobalamin for Resident #3 when the medication ran out.	C 330		

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C 330	Continued From page 10 -She completed a medication cart audit with a pharmacist from the facility's contracted pharmacy on 08/24/22. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/26/22 at 9:13am revealed: -Cyanocobalamin was previously dispensed on 06/30/22 in the quantity of 1 dose for Resident #3. -Resident #3's cyanocobalamin was not on a cycle fill and a refill must be requested by the facility when needed. Refer to the interview with the Manager on 09/26/22 at 12:45pm. b. Review of Resident #3's physician's orders dated 08/01/22 revealed Premarin vaginal cream (a medication used to treat vaginal dryness caused by the body making less estrogen) place ½ gram vaginally twice weekly on Tuesday and Friday. Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Premarin vaginal cream apply ½ gram vaginally twice weekly on Tuesday and Friday. -Premarin vaginal cream was documented as not administered 5 instances of 9 opportunities with a comment "withheld per orders". -There was documentation Premarin vaginal cream was administered on 08/02/22, 08/05/22, 08/12/22, and 08/26/22. Review of Resident #3's September 2022 eMAR revealed: -There was an entry for Premarin vaginal cream apply ½ gram vaginally twice weekly on Tuesday	C 330		

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C 330	Continued From page 11 and Friday. -Premarin vaginal cream was documented as not administered 6 instances out of 7 opportunities with a comment "withheld per orders". -There was documentation Premarin vaginal cream was administered on 08/09/22. Observation of Resident #3's medications on hand on 09/23/22 at 3:45pm revealed there was no Premarin vaginal cream available for administration. Interview with the RCC/MA on 09/23/22 at 3:45pm revealed: -Resident #3's Premarin vaginal cream "just ran out" and the refill had not been dispensed by the facility's contracted pharmacy. -She was responsible for medication cart audits making sure all medications were in date and available for administration. -She completed a medication cart audit with a pharmacist from the facility's contracted pharmacy on 08/24/22. -She was responsible for requesting refills from the pharmacy when medications were low or had run out. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/26/22 at 9:13am revealed Premarin vaginal cream 30-gram tube was last dispensed on 07/13/22 and if administered as ordered should last for 60 doses. Refer to the interview with the Manager on 09/26/22 at 12:45pm. c. Review of Resident #3's physician's orders dated 08/01/22 revealed amlodipine (a medication used to treat elevated blood	C 330		

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C 330	Continued From page 12 pressures) 2.5mg take 1 tablet daily as needed for systolic blood pressure 170 or greater. Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 2.5mg take 1 tablet daily as needed for systolic blood pressure 170 or greater. -There was no documentation amlodipine was administered from 08/01/22 through 08/31/22. Review of Resident #3's September 2022 eMAR revealed: -There was an entry for amlodipine 2.5mg take 1 tablet daily as needed for systolic blood pressure 170 or greater. -There was no documentation amlodipine was administered from 09/01/22 through 09/23/22. Observation of Resident #3's medications on hand on 09/23/22 at 3:45pm revealed there was a bubble pack of amlodipine 2.5mg in the quantity of 30 tablets dispensed on 08/17/21 with a discard date of 08/17/22. Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 09/23/22 at 3:45pm revealed: -Resident #3's amlodipine was to be administered as needed and she had not required any doses of the medication. -She did not know Resident #3's amlodipine was expired. -She was responsible for medication cart audits making sure all medications were in date and available for administration. -She completed a medication cart audit with a pharmacist from the facility's contracted pharmacy on 08/24/22 and "missed" the	C 330		

