STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067013	A. BUILDING: _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHT HOUSE VILLAGE	182 VILLAGE DRIVE JACKSONVILLE, NC 28546

(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 Licensure Section conducted an annual survey on December 03, 2024 through December 05, 2024.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .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 interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#2) related to monthly and weekly weight checks. The findings are: Review of Resident #2's FL-2 dated 01/17/24 revealed: -Diagnoses included Alzheimer's Disease, essential hypertension, bipolar disorder unspecified, dementia without behavioral disturbance, anxiety disorder unspecified, dementia unspecified, dysphagia unspecified, and major depressive disorder. -He was non-ambulatory and used a wheelchair. -He was intermittently disoriented. Review of Resident #2's Resident Care Plan dated 01/17/24 revealed: -Resident #2 required assistance with feeding. -He was wheelchair and bed bound.	D 276		

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-He required total assistance with activities of daily living (ADL).
-He was non-ambulatory and required a wheelchair.

Review of Resident #2's signed physician's order sheet dated 04/17/24 revealed an order to check the resident's weight weekly for monitoring.

Review of Resident #2's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight weekly for monitoring scheduled for the 7:00am to 3:00pm shift.
-Resident #2's weight was documented as not recorded on 04/03/24, 04/10/24, 04/17/24, and on 04/24/24 at 8:00am with the exception documented as resident refused.

Review of a physician's order for Resident #2, signed and dated 05/01/24, revealed an order to discontinue weekly weights.

Review of Resident #2's primary care provider (PCP) visit note dated 09/18/24 revealed:
-There was a diagnosis of abnormal weight loss.
-Staff reported the resident was eating well.
-The resident was assisted with meals secondary to dysphagia (difficulty swallowing food and liquids).
-Orders: please weigh the resident monthly.

Review of a physician's order for Resident #2, signed and dated 09/18/24, revealed an order to please weigh the resident every month.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry to obtain and record weight

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once monthly due to abnormal weight loss scheduled on the 7:00am to 3:00pm shift.
-There was no weight or exception recorded on the September eMAR for Resident #2.

Review of Resident #2's PCP visit note dated 10/23/24 revealed:
-Treatment plan, history of abnormal weight loss.
-The last noted weight was 137.2 pounds in 2022.
-Orders, please obtain height and weight.
-Weigh resident every month.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry to obtain and record weight once monthly to monitor due to abnormal weight loss, scheduled on the 7:00am to 3:00pm shift.
-Resident #2's weight was documented as not recorded on 10/25/24 at 8:00am with the exception documented as resident refused.

Review of Resident #2's PCP visit note dated 11/13/24 revealed:
-Treatment plan, history of abnormal weight loss.
-Last noted weight was 137.2 in 2022.
-Orders, please weigh the resident every week for 4 weeks then every month.
-Please send the most recent weight to the provider.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry to obtain and record weight monthly to monitor due to abnormal weight loss, scheduled on the 7:00am to 3:00pm shift.
-Resident #2's weight was documented as not recorded on 11/25/24 at 8:00am with the exception documented as resident refused.
-There was no entry for weekly weights starting 11/13/24.

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D 276	Continued From page 3 Review of Resident #2's December 2024 eMAR revealed: -There was an entry to obtain and record weight once monthly to monitor due to abnormal weight loss, scheduled on the 7:00am to 3:00pm shift. -Resident #2's weight was scheduled to be obtained on 12/25/24. -There was no entry to obtain weekly weights starting 11/13/24. Resident #2's last recorded weight was requested on 12/04/24 at 11:40am and the surveyor was provided with an emergency department after visit summary (AVS) dated 02/22/24 which documented the resident's weight as 63.503 kilograms (140 pounds) and height as 5 feet and four inches. Interview with Resident #2 on 12/05/24 at 9:59am revealed: -He was not sure if he had gained or lost weight. -He did not recall being asked to weigh or refusing to weigh. -He used a wheelchair to ambulate. -Staff assisted him in and out of bed. -He felt pretty good. Interview with the personal care aide (PCA) on 12/05/24 at 10:03am revealed: -The medication aides (MA) were responsible for weighing and recording the residents' weights. -The PCAs assisted the MA with weighing the residents if needed. -The facility could not weigh a resident if they could not bear weight. -The facility used to have a wheelchair scale, they weighed the wheelchair first then weighed the resident in the wheelchair, but the wheelchair scale was broken.	D 276		

