STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 Hoke County Department of Social Services conducted an annual survey and complaint investigation on 06/04/2019 - 06/07/2019. Complaint investigations were initiated by the Hoke County Department of Social Services on 04/02/19, 05/02/19, and 05/28/19.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide personal care assistance to 3 of 5 residents (Residents #1, #2, and #3) sampled related to incontinence care. The findings are: 1. Review of Resident #1's current FL-2 dated 02/11/19 revealed: -Diagnoses included Alzheimer's unspecified, cerebral infarction, general anxiety, urinary tract infection, chest pain unspecified, excessive	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 1	D 269		

crying, and dementia without behavioral.
-She required personal care assistance for bathing and dressing.
-She was semi-ambulatory using a wheelchair.
-She was incontinent of bowel and bladder.

Review of Resident #1's care plan dated 01/05/19 revealed Resident #1 required limited assistance from staff for toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring and extensive assistance with bathing.

Observation of Resident #1 on 06/04/19 at 9:44am revealed:
-The resident came in the dining room in a wheelchair.
-There was a chair alarm attached to the back of the wheelchair.

Observation of Resident #1 on 06/05/19 at 9:20am revealed she was seated in her wheelchair in the tv room.

Observation of Resident #1 on 06/06/19 at 9:40am revealed the Medication Aide (MA) prepared Resident #1 for an activity and relocated her wheelchair at a table in the tv room.

Observation of Resident #1 on 06/06/19 at 10:00am revealed:
-Another PCA relocated the resident to the dining room for a BINGO activity.
-Resident #1 was not toileted prior to being relocated to the dining room.

Observations of Resident #1 on 06/06/19 between 10:00am and 1:00pm revealed:
-Resident #1 remained in the dining room playing BINGO from 10:15am - 11:15am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 2	D 269		

-At 11:35am, Resident #1 was eating her lunch meal in the dining room.
-At 12:10pm, Resident #1 self-propelled herself in the wheelchair into the hallway. A PCA instructed the resident to "come this way" and the resident continued to self-propel the wheelchair in the hall.
-At 12:18pm, the MA transported the resident to the tv room in her wheelchair. Resident #1 was not toileted.
-At 12:27pm, Resident #1 was seated in her wheelchair in front of the dining room. The resident was not toileted.
-At 12:31pm, Resident #1 was assisted to the tv room by staff. The staff returned to the dining room area within 10-15 seconds.
-At 12:43pm, Resident #1 was assisted by the MA to the bathroom. The MA instructed Resident #1 to stand up from the wheelchair and sit on the commode after the MA removed the completely saturated incontinent brief.

Observation of the MA on 06/06/19 at 12:51pm revealed she provided incontinent care by just changing the incontinent brief and drying the resident off with clean dry tissue paper.

Interview with the MA on 06/06/19 at 12:54pm revealed sometimes she used a wet wipe to provide incontinent care, if there were wet wipes available, but she did not have any to use.

Observation of Resident #1 on 06/06/19 at 12:59pm revealed she was back in the tv room in her wheelchair.

Refer to the interview on 06/07/19 at 10:30am with the Special Care Unit Coordinator.

2. Review of Resident #2's current FL-2 dated 02/11/19 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 3	D 269		

-Diagnoses included Alzheimer's disease, altered mental status, Diabetes Mellitus type 2, hypertension, migraines, vitamin D deficiency, dementia, hypercholesterolemia, osteoarthritis, chronic lymphedema, hiatal hernia, and iron deficiency anemia.
-She required personal care assistance for bathing and dressing.
-She was semi-ambulatory using a wheelchair.
-She was incontinent of bowel.
-She was continent of bladder.

Review of Resident #2's care plan dated 09/19/18 revealed Resident #2 required extensive to total assistance from staff for toileting, bathing, dressing, grooming/personal hygiene, and transferring.

Observation of Resident #2 on 06/04/19 at 10:30am revealed Resident #2 was coming out of the community shower in a wheelchair.

Observation of Resident #2 on 06/04/19 at 5:15pm revealed Resident #2 remained seated in her wheelchair.

Interview with a Personal Care Aide (PCA) on 06/04/19 at 5:15pm revealed:
-Resident #2 was supposed to be toileted every 2 hours.
-Sometimes the resident did not want anyone to touch her but when she talked to the resident she would allow her to provide care.

Observation of Resident #2 on 06/06/19 at 9:40am revealed she was seated in her wheelchair in the tv room.

Observation of Resident #2 on 06/06/19 at 9:45am revealed the Medication Aide (MA) told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 4	D 269		

Resident #2 to wake up and relocated her wheelchair at a table in the tv room.

Observation of Resident #2 on 06/06/19 at 10:00am revealed:
-Another PCA relocated the resident to the dining room for a BINGO activity.
-Resident #2 was not toileted prior to being relocated to the dining room.

Observations of Resident #2 on 06/06/19 between 10:00am and 1:00pm revealed:
-Resident #2 remained in the dining room playing BINGO from 10:15am - 11:15am.
-At 11:20am the MA took Resident #2 to the medication room and checked the resident's finger stick blood sugar and administered the resident an insulin injection and returned the resident to the dining room. Resident #2 was not toileted.
-At 11:35am, Resident #2 was served her lunch meal in the dining room.
-At 12:12pm, Resident #2 remained in the dining room eating her lunch meal.
-At 12:42pm, the MA transported the resident to the tv room in her wheelchair. Resident #2 was not toileted.
-At 12:58pm, Resident #2 was seated in her wheelchair in the tv room. The resident was not toileted. There was no staff present in the tv room.

Interview with a PCA on 06/06/19 at 1:00pm revealed:
-She was getting ready to change Resident #2.
-The resident was not wet when she got the resident up at 6:00am.
-She took Resident #2 to the bathroom "like 9:30am" before a snack.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 5	D 269		

Observation of Resident #2 on 06/06/19 at 1:16pm revealed:
-The PCA transported the resident to her bedroom and provided incontinence care.
-When Resident #2 stood up from her wheelchair, there was a wet spot on the back of her pants the approximate size of a basketball.
-The resident stated "anytime, I'm already through" when the PCA asked the resident if she was ready to stand and transfer to the commode.
-Resident #2's incontinent brief was completely saturated.
-When the resident sat on the commode, she continued to urinate.

Interview with the PCA on 06/06/19 at 1:20pm revealed:
-Resident #2 would tell staff when she had to go to the bathroom, and when she went it was like a "waterfall."
-Resident #2's incontinent brief was wet.
-She was going to have to change Resident #2's pants because the resident was urinating while she was in the wheelchair.
-Sometimes the resident would say she did not want staff to take her to the bathroom for toileting and the resident would end up urinating on herself.

Observation of Resident #2 on 06/06/19 at 1:35pm revealed there was a closed healed area of pink skin on the inner aspect of the right upper thigh.

Refer to the interview on 06/07/19 at 10:30am with the Special Care Unit Coordinator.

3. Review of Resident #3's current FL-2 dated 08/16/19 revealed:
-Diagnoses included Alzheimer's disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 269	Continued From page 6 Diabetes Mellitus 2 (DM2), insomnia, hypertension, hyperlipidemia, and gastro-esophageal reflux disorder (GERD). -He required personal care assistance for bathing and dressing. -He was non-ambulatory. -He was incontinent of bowel and bladder. Observation of Resident #3 on 06/06/19 at 11:26 am revealed: -Resident #3 was lying in bed covered head to toe with a blanket. -The Special Care Unit Coordinator and a personal care aide repositioned Resident #3 to change his incontinent brief. -Resident #3 did not receive any incontinence care when the incontinent brief was changed. -Staff only removed the wet incontinent brief and replaced it with a dry incontinent brief. -Resident #3's skin was pink and intact. -He had an area of pink intact skin above his anus with white cream over the area. -Staff said the area was a healed sore that they had used a skin barrier cream to heal it. Refer to interview with the Special Care Unit Coordinator on 06/07/19 at 10:30 am. Interview with the Special Care Unit Coordinator on 06/07/19 at 10:30am revealed: -She noticed on 06/06/19 that residents were not toileted every two hours by personal care aides. -Staff have a lot to do "like showers." -She had not talked to anybody about the amount of work staff had to do.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 7 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#5, #6) who had multiple falls that resulted in multiple injuries and visits to the local emergency department (ED). The findings are: Review of the facility's Emergency and Accident Procedure revealed: -Staff were to follow these procedures including when a resident had a fall, sustained a head injury or hits head during a fall, and if the resident was involved in an incident and it was not witnessed. -Staff were to determine if the resident appeared to be in a life threatening situation by: checking to see if the resident was breathing; checking for signs of bleeding; taking complete vital signs; checking range of motion while asking the resident if they are in any pain; watching for facial expressions for signs of discomfort or pain; and checking the medication administration records (MARs) for any new meds or changes in meds	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 8	D 270		

that may contribute to the problem the resident is experiencing.
-The emergency protocol included: taking vital signs, checking breathing and oxygen levels, checking for bleeding, and checking blood sugar levels.
-Staff were to call the supervisor and notify administrative staff.
-If determined that the situation is life threatening, the resident appeared to hit their head, or the resident is injured more severely than basic first aid would handle, or if the incident was not witnessed and the resident could have hit their head, call for emergency medical attention 911.
-If it is determined the situation can be handled by basic first aid or the resident refused further treatment from 911 personnel contact the family or responsible party to make sure their wishes are followed in the resident's care.
-If basic first aid could be administered, follow first aid procedures and document.
-If resident is to be transported from facility by 911, prepare necessary transport documents to include demographic sheet, MARS, treatment MARS, and other important information to be sent to the emergency room.
-Call family or responsible person. If you are unsuccessful in speaking with an actual person on you call, continue to call every thirty minutes and document attempts. If shift changes prior to making contact, report to oncoming supervisor to continue contact procedures.
-Complete the incident and accident form. Fax to DSS if the resident was transported to emergency room. Put a copy of all documentation and reports under director's door.

