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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up and complaint investigation on 12/19/23 to 12/20/23.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the environmental storage room, containing hazardous materials, was locked and not accessible to residents. The findings are: Observation of the storage room on 12/19/23 at 8:26am revealed: -The door was not locked. -There were four large bottles of concentrated chemicals in a dispenser fixed to the wall. -One of the bottles of chemicals was labeled with caution; may cause eye and skin irritation. -A second bottle was labeled with a warning, avoiding contact with liquid concentrated product with eyes and skin.	D 056		

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-A third bottle was labeled with a warning, contained flammable liquid and vapor, and caused skin and eye irritation.
-A fourth bottle was labeled with first aid instructions including for contact with the eyes and/or skin, and instructions in inhaled or swallowed.

Observation of the same storage room on 12/19/23 at 1:10pm revealed the door was not locked.

Observation of the same storage room on 12/19/23 at 3:20pm revealed the door was not locked; the door was not closed completely and light from inside the room was visible.

Observation of the hallway of the storage room on 12/19/23 at various times between 8:30am-3:30pm revealed multiple residents walking up and down the hallway by the unlocked door.

Interview with the Maintenance Director on 12/19/23 at 3:30pm revealed:
-There was no housekeeper on duty today, 12/19/23.
-He was responsible for housekeeping.
-He had been in the storage room multiple times today, 12/19/23, but the room had been locked.
-Other staff also had access to the storage room to get the mop for spills.
-The storage room was supposed to always be locked.
-The room was supposed to be locked so the residents could not get to the chemicals.
-The residents could be curious and could get into the chemicals if the door was not locked.

Interview with the Administrator on 12/19/23 at

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D 056	Continued From page 2 3:56pm revealed: -Cleaning supplies should be locked in the janitorial closet (storage room). -The door to the room should be locked because of the chemicals and "we do not want our resident to drink it." Observation of the storage room on 12/19/23 at 4:40pm revealed the door was not locked. Observation of the storage room on 12/20/23 at 4:02pm revealed the door had a newly installed keypad lock and was locked.	D 056		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have an adequate supply of fitted sheets available on hand for resident use. The findings are: Observations during the initial tour of the facility on 12/19/23 at 8:20am revealed: -The facility census was 46. -Room 418 had two beds in the room. -418A had an exposed mattress with no sheet	D 080		

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covering it and a bedspread pushed over to the side.
-418B had an exposed mattress with no sheet covering it and a bedspread pushed over to the side.

Observation of a resident room 205 on 12/19/23 at 8:16am revealed the bed did not have a top or bottom sheet on the bed.

Observation of a second resident room 301 on 12/19/23 at 8:17am revealed:
-The resident was covered with a sheet.
-There was no fitted sheet, and the resident was lying directly on the uncovered mattress.

Observation on three rooms on 12/19/23 between 8:20am-8:21am revealed:
-The beds had one flat sheet and a blanket on the bed.
-There was no fitted sheet, or a second flat sheet used to cover the entire mattress.

Observation of resident rooms on 12/20/23 at 9:07am and 10:16am revealed:
-Room 418 did not have a sheet in place to cover the mattress.
-Room 315A did not have a sheet to cover the mattress.
-Room 315B did not have a sheet to cover the mattress.
-Room 317A did not have any sheets on the bed.
-Room 317B did not have a sheet to cover the mattress.

Observation of a clean linen closet on the 300-hall revealed:
-The door to the closet was open.
-The closet contained four blankets, one incontinence pad, three bedspreads and six

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pillowcases.
-There were no sheets available for resident use.

Observation of the second clean linen closet on the 300-hall revealed:
-The door of the closet was open.
-There were seven comforters.
-There were no sheets available for resident use.

Observation of the clean linen storage in the basement of the facility on 12/20/23 at 10:10am revealed:
-There was a large cart for clean linen storage.
-There were fourteen flat sheets on the shelf.