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D 276	Continued From page 4 -Resident #2 required total assistance with ADLs. -Resident #2 could be weighed if there was a staff member on each side supporting him, staff could let go of him very briefly to obtain his weight. Interview with the lead MA on 12/04/24 at 3:18pm revealed: -When the provider saw residents in the facility, she faxed over any orders and the visit notes. -The MAs could fax orders to the pharmacy, but this was usually handled by the Administrator or the Business Office Manager (BOM). -She reviewed the PCP's progress notes if she had time, but these were reviewed by the Administrator. Second interview with the lead MA on 12/05/24 at 10:07am revealed: -Resident #2 always refused to be weighed. -She notified Resident #2's PCP verbally of his weight refusals when she was in the facility to see the residents. -She was not sure if she had documented that she notified Resident #2's PCP of the weight refusals. -She was not sure when Resident #2 had been weighed last. -She would weigh Resident #2 when she completed her medication pass at the request of the surveyor. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 12/05/24 at 2:09pm revealed: -The pharmacy last received an order to weigh Resident #2 monthly on 09/25/24. -The pharmacy had not received any orders regarding Resident #2's weights since 09/25/24.	D 276		

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D 276	Continued From page 5 The MA reported Resident #2's weight as 153.3 at 10:38am on 12/05/24. Interview with the Administrator on 12/05/24 at 2:57pm revealed: -After the residents were seen by the PCP, the PCP emailed orders and the visit progress note to her, and the BOM within 24 hours of the visit. -The lead MA also had access to the PCP's orders and progress notes. -She or the BOM reviewed the progress notes and faxed any orders for the residents to the pharmacy. -She knew Resident #2 was to be weighed monthly. -She knew that Resident #2 often refused weight checks. -She was not aware of the order for Resident #2 to be weighed weekly for four weeks from his 11/13/24 PCP visit. -The PCP was to be notified after three refusals of any medications or treatments. -The residents were also supposed to sign any refusals. -It was ultimately her responsibility to review the PCP's orders and visit progress notes for orders. Interview with Resident #2's PCP on 12/05/24 at 1:23pm revealed: -She had started as the facility's contracted PCP in early August 2024. -The last weight she had recorded for Resident #2 was 137.2 pounds in 2022. -There was a note in July 2022 that Resident #2 had a 20-pound weight loss, but no weight was recorded. -There was documentation that Resident #2 had a history of abnormal weight loss. -Resident #2 had a history of dysphagia but it was documented that he ate well.	D 276		

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D 276	Continued From page 6 -She requested monthly weights for Resident #2 in September 2024 and October 2024 to obtain his baseline and to monitor for further weight loss or weight gain. -She requested weekly weights for four weeks then monthly for Resident #2 at his 11/13/24 visit to see if there was a trend for weight loss or weight gain. -She had no documentation of the Resident #2's weight or height since 2022. -She had no documentation of Resident #2's weight refusals. -She did not recall being told of Resident #2's weight refusals. -It was important that Resident #2 be weighed at least monthly to monitor his body mass index (BMI) for weight loss or weight gain due to his history of dysphagia and abnormal weight loss. Attempted telephone interview with Resident #2's responsible party (RP) on 12/05/24 at 10:31am was unsuccessful.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the	D 280		

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resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) task was identified for 1 of 5 sampled residents (#2) with full bedrails pertaining to the LHPS task of care of residents who are physically restrained and the use of care practices as alternatives to restraints.

The findings are:

Review of Resident #2's FL-2 dated 01/17/24 revealed:
-Diagnoses included Alzheimer's Disease, essential hypertension, bipolar disorder unspecified, dementia without behavioral disturbance, anxiety disorder unspecified, dementia unspecified, dysphagia unspecified, and major depressive disorder.
-He was non-ambulatory and used a wheelchair.
-He was intermittently disoriented.

Review of Resident #2's Resident Care Plan dated 01/17/24 revealed:
-Resident #2 required assistance with feeding.
-He was wheelchair and bed bound.
-He required total assistance with activities of daily living (ADL).

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-He was non-ambulatory and required a wheelchair.
-His ADLs were documented as totally dependent (4) for eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.
-Licensed Health Professional Support tasks were documented as medication administration and blood pressure and pulse check daily.

Review of Resident #2's LHPS Quarterly Evaluation dated 07/06/24 revealed:
-The date of the last evaluation was 05/24/24.
-The resident's identified LHPS personal care tasks included forcing and restricting fluids, ambulation using assistive devices that requires physical assistance, transferring semi-ambulatory or occupational therapy.
-There was no task identified for care of residents who are physically restrained and care practices as alternatives to restraints.
-The LHPS evaluation was signed on 07/06/24.