1. Review of Resident #6's current FL-2 dated 07/23/18 revealed:
-Diagnoses included frequent falls, dementia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 9	D 270		

Parkinson's disease, and hydrocephalus.
-Resident #6 was ambulatory.

Review of Resident #6's care plan dated 08/15/18 revealed:
-Resident #6 required supervision when ambulating.
-Resident #6 required limited assistance with toileting, bathing, dressing, grooming/personal hygiene and transferring, staff was to assist with these.

Review of the Licensed Health Professional Support form dated 08/22/18 revealed:
-Resident #6's primary diagnosis was documented as frequent falls.
-Resident #6 had limited sight.
-Resident #6 was unsteady on the feet and recently had repeated falls.

Review of Resident #6's progress notes dated 01/09/19 revealed:
-Resident #6 was observed on the floor in front of the bathroom.
-Resident #6 did not appear to be hurt and was not sent to the local emergency department (ED).

Review of Resident #6's progress notes dated 02/05/19 revealed:
-Resident #6 was observed lying on the floor in the dining room.
-Resident #6 had lost his balance fell and hit head on the floor.
-Resident #6 had a hematoma on the head.
-Emergency medical services (EMS) was called and Resident #6 was transported to the local ED.

Review of Resident #6's EMS transport notes dated 02/05/19 revealed:
-Resident #6 was confused.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 10 -When EMS arrived Resident #6 was lying supine on the floor in the dining room. -Resident #6 stated he had pain in the top of his head. Review of Resident #6's ED provider notes dated 02/05/19 revealed: -Resident #6's chief complaint was documented as a fall. -Resident #6 struck his head on the floor and sustained a large hematoma. -The facility felt Resident #6 needed to be evaluated due to the size of the hematoma and the amount of swelling. -Diagnosed included closed head injury, hematoma of the scalp, and neck strain. Review of Resident #6's physical therapy (PT) notes dated 02/06/19 revealed: -Resident #6 was a high risk for falls. -PT requested that a sensor be placed on Resident #6 so staff would be alerted when he attempted to get up. -Resident #6 will be followed by PT for 4 weeks due to higher risk of falls. -Resident #6 had two recent falls with injury. Review of Resident #6's progress notes dated 02/12/19 revealed: -Resident #6 was observed laying on the floor in the dining room. -Resident #6 had lost his balance and fell. -Resident #6 had a skin tear on his head. -Resident #6 was transported to the local ED. Review of Resident #6's EMS transport notes dated 02/12/19 revealed: -Resident #6 had a small laceration to the back of the head. -When EMS arrived Resident #6 was lying supine	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 11	D 270		

on the dining room floor.
-Staff reported Resident #6 was walking with his walker missed a step and fell.
-Resident #6 had fallen, hit the back of the head on the corner of the wall.
-Resident #6 had an old wound that had reopened on the right elbow.
-Resident #6 had a 2cm cut on the back of the head.

Review of Resident #6 ED provider notes dated 02/12/19 revealed:
-Resident #6's chief complaint was a fall from standing position with a hematoma to the back of the head.
-Resident #6 reported that there was a dull throbbing moderate pain to the back of the head.
-Resident #6 had a two-centimeter area of hematoma to the left back side of the head.
-Diagnoses included closed head injury, hematoma of the scalp, and skin tear of the right elbow.

Review of Resident #6's primary care provider (PCP) follow up visit form dated 02/13/19 revealed:
-The PCP documented the facility staff that Resident #6 had too many falls in the past three months.
-The PCP felt Resident #6 needed to be in a skilled facility.
-The PCP wrote an order for Resident #6 to have a chair alarm and a bed alarm to be used while in the bed.
-Resident #6 needed to have fall risk signs posted in the room.
-The PCP documented the facility staff that Resident #6 was not allowed to ambulate without assistance.
-Resident #6 had an history of an unsteady gait.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 12 Observation on 06/06/19 at 12:35pm revealed there were no high fall risk sign posted in Resident #6's room. Interview with the personal care aide coordinator (PCAC) on 06/06/19 at 12:47pm revealed: -The PCAC was not aware Resident #6's PCP ordered high fall risk signs be posted in the resident's room. -The PCAC would post the signs in Resident #6's room immediately Review of Resident #6's progress notes dated 02/18/19 revealed: -Resident #6 was found on the floor in the bedroom flat on the back. -Resident #6 complained of pain in the lower left leg. -Resident #5 was transported to the local ED. Review of Resident #6's EMS transport notes dated 02/18/19 revealed: -When EMS arrived Resident #6 was found lying the floor in his room on the right side. -Resident #6 complained of left lower leg pain. -Resident #6 was transported to the local ED. Review of Resident #6 ED provider notes dated 02/18/19 revealed: -Resident #6 had an unwitnessed fall. -Resident #6 complained of left lower leg pain and lower back pain. -Resident #6 had fallen while attempting to transfer from the wheel chair to the recliner. Review of Resident #6's progress notes dated 02/20/19 revealed: -Resident #6 was found on the floor in his room. -Resident #6 refused to be sent to the local ED.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 13 Review of Resident #6's progress notes dated 02/25/19 revealed: -Resident #6 had an unwitnessed fall in his room. -Resident #6 had some redness in the middle of the back and a hematoma to the backside of the head. -Resident #6 was transported to the local ED. Review of Resident #6's ED provider notes dated 02/25/19 revealed: -Resident #6's chief complaint was an unwitnessed fall. -Resident #6 had fallen while he transferred from one chair to another chair. -Resident #6 had fallen approximately three feet. -Resident #6 had been seen in the local ED multiple times within the last 2 weeks for falls and minor head injuries. -Resident #6 had a headache and was given acetaminophen (used to treat mild pain). -The diagnosis was documented as head injury. Review of Resident #6's progress notes dated 02/26/19 revealed: -Resident #6's PCP called the facility and expressed her concern about the number of falls the resident had sustained. -The PCP felt Resident #6's Parkinson disease had progressed to the point that the resident needed a geriatric chair. -The PCP sent the order for Resident #6 to have a geriatric chair with lap tray. Review of Resident #6's progress notes dated 03/01/19 revealed: -Resident #6 had an unwitnessed fall. -Resident #6 was observed sitting on the floor leaving the bathroom. -Resident #6 had missed the wheelchair when he	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 14	D 270		

went to sit down.
-Resident #6 refused to be transported to the local ED.

Review of Resident #6's progress notes dated 03/04/19 revealed:
-Resident #6 had fallen twice today.
-Resident #6's first fall was at 6:55pm.
-Resident #6 sustained a small cut on the wrist.
-After the first fall Resident #6 refused to be transported to the local ED.
-Resident #6's second fall was at 7:53pm.
-Resident #6 hit his head on the dresser in his room.
-After the second fall, Resident #6 was transported to the local ED.

Review of Residents #6's EMS transport records dated 03/04/19 revealed:
-When EMS arrived Resident #6 was laying on the floor in the left lateral recumbent position with a pillow supporting his head.
-Staff reported to EMS that Resident #6 had stood up out of the wheelchair and slipped to the floor.
-Resident #6 had a pain level of 2/10 dull pain to the back of the head.
-Resident #6 complained of a headache.
-Resident had two bruises to the back of the head.