Observation of the soiled linen area in the facility's basement on 12/20/23 at 10:15am and 11:40am revealed:
-There were two large containers full of soiled residents' personal clothing.
-There was one large container that contained multiple bags of soiled linen.
-There were 20 soiled sheets.

Interview with a Personal Care Aide (PCA) on 12/20/23 at 10:05am revealed:
-There was not always enough sheets for the beds.
-When residents had incontinence and the sheets were soiled, she was supposed to rinse the linen out, put it in a bag, and throw it in the linen chute that went to the laundry room.
-She thought some staff members threw the linen away when it was soiled.
-The laundry staff were supposed to bring the linen up and put it in the linen closet.
-She did not go to the laundry room to get linen.
-She used a flat sheet in place of a fitted sheet if there were no fitted sheets available.

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D 080	Continued From page 5 Interview with a third PCA on 12/20/23 at 3:51pm revealed: -She worked the second shift from 3:00pm to 11:00pm. -There were not always enough sheets. -Laundry was done downstairs in the facility's basement. -She did not know how often the linen was washed. -She did not go down to the laundry to get clean linen. -She used two flat sheets if there were no fitted sheets available. Interview with a Medication Aide (MA) on 12/20/23 at 10:16am revealed: -She didn't think there were enough sheets in the facility. -She witnessed staff throwing away linen if it was soiled. -Staff were supposed to rinse the linen out and then send it to the laundry. Interview with a staff member in the laundry on 12/20/23 at 10:10am revealed: -She worked full time but only four hours in the laundry. -She was responsible for residents' personal clothes. -The staff member that worked 11:00pm - 7:00am was responsible for laundering the linen and placing it in the linen closets on the hall. Interview with a second staff member in the laundry on 12/20/23 at 10:25am revealed: -He worked in the laundry from 11:00pm to 7:00am. -He was responsible for laundering the linen in the facility. -When the linen was cleaned, he brought it	D 080		

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D 080	Continued From page 6 upstairs and put it in the clean linen closet. -He believed there were enough fitted and flat sheets available in the facility. Interview with the Housekeeping Director on 12/20/23 at 10:30am revealed: -Both laundry employees have reported the facility was low on fitted and flat sheets. -He reported the shortage to the Administrator. -The Administrator sent an order to corporate about a month ago. -The linen had not been delivered yet. Interview with the Administrator on 12/20/23 at 10:50am revealed: -There was not a corporate linen account. -When they were low on linen, they went to the local department store and purchased more. -She just purchased new linen last month. -There was enough linen. -Has been told there is a shortage of sheets. -PCA's were supposed to rinse soiled linen before sending it to the laundry. -She did not know why there weren't fitted and flat sheets on the residents' beds.	D 080		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 1 residents (#7) with physician's orders for a mechanical soft (MS) diet.

The findings are:

Observation of the kitchen on 12/19/23 at 8:33am revealed:
-There was a regular menu posted on a bulletin board in the kitchen and the therapeutic diet list was posted on the entrance door to the kitchen.
-There was no therapeutic diet menu posted or available for review for reference for staff.

Review of Resident #7's current FL-2 dated 02/16/23 revealed:
-Diagnoses included Alzheimer's dementia, B12 deficiency and weight loss.
-Resident #7 was ordered a mechanical soft diet.

Review of a signed physicians order for Resident #7 dated 10/16/23 revealed an order for mechanical soft ground diet.

Review of the facility's undated therapeutic diet list posted entrance door to the kitchen revealed Resident #7 was to be served a MS ground diet.

Review of the facility's week-at-a-glance menu for Tuesday, 12/19/23, for regular diets revealed pork loin, yams, peas with onions, a dinner roll, canned pears, water, lemonade, and milk were to be served.

