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	HAL046020	A. BUILDING: _____ B. WING _____	R-C 06/20/2024

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 06/18/24 - 06/20/24.	D 000		
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 a resident from voluntarily getting out of bed as	D 482		

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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:
Based on observations, interviews, and record reviews, the facility used physical restraints for convenience purposes without a physician's order for 1 of 3 sampled residents (#2) in the special care unit (SCU).

The findings are:

Review of the facility's physical restraints and use of alternatives policy (not dated) revealed:
-The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts freedom to movement or normal access to one's body and includes bed rails when used to keep the resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed.
-Residents shall be physically restrained only in accordance with the following.
-Restraints cannot be used for discipline or staff convenience.
-The restraint can only be applied for medical

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symptoms such as but not limited to, confusion with risk of falls and risk of abusive or injurious behaviors to self or others.
-Alternatives must be tried before the use of physical restraints and documented.
-Some examples of alternatives are physical therapy to restore mobility, devices that assist, frequent monitoring by staff, pain control, family involvement, and communication.
-If alternative to physical restraints have failed, the least restrictive restraint will be used.
-A restraint assessment and care plan will be completed and the decision for restraints will be a team decision.
-The resident has the right to accept or refuse restraints, after the team explains the reason for use of restraints.
-Emergency restraints will only be used in a temporary situation and the physician notified within 24-hours only approved by administrator and the Licensed Health Professional Support (LHPS).

Review of Resident #2's current FL-2 dated 03/12/24 revealed:
-Diagnoses included unspecified dementia with behavioral disturbance, palpitations, major depressive disorder, generalized anxiety disorder, tremor, and bipolar disorder.
-The resident was ambulatory and constantly disoriented.
-The resident had wandering behaviors.
-The resident's current level of care was special care unit (SCU).

Review of Resident #2's current Resident Register revealed admission date was 03/01/22.

Review of Resident #2's current care plan dated 03/12/24 revealed:

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-The resident displayed wandering behaviors.
-The resident was constantly disoriented.
-The resident needed supervision during ambulation/locomotion.
-The resident's social/mental health history noted that she liked to piddle around, she wandered from room to room, and she liked to stand close to others in their personal space but could be redirected easily.
-There was no documentation concerning the need for physical restraint.

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 03/26/24 revealed the LHPS task physical restraint and/or alternatives to restraints were not checked or indicated as a need for Resident #2.

Review of Resident #2's primary care provider (PCP) orders dated 03/12/24 revealed there was no order for physical restraint or alternatives to restraints.

Review of Resident #2's accident and incident (A/I) report dated 05/13/24 revealed:
-The A/I occurred on 05/13/24 at 7:39am.
-The resident was sitting in another resident's wheelchair secured by a seat belt using a Hoyer lift pad with straps and one strap was attached to the wheelchair and the other strap was attached to the bed.
-There were no injuries or vital signs for Resident #2 documented.
-The PCP was contacted.
-Resident #2's legal guardian was contacted.
-The Health Care Personnel Registry (HCPR), the local County Department of Social Services (DSS), and the local County Sheriff's Department were notified.

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Telephone interview with a personal care aide (PCA) on 06/20/24 at 11:00am revealed:
-She worked second shift from 3:00pm to 11:00pm on 05/12/24 on the B hall on the SCU side.
-Resident #2 wandered a lot and that night she and a another PCA sat with her in the day room because she would not lie down.
-When she tried to put Resident #2 to bed, the resident would get back up, so she decided to let her stay in the day room to keep an eye on her.
-The resident was fine and watching TV during second shift.
-At the end of second shift, she reported to the next PCA starting her shift that Resident #2 had been walking around, sitting in the day room, and that she needed to keep an eye on the resident in case she walked away.
-It was usual for Resident #2 to not lie down to go to sleep.

Interview with a second PCA on 06/19/24 at 12:50pm revealed:
-She worked third shift from 11:00pm to 7:00am on 05/13/24 on the B hall on the SCU side.
-She could not recall if she was assigned to Resident #2 on this shift.
-Resident #2 was walking in the hall back and forth but did not walk in the resident's rooms.
-Resident #2 was at the medication cart touching the water dispenser that sat on top of the medication cart and getting close to the PCA.
-The PCA removed the medication cart to the day room.
-She and a second PCA took turns walking Resident #2 back to her room.
-Around 5:30am, the PCA walked Resident #2 back to her room and the resident sat in her roommate's wheelchair.
-She grabbed a seat belt restraint (unsure of what

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kind of belt it was) and placed it on the resident in case she leaned forward so she would not fall out of the wheelchair.
-She retrieved the seat belt restraint from another resident down the hall.
-Resident #2 propelled out into the hallway and she escorted her back to her room and grabbed a Hoyer lift pad with straps and attached one strap to the wheelchair and the other strap to her bed because she wanted to keep the resident in her room.
-She did not think it was a problem putting the safety belt around the resident in the wheelchair and it did not "click" that attaching the Hoyer lift pad straps to the wheelchair was not appropriate until she received a call from facility management later that day.
-She never received restraint training and did not know a physician's order was needed to confine a resident.