Review of Resident #6's ED provider notes dated 03/04/19 revealed:
-Resident #6's chief complaint was a fall.
-Resident #6 was standing and fell approximately 4 feet to the floor.
-Resident #6 stumbled and fell due to his chronic gait disturbance.
-Diagnoses included head injury, abrasion of the scalp, and a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 15 Review of Resident #6 progress notes dated 03/18/19 revealed: -Resident #6 did not ask for help. -A personal care aide (PCA) stood outside the door and watched Resident #6 as he tried to transfer. -Resident #6 fell. -Resident #6 was not transported to the local ED. Review of Resident #6 progress notes dated 03/20/19 revealed: -Resident #6 was found sitting on the bathroom floor. -Resident #6 tried to go the bathroom on his own. -Resident #6 was not transported to the local ED. Review of Resident #6 progress notes dated 03/24/19 revealed: -Resident #6 flipped over his geriatric chair. -Resident #6 had scrapped his left hip. -Resident #6 was transported to the local ED. Review of Residents #6's EMS transport records dated 03/24/19 revealed: -Resident #6 reported he had slid out the wheelchair and hit his left thigh on the wheel of the chair. -Resident #6 had an injury to his left thigh. Review of Resident #6's ED provider notes dated 03/24/19 revealed: -Resident #6's chief complaint was a fall. -Resident #6 complained of left hip discomfort. -The wound to Resident #6's left hip area was cleaned and a dressing was applied. -The diagnosis was documented as left hip abrasion. Review of Resident #6's incident/accident report	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 16	D 270		

dated 04/05/19 revealed:
-Resident #6 had an unwitnessed fall.
-Resident #6 had fallen when he got up to get the remote control.
-Resident #6 was transported to the local ED.

Review of Resident #6's ED provider notes dated 04/05/19 revealed:
-Resident #6's chief complaint was a fall.
-The diagnosis was documented as multiple contusions to the right lower extremities.

Review of an order from Resident #6's PCP dated 05/06/19 revealed:
-Resident #6 was not to ambulate without assistance.
-The call bell should be in Resident #6 's reach at all times.

Review of Resident #6's incident/accident report dated 05/09/19 revealed:
-Resident #6 has an unwitnessed fall.
-Resident #6 had fallen and was found on the bedroom floor.
-Resident #6 had a skin tear to the right wrist and complained of right thigh pain.
-Resident #6's chair alarm did not go off.
-Resident #6 was transported to the local ED.

Review of Resident #6 ED provider notes dated 05/09/19 revealed:
-Resident #6's chief complaint was a fall.
-Diagnoses included a fall and skin tear to the right wrist.

Review of Resident #6's incident/accident report dated 05/25/19 revealed:
-Resident #6 was very agitated.
-Prior to, falling the resident had removed the table top from the geriatric chair two times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 17 -Resident #6 did not appear to be hurt and was not transported to the local ED. Interview with facility nurse on 06/07/19 at 3:17pm revealed: -Resident #6 had gotten a new geriatric chair on 06/07/19. -The catch and the knob on Resident #6's geriatric chair was broken, which allowed him to remove the table top of the geriatric chair. -The facility utilized the chair alarm, bed alarm and the geriatric chair with table top to help decrease falls. -Resident #6's falls had decreased. -Resident #6 was legally blind which could contribute to his falls.. Telephone interview with Resident #6's family member/Power of Attorney (POA) on 06/6/19 at 12:26pm revealed: -The POA visited Resident #6 at least once a month. -Resident #6 had received PT at home and continued to get PT after he was admitted to the facility. -The POA was notified of all the falls Resident #6 had in the facility. -Resident #6 was legally blind and could not understand he could not ambulate without assistance. Telephone interview with Resident #6's PCP dated 06/06/19 at 8:38am revealed: -She was concerned about the number of falls Resident #6 had. -Resident #6 should not be up without staff assistance. -She had written an order for Resident #6 to use a geriatric chair -She felt that Resident #6 should be moved to a	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 18	D 270		

"skilled facility."
-She had not verbally told facility staff Resident #6 needed skilled care; it was documented in the ED follow up visit dated 02/14/19.
-Resident #6 was not supervised at the facility; which resulted in so many falls with injury.
-She had been notified of some to the falls that Resident #6 had but not all of them.
-Resident #6 was not safe getting up by himself.

Interview with a PCA on 06/06/19 at 10:20 am revealed:
-Resident #6's gait was unsteady and he needed staff assistance with ambulation
-Resident #6 knew how to use the call light but would not use.
-Resident #6 would get impatient and would not wait for assistance.

Interview with another PCA on 06/07/19 at 3:32pm revealed:
-Resident #6 knew how to use the call light when he needed help.
-Resident #6 would not always wait for assistance.
-She tried to take Resident #6 to the bathroom every 2 hours or sometimes sooner.
-Now that Resident #6 had the geriatric chair she checked on him more often.

Interview with a supervisor on 06/06/19 at 11:08am revealed:
-Resident #6 was not supposed to ambulate without staff assistance.
-Resident #6 knew how to use the call light.
-Resident #6 would throw the call light in the trash can.
-Resident #6 had received PT to help with the falls.
-Resident #6 would not wait for the PCA's to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 19	D 270		

assist him to the bathroom because he stated they took too long.
-The PCA's immediately responded to Resident #6's request for assistance.
-Resident #6 swayed when he walked because of the Parkinson's.
-Resident #6's gait was "terrible".

Observation on 06/06/19 at 12:00 pm revealed Resident #6's call light was on the bedroom floor.

Interview with Resident #6 on 05/02/19 at 12:00pm revealed:
-When he needed to call for help, he would pull the call light towards him and push the red button.
-He had fallen the other day going to the bathroom.
-The staff would help him to the bathroom, "at times."
-He had been trying to get staff assistance to the bathroom since 11:00am, no one had been to assist him.
-He had not gotten up to go to the bathroom on his own because he was tired of falling.

2. Review of Resident #5's current FL-2 dated 09/12/18 revealed:
-Diagnoses included hypertension, Diabetes type II, dementia, hyperlipidemia, neuropathy, allergic rhinitis and urinary tract infection.
-There was documentation the resident was intermittently disoriented.
-There was documentation the resident was incontinent of bowel and bladder.
-There was documentation the resident required assistance with bathing and dressing.

Review of Resident #5's current assessment and care plan dated 09/17/18 revealed:
-There was documentation the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 20	D 270		

intermittently disoriented.
- There was documentation the resident was forgetful and needed reminders.
-There was documentation the resident required extensive assistance with toileting, bathing, dressing and transferring.
-The resident had an indwelling catheter.
-The resident had a wheelchair and could wheel himself at times but most of the time staff had to push him.

Observation of Resident #5's room 06/06/19 at 10:30am revealed his room was located on the left side of the hallway and was the third room from the farthest end from the nurses station.

Review of Resident #5's Accident/Injury reports, progress notes, and hospital records revealed:
-The resident had 11 falls from 01/29/19 - 06/04/19.
-The resident went to the emergency department (ED) for evaluation for injuries for all 11 of the falls.
-The resident's injuries included a knot on the head, leg pain, skin tear to right elbow, and right hip pain.

Review of Resident #5's Accident/Injury report dated 01/29/19 at 6:55pm revealed:
-The resident was observed lying on the floor next to the bed.
-The resident had no bruises or skin tears.
-The resident complained of right hip pain.
-The resident was taken to the ED.