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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
C 330	Continued From page 13 expiration date on Resident #3's amlodipine. -She was responsible for requesting refills from the pharmacy when a medication expired. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/26/22 at 9:13am revealed: -Resident #3's amlodipine 2.5mg was last dispensed on 08/17/21 in the quantity of 30 tablets. -The amlodipine for Resident #3 had an expiration date of 08/17/22. -The amlodipine for Resident #3 was not on a cycle fill and a refill must be requested by the facility. Refer to the interview with the Manager on 09/26/22 at 12:45pm. Interview with the Manager on 09/26/22 at 12:45pm revealed: -The third shift medication aide (MA) was responsible for completing a medication cart audit every 2 weeks to check for expired medications or requesting medication refills when a medication was running low or missing from the cart. -The Resident Care Coordinator (RCC) was responsible for completing cart audits, making sure medications were available for administration, and medications had not expired.	C 330		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical	C 453	Please see next page for the plan of correction	10/20/22

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C 453	Continued From page 14 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	C 453	Moving forward assessment will be completed by a team composed of the facility Nurse, RCC, Manager, Family and DR. The assessment will be completed in two parts. A. First meeting will consist of discussing the need for bed rails. We will discuss what alternative measures will try and for what period we will try the alternative. B. Second part will be the team discussing if the alternative measure discussed in the prior meeting, was a success. Are there any other options, or if we should proceed with bed rails. All discussion will be documented, and care planned in the resident chart. Family will sign consent form for use of bed rails. The Dr will sign an order detailing what type of restraint should be used, when the restraint should be used and how long.	

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C 453	Continued From page 15 cushions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure bed rails were used only after a team assessment and care planning process, and alternatives were tried prior to the restraint that would provide safety to the resident for 3 of 3 sampled residents (#1, #2, #3), who had bed rails to keep the residents from getting out of bed. The findings are: 1. Observation during initial tour on 09/23/22 at 9:06am revealed: -There were full bed rails in the down position on each side of Resident #1's bed. -Resident #1 was not in the bed. Review of Resident #1's current FL2 dated 09/08/22 revealed: -Diagnoses included dementia and a history of COVID pneumonia. -The resident was non-ambulatory and constantly disoriented. -The resident required total care with all activities of daily living. -There was an order for bed rails on the bed at night. Review of Resident #1's care plan revealed: -The facility's Registered Nurse (RN) consultant completed the care plan assessment on 08/23/22. -Resident #1 had a significant decline in the past month. -Resident #1 was non-ambulatory and was propelled by staff in a wheelchair. -Resident #1 was totally dependent on staff for	C 453	-The team will communicate on a quarterly basis to determine if restraint is still needed for resident. -Staff will also be responsible for keeping an hourly monitoring report during hours the restraint are being used. Resident 1: A team assessment has been conducted and the findings of this assessment are that we will remove bed rails. In place of bed rails, we will try the following alternative 1. resident bed will be lowered to the lowest possible position. 2. A cushioned mat will be placed on the floor beside the bed. Resident 2: A team assessment has been conducted and the findings of this assessment are that we will remove bed rails. In place	

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C 453	Continued From page 16 transfers. -Resident #1 was constantly disoriented. -Memory was documented as significant loss. -There was no documentation bed rails were needed. Review of Resident #1's physician restraint order dated 08/02/22 revealed: -There was an order for bed rails while the resident was in bed. -Dementia was documented as the medical reason why the restraint was needed. -The type of restraint was documented as bed rails while in bed. -Alternatives to restraints tried were documented as redirection and monitoring. Interview with Resident #1's hospice RN on 09/23/22 at 11:53am revealed Resident #1 needed bed rails on her bed because she did not have bed boundary knowledge. Telephone interview with Resident #1's responsible person on 09/23/22 at 3:28pm revealed: -Resident #1 was non-ambulatory, disoriented and Resident #1 thought she could still walk and get out of bed on her own. -Resident #1 was hospitalized in August 2022 and when she returned to the facility on 08/19/22 bed rails were put on her bed to prevent her from falling when she attempted to get out of bed. -She did not know bed rails were ordered on 08/02/22. Review of Resident #1's record revealed there was no documentation of any team assessment, care planning process or alternatives tried prior to the initiation of bed rails ordered on 08/02/22.	C 453	of bed rails, we will try the following alternative 1. resident bed will be lowered to the lowest possible position. 3. A cushioned mat will be placed on the floor beside the bed. Resident 3: Resident was placed on a 72 monitor to assess the continued need of bed rails. In conclusion of the monitoring period, it has been determined that bed rails will be removed. In return the following alternative will be in place. 1. The bed will place in the lowest possible position. 2. A cushioned mat will be placed on the floor beside the bed.	