Observation of Resident #2 on 12/03/24 at 8:55am during the initial facility tour revealed:
-A personal care aide (PCA) rolled Resident #2 to his room via a wheelchair and closed the door.
-The PCA opened Resident #2's door and exited his room and left the door open.
-Resident #2's bed was against the wall.
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Second observation of Resident #2 on 12/03/24 at 3:41pm revealed:
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on

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the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Third observation of Resident #2 on 12/04/24 at 3:16pm revealed:
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Observation and interview with Resident #2 on 12/05/24 at 9:59am revealed:
-He was lying in bed with the bedrail on the side of the bed against the wall in the upright position.
-The bedrail on the side of his bed facing the door was in the down position.
-There was a wheelchair at his bedside.
-Staff helped him in and out of bed.
-He was not sure how long he had bedrails on his bed.
-Both bedrails on his bed were often in the upright position.
-He denied any recent falls from his bed or while transferring.

Review of a signed primary care provider's (PCP) order for Resident #2 dated 02/02/18 revealed an order for a hospital bed with half rails.

Review of Resident #2's PCP's progress note dated 02/21/23 with an addendum signed and dated 03/01/23 revealed:
-He was wheelchair bound and minimally ambulatory for transfer with assistance.
-The resident had multiple falls and remained at a higher risk for injury and mobility/mortality secondary to his disease process and safety unawareness and possible polypharmacy.

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-A hospital bed was ordered for resident safety, since it appeared to be when most of his falls occurred.
-There was an order for a hospital bed as follows, the resident's condition required positioning of the body in ways not feasible in an ordinary bed, in order to alleviate pain, and/or promote good body alignment, and/or prevent contractures, and or avoid respiratory infections.
-The resident's condition required special attachments that cannot be fixed and used on an ordinary bed as follows, bed rails, half bedrails.

Review of Resident #2's current Licensed Health Professional Support (LHPS) Quarterly Evaluation dated 11/15/24 revealed:
-The date of last evaluation was 07/06/24.
-The resident's identified LHPS personal care tasks included forcing and restricting fluids, ambulation using assistive devices that required physical assistance, and transferring semi-ambulatory or occupational therapy.
-There was no task identified for care of residents who are physically restrained and the use of care practices as alternatives to restraints.
-The LHPS evaluation was signed on 11/15/24.

Interview with the Administrator on 12/05/24 at 3:06pm revealed:
-She described a restraint as anything that prevented a resident from being able to get up and move around on their own.
-Resident #2 received the hospital bed with bed rails when he received hospice services a year or so ago.
-She had not realized Resident #2 had an order for half bedrails instead of full bedrails.
-She did not consider full bedrails to be a restraint for Resident #2 because he could get out of bed with the bedrails in place if he wanted to.

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D 280	Continued From page 11 -She kept a spreadsheet for the residents' LHPS tasks and evaluation due dates and provided the spreadsheet to the Registered Nurse that conducted the LHPS evaluations. -She was ultimately responsible for ensuring the LHPS evaluations were done quarterly and complete to reflect all tasks. -She did not realize that bedrails were considered restraints, and that care of a physically restrained resident required an LHPS task.	D 280		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 ensure medications were administered as ordered for 1 of 5 sampled residents (#4) who was prescribed a fast-acting insulin to treat high blood sugars. Review of Resident #4's current FL-2 dated 10/23/24 revealed: -Diagnoses included diabetes mellitus type 2, chronic kidney disease, hypertension, and peripheral vascular disease. -There was an order for FIASP 100unit/ml FlexTouch insulin (FIASP is a fast-acting insulin	D 358		

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used to treat high blood glucose) inject subcutaneously (under the skin) two times per day per sliding scale insulin (SSI) finger stick blood sugar (FSBS) 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units of insulin, and call the primary care provider (PCP).

a. Review of Resident #4's electronic medication administration record (eMAR) for October 2024 revealed:
-There was an entry for FIASP 100unit/ml FlexTouch insulin, check FSBS and inject subcutaneously two times a day per SSI FSBS 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units of insulin, and call the provider for instructions.
-A FSBS of 237 was documented on 10/04/24 at 5:00pm with 8 units of insulin documented as administered; 6 units of insulin should have been administered.
-A FSBS of 284 was documented on 10/13/24 at 5:00pm with 6 units of insulin documented as administered, 8 units of insulin should have been administered.
-A FSBS of 206 was documented on 10/25/24 at 5:00pm with 4 units of insulin documented as administered, 6 units of insulin should have been administered.

Review of Resident #4's eMAR for November 2024 revealed:
-There was an entry for FIASP 100unit/ml FlexTouch insulin, check FSBS and inject subcutaneously two times a day per SSI FSBS 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units

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of insulin, and call the provider for instructions.
-A FSBS of 222 was documented on 11/06/24 at 5:00pm with 4 units of insulin documented as administered; 6 units of insulin should have been administered.
-A FSBS of 218 was documented on 11/08/24 at 5:00pm with 4 units of insulin documented as administered, 6 units of insulin should have been administered.