Review of Resident #5's progress notes dated 01/29/19 at 6:55pm revealed:
-The resident reported he was trying to get in his wheelchair and it moved, and he fell on the floor.
-The resident reported he hit his head on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 21 night stand. Review of Resident #5's progress notes dated 01/29/19 at 9:45pm revealed: -The x-rays were negative. -The resident had a urinary tract infection and was started on an antibiotic in the ED. Review of Resident #5's Accident/Injury report dated 01/30/19 at 12:30pm revealed: -The resident was found on the floor between the bathroom door and the room. -The resident reported he unfastened his wheelchair seatbelt and tried to transfer, but the wheelchair rolled from beneath him. -There was no documentation of injury. -The resident was taken to the ED. Review of the Resident #5's progress notes dated 01/30/19 at 1:00pm revealed: -The resident reported he was going to the bathroom when he fell. -The resident had range of motion performed and vital signs taken. Review of Resident #5's accident/injury report dated 01/31/19 at 5:50am revealed: -The resident was found on the floor in his bathroom. -The resident's bed alarm was on and went off. -There was no documentation of injury. -The resident was sent to the ED. -The resident's family was notified. Review of physician's orders for Resident #5 dated 02/15/19 revealed: -There was an order for a bed alarm to be on at all times. -There was an order for strict 15-minute rounding with documentation.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 22 -There was an order for the resident's room to be moved closer to the nursing station. Review of Resident #5's Accident/Injury report dated 04/02/19 at 6:31pm revealed: -The resident was found lying on his back on the floor. -The resident was alert and talkative. -The resident was taken to the ED at 6:45pm. Review of Resident #5's progress notes dated 04/02/19 at 6:31pm revealed the resident reported he fell out of the bed. Review of the 15-minute check documentation for Resident #5 dated 04/02/19 revealed staff documented 15-minute checks were completed every 15 minutes to include 6:45pm to 12:45am while the resident was at the hospital. Review of Resident #5's progress notes dated 04/03/19 at 12:57am revealed the resident was back at the facility from the ED. Review of a physician's orders for Resident #5 dated 04/08/19 revealed: -There was an order for strict 15-minute rounding with documentation. -There was an order for the resident's room to be moved closer to the nursing station. -There was an order for physical therapy 2 times a week for 8 weeks. Review of Resident #5's Accident/Injury report dated 04/11/19 at 8:04pm revealed: -The resident was found lying on the floor with his head against the wall. -The resident had a knot on the back of his head. -The resident's bed alarm was on and went off. -The resident was sent to the ED at 8:21pm.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 23 Review of Resident #5's progress notes dated 04/11/19 at 9:00pm revealed: -The resident's bed alarm went off but by the time the personal care aide (PCA) arrived at the resident's room he was on the floor. -The resident's family was notified and reported the resident was supposed to be moved closer to the desk. Review of Resident #5's progress notes dated 04/11/19 at 11:48pm revealed the resident was back in the facility. Review of the 15-minute check documentation for Resident #5 dated 04/11/19 revealed staff documented 15-minute checks were completed every 15 minutes to include 8:30pm to 11:45pm while the resident was at the hospital. Review of Resident #5's Accident/Injury report dated 04/18/19 at 12:30am revealed: -The resident tried going to the bathroom by himself. -The resident's bed alarm was on the floor under the bed. -The resident was sent to the ED at 12:45am. Review of Resident #5's progress notes dated 04/18/19 at 4:15am revealed the resident was back in the facility. Review of the 15-minute check documentation for Resident #5 dated 04/18/19 revealed staff documented 15-minute checks were completed every 15 minutes to include 12:45am to 4:15am while the resident was at the hospital. Review of Resident #5's Accident/Injury report dated 05/01/19 at 2:40pm revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 24 -The resident was pushing his wheelchair onto the sidewalk and the wheelchair flipped over. -The resident fell onto the cement. -The resident had a skin tear on his right elbow. -The resident was sent to the ED at 3:45pm. Review of Resident #5's progress notes dated 05/01/19 at 5:00pm revealed the resident was back in the facility. Review of the 15-minute check documentation for Resident #5 dated 05/01/19 revealed staff documented 15-minute checks were completed every 15 minutes to include 3:34pm to 5:00pm while the resident was at the hospital. Review of Resident #5's Accident/Injury report dated 05/23/19 at 7:30am revealed: -The resident was observed on the floor. -The bed rails were up. -The bed alarm was on. -The resident was sent to the ED at 7:43am. . Review of the 15-minute check documentation for Resident #5 dated 04/02/19 revealed staff documented 15-minute checks were completed every 15 minutes to include starting at 7:45am while the resident was at the hospital. Interview with the Supervisor on 06/06/19 at 11:05am revealed: -Sometimes the supervisors would help the personal care aides (PCAs) with the 15-minute checks. -The proper way to document on the 15-minutes checks was after each check was completed and not wait until the end of the shift. -She acknowledged the initials on Resident #5's 15-minute check form dated 05/23/19 from 6:00am - 13:30pm were her initials.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 25 -She acknowledged she did not do all the 15-minute checks. Review of Resident #5's Accident/Injury report dated 05/29/19 at 9:43pm revealed: -The resident fell in the bathroom. -The resident lost his balance. -The bed alarm was on but did not alarm. -The resident was sent to the ED at 10:05pm. Review of resident #5's progress notes dated 05/29/19 at 10:00pm revealed: -The resident was found on the bathroom floor. -The resident complained of right thigh pain. Review of the 15-minute check documentation for Resident #5 dated 05/29/19 revealed staff documented 15-minute checks were completed every 15 minutes to include starting at 10:15 while the resident was at the hospital. Review of Resident #5's Accident/Injury report dated 06/02/19 at 12:25pm revealed: -The resident was observed on the floor. -The bed alarm was on and the alarm went off. -The resident was alert. -The resident reported he was trying to get in his wheelchair. -There was no documentation of any injuries. -The resident was sent to the ED at 12:57pm. Review of Resident #5's progress notes dated 06/02/19 at 1:45pm revealed: -The resident was back in the facility. -The resident was "very agitated. " Review of Resident #5's Accident/Injury report dated 06/04/19 at 3:05am revealed: -The resident was observed on the floor. -The bed alarm was on and the alarm went off.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 26	D 270		

-The resident was alert.
-The resident reported he was trying to get in his wheelchair.
-There was no documentation of any injuries.
-The resident was sent to the ED at 3:25am.

Observation of Resident #5 on 06/06/19 at 10:30am revealed he was in bed asleep with the split bed rales up on the bed. There was a half bed rail at the head of the bed and a half bed rail at the foot of the bed which left a space in the middle. The bed alarm was on the bed.

Observation of Resident #5 on 06/06/19 from 11:10am - 11:30am revealed he was in bed asleep with the split bed rales up on the bed and was checked on by a PCA at 11:25am.

A second interview with the Supervisor on 06/06/19 at 10:04am revealed:
-Resident #5 was confused at times.
-He got out of bed by coming between the split bed rails.
-He had a bed alarm because of getting out of the bed and falling.
-He was on 15-minutes checks.
-The PCAs did the 15-minute checks.
-The purpose of the 15-minute check was to see the resident and make sure he was in bed or in the wheelchair.
-His room had not been moved closer to the nurse's station.
-Most of Resident #5's falls were unwitnessed.

Interview with a PCA on 06/06/19 at 10:20am revealed:
-Resident #5 had days he was confused.
-He forgot he had a catheter and tried to go to the bathroom.
-He was on 30-minute checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 27	D 270		

-The Supervisor was responsible for the 30-minute checks.
-He had to be checked to make sure his catheter was "ok."
-She was not sure if anything had to be documented.

Interview with a medication aide (MA) on 06/06/19 at 10:36am revealed:
-Resident #5 was oriented at times.
-Resident #5 could walk short distances with assistance at times.
-There were days he stayed in his room and slept a lot.
-The PCAs were responsible for completing the 15-minute checks for Resident #5.
-The 15-minute checks were safety checks to make sure he was in bed with the bed rails up or in wheelchair with the seatbelt on.
-There was a book at the desk the PCAs signed after each 15 min check.

Interview with a second PCA on 06/06/17 at 10:43am revealed:
-Resident #5 was confused at times.
-He was on 15-minute checks to make sure he was safe and had not fallen.
-She asked the resident about toileting when she did the 15-minute checks.
-The PCAs were responsible for completing the 15-minute checks.
-The documentation was supposed to be completed after every 15-minute check.
-The documentation was kept at the nurse's station.

Interview with a Patient Care Aide Coordinator (PCAC) on 06/06/19 at 12:11pm revealed:
-The PCAs were to do the 15-minute checks.
-Every time the PCAs checked the resident they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 28	D 270		

were to document the 15-minute checks.
-The PCAs were to let the supervisor or MA know if they were unable to do the 15-minute checks.
-It was the responsibility of the Supervisor to ensure that the PCAs were performing the 15-minute checks and documenting them.
-The Supervisor was to sign the 15-minute check sheets at the end of each shift.
-Her expectation was that the PCAs were seeing the resident at each 15-minute check and documenting that they had seen him.
-If the resident was not in the building, then the PCA should not be documenting they had seen him.
-The Supervisor should document on the 15-minute check sheets that the resident was out of the building and where he was.
-When he arrived back in the building it should be documented that he was back.

