STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023051	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS MOUNTAIN MEMORY CARE CENTER	115 FERGUSON DRIVE KINGS MOUNTAIN, NC 28086

(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 and the Cleveland County Department of Social Services conducted a annual survey and complaint investigation on 02/25/25 through 02/26/25.	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	D 482		

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D 482	Continued From page 1	D 482		

a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure restraints were applied correctly according to the manufacturer's instructions for 1 of 3 sampled residents (#2) with orders for restraints.

The findings are:

Review of Resident #2's current FL2 dated 04/17/24 revealed diagnoses included dementia, history of stroke, degenerative disc disease, osteoporosis, and pacemaker.

Review of Resident #2's Care Plan dated 04/17/24 revealed:
-Resident #2 had limited sight.
-Resident #2 was totally dependent for assistance with toileting, ambulation/locomotion, bathing, dressing, and grooming/personal hygiene.

Observation of Resident #2 in a common sitting room on 02/25/25 at 9:41am revealed:
-Resident #2 was seated in a wheelchair.

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D 482	Continued From page 2 -Resident #2 was restrained to the wheelchair with a transfer belt. -The transfer belt was positioned across Resident #2's upper chest with the sides of the belt under the resident's arms. -There were six green handles on the belt that laid across the resident's chest. -The transfer belt was secured at the back of the wheelchair with a quick-release buckle. Review of the transfer belt manufacturer's application instructions revealed: -The transfer belt was intended to be used as a secure hold point for caregivers to assist residents during supervised walking and transfers. -The transfer belt was never to be used to position a person in a chair. -The belt was to be worn centered around the resident's waist with the quick-release buckle in the center front. -The green handles on the belt were to be used to assist residents during transfers. Review of Resident #2's consent form for physical restraint use dated 05/28/24 revealed: -The type of restraint ordered was a soft belt. -The medical reason for the use of the restraint was fall prevention. Review of Resident #2's current physician's restraint order dated 01/08/25 revealed the type of restraint to be used was a waist belt. Interview with the Administrator on 02/26/25 at 3:00pm revealed: -She was aware Resident #2 was being physically restrained with a waist belt to her wheelchair. -She did not know the belt being used to restrain Resident #2 was a transfer belt.	D 482		

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D 482	Continued From page 3 -The same type of transfer belt was used as a waist restraint for several residents in the facility. -The transfer belts were being used when she took over management of the facility August 2024. -The former Administrator told her a nurse had recommended the transfer belt to be used as a restraint because the transfer belt had a quick-release buckle. Interview with Resident #2's physician on 02/26/25 at 4:29pm revealed: -He wrote an order for Resident #2 to use a waist belt as a restraint to prevent Resident #2 from falling. -He did not know the facility was using a transfer belt to restrain Resident #2 to her wheelchair. -He did not look at the specific belt the facility intended to use to restrain Resident #2 prior to writing the order for a waist belt restraint. -He did not know restraint orders should specify the exact restraint product to be used. Based on observations, interviews, and record review it was determined Resident #2 was not interviewable.	D 482		