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C 453	Continued From page 17 Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:35pm. Refer to interview with the facility's Manager on 09/26/22 at 12:30pm. 2. Observation during initial tour on 09/23/22 at 9:05am revealed: -There were full length bed rails in the down position on each side of Resident #3's bed. -Resident #3 was not in the bed. Review of Resident #3's current FL2 dated 11/18/21 revealed: -Diagnoses included dementia and glaucoma with blindness. -Ambulatory status was documented as non-ambulatory. -Personal care assistance was documented as total care. -There was an order for restraints with documentation of 2 hours checks. Review of Resident #3's care plan dated 07/22/22 revealed: -Ambulation was documented as non-ambulatory and wheelchair for locomotion. -Resident #3 was constantly disoriented with significant memory loss. -Resident #3 required total assistance with activities of daily living. -There was documentation of bed rails with Resident #3 being totally dependent on staff. -There was no documentation or assessment why bed rails were needed.	C 453		

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C 453	Continued From page 18 Review of the physician's restraint order dated 08/01/22 revealed: -The Resident Care Coordinator (RCC) documented the date of the restraint order as 09/23/22. -The medical reason for restraints was documented as high risk for falls. -The type of restraint was documented as bed rails while in bed. -Alternatives to restraints tried were documented as redirection and repositioning. Review of Resident #3's Licensed Health Professional Support (LHPS) quarterly evaluation dated 07/22/22 revealed: -The care of residents who are physically restrained and the use of care practices as alternatives to restraints was marked with a check mark with documentation of "siderails" hand-written in the box. -There was documentation of a LHPS task of siderails and staff were competency validated. Review of Resident #3's record revealed there was no documentation of any team assessment, care planning process or alternatives tried prior to the initiation of bed rails ordered on 08/01/22. Interview with the hospice registered nurse (RN) on 09/23/22 at 12:05pm revealed bed rails for Resident #3's bed were ordered by the hospice physician as a restraint because the resident was at high risk for falls and was not aware of bed boundaries. Telephone interview with Resident #3's primary care provider (PCP) on 09/26/22 at 1:18pm revealed she ordered the full length bed rails as a restraint for Resident #3 per the facility's request due to the resident was at high risk for falls.	C 453		

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C 453	Continued From page 19 Attempted telephone interview with Resident #3's responsible person on 09/26/22 at 12:27pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:35pm. Refer to the interview with the facility's Manager on 09/26/22 at 12:30pm. 3. Observation during the initial tour on 09/23/22 at 9:05am revealed: -There were ½ bed rails in the down position on Resident #2's bed. -Resident #2 was not in the bed. Review of Resident #2's current FL2 dated 08/01/22 revealed: -Diagnoses included dementia. -There was documentation Resident #2 was intermittently disoriented and non-ambulatory. Review of Resident #2's restraint order dated 08/01/22 revealed: -The order was for bed rails. -Fall prevention and being unaware of bed boundaries was documented as the reason for the restraint. Interview with Resident #2's Hospice Registered Nurse (RN) on 09/23/22 at 11:53am revealed Resident #2 needed bed rails on her bed because she did not have bed boundary knowledge.	C 453		