Interview with Resident #5's family on 06/06/19 at 11:37am revealed:
-She was concerned about the resident's falls.
-The primary care physician (PCP) had ordered a bed with full rails but the bed came with split beds rails, 2 half bed rails that created an opening in the middle.
-The PCP also ordered for the resident to be moved closer to the nurse's station and that had not been done.
-The Director of Resident Services informed her there was not a room closer to the nurse's station to move Resident #5 into.
-She had spoken to Director of Resident Services this morning 06/06/19 about the falls and moving him closer to the nurse's station but was told there was still not a room available.
-She had also spoken to the Administrator regarding the falls for Resident #5 and moving him closer to the nurse's station.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 29 Interview with the Director of Resident Services and the Nurse Consultant on 06/06/19 at 12:45pm revealed: -The things that were put into place to help prevent Resident #5 from falling were the bed alarm, chair alarm and 15-minute checks. -The PCAs should be seeing the resident every 15-minutes to make sure he had not fallen. -The PCAs were to document on the 15-minute check sheet every 15-minutes after seeing the resident. -The Supervisor was to check behind the PCAs at the end of the shift and make sure the checks had been completed and documented. -They were aware of the order to move Resident #5 closer to the nurse's station but there was no room available. -They were not aware 15-minute checks had been documented as being done when the resident was not in the building. -It was their expectation that the Supervisor ensured the PCAs completed the 15-minute checks and documented correctly. Interview with the Administrator on 06/06/19 at 4:39pm revealed: -She and the family were afraid Resident #5 would fall over a full set of bedrails and get hurt so we started with the half rail. -When the half rail did not work staff got an order for full bed rails and the company sent the 2 half rails or split bed rails. -The PCP felt if staff moved him closer to the nurse's station he would be seen and heard quicker, but the building did not have a room to move him into. Telephone interview with Resident #5's current PCP on 06/07/19 at 11:30am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 30 -The former PCP that Resident #5 had been seeing was no longer at the practice. -The former PCP documented she was made aware on 05/03/19 that Resident #5 had not been moved closer to the nurse's station because there were no rooms available. A second interview with the Administrator on 06/07/19 at 2:54pm revealed: -Yesterday, 06/06/19 the facility started placing a body pillow along the split bed rails so that Resident #5 could not slip between the rails as easily. -The family was contacted yesterday about getting a full bed rail for the bed instead of split bed rails. -They would continue to do the 15-minute checks. -The staff had to document what the resident was doing when they saw him during the 15-minute checks. _____ The facility failed to provide supervision for 2 of 6 sampled residents (#5, #6) is accordance with their assessed needs and current symptoms. Resident #6 had 14 falls in 6 months resulting in the resident sustaining head injuries, contusions, and abrasions. The facility failed to implement two PCP orders to move Resident #5, who had 11 falls in 6 months, to a room closer to the nurses' station. Staff documented finding the resident on the floor when responding to the resident's bed alarm on at least 3 occasions when the bed alarm was in use and sounding. The facility's failure resulted in and placed the residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/19 for this violation.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 31 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 7, 2019.	D 270		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure infection control measures were implemented during the morning medication pass on 06/05/19 by 3 of 3 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering oral medications, eye drops, an eye ointment, insulin, and a fingerstick blood sugar to multiple residents. The findings are: Observation of a medication aide (MA) administering medications on the Jordan Hall on 06/05/19 from 8:23am - 8:38am revealed: -There was a large bottle of hand sanitizer sitting on top of the medication cart. -The MA was about to prepare medications for a resident. -The MA did not sanitize or wash her hands prior to preparing the medications and she was not	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 371	Continued From page 32	D 371		

wearing gloves.
-The MA prepared 4 oral medications and mixed a powdered medication in water for the resident.
-The MA put the medication cup to the resident's lips and poured the pills into the resident's mouth at 8:31am.
-The MA held the cup while the resident drank the water with the powdered medication.
-The MA's ungloved hand came in contact with the resident's skin, near his mouth.
-The MA went back to the medication cart, documented on the electronic medication administration record (e-MAR), touching the computer keys and mouse.
-The MA then started preparing medications for a second resident.
-The MA did not sanitize or wash her hands.
-The MA prepared 7 oral medications for the second resident.
-The MA handed the cup of pills to the resident at the dining room table and the resident took the medications at 8:37am.
-The MA went back to the medication cart, documented on the e-MAR, touching the computer keys and mouse.
-The MA then started preparing medications for a third resident.
-The MA did not sanitize or wash her hands.

Interview with the MA on 06/05/19 at 12:22pm revealed:
-The hand sanitizer was always kept on top of the medication cart.
-She was supposed to sanitize her hands between each resident when she was administering medications.
-She forgot to sanitize that morning (06/05/19) because she was "nervous".

Observation of a second MA administering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 371	Continued From page 33	D 371		

medications on the Townsend Hall on 06/05/19 from 8:40am - 8:47am revealed:
-There was a large bottle of hand sanitizer sitting on top of the medication/treatment cart.
-The MA was about to prepare to check a resident's blood sugar.
-The MA did not sanitize or wash her hands prior to preparation.
-The MA gathered supplies to check a blood sugar and put on gloves.
-The MA checked the resident's fingerstick blood sugar while wearing gloves at 8:45am.
-The MA took supplies back to the medication cart, disposed of trash, and took gloves off.
-The MA went back to the medication cart, documented on the e-MAR, touching the computer keys and mouse.
-The MA reported she would administer more medications/treatments later, once the residents came out of the dining room.
-The MA did not wash or sanitize her hands after she checked the resident's blood sugar.

Interview with the second MA on 06/05/19 at 12:24pm revealed:
-She did not know what the facility's policy was for hand hygiene while administering medications or treatments.
-She usually sanitized or washed her hands after every 2 residents except when she administered eye drops, nasal sprays, or inhalers.
-She usually washed or sanitized her hands after each resident only if she administered those type of medications.

Observation of a third MA administering medications on the North Hall (special care unit) on 06/05/19 from 8:54am - 9:32am revealed:
-There was no hand sanitizer on top of or inside of the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 371	Continued From page 34 -The MA had just finished administering medications to a resident at 8:54am. -The MA did not sanitize or wash her hands after administering the medications and she was not wearing gloves. -The MA documented on the e-MAR, touching the computer keys and mouse. -The MA began preparing medications for a second resident. -The MA prepared 4 oral medications and administered them to the resident at 9:02am. -The MA put the medication cup to the resident's lips and poured the pills into the resident's mouth. -The MA's ungloved hand came in contact with the resident's skin, near her mouth. -The MA used gloves and administered eye drops in the resident's eyes at 9:11am. -The MA changed gloves and administered an eye ointment in the resident's left eye at 9:12am. -The MA changed gloves and administered insulin to the resident at 9:15am. -The MA went back to the medication cart, disposed of trash, and documented on the e-MAR, touching the computer keys and mouse. -The MA did not sanitize or wash her hands. -The MA then started preparing medications for a third resident. -The MA prepared 7 oral medications for the third resident. -The MA put the medication cup to the resident's lips and poured the pills into the resident's mouth at 9:22am. -The MA's ungloved hand came in contact with the resident's skin, near his mouth. -The MA put on gloves and administered a nasal spray in each nostril to the resident at 9:26am. -The MA went back to the medication cart, took off the gloves, and documented on the e-MAR, touching the computer keys and mouse. -The MA pushed the medication cart to the	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 371	Continued From page 35	D 371		

nurse's station and unlocked the medication room.
-The MA went into the medication room and washed her hands.
-The MA brought out a bottle of hand sanitizer and put on top of the medication cart at 9:31am.

Interview with the third MA on 06/05/19 at 12:40pm revealed:
-The hand sanitizer was supposed to be kept on the medication cart.
-She did not realize there was no hand sanitizer on the medication cart that morning (06/05/19) until after she had administered medications to some residents.
-She usually sanitized her hands before and after each resident when she administered medications or a treatment.
-She "forgot" it that morning on 06/05/19.

Interview with the Special Care Unit Coordinator (SCUC) on 06/05/19 at 12:48pm revealed:
-The MAs were supposed to use hand sanitizer between each resident when administering medications.
-The MAs should wash their hands after treatments including blood sugars, insulin, eye drops, and nasal sprays.
-The hand sanitizer was supposed to be kept on the medication cart.

Interview with the Director of Resident Services (DRS) on 06/05/19 at 1:06pm revealed:
-The facility's policy was for the MAs to wash or sanitize their hands between each resident.
-For treatments, staff were supposed to wear gloves and then use sanitizer or wash their hands between each resident.

Interview with the Nurse Consultant on 06/05/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 371	Continued From page 36 at 1:12pm revealed: -She trained the MAs and the MAs knew they were supposed to sanitize their hands between each resident when administering oral medications. --The MAs should wash their hands after every third resident when administering medications in addition to sanitizing between each resident. -The MAs should wash their hands before and after every treatment.	D 371		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 3 of 3 residents sampled (#7, #8, #9) who self-administered medications had physicians' orders to self-administer including a resident with an insulin pen and medications to prevent heart disease and enlarged prostate (#7); a resident	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 37	D 375		

with medications for sore throat, pain/inflammation/fever, cough, acid reflux, cold symptoms, and sleep aid (#8); and a resident with medications for seasonal allergies, lung disease, pressure and inflammation of the eye, dry eyes, pain/arthritis, stomach acid, and nausea/diarrhea.

The findings are:

Review of the facility's policy and procedure for self-administration of medications revealed:
-Resident will be competent and physically able.
-Part of the quarterly assessment completed by the registered nurse will include the assessment of the resident to ensure the resident is still competent and physically able to self-administer medications.
-If the registered nurse determines during this assessment that the resident is not able to continue to self-administer medications, the physician will be notified of the findings.
-Self-administration of medications will be ordered by a physician or other legally authorized person to prescribe and kept in the resident's record.
-Specific instructions for administration of the medication will be printed on the label.
-The physician will be notified if a resident has a change in mental or physical ability or is non-compliant with the physician's orders or facility policies.
-Self-administered medications that are kept in a resident's room will be stored in a safe and secure manner.