Interview with a medication aide (MA) on 12/04/24 at 3:40pm revealed:
-MAs were expected to check Resident #4's FSBS twice a day and based on the FSBS they were supposed to follow the SSI.
-The SSI was listed on the eMAR and MAs were expected to follow the SSI order to administer the correct units of insulin.
-She was not sure why she administered the incorrect units of insulin to Resident #4.
-Resident #4 was at risk of cardiac arrest if he was administered too many units of insulin based on the SSI.

Interview with the Administrator on 12/05/24 at 2:57pm revealed:
-She expected the MAs to follow PCP orders correctly.
-She was not aware that there were 3 times in October 2024 and 2 times in November 2024 that Resident #4 was not administered the correct units of insulin based on the SSI and his FSBSs.
-She expected MAs to read any order on the eMAR at least three times to ensure accuracy.
-MAs should not rush when administering medications to avoid errors.
-The MAs placed Resident #4 at risk of becoming seriously ill when he was not administered the correct units of insulin per the SSI.

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Telephone interview with Resident #4's PCP on 12/05/24 at 1:22pm revealed:
-MAs should follow her orders to ensure Resident #4 was administered the correct units of insulin based on the SSI order.
-When one single unit of insulin was not administered correctly, it placed Resident #4 at risk of his blood glucose dropping too low which would lead to hypoglycemia.
-When Resident #4 was not administered the correct amount of insulin based on the SSI it increased the resident's risk of an increased Hemoglobin A1C (Hemoglobin A1C is a blood test that measures your average blood sugar levels over the past 3 months; a normal A1C is 5.7), placed more strain on his vascular system which increased his risk of higher blood pressure and heart problems.

b. Review of Resident #4's current FL-2 dated 10/23/24 revealed:
-Diagnoses included diabetes mellitus type 2, chronic kidney disease, hypertension, and peripheral vascular disease.
-There was an order for FIASP 100unit/ml FlexTouch insulin (FIASP is a fast-acting insulin used to treat high blood glucose) inject subcutaneously (under the skin) two times per day per sliding scale insulin (SSI) finger stick blood sugar (FSBS) 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units of insulin, and call the primary care provider (PCP).

Review of Resident #4's electronic medication administration record (eMAR) for October 2024 revealed:
-There was an entry for FIASP 100unit/ml FlexTouch insulin, check FSBS and inject

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subcutaneously two times a day per SSI FSBS 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units of insulin, and call the provider for instructions.
-FSBS was documented as 321 at 5:00pm on 10/02/24.
-FSBS was documented as 313 at 5:00pm on 10/10/24.
-FSBS was documented as 384 at 5:00pm on 10/22/24.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 300.

Review of Resident #4's eMAR for November 2024 revealed:
-There was an entry for FIASP 100unit/ml FlexTouch insulin, check FSBS and inject subcutaneously two times a day per SSI FSBS 151-200 administer 4 units of insulin, 201-250 administer 6 units of insulin, 251-300 administer 8 units of insulin, 300 or greater administer 10 units of insulin, and call the provider for instructions.
-FSBS was documented as 363 at 5:00pm on 11/03/24.
-FSBS was documented as 358 at 5:00pm on 11/20/24.
-FSBS was documented as 322 at 5:00pm on 11/30/24.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 300.

Interview with a medication aide (MA) on 12/04/24 at 3:40pm revealed:
-MAs notified the Administrator when Resident #4's blood glucose was over 300; the Administrator notified the PCP.
-MAs also faxed a communication note to the

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PCP and placed a copy of the fax in the PCPs weekly visit folder.
-MAs also placed a copy of the communication note to the PCP under the Administrators door.

Interview with the Administrator on 12/05/24 at 2:57pm revealed:
-The MAs were expected to notify her and the Business Office Manager (BOM) who was also a MA when Resident #4's FSBSs were over 300.
-She or the BOM would notify the PCP that Resident #4's FSBS was over 300.
-MAs placed a copy of a communication note under her door after notifying her or the BOM by text message or through the company's group chat application.
-She had not been notified by MAs that Resident #4 had a blood glucose over 300 three times in October 2024 and three times in November 2024.
-The MAs should have notified her or the BOM that Resident #4's blood glucose was over 300 so they could notify the PCP.

Telephone interview with Resident #4's PCP on 12/05/24 at 1:22pm revealed:
-The Administrator, BOM and MAs had not notified her that Resident #4's blood glucose was over 300 in October 2024 and November 2024.
-She would have remembered if facility staff had notified her the resident's blood glucose was over 300 three times in October 2024 and three times in November 2024 because it was so many times the resident's blood glucose was over 300.
-There were not any triage progress notes in October 2024 or November 2024 that facility staff had notified her about Resident #4's blood glucose being over 300.
-Facility staff should have notified her of the resident's blood glucose when it was over 300 so she could adjust the resident's SSI if needed.