Observation of the lunch meal service on

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D 296	Continued From page 8 12/19/23 between 12:58 and 1:35pm revealed: -Resident #7 was served a ground up piece of pork loin, cut up yams, peas with onions, diced canned pears, water, lemonade, and milk; she was not served a dinner roll. -Resident #7 consumed 100% of her meal. Based on observation of the lunch meal service on 12/19/23, it could not be determined if Resident #7 was served the correct MS ground diet because there was not a therapeutic diet menu available for staff guidance. Interview with the Dietary Manager/Cook (DM/Cook) on 12/19/23 at 12:14pm revealed: -She did not have a therapeutic diet menu for reference or guidance when preparing a MS ground diet. -The facility wanted all the residents to have the same food, so she only had a regular menu for reference. -She followed the regular menu for the MS ground diet but ground the meat and cooked the vegetables until they were soft. Interview with the DM/Cook on 12/20/23 at 12:32pm revealed: -She knew what to prepare for the residents who were ordered MS ground diet based on her experience. -She also knew what the residents liked to be served and she tried to honor residents' choices. Interview with the Administrator on 08/03/23 at 4:59pm revealed: -The facility had a menu system that included therapeutic diet menus. -The kitchen staff should have had the menus and using them for reference when preparing the meals.	D 296		

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D 296	Continued From page 9 -She printed the therapeutic diet menus a week in advance and provided them to the kitchen staff. -She had trained the kitchen staff to on how to use the therapeutic diet menus. -She was not aware the staff were not using the therapeutic diet menus. Attempted telephone interview with Resident #7's primary care provider (PCP) on 12/20/23 at 11:38am was unsuccessful. Based on observations, record reviews, and interviews Resident #7 was not interviewable.	D 296		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) The facility shall provide staff for individual feeding assistance in accordance to residents' needs. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was sufficient staff available to provide feeding assistance for 2 of 2 sampled residents (#6 and #7)) resulting in staff feeding two residents at the same time. The findings are:	D 311		

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Observation of the lunch meal on 12/19/23 from 12:56pm to 1:35pm revealed:
-There was one long table pushed up against the wall in the dining room.
-There were six residents seated at the table.
-There were three staff assisting the residents with eating at the table.
-Resident #6 was seated on the end of the table and Resident #7 was seated on the long side at the corner seat of the table.
-One personal care assistant (PCA) was seated between Resident #6 and Resident #7 at the corner of the table.
-The PCA sat at the corner of the table and fed the two residents at the same time.

1. Review of Resident #6's current FL-2 dated 06/20/23 revealed:
-Diagnoses included dementia, anxiety and protein calorie malnutrition.
-Resident #6 was ordered a mechanical-soft ground meat diet.

Review of a signed physicians order for Resident #6 dated 07/03/23 revealed an order for mechanical soft ground-meats only diet.

Review of Resident #6's current care plan dated 05/10/23 revealed she required limited assistance with eating.

Review of Resident #6's special care unit profile dated 09/26/23 revealed she required assistance with meals while eating.

Observation of the lunch meal on 12/19/23 from 12:56pm to 1:35pm revealed:
-Resident #6 was seated to the right of a PCA and another resident was seated at the PCA's

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left.
-Each resident had a fork, knife, a spoon, a plate of food and beverages in front of them.
-The PCA wore gloves while she feed both residents.
-The PCA alternated feeding Resident #6 and the other resident.
-The PCA feed each resident a couple of bites of food and then switched to the next resident.
-The PCA did not verbally que or interact with either resident.
-The PCA alternated offering beverages to each resident.
-Resident #6 ate 100 percent of her meal.

Refer to interview with a PCA on 12/20/23 at 2:52pm.

Refer to interview with a second PCA on 12/20/23 at 2:57pm.

Refer to interview with the Resident Care Coordinator (RCC) on 12/20/23 at 3:21pm.

Refer to the interview with the Administrator on 12/20/23 at 3:31pm.

Based on observations, record reviews and interviews it was determined Resident #6 was not interviewable.