1. Review of Resident #8's current FL-2 dated 02/04/19 revealed:
-Diagnoses included delirium, hypertension, benign prostatic hypertrophy, gastroesophageal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 38	D 375		

reflux disease, history of constipation, and history of nephrolithiasis.
-There was an order for Acetaminophen 500mg 1 tablet every 6 hours as needed for pain, may keep at bedside. (Acetaminophen is for pain/fever.)
-There was an order for Sucrets dissolve 1 every 2 to 3 hours as needed for irritated throat, may keep at bedside. (Sucrets is a lozenge for sore throat.)

Review of Resident #8's Resident Register revealed:
-The resident was admitted to the facility on 06/28/16.
-The resident had significant memory loss and must be redirected.

Review of Resident #8's current assessment and care plan dated 02/03/19 revealed:
-The resident was documented as sometimes disoriented.
-The resident was documented as having adequate memory.
-The resident documented as requiring limited assistance with bathing, dressing, and grooming.
-The resident was documented as independent with eating, toileting, ambulation, and transferring.

Review of a faxed written request to Resident #8's primary care provider (PCP) dated 05/16/19 revealed:
-Facility staff requested "bedside orders" for the following: Tums as needed for heartburn; Alka Seltzer Heartburn Relief; Sore Throat Lozenges; and Cough Drops. (Tums is an antacid. Alka Seltzer is for heartburn. Sore Throat Lozenges are for sore, irritated throats. Cough drops are used to relieve cough.)
-Staff noted the family brought those medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 39	D 375		

for the resident to use but he could not keep the medications in his room without an order.
-The PCP signed the request on 05/16/19.

Observation of Resident #8's room on 06/04/19 at 10:16am revealed:
-Resident #8 had several medications on top of and inside his night stand beside his recliner.
-Resident #8 did not have a roommate.
-There was a large bottle of (200 tablets size) of Aleve. (Aleve is for pain and inflammation.)
-There was a large bottle of (200 capsules size) of Advil Liqui-gels. (Advil is for pain and inflammation.)
-There were 3 bottles of Alka Seltzer PM gummies. (Alka Seltzer PM is for heartburn and it also contains a sleep aid. Alka Seltzer PM is not the same as Alka Seltzer.)
-There was a large bottle of (200 tablets size) of Extra Strength Tums 750mg. (Tums is an antacid. Regular Tums are 500mg and not the same as the Extra Strength Tums.)
-There were 4 boxes of Chloraseptic Sore Throat Lozenges. (Chloraseptic Sore Throat Lozenges are used to soothe sore throat. Chloraseptic and Sucrets lozenges do not have the same active ingredients and are not equivalent.)
-There were 2 bags of sugar free Cough Drops. (Cough Drops sore throat and relieve coughing.)

Interviews with Resident #8 on 06/04/19 at 10:16am and 4:05pm revealed:
-He had some medications in his room and self-administered them.
-His "friend" who visited him brought the medications to him.
-He did not know how long he had the medications in his room.
-He usually took 3 Tums tablets at a time because the tablets were "small".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 40	D 375		

-He took the Tums after he ate his meals.
-He used the Alka Seltzer PM when he had a cold but he could not remember when he last used any.
-He took 1 Aleve tablet every 2 days.
-He took Advil every day but did not answer when asked how many tablets or how many times a day.
-He used 3 Chloraseptic Lozenges every day.
-He did not know how often he used the Cough Drops.

Review of Resident #8's physician's orders revealed:
-There were no orders for the resident to receive or self-administer Aleve, Advil, Alka Seltzer PM, Extra Strength Tums, or Chloraseptic Lozenges.

Review of Resident #8's primary care provider (PCP) orders dated 05/16/19 revealed an order for "No Advil".

Interview with the Director of Resident Services (DRS) on 06/04/19 at 4:58pm revealed:
-She was not aware Resident #8 had any medications in his room or was self-administering any medications currently.
-She had requested an order for the resident to self-administer Tums, Alka Seltzer, Sore Throat Lozenges, and Cough Drops on 05/16/19 because the family wanted the resident to have the medications.
-She had not implemented any of the orders signed by the primary care provider (PCP) on 05/16/19 because the orders were incomplete with no clear instructions on how to administer them.
-She had not heard back from the PCP for clarification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 41	D 375		

-There had to be a complete order to self-administer any medications.
-Staff should report to her if medications were found in a resident's room.
-No one had reported seeing any medications in Resident #8's room.
-She did not think Resident #8 should be self-administering any medications because he was confused at times.
-The Licensed Health Professional Support (LHPS) nurse usually assessed resident's for self-administration during the quarterly reviews.
-Resident #8 had not been assessed for self-administration because he did not have complete orders to self-administered and he was not supposed to be self-administering medications.

Review of Resident #8's current licensed health professional support (LHPS) review dated 04/11/19 revealed there was no documentation regarding Resident #8 self-administering medications or being assessed for self-administration.

Interview with the Administrator on 06/04/19 at 5:15pm revealed:
-A resident had to have physician's orders to self-administer any medications.
-She thought the resident's family or a friend may have brought the medications to the resident.
-Staff should report to the supervisors if medications are observed in a resident's room.
-Resident #8 should not be self-administering any medications.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/06/19 at 8:47am was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 42	D 375		

2. Review of Resident #9's current FL-2 dated 4/12/19 revealed:
-Diagnoses included anemia, anxiety, chronic neck pain, hypertension, hearing difficulty, and gastroesophageal reflux disease.
-There was an order for Azelastine 137mcg, inhale 2 sprays nasally twice a day (Azelastine is a nasal spray used to treat allergic rhinitis).
-There was an order for Atrovent HFA 17mcg, 2 puffs by mouth as needed three times a day (Atrovent is used to open airways in the lungs to treat lung disease.)
-There was an order for Dorzolamide Ophthalmic, 1 drop in both eyes three times a day (Dorzolamide is used to treat high pressure inside the eye.)
-There was an order for Fluoromethalone 0.1% Ophthalmic, 1 drop in both eyes four times a day (Fluoromethalone is a steroid used to treat eye swelling.)

Review of Resident #9's Resident Register revealed she was admitted to the facility on 04/22/19.

Review of Resident #9's assessment and care plan dated 04/25/19 revealed the resident was documented as oriented with adequate memory.

Review of a physician's order for Resident #9 dated 04/23/19 revealed:
-There were orders to self-administer and to keep these medications at bedside: Azestaline, Atrovent HFA, Dorzolamide Ophthalmic, and Fluoromethalone.
-There was an order to self-administer and keep at bedside, a topical compounded medication that contained Baclofen 2%, Diclofenac 5%, Gabapentin 6%, Ketamine 10%, and Tetracaine 3%, apply 1 gram (1 gram=1 pump) to affected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 43	D 375		

area (neck) four times a day (used to treat pain).

Observation of Resident #9's room on 06/07/19 at 3:45pm revealed:
-Resident #9 had medications on her dresser, in the top left dresser drawer, and on the nightstand.
-Resident #9 did not have a roommate.
-There was a prescription bottle of Azestaline.
-There was a prescription box with an Atrovent HFA inhaler.
-There was a prescription bottle of Dorzolamide Ophthalmic Drops.
-There were 3 bottles of Baclofen 2% Diclofenac 5% Gabapentin 6% Ketamine 10% and Tetracaine 3% with use by dates of 08/10/18, 10/06/18, and 03/28/19.
-There was a bottle of Liquid Antacid. (Liquid Antacid is used to treat too much stomach acid.)
-There was a bottle of Pepto-Bismol. (Pepto-Bismol is used to treat nausea and diarrhea).
-There was a box of Refresh Lubricant Eye Drops with an expiration date of February 2019. (Refresh Lubricant Eye Drops are used to treat burning and irritation of the eye.)

Review of Resident #9's physician's orders revealed there were no orders for Liquid Antacid, Pepto- Bismol, and Refresh Lubricant Eye Drops.

Interview with Resident #9 on 06/07/19 at 3:45pm revealed:
-She used 2 sprays of Azestaline 1 time a day.
-She used the Atrovent inhaler 2 puffs, 2 or 3 times a day as she needed.
-She used the Dorzolamide Eye drops 1 drop in both eyes, 3 times a day morning, noon, and night.
-She used the Baclofen 2%, Diclofenac 5%, Gabapentin 6%, Ketamine 10%, and Tetracaine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 44	D 375		

3%, 4 times a day when she needed it for pain in her neck and back.
-She used the Liquid Antacid 1 medicine cup (15ml) 1 time a day.
-She had not used any of the Pepto Bismol.
-She used the Refresh Lubricant Eye Drop in both eyes whenever she needed them for dry eyes.
-She did not have any Fluoromethalone Ophthalmic in her room.