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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 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	D 484		

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D 484	Continued From page 18 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, interviews, and record reviews, the facility failed to ensure documentation of an assessment prior to the use of restraints for 1 of 1 residents (#2) with full bedrails. The findings are: Review of the undated physical restraint policy provided by the facility revealed: -The use of physical restraints is to be allowed only on the written instruction of a licensed physician. -This order must specify the reason for their use, the type to use and the time intervals at which the restraint is to be loosened or removed. -The order must be on or attached to the FL2 or the medical record (upon entering the home) or the report of health services to residents from DSS-1867 or approved equivalent for subsequent orders. -The use of physical restraint refers to the application of a mechanical device to a person to limit movements for therapeutic or protective reasons, these include anklets, wristlets and retaining sheets for non-invalids. -Side rails and restraining sheets (when used in a chair) for invalids are not considered restraints.	D 484		

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D 484	Continued From page 19 Review of Resident #2's FL-2 dated 01/17/24 revealed: -Diagnoses included Alzheimer's Disease, essential hypertension, bipolar disorder unspecified, dementia without behavioral disturbance, anxiety disorder unspecified, dementia unspecified, dysphagia unspecified, and major depressive disorder. -He was non-ambulatory and used a wheelchair. -He was intermittently disoriented. Review of Resident #2's Resident Care Plan dated 01/17/24 revealed: -Resident #2 required assistance with feeding. -He was wheelchair and bed bound. -He required total assistance with activities of daily living (ADL). -He was non-ambulatory and required a wheelchair. -His ADLs were documented as totally dependent (4) for eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring. Licensed Health Professional Support tasks were documented as medication administration and blood pressure and pulse check daily. -There was no documentation of restraints or bedrails on the care plan dated 01/17/24. -There were no LHPS tasks for restraints or bedrails documented on the care plan dated 01/17/24. -There was no other care plan assessment provided. Review of Resident #2's current Licensed Health Professional Support (LHPS) Quarterly Evaluation dated 11/15/24 revealed: -The date of last evaluation was 07/06/24. -There was no task identified for care of residents	D 484		

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who are physically restrained and the use of care practices as alternatives to restraints.
-The LHPS evaluation was signed on 11/15/24.

Review of Resident #2's LHPS Quarterly Evaluation dated 07/06/24 revealed:
-The date of the last evaluation was 05/24/24.
-There was no task identified for care of residents who are physically restrained and the use of care practices as alternatives to restraints.
-The LHPS evaluation was signed on 07/06/24.

Observation of Resident #2 on 12/03/24 at 8:55am during the initial facility tour revealed:
-A personal care aide (PCA) rolled Resident #2 to his room via a wheelchair and closed the door.
-The PCA opened Resident #2's door and exited his room and left the door open.
-Resident #2's bed was against the wall.
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Interview with the Administrator on 12/03/24 at 10:17am revealed:
-The surveyor requested a list of residents with restraints.
-The Administrator said there were no residents in the facility with restraints.

Second observation of Resident #2 on 12/03/24 at 3:41pm revealed:
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

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D 484	Continued From page 21 Third observation of Resident #2 on 12/04/24 at 3:16pm revealed: -Resident #2 was lying in bed. -There was a full bedrail in the upright position on the side of Resident #2's bed against the wall. -There was a full bedrail in the upright position on the side of Resident #2's bed facing the door. Observation and interview with Resident #2 on 12/05/24 at 9:59am revealed: -He was lying in bed with the bedrail on the side of the bed against the wall in the upright position. -The bedrail on the side of his bed facing the door was in the down position. -There was a wheelchair at his bedside. -Staff helped him in and out of bed. -He was not sure how long he had bedrails on his bed. -Both bedrails on his bed were often in the upright position. -He denied any recent falls from his bed or while transferring. -He was not bothered by the bedrails. Review of a signed primary care provider's (PCP) order for Resident #2 dated 02/02/18 revealed an order for a hospital bed with half rails. Review of Resident #2's PCP's progress note dated 02/21/23 with an addendum signed and dated 03/01/23 revealed: -He was wheelchair bound and minimally ambulatory for transfer with assistance. -The resident had multiple falls and remained at a higher risk for injury and mobility/mortality secondary to his disease process and safety unawareness and possible polypharmacy. -A hospital bed was ordered for resident safety, since it appeared to be when most of his falls occurred.	D 484		