2. Review of Resident #7's current FL-2 dated 02/16/23 revealed:
-Diagnoses included Alzheimer's dementia, B12 deficiency and weight loss.
-Resident #7 was ordered a mechanical soft diet.
-Resident #7 required assistance with feeding.

Review of a signed physicians order for Resident

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D 311	Continued From page 12 #7 dated 10/16/23 revealed an order for mechanical soft ground diet. Review of Resident #7's current care plan dated 06/07/23 revealed she totally dependent with feeding assistance. Review of Resident #7's special care unit profile dated 09/26/23 revealed she required staff assistance with meals while eating. Observation of the lunch meal on 12/19/23 from 12:56pm to 1:35pm revealed: -Resident #7 was seated to the left of a PCA and another resident was seated at the right of the PCA. -Each resident had a fork, knife, a spoon, a plate of food and beverages in front of them. -The PCA wore gloves while she feed both residents. -The PCA stirred the foods on Resident #7's plate together and then fed the mixture to her. -The PCA alternated feeding Resident #7 and the other resident. -The PCA feed each resident a couple of bites of food and then switched back to the other resident. -The PCA did not verbally que or interact with either resident. -The PCA alternated offering beverages to each resident. -Resident #7 ate 100 percent of her meal. Refer to interview with a PCA on 12/20/23 at 2:52pm. Refer to interview with a second PCA on 12/20/23 at 2:57pm. Refer to interview with the Resident Care	D 311		

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D 311	Continued From page 13 Coordinator (RCC) on 12/20/23 at 3:21pm. Refer to the interview with the Administrator on 12/20/23 at 3:31pm. Based on observations, record reviews and interviews it was determined Resident #7 was not interviewable. _____ Interview with a personal care aide (PCA) on 12/20/23 at 2:52pm revealed: -The PCAs were not assigned to feed a certain resident they just choose who they wanted to assist with feeding and began to feed them. -She was trained on how to provide feeding assistance to residents by another PCA. -She was trained to offer 2 bytes of food and then a liquid. -She was trained to watch for gagging while the resident was swallowing their food. -She was not told to not to mix food on the plate together, but she had seen other PCAs mixing food on the plate together. -She could assist two residents at a time with feeding she went back and forth between the residents. -Most times she assisted two residents with feeding at the same time during a meal. -She had not seen management in the dining room during meal times and no one had told her not to feed assist residents two at a time. Interview with a second PCA on 12/20/23 at 2:57pm revealed: -He learned how to provide feeding assistance during his PCA training. -He was never assigned a certain resident to feed; he just sat with the residents that needed assistance. -He never mixed foods on the plate together	D 311		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(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 311	Continued From page 14	D 311		

unless it was a sauce or gravy and he had never seen any other staff mixing food together on the plate.
-On regular days he would assist feed two residents at once.
-If there was enough staff the PCAs would provide one on one feeding assistance for the residents.
-Management came into the dining room during meals on a regular basis.
-He had never been told not to feed two residents at once.

Interview with the Resident Care Coordinator (RCC) on 12/20/23 at 3:21pm revealed:
-Staff identified the residents who required feeding assistance by observation in the dining.
-The facility provided in service training videos for techniques on feeding assistance.
-Staff were supposed to provide small bites and sips of beverages hand over hand and slowly feed assist the residents.
-Staff were trained and did not to stir foods on the plate together; she had not observed staff mixing food together on the plate.
-Normally staff provided feeding assistance to residents one at a time.
-She observed meals in the dining room around twice a week.
-She had not observed staff providing feeding assist to more than one resident at a time.
-There should always be enough staff to provide one on one feeding assistance.