Interview with a medication aide (MA) on 06/07/19 at 4:00pm revealed:
-She did not know Resident #9 had any medications other than the ones she had orders to self-administer in her room.
-She was not aware any medications the resident had in her room had expired.
-She had not checked for any expiration dates.
-She asked the resident if she had taken her medications when the MA did the medication pass.

Interview with a supervisor on 06/07/19 at 4:05pm revealed:
-She knew Resident #9 had some medications that the resident self-administered and kept in her room.
-She did not know the resident had Liquid Antacid, Pepto Bismol and Refresh Lubricant Eye Drops in her room.
-Resident #9 became hostile when staff went in the resident's room and looked at her medications.
-The resident would call her family complaining and the family would call the facility.

Interview with the current licensed health professional support (LHPS) on 06/07/19 at 4:13pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 45	D 375		

-There was no self-administration assessment completed for the resident.
-She had documented on the LHPS evaluation that Resident #9 self - administered nasal spray, eye drops, and cream to her neck and back.
-The facility did not use the self - administration assessment form.

Interview with a Personal Care Aide Coordinator (PCAC) on 06/07/19 at 4:19pm revealed:
-The family requested Resident #9 be allowed to self-administer her inhaler, eye drops and nasal spray.
-The primary care physician (PCP) wrote an order for Resident #9 to self - administer some medications.
-The floor supervisor was to check for expiration dates.
-She did an assessment to see if the resident could read the prescription labels and demonstrate how to use the medications.
-She did not use a special form for the assessment.
-She documented it in her own paperwork.
-Resident #9 did not understand why over the counter medication (OTC) required doctor's orders to keep in her room.
-She would determine if there was a mental status change by talking with Resident #9.
-She would notify the PCP if she saw a change in the resident's mental status.
-Resident #9's family brought OTC medications to her.
-She was not aware the resident had OTC medications, without orders in her room and was self-administering them.

3. Review of Resident #7's current FL-2 dated 08/14/18 revealed:
-Diagnoses included uncontrolled type II diabetes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 46	D 375		

hypertension, hyperlipidemia, and mental retardation.
-There was an order for Aspirin 81mg daily. (Aspirin is used to treat pain, fever and reduce the risk of heart attack.)
-There was no order for self-administration of medications.
-The resident was documented as oriented.

Review of Resident #7's Resident Register revealed he was admitted to the facility on 08/03/18.

Review of physician orders for Resident #7 revealed:
-There was an order written on 05/23/19 for Tresiba Flex Touch Insulin Pen 36 units subcutaneous daily. (Tresiba is a long acting insulin used to control high blood sugar.)
-There was no order to self-administer Tresiba Flex Touch Insulin.

Observation of Resident #7's room on 06/04/19 at 10:00am revealed:
-He removed medications out of the top drawer of the night stand.
-There was a Tresiba Insulin pen.
-There was a bottle of EC Aspirin 81 mg that expires June 2019.
-There was Tamsulosin 0.4mg dispensed on 05/15/18. (Tamsulosin is used to treat an enlarged prostate.)
-There were no pen needles in the drawer where the Tresiba Flex Touch Insulin Pen was kept.

Review of Resident#7's physician orders revealed there was no order for Tamsulosin HCL 0.4mg.

Interview with Resident #7 on 06/04/19 at 10:00am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 375	Continued From page 47 -These were "old" medications. -He did not administer his own Tresiba injections the staff administered the injections to him. -He did not take the medications in his room. -He brought them from home. Interview with a Supervisor on 06/07/19 at 12:45pm revealed: -She had never known Resident #7 to have medications in his room. -He did not self-administer medications to her knowledge. -She did not think he could self-administer medications. Interview with a Personal Care Aide Coordinator (PCAC) on 06/07/19 at 12:47pm revealed: -The resident never had any medications in his room to her knowledge. -The resident frequently went out with family. -The resident did not have an order to self-administer any medications. Interview with the current Licensed Health Professional Support (LHPS) nurse on 06/07/19 at 12:58pm revealed: - Resident #7 would go out with family and friends frequently. -The resident probably got the medications when he went home. -The resident had no order to self- administer medications. Attempted telephone interview with Resident #7's primary care physician (PCP) on 06/07/19 at 3:02pm was unsuccessful. Attempted telephone interview with Resident #7's family on 06/07/19 at 3:05pm was unsuccessful.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 48	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure allegations of suspected physical abuse and any facility investigation was reported to Health Care Personnel Registry (HCPR) within the 24 hour and 5-day requirements for allegations of 1 of 1 sampled staff (Staff C) restraining a resident (Resident #1) in a wheelchair using a gait belt, without any physician orders for restraints. The findings are: Review of Resident #1's current FL-2 dated 05/05/19 revealed: -Diagnoses included dementia without behavioral, Alzheimer's unspecified, cerebral infarction, general anxiety disorder, and excessive crying. -The resident was constantly disoriented. Review of the physician's orders revealed there were no physician orders for restraints to be used for Resident #1 prior to 03/27/19.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 49	D 438		

Review of Resident #1's current care plan assessment dated 01/03/19 revealed:
-Resident #1 was physically abusive.
-The resident was documented as ambulatory with use of a wheelchair.
-The resident was documented as forgetful and needed reminders.

Review of progress notes for Resident #1 revealed:
-On 01/04/19 during the 8:00am-5:00pm timeframe, Resident #1 was agitated and refusing to shower. There were no interventions documented for the agitation.
-On 04/01/19 at 10:15am, staff documented Resident #1 was agitated, fighting, and kicking when staff tried to remove the resident's clothes to shower the resident. There were no interventions documented for the agitation.

Review of a communication log for Resident #1 revealed:
-On 02/26/19, the resident was "very agitated", fighting with the Supervisor-In-Charge/Medication Aide (SIC/MA) and the Special Care Unit Coordinator (SCUC), cursing, and kicking the patio door "trying to get out". There were no interventions documented for the agitation.
-On 03/17/19, resident was "a little agitated." There were no interventions documented for the agitation.

Review of a separate page of progress notes for Resident #1 dated 03/27/19 revealed:
-At 2:45am, Resident #1 became agitated and frustrated, accusing the SIC/MA of being in her room. Staff tried to calm the resident down. Resident "became hostile and started kicking and screaming and scratching" at staff.
-The SIC/MA documented she knew she "couldn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 50	D 438		

just leave her in her room like that" so she asked her co-worker to stay with the resident until she got back.
-The SIC/MA and the co-worker put Resident #1 in her wheelchair and "used a transfer belt as a seatbelt" since there was no seatbelt in the facility. The SIC/MA was afraid if the transfer belt was not used, Resident #1 would fall on the floor.
-At 3:15am, the SIC/MA tried to administer Resident #1 medication and the resident refused and was screaming and punching at a plexiglass window in the hall.
-At 3:45am, the SIC/MA tried to get the resident to drink and eat, but the resident refused.
-At 4:00am, resident #1 had "seemed to calm down but still refusing to go to bed". The SIC/MA documented she had "released her from the transfer belt and she's still refusing anything to eat, drink, go to the bathroom or lay back down."
-There was no documentation the physician was notified of the gait "transfer" belt restraint being applied to Resident #1 on 03/27/19 for documented behaviors.
-There was no documentation the resident being "tied" in a wheelchair with a gait belt was reported to the Health Care Personnel Registry as required.

Interview with the SIC/MA on 06/05/19 at 9:12am revealed:
-On 03/27/19, she assisted Resident #1 to the bathroom and put the resident back to bed and the resident started cursing and fussing at the SIC/MA and did not want to lay down or get in her wheelchair.
-She put the gait belt around Resident #1 to protect the resident from falling.
-She sat with the resident in the hallway.
-She knew there was no order for a restraint.
-There was no order for a seat belt for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 51	D 438		

#1.
-She did not tell anybody about the incident and did not report it.

Interview with the Administrator on 06/07/19 at 8:45am revealed:
-An Adult Protective Services (APS) worker told her on 04/02/19 that Resident #2 had been "tied" in a wheelchair, when the APS worker came to the facility to conduct an APS investigation of the occurrence.
-The APS worker thld he the SIC/MA had taken a gait belt and used it as a seatbelt.
-She did not believe what had happened.
-She told the APS worker she would "look into" it.
-The Business Office Manager (BOM) reviewed the facility video monitor of the occurrence before the incident was recorded over.
-She spoke to a local Police Detective (PD) about the incident the morning of 05/01/19.
-She told the PD she did not know what had happened and referred him to the BOM.
-The PD reported to the Administrator on 05/01/19 that Resident #1 had been "tied" to a wheelchair.
-She asked the BOM about the incident after speaking to the PD.
-She did not document any of her actions regarding the incident.
-The SIC/MA had done what she was supposed to do.
-She did not think what the SIC/MA did had endangered the resident's life.
-The process when there was an allegation of someone being "tied" was to interview the staff and turn them into the HCPR.
-She did not report to the HCPR because she did not think there was any abuse.