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D 484	Continued From page 22 -There was an order for a hospital bed as follows, the resident's condition required positioning of the body in ways not feasible in an ordinary bed, in order to alleviate pain, and/or promote good body alignment, and/or prevent contractures, and or avoid respiratory infections. -The resident's condition required special attachments that cannot be fixed and used on an ordinary bed as follows, bed rails, half rails. Interview with a PCA on 12/05/24 at 10:03am revealed: -Resident #2 was not ambulatory and depended upon a wheelchair. -Resident #2 required assistance with all ADLs and he was a 1-2 person assist. -Resident #2 required assistance to get in and out of bed. -The side rail on the wall side of Resident #2's bed stayed in the upright position. -She never raised the side rail on the door side of Resident #2's bed. -She had never seen the side rail in the upright position on the door side of Resident #2's bed during her shifts. Review of Resident #2's record revealed: -There was no order for full bedrails for Resident #2. -There was no record of a resident assessment for bedrails in Resident #2's record. -There was no signed consent for bedrails for Resident #2. -There was no resident care plan assessment regarding the use of bedrails as a restraint for Resident #2. -There was no record or documentation of alternatives to use of bedrails as restraints for Resident #2.	D 484		

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D 484	Continued From page 23 Interview with the Administrator on 12/05/24 at 3:06pm revealed: -She described a restraint as anything that prevented a resident from being able to get up and move around on their own. -Resident #2 received the hospital bed with bedrails when he received hospice services a year or so ago. -She had not realized Resident #2 had an order for half bedrails instead full bedrails. -She thought Resident #2 had full bedrails instead of half bedrails because his family had purchased the hospital bed with the full bedrails. -She did not consider full bedrails to be a restraint for Resident #2 because he could get out of bed with the bedrails in place if he wanted to. -She thought she had received verbal consent from Resident #2's responsible party (RP) for the bedrails when they were ordered. -She had not completed a care plan assessment for Resident #2 pertaining to the use of the bedrails. -She was responsible for care plan assessments for the residents but again she did not consider the full bedrails to be a restraint for Resident #2. Interview with Resident #2's PCP on 12/05/24 at 1:19pm revealed: -She started seeing Resident #2 at the facility at the end of August 2024. -She considered full bedrails to be a restraint to decrease risk of falling. -Full bedrails required a signed provider order. -Bedrails must have been ordered for Resident #2 by the previous PCP. -The facility should have clarified with her regarding the bedrail order for Resident #2. -She had not ordered full bedrails for Resident #2.	D 484		

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D 484	Continued From page 24 Attempted telephone interview with Resident #2's responsible party (RP) on 12/05/24 at 10:31am was unsuccessful.	D 484		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (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.	D 485		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an order for the use of restraints for 1 of 1 residents (#2) with full bedrails.

The findings are:

Review of the undated physical restraint policy provided by the facility revealed:
-The use of physical restraints is to be allowed only on the written instruction of a licensed physician.
-This order must specify the reason for their use, the type to use and the time intervals at which the restraint is to be loosened or removed.
-The order must be on or attached to the FL2 or the medical record (upon entering the home) or the report of health services to residents from DSS-1867 or approved equivalent for subsequent orders.
-The use of physical restraint refers to the application of a mechanical device to a person to limit movements for therapeutic or protective reasons, these include anklets, wristlets and retaining sheets for non-invalids.
-Side rails and restraining sheets (when used in a chair) for invalids are not considered restraints.

Review of Resident #2's FL-2 dated 01/17/24 revealed:
-Diagnoses included Alzheimer's Disease, essential hypertension, bipolar disorder unspecified, dementia without behavioral

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disturbance, anxiety disorder unspecified, dementia unspecified, dysphagia unspecified, and major depressive disorder.
-He was non-ambulatory and used a wheelchair.
-He was intermittently disoriented.

Review of Resident #2's Resident Care Plan dated 01/17/24 revealed:
-Resident #2 required assistance with feeding.
-He was wheelchair and bed bound.
-He required total assistance with activities of daily living (ADL).
-He was non-ambulatory and required a wheelchair.
-His ADLs were documented as totally dependent (4) for eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.

Observation of Resident #2 on 12/03/24 at 8:55am during the initial facility tour revealed:
-A personal care aide (PCA) rolled Resident #2 to his room via a wheelchair and closed the door.
-The PCA opened Resident #2's door and exited his room and left the door open.
-Resident #2's bed was against the wall.
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Interview with the Administrator on 12/03/24 at 10:17am revealed:
-The surveyor requested a list of residents with restraints.
-The Administrator said there were no residents in the facility with restraints.

Second observation of Resident #2 on 12/03/24

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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
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at 3:41pm revealed:
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Third observation of Resident #2 on 12/04/24 at 3:16pm revealed:
-Resident #2 was lying in bed.
-There was a full bedrail in the upright position on the side of Resident #2's bed against the wall.
-There was a full bedrail in the upright position on the side of Resident #2's bed facing the door.

Observation and interview with Resident #2 on 12/05/24 at 9:59am revealed:
-He was lying in bed with the bedrail on the side of the bed against the wall in the upright position.
-The bedrail on the side of his bed facing the door was in the down position.
-There was a wheelchair at his bedside.
-Staff helped him in and out of bed.
-He was not sure how long he had bedrails on his bed.
-Both bedrails on his bed were often in the up position.
-He denied any recent falls from his bed or while transferring.
-He was not bothered by the bedrails.