Interview with the Administrator on 12/20/23 at 3:31pm revealed:
-The staff were trained when they were hired on how to feed assist a resident
-Staff were trained to verbally prompt the resident, provide small bytes, and to offer fluids

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D 311	Continued From page 15 between bites to assist with swallowing. -Staff were trying to sit at the same table so one staff can feed 2 residents at a time. -Staff were trained to sit between the residents and go back and forth while providing feeding assistance. -While one resident was chewing the PCA could offer fluids to the second resident they were assisting with feeding. -Staff were also trained to watch for choking while eating. -The facility had enough staff at meal times to provide one-on-one feeding assistance for the residents. -She had observed staff mixing food together on the plate while feeding residents; she did not know where the practice had started, and she had not stopped it. -She did meal rounds in the dining room about two to three times a week.	D 311		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (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	D 484		

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D 484	Continued From page 16 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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an order for a restraint was current as required for 1 of 1 sampled resident (#2) with a reclining wheelchair. The findings are:	D 484		

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D 484	Continued From page 17 Observation of Resident #2 on 12/19/23 at 12:08pm and 12:17pm revealed: -At 12:08pm Resident #2 was sitting in a high back reclining wheelchair in the common area. -The wheelchair was in a reclining position and her legs were parallel to the floor and were resting on the leg supports and her feet were hanging freely. -At 12:17pm Resident #2 was sitting in her high back reclining wheelchair in the common area; the wheelchair was in a reclining position. -Resident #2's right leg was to the right of the leg support and her toes were touching the floor; her left leg was resting on the right leg support. Observation of Resident #2 on 12/20/23 at 12:16am and 12:34 revealed: -At 12:16pm, Resident #2 was in the common area in her high back reclining wheelchair. -The high back reclining wheelchair was in a reclined position and her legs were on the leg supports. -At 12:34pm, Resident #2 was in the common area in her high back reclining wheelchair. -The high back reclining wheelchair was in a reclined position and her legs were on the leg supports. -There was no staff in the common area with Resident #2; staff were in the adjacent room with other residents. -Resident #2 moved both legs over the leg braces and leg supports and placed both feet on the ground; the wheelchair was still in the relining position. -She began to stand by placing her hands on the seat of the wheelchair and pushing herself up. -Two staff came to the side of Resident #2 before she was standing and assisted her back into the reclined wheelchair.	D 484		

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D 484	Continued From page 18 Review of Resident #2's current FL-2 dated 08/10/23 revealed: -Diagnosis included Alzheimer's dementia, osteoporosis with history of a hip fracture and a history of depression. -There was nothing documented for ambulation. Review of Resident #2's current care plan dated 11/06/23 revealed: -Resident #2's care plan indicated there had a significant change and was the reason for the current care plan. -Resident #2 required limited assistance with transfers and ambulating. Review of Resident #2's most recent Licensed Health Professional support (LHPS) task dated 12/14/23 revealed there was a task checked off for ambulation with an assisted device. Telephone interview with Resident #2's family member on 12/20/23 at 8:00am revealed: -Resident #2 wanted to leave the facility and go back home; she would try to stand up and walk. -Resident #2 would say she was leaving when she tried to stand. -Resident #2 did not have the strength to stand on her own and would fall once she was standing. -She had seen Resident #2's wheelchair in a reclining position when she visited. -She was never told why Resident #2's wheelchair was in a reclining position. -Resident #2 probably tried to stand up to leave so the staff reclined her chair. Telephone interview with Resident #2's physical therapist on 12/20/23 at 11:12am revealed: -Resident #2 was unable to transfer or sit to stand independently.	D 484		

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-Resident #2 was ordered physical therapy (PT) for transfers and changed to safer transfers during the therapy.
-Even with therapy she was unable to go from a sit to stand independently and safely.
-There were occasions when Resident #2 would try to get up and walk on her own.
-The reclining wheelchair was ordered by hospice for Resident #2.

Telephone interview with Resident #2's hospice nurse on 12/20/23 at 1:27pm revealed:
-Hospice provided high back reclining wheelchairs with foot rest for residents who attempted to stand up.
-The reclining wheelchairs also enabled staff to reposition residents because of leaning.
-The high back reclining wheelchairs also prevented falls when the foot rest was up.
-The high back reclining wheelchairs were not able to be repositioned into an upright position by the resident sitting in the wheelchair; they could only be repositioned from someone standing behind the chair.
-She did not know if Resident #2 could go from a sit to stand position without assistance.
-She was told by facility staff Resident #2 was not attempting to stand.
-She did not know if the reclining wheelchair prevented Resident #2 from standing.
-When a resident would lean forward while sitting the staff would recline the wheelchair to prevent the resident from falling.