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C 453	Continued From page 20 Telephone interview with Resident #2's Health Care Power of Attorney (HCPOA) on 09/28/22 at 6:46pm revealed bed rails were put in place when she was admitted to the facility in April 2021 due to a fall at her previous facility. Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:25pm. -The bed rails on Resident #2's bed had been there since she was admitted in April 2021. -The bed rails were placed to prevent her from falling out of the bed. Review of Resident #2's record revealed there was no documentation of any team assessment, care planning process or alternatives tried prior to the initial order for bed rails in April 2021. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:35pm. Refer to interview with the facility's Manager on 09/26/22 at 12:30pm. Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:35pm revealed she did not know an assessment was required prior to the use of restraints. Interview with the facility's Manager on 09/26/22 at 12:30pm revealed: -The RCC was responsible for ensuring all paperwork was completed prior to the use of restraints. -She thought an assessment consisted of staff monitoring the resident off and on for a period of	C 453		

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C 453	Continued From page 21 time, determining what type of restraint was necessary and then recommending that to the primary care provider who would order the restraint.	C 453		
C 454	10A NCAC 13G .1301(b) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to receive informed consent from the legal representative prior to the use of restraints for 2 of 3 sampled residents (#1 & #2) who had physician orders for bed rails.	C 454	1. When having team assessment all parties included will sign off that they are aware and understand all actions discussed. 2. The legal representative will be asked to sign a separate consent form agreeing or disagreeing with the use of a restraint. 3. The consent form will then be placed in the resident chart. 4. The RCC will be responsible for making sure the consent form is signed and placed in the chart.	10/20/22

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C 454	Continued From page 22 The findings are: 1. Observation during initial tour on 09/23/22 at 9:06am revealed there were full bed rails in the down position on each side of Resident #1's bed. Review of Resident #1's current FL2 dated 09/08/22 revealed: -Diagnoses included dementia and a history of COVID pneumonia. -The resident was non-ambulatory and constantly disoriented. -The resident was dependent on staff for all activities of daily living. Review of Resident #1's physician restraint order dated 08/02/22 revealed: -There was an order for bed rails. -Dementia was documented as the medical reason why the restraints were needed. -There was no documentation of a signed consent from Resident #1's responsible person. Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:35pm revealed: -Resident #1's responsible party was told about the use of bed rails as restraints after Resident #1 returned from the hospital in August 2022. -She thought the consent form was sent to the responsible party. Interview with Resident #1's responsible party on 09/23/22 at 3:28pm revealed: -She knew the bed rails were on Resident #1's bed to prevent her from getting out of bed on her own. -She did not know bed rails were considered a restraint. -She was not asked to sign a consent form.	C 454		

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C 454	Continued From page 23 Refer to interview with the facility Manager on 09/26/22 at 12:30pm. 2.Observation during the tour on 09/23/22 at 9:05am revealed there were ½ bed rails in the down position on Resident #2's bed. Review of Resident #2's current FL2 dated 08/01/22 revealed -Diagnoses included dementia. -Resident #2 was intermittently disoriented and non-ambulatory. Review of Resident #2's restraint order dated 08/01/22 revealed: -The order was for bed rails. -Fall prevention and being unaware of bed boundaries was documented as the reason for the restrain. Telephone interview with Resident #2's Health Care Power of Attorney (HCPOA) on 09/28/22 at 6:46pm revealed: -bed rails were put in place due to a fall at her previous facility. -He thought he gave consent for the use of bed rails when Resident #2 was admitted. Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 2:25pm. -The bed rails on Resident #2's bed had been there since she was admitted in April 2021. -The bed rail was put in place to prevent her from falling out of bed. Review of Resident #2's record revealed there was no documentation Resident #2's POA gave consent for restraints.	C 454		

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C 454	Continued From page 24 Refer to interview with the facility's Manager on 09/26/22 at 12:30pm. _____ Interview with the facility's Manager on 09/26/22 at 12:30pm revealed: -The RCC was responsible for obtaining all necessary restraint consents. -She did not know why the RN consultant did not catch the missing consent forms when she was at the facility in August 2022.	C 454		
C9999	Final Observation As a result of Informal Dispute Resolution (IDR) of November 21, 2022, tag C0453 was reduced to a standard deficiency.	C9999		