Review of a signed primary care provider's (PCP) order for Resident #2 dated 02/02/18 revealed an order for a hospital bed with half rails.

Review of Resident #2's PCP's progress note dated 02/21/23 with an addendum signed and dated 03/01/23 revealed:
-He was wheelchair bound and minimally ambulatory for transfer with assistance.

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-The resident had multiple falls and remained at a higher risk for injury and mobility/mortality secondary to his disease process and safety unawareness and possible polypharmacy.
-A hospital bed was ordered for resident safety, since it appeared to be when most of his falls occurred.
-There was an order for a hospital bed as follows, the resident's condition required positioning of the body in ways not feasible in an ordinary bed, in order to alleviate pain, and/or promote good body alignment, and/or prevent contractures, and or avoid respiratory infections.
-The resident's condition required special attachments that cannot be fixed and used on an ordinary bed as follows, bed rails, half rails.

Interview with a PCA on 12/05/24 at 10:03am revealed:
-Resident #2 was not ambulatory and depended upon a wheelchair.
-Resident #2 required assistance with all ADLs and he was a 1-2 person assist.
-Resident #2 required assistance to get in and out of bed.
-The side rail on the wall side of Resident #2's bed stayed in the upright position.
-She never raised the bedrail on the door side of Resident #2's bed.
-She had never seen the bedrail in the upright position on the door side of Resident #2's bed during her shifts.

Review of Resident #2's record revealed there was no order for full bedrails.

Interview with the Administrator on 12/05/24 at 3:06pm revealed:
-She described a restraint as anything that prevented a resident from being able to get up

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D 485	Continued From page 29 and move around on their own. -Resident #2 received the hospital bed with bedrails when he received hospice services a year or so ago. -She had not realized Resident #2 had an order for half bedrails instead full bedrails. -She thought Resident #2 had full bedrails instead of half bedrails because his family had purchased the hospital bed with the full bedrails. -She knew full bedrails required a provider's order. -She was ultimately responsible to ensure that all orders were in place for the residents. Interview with Resident #2's PCP on 12/05/24 at 1:19pm revealed: -She started seeing Resident #2 at the facility at the end of August 2024. -She considered full bedrails to be a restraint to decrease the risk of falling. -Full bedrails required a signed provider order. -Bedrails must have been ordered for Resident #2 by the previous PCP. -The facility should have clarified with her regarding the bedrail order for Resident #2. -She had not ordered full bedrails for Resident #2. Attempted telephone interview with Resident #2's responsible party (RP) on 12/05/24 at 10:31am was unsuccessful.	D 485		
D 486	10A NCAC 13F .1501 (e) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives	D 486		

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D 486	Continued From page 30 (e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following: (1) restraint alternatives that were provided and the resident's response; (2) type of restraint that was used; (3) medical symptoms warranting restraint use; (4) the time the restraint was applied and the duration of restraint use; (5) care that was provided to the resident during restraint use; and (6) behavior of the resident during restraint use. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation of the type of physical restraint used, attempted restraint alternatives, and time and duration of restraint use for 1 of 1 residents (#2) with full bedrails. The findings are: Review of the undated physical restraint policy provided by the facility revealed: -The use of physical restraints is to be allowed only on the written instruction of a licensed physician. -This order must specify the reason for their use, the type to use and the time intervals at which the restraint is to be loosened or removed.	D 486		

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-The order must be on or attached to the FL2 or the medical record (upon entering the home) or the report of health services to residents from DSS-1867 or approved equivalent for subsequent orders.
-The use of physical restraint refers to the application of a mechanical device to a person to limit movements for therapeutic or protective reasons, these include anklets, wristlets and retaining sheets for non-invalids.
-Side rails and restraining sheets (when used in a chair) for invalids are not considered restraints.

Review of Resident #2's FL-2 dated 01/17/24 revealed:
-Diagnoses included Alzheimer's Disease, essential hypertension, bipolar disorder unspecified, dementia without behavioral disturbance, anxiety disorder unspecified, dementia unspecified, dysphagia unspecified, and major depressive disorder.
-He was non-ambulatory and used a wheelchair.
-He was intermittently disoriented.

Review of Resident #2's Resident Care Plan dated 01/17/24 revealed:
-Resident #2 required assistance with feeding.
-He was wheelchair and bed bound.
-He required total assistance with activities of daily living (ADL).
-He was non-ambulatory and required a wheelchair.
-His ADLs were documented as totally dependent (4) for eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.
-There was no other care plan assessment provided.