Interview with a personal care aide (PCA) on 12/20/23 at 12:17pm revealed:
-He had put Resident #2's feet up on the foot rest and reclined her because she was leaning forward.
-He did not want Resident #2 to fall, she could not

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D 484	Continued From page 20	D 484		

recline her high back reclining wheelchair herself the staff had to do it for her.
-Resident #2 tried to stand up and the staff didn't want her to bruise her legs around the leg rest and supports when she tried to stand.
-He was afraid Resident #2 would try to stand up and would fall so he put her reclining wheelchair into a reclining position.

Interview with a medication aide (MA) on 12/20/23 at 11:07am revealed:
-Resident #2 tried to get up and walk around on her own.
-Once Resident #2 was up she would tumble and fall.
-Resident #2 required assistance from a sit to standing position.
-Resident #2 forgot she could not walk on her own and would try to stand up.
-Resident #2 would request for the wheelchair to be reclined so she could shut her eyes and relax.

Interview with the Resident Care Coordinator (RCC) on 12/20/23 at 12:05pm revealed:
-Hospice provided Resident #2 her wheelchair.
-The wheelchairs hospice provided were always the high back reclining ones.
-There were no instructions given to staff when they provided the wheelchairs.
-The high back reclining wheelchairs were for the residents comfort they could be reclined, or they could sit up.
-The high back reclining wheelchairs could be reclined to reposition a resident when they began to slump forward but would have to be returned in the upright position again.
-Residents were not allowed to be reclined in the high back reclining wheelchairs.
-Residents were not allowed to sleep in the high back reclining wheelchairs.

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D 484	Continued From page 21 -Resident #2 did not have an order to recline her chair. -Resident #2 could not go from a sit to stand independently. -She was not aware Resident #2's wheelchair was being placed in a reclining position by staff. -She doubted Resident #2 could recline her own wheelchair or return it to an upright position if it was reclined. -Resident #2 moved around within her wheelchair and would sometimes throw her legs over each other or over the foot rest while she was sitting. -The facility did not do restraints of any sort. -Staff had been instructed not to recline the resident's wheelchairs. Interview with the Administrator on 12/20/23 at 3:50pm revealed: -The facility was a restraint free facility; none of the residents had restraints. -Hospice provided the reclining wheelchair for Resident #2. -The staff had been instructed not to recline Resident #2's wheelchair but to take her to her room and lay her down if she wanted to rest. -Staff have been instructed to simply monitor Resident #2 instead of reclining her chair to prevent her from trying to stand up while in her wheelchair. -She had seen resident number 2 with her legs up in the wheelchair and reclined; she had instructed staff to put Resident #2 in an upright position. -She thought the staff were reclining the chair because they thought they were providing a safety measure for Resident #2.	D 484		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives	D 485		

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D 485	Continued From page 22 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 485		

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D 485	Continued From page 23	D 485		

reviews, the facility failed to ensure documentation of an order for the use of restraints for 1 of 1 sampled residents (#2) with a reclining wheelchair.

The findings are:

Observation of Resident #2 on 12/19/23 at 12:08pm and 12:17pm revealed:
-At 12:08pm Resident #2 was sitting in a high back reclining wheelchair in the common area.
-The wheelchair was in a reclining position and her legs were parallel to the floor and were resting on the leg supports and her feet were hanging freely.
-At 12:17pm Resident #2 was sitting in her high back reclining wheelchair in the common area; the wheelchair was in a reclining position.
-Resident #2's right leg was to the right of the leg support and her toes were touching the floor; her left leg was resting on the right leg support.