Telephone interview with a medication aide (MA) on 06/20/24 at 3:45pm revealed:
-She worked third shift from 11:00pm to 7:00am on 05/12/24 and was responsible for the entire building (A hall, and B and C hall on the SCU side).
-Resident #2 walked the halls between 3:00am to 4:00am because she remembered it was mid-shift.
-Resident #2 was walking with a male resident.
-She left Resident #2 with the PCA and walked the male resident back to his room on the C hall and when she returned, Resident #2 was gone, and she assumed the PCA returned the resident to her room.
-She moved to the A hall and did not return to the B hall until 6:00am to give two residents morning medication.
-She did not see Resident #2 anymore before she

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left work and did not know anything had happened until the Administrator called her about the incident.
-She should have double checked behind the PCA to be sure Resident #2 was in bed, but she did not check.
-When on third shift, staff were to check residents every 2 hours.

Interview with a second MA on 06/20/24 at 9:35am revealed:
-She worked first shift from 7:00am to 3:00pm on 05/13/24 and did a walkthrough of the building when she arrived at work.
-When she walked on the B hall on the SCU side around 7:20am, she found Resident #2 sitting in a wheelchair with a seat belt restraint and a Hoyer lift pad with straps attached to her wheelchair and to her bed.
-When she walked into the room, she found the resident "fumbling" with the seat belt, and Resident #2 did not say anything to her.
-She took a picture of the restraint and then removed it immediately.
-She had no idea how long the resident sat in the wheelchair in the restraint.
-Resident #2 walked with her and followed her around.
-She asked a PCA to watch her so she could go and notify the Administrator what had happened.
-She completed the A/I report.
-She did receive restraint training and she understood that the PCP must be notified of a drastic change in a resident who may need a restraint order.

Interview with the Special Care Coordinator (SCC) on 06/20/24 at 5:30pm revealed:
-Resident #2 did not have a doctor's order for a restraint.

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-She became aware of the incident with Resident #2 around 8:15am on 05/13/24.
-She notified the legal guardian and contacted the local DSS.
-The PCA in question left work that morning and did not give her report about how the resident did during the night to the oncoming PCA.
-When she spoke with the third shift PCA, she admitted that she put Resident #2 in restraints and that she was trying to get the resident to stop walking.
-The 2nd PCA in question was assigned to Resident #2.
-The resident could have strangled herself or injured herself while in the restraint.
-The facility's restraint policy included notifying the doctor and speaking with the responsible party about the pros and cons of a restraint.
-The responsible party must sign off as well as the PCP.
-Once a restraint order was in place staff must do check and release every two hours and the order was reassessed every three months.
-The staff was aware of the restraint policy and had training on restraints upon hire and annually.
-An order was important because a restraint was used to restrict a person, and it was the resident's right not to be restrained.

Interview with the Administrator on 06/20/24 at 6:00pm revealed:
-Staff should have never used a restraint on a resident.
-She was told by the third shift PCA on 05/12/24 that Resident #2 had been up all night and that she could not get her rounds completed so she placed the resident in the wheelchair.
-Resident #2 was released from the restraints around 7:15am.
-The third shift PCA did not understand the need

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for an order for restraints.
-She was concerned because an employee felt it was okay to restrain a resident without an order.
-This could have been harmful to Resident #2 because she could have been injured.

Telephone interview with Resident #2's mental health provider (MHP) on 06/20/24 at 2:50pm revealed:
-She was made aware on 5/13/24 that Resident #2 was placed in an illegal restraint.
-Resident #2 wandered aimlessly and she wandered at night.
-She was "shocked" about Resident #2 being placed in an illegal restraint.
-She saw the resident on 05/15/24 and she seemed like herself; she was at her baseline.
-While in an illegal restraint, Resident #2 could have flipped the wheelchair and gotten hurt or worse, or wiggled herself down in the seat and the strap could have gotten around her neck and strangled her.

Based on observations, record reviews, and interviews, it was determined that Resident #2 was not interviewable.

Attempted telephone interview with a third PCA on 06/20/24 at 10:50am was unsuccessful.

Attempted telephone interview with Resident #2's legal guardian on 06/20/24 at 10:55am was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/20/24 at 12:00pm was unsuccessful.