Observation of Resident #2 on 12/03/24 at

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D 486	Continued From page 32 8:55am during the initial facility tour revealed: -A personal care aide (PCA) rolled Resident #2 to his room via a wheelchair and closed the door. -The PCA opened Resident #2's door and exited his room and left the door open. -Resident #2's bed was against the wall. -Resident #2 was lying in bed. -There was a full bedrail in the upright position on the side of Resident #2's bed against the wall. -There was a full bedrail in the upright position on the side of Resident #2's bed facing the door. Interview with the Administrator on 12/03/24 at 10:17am revealed: -The surveyor requested a list of residents with restraints. -The Administrator said there were no residents in the facility with restraints. Second observation of Resident #2 on 12/03/24 at 3:41pm revealed: -Resident #2 was lying in bed. -There was a full bedrail in the upright position on the side of Resident #2's bed against the wall. -There was a full bedrail in the upright position on the side of Resident #2's bed facing the door. Third observation of Resident #2 on 12/04/24 at 3:16pm revealed: -Resident #2 was lying in bed. -There was a full bedrail in the upright position on the side of Resident #2's bed against the wall. -There was a full bedrail in the upright position on the side of Resident #2's bed facing the door. Observation and interview with Resident #2 on 12/05/24 at 9:59am revealed: -He was lying in bed with the bedrail on the side of the bed against the wall in the upright position. -The bedrail on the side of his bed facing the door	D 486		

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was in the down position.
-There was a wheelchair at his bedside.
-Staff helped him in and out of bed.
-He was not sure how long he had bedrails on his bed.
-Both bedrails on his bed were often in the upright position.
-He denied any recent falls from his bed or while transferring.
-He was not bothered by the bedrails.

Review of a signed primary care provider's (PCP) order for Resident #2 dated 02/02/18 revealed an order for a hospital bed with half bed rails.

Review of Resident #2's PCP's progress note dated 02/21/23 with an addendum signed and dated 03/01/23 revealed:
-He was wheelchair bound and minimally ambulatory for transfer with assistance.
-The resident had multiple falls and remained at a higher risk for injury and mobility/mortality secondary to his disease process and safety unawareness and possible polypharmacy.
-A hospital bed was ordered for resident safety, since it appeared to be when most of his falls occurred.
-There was an order for a hospital bed as follows, the resident's condition required positioning of the body in ways not feasible in an ordinary bed, in order to alleviate pain, and/or promote good body alignment, and/or prevent contractures, and or avoid respiratory infections.
-The resident's condition required special attachments that cannot be fixed and used on an ordinary bed as follows, bedrails, half rails.

Interview with a PCA on 12/05/24 at 10:03am revealed:
-Resident #2 was not ambulatory and depended

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upon a wheelchair.
-Resident #2 required assistance with all ADLs and he was a 1-2 person assist.
-Resident #2 required assistance to get in and out of bed.
-The bedrail on the wall side of Resident #2's bed stayed in the upright position.
-She never raised the bedrail on the door side of Resident #2's bed.
-She had never seen the bedrail in the upright position on the door side of Resident #2's bed during her shifts.

Review of Resident #2's record revealed:
-There was no order for full bedrails for Resident #2.
-There was no record of a resident assessment for any type of bedrails in Resident #2's record.
-There was no signed consent for bedrails for Resident #2.
-There was no resident care plan regarding the use of bedrails as a restraint for Resident #2.
-There was no record or documentation of restraint alternatives provided or the resident's response to the restraint alternatives.
-There was no documentation of the type restraint used.
-There was no documentation of the resident 's medical symptoms that warranted restraint use.
-There was no documentation of the time, duration or release of the restraints.

Interview with the Administrator on 12/05/24 at 3:06pm revealed:
-She described a restraint as anything that prevented a resident from being able to get up and move around on their own.
-Resident #2 initially received the hospital bed with bedrails when he received hospice services a year or so ago.

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D 486	Continued From page 35 -She had not realized Resident #2 had an order for half bedrails instead full bedrails. -She thought Resident #2 had full bedrails instead of half bedrails because his family had purchased the hospital bed with the full bedrails. -She did not consider full bedrails to be a restraint for Resident #2 because he could get out of bed with the bedrails in place if he wanted to. -She was not aware that documentation of the type of restraint, restraint alternatives provided, and time, duration and release of the restraint were required. Interview with Resident #2's PCP on 12/05/24 at 1:19pm revealed: -She started seeing Resident #2 at the facility at the end of August 2024. -She considered full bedrails to be a restraint to decrease risk of falling. -Full bedrails required a signed provider order. -Bedrails must have been ordered for Resident #2 by the previous PCP. -The facility should have clarified with her regarding the bedrail order for Resident #2. -She had not ordered full bedrails for Resident #2. Attempted telephone interview with Resident #2's responsible party (RP) on 12/05/24 at 10:31am was unsuccessful.	D 486		