Observation of Resident #2 on 12/20/23 at 12:16am and 12:34 revealed:
-At 12:16pm, Resident #2 was in the common area in her high back reclining wheelchair.
-The high back reclining wheelchair was in a reclined position and her legs were on the leg supports.
-At 12:34pm, Resident #2 was in the common area in her high back reclining wheelchair.
-The high back reclining wheelchair was in a reclined position and her legs were on the leg supports.
-There was no staff in the common area with Resident #2; staff were in the adjacent room with other residents.
-Resident #2 moved both legs over the leg braces and leg supports and placed both feet on the ground; the wheelchair was still in the relining

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D 485	Continued From page 24	D 485		

position.
-She began to stand by placing her hands on the seat of the wheelchair and pushing herself up.
-Two staff came to the side of Resident #2 before she was standing and assisted her back into the reclined wheelchair.

Review of Resident #2's current FL-2 dated 08/10/23 revealed:
-Diagnosis included Alzheimer's dementia, osteoporosis with history of a hip fracture and a history of depression.
-There was nothing documented for ambulation.

Review of Resident #2's current care plan dated 11/06/23 revealed:
-Resident #2's care plan indicated there had a significant change and was the reason for the current care plan.
-Resident #2 required limited assistance with transfers and ambulating.

Review of Resident #2's most recent Licensed Health Professional support (LHPS) task dated 12/14/23 revealed there was a task checked off for ambulation with an assisted device.

Review of Resident #2's record on 12/19/23 revealed there was no order for the use of a reclining wheelchair as a restraint.

Telephone interview with Resident #2's hospice nurse on 12/20/23 at 1:27pm revealed:
-Hospice provided high back reclining wheelchairs with foot rest for residents who attempted to stand up.
-The reclining wheelchairs also enabled staff to reposition residents because of leaning.
-The high back reclining wheelchairs also prevented falls when the foot rest was up.

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-The high back reclining wheelchairs were not able to be repositioned into an upright position by the resident sitting in the wheelchair; they could only be repositioned from someone standing behind the chair.
-Resident #2 did not have an order for the use of a physical restraint.

Interview with a personal care aide (PCA) on 12/20/23 at 12:17pm revealed:
-He had put Resident #2's feet up on the foot rest and reclined her because she was leaning forward.
-He did not want Resident #2 to fall, she could not recline her high back reclining wheelchair herself the staff had to do it for her.
-He was afraid Resident #2 would try to stand up and would fall so he put her reclining wheelchair into a reclining position.

Interview with the Resident Care Coordinator on 12/20/23 at 12:05pm revealed:
-Hospice provided Resident #2 her wheelchair.
-The wheelchairs hospice provided were always the high back reclining ones.
-There were no instructions given to staff when they provided the wheelchairs.
-Residents were not allowed to be reclined in the high back reclining wheelchairs.
-Resident #2 did not have an order to recline her chair.
-She was not aware Resident #2's wheelchair was being placed in a reclining position by staff.
-She doubted Resident #2 could recline her own wheelchair or return it to an upright position if it was reclined.
-Resident #2 moved around within her wheelchair and would sometimes throw her legs over each other or over the foot rest while she was sitting.
-The facility did not do restraints of any sort.

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D 485	Continued From page 26 Interview with the Administrator on 12/20/23 at 3:50pm revealed: -The facility was a restraint free facility; none of the residents had orders for the use of restraints. -Hospice provided the reclining wheelchair for Resident #2. -The staff had been instructed not to recline Resident #2's wheelchair but to take her to her room and lay her down if she wanted to rest. -Staff have been instructed to simply monitor Resident #2 instead of reclining her chair to prevent her from trying to stand up while in her wheelchair. -She had seen resident number 2 with her legs up in the wheelchair and reclined; she had instructed staff to put Resident #2 in an upright position. -She thought the staff were reclining the chair because they thought they were providing a safety measure for Resident #2.	D 485		