Interview with the BOM on 06/07/19 at 9:30am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 52	D 438		

revealed:
-She reviewed the video monitor on the morning of 03/27/19 after a staff asked her to review it because Resident #1 was "tied with a belt."
-She watched the video monitor on the morning of 03/27/19 and saw the SIC/MA get a gait belt from the medication room, put it around Resident 1's waist, and tie it to the bottom of the wheelchair.
-Staff C and another named staff stayed with Resident #1.
-The belt was on Resident #1 for 59 minutes, according to the video monitor.
-She saw Resident #1 trying to swing her arms at a resident and sliding down in the wheelchair before the gait belt was applied.
-Resident #1 self-propelled her wheelchair in the hallway once the belt was placed on the resident.
-She did not make any notes on the incident.
-She did not see anything concerning when she viewed the video monitoring of the occurrence.
-She could not tell how thick the belt used was, but it was a cloth material.
-The Resident Care Coordinator (RCC) and SCUC watched the video monitor on the morning of 03/27/19.
-The RCC would be responsible to talk to the staff about the occurrence.

Interview with the RCC on 06/07/19 at 10:15am revealed:
-When she viewed the video monitoring of the occurrence, she saw Staff C come out of Resident #1's room, go to the desk, get the gait belt, and return to inside the resident's room.
-A second staff pushed the wheelchair Resident #1 was sitting in out of the resident's room.
-The gait belt was around Resident #1's waist while the resident was in the wheelchair.
-She thought the belt was a thick beige belt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 53 -Resident #1 did not look upset coming out of her room but got upset when Staff C went to get her after she was self-propelling the wheelchair in the hall. -She did not report anything to the Administrator. -She had not spoken to any physician's notifying them of the occurrence. Interview with the SCUC on 06/07/19 at 10:30am revealed: -She spoke to Staff C about the occurrence and Staff C said Resident #1 was "cutting up real bad so she had no choice." -She told Staff C that the facility did not use gait belts for restraints. -She did not conduct an internal investigation and did not know if one had been done. -She had only talked to the staff she saw coming out of Resident #1's room on the video monitoring on 03/27/19. -She only saw "bits and pieces" of the video monitoring of the occurrence. -The "strap" looked white and folded. -She did not notify any doctor the resident had been restrained because of an emergency. -The shift supervisor would be responsible to notify the physician. -She did not ask the shift supervisor if the physician had been contacted. The facility failed to complete an initial report within 24 hours, investigate and complete an investigation report with 5 days for 1 of 1 sampled resident (#1) who was physically restrained to a wheelchair with a gait belt used to assist residents while ambulating. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 438	Continued From page 54 accordance with G.S. 131D-34 on 06/07/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 22, 2019.	D 438		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 468	Continued From page 55 which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 1 of 6 sampled staff (Staff C) assigned to perform duties in a Special Care Unit (SCU), received 6 hours of orientation training within the first week of hire. The findings are: Review of Staff C, personal care aide (PCA) / supervisor's personnel record revealed: -Staff C was hired on 01/12/17 as a personal care aide (PCA), and MA and supervisor. -There was documentation Staff C completed the state certified nursing assistant training course on 10/09/17. -There was no documentation of six hours of SCU training being completed. -There was documentation of completion of 20 hours of additional SCU training for Staff C dated 03/03/17. Interviews with the Business Office Manager (BOM) on 06/07/19 at 11:40 am and 4:45 pm revealed: -She was responsible for personnel records. -She had been responsible of personnel files and training schedules. -She had a spreadsheet to keep track of staff CEUs and annual training for staff members. -She posted training on the bulletin board. -She was not aware that Staff C had not completed the required 6 hours of training within the first week of employment for the Special Care Unit (SCU). -She did her own file audits to ensure everything	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 468	Continued From page 56 was in the files. -All new hires complete the SCU training regardless of where they were scheduled to work in the facility. -By assuring all new hires were trained, the facility did not have to be concerned if a staff member from the Assisted Living side had to work on the SCU. -All new hires were assigned to complete online training before being placed on the floor to work. -She was not sure how Staff C missed completing the required 6 hours training. Interview with the Administrator on 05/07/19 at 5:05 pm revealed: -She was not aware of Staff C not having the required 6 hour training within one week of hire. -She said the Business Office Manager was responsible to get those scheduled. -The Business Office Manager was responsible for the personnel records and ensuring the staff had completed their all of their training required before being placed on the floor to work. -The Business Office Manager assigned the training, scheduled training, sent reminders for training and audited the training records. -She did not audit personnel records; she expected the Business Office Manager to keep the personnel records in order. -She expected the staff to complete their required training.	D 468		
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	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 57	D 482		

device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:
(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 58 cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used according to physician's orders for 3 of 5 residents sampled (#1, #2, #4) including use only after an assessment and care planning process had been completed through a team process and used only with a written order from a physician who had full bilateral bed rails (#4), and restraints were released every two hours for 30 minutes according to physician orders for two residents (#1, #2). The findings are: 1. Review of Resident #4's current FL-2 dated 05/02/19 revealed: -Diagnoses included late onset Alzheimer's disease without behavior disturbance, dysphagia, acute kidney injury, nausea, vomiting, dehydration with hyponatremia, elevated troponin, infectious colitis, and sepsis due to undetermined organism. -The resident was documented as intermittently disoriented. -The resident was documented as semi-ambulatory and incontinent of bladder. -The resident documented as requiring assistance with bathing, feeding, and dressing. -The section for restraints was blank. Review of Resident #4's Resident Register	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 59	D 482		

revealed the resident was admitted to the facility on 05/02/19.

Review of Resident #4's hospice plan of care form revealed the resident was admitted to hospice services on 05/02/19.

Review of Resident #4's current resident care plan signed and dated 05/15/19 revealed:
-The resident was documented as verbally abusive and resisted care.
-The resident was documented as ambulatory with a wheelchair.
-The resident was documented as having limited range of motion and limited strength in upper extremities.
-The resident was documented as incontinent of bowel and bladder.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.
-The resident was documented as requiring limited assistance with eating.
-The resident was documented as requiring extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident was documented as having "physical restraints"; no other details were provided regarding the restraints.

Review of a durable medical equipment delivery ticket for Resident #4 revealed a semi-electric hospital bed with rails was delivered to the facility on 05/02/19.

Observation of Resident #4's room on 06/04/19 at 10:15am revealed:
-The resident was lying in a hospital bed with the rail next to the wall in the up position.
-The second bed rail was in the down position with the table tray pushed over that side of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 60 bed. Interview with Resident #4 on 06/04/19 at 10:15am revealed: -The resident ate in his room and staff would put the other bed rail back up after his meals. -The bed rails had always been on his bed and they had been used since he came to the facility (05/02/19). -He did not answer when asked why the bed rails were used. -He could not get out of the bed when the bed rails were up and he could not put the rails up or down himself. -He had not had any falls at the facility. Review of a physical restraint consent form revealed Resident #4's family member signed consent for the use of bed rails on 05/02/09, on the date of his admission to the facility. Review of a physical restraint care plan form for Resident #4 dated 05/02/19 revealed: -The section for alternatives to restraints currently being used and projected goals was blank with no documentation. -The section for noting if the facility was using the least restrictive type of restraint was blank with no answer marked. -The care to be provided while the resident was restrained included: bowel and bladder assistance to be offered every 2 hours; snacks to be served at 10:00am, 3:00pm, and 7:00pm; fluids to be offered every 2 hours; and activities to be offered. -There was no physical restraint assessment page attached to the care plan form. -There was no documentation of the medical symptoms that warranted the use of a physical restraint.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 61 -There was no documentation of how the medical symptoms affected the resident, when the symptoms were first observed, or how often the symptoms occurred in the resident. -There was no documentation of an assessment of alternative attempted, how long the alternatives were tried, or the resident's response to the alternatives. -The restraint care plan form was signed by the Director of Resident Services (DRS), a registered nurse, and the resident's family member on 05/02/19. Review of Resident #4's physician's order for physical restraint revealed: -There was a restraint order for bed rails signed and dated by the physician on 06/04/19. -The medical needs for the physical restraint included: anytime the resident was left unattended and their safety might be jeopardized; the resident was unable to be in charge of their well-being due to mental/physical capacity; and there was a history of falls or the resident was known to wander. -The restraint was to be checked every 30 minutes and released every 2 hours. -There were no restraint orders for the bed rails prior to 06/04/19. Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 06/05/19 revealed: -The marked LHPS tasks were ambulation with assistive device, transferring, and physical restraints. -Staff must "wheel" the resident in his wheelchair at all times. -Staff must also transfer the resident. -The resident had behavioral issues upon admission.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 62	D 482		

-A restraint order for bed rails was received on 06/04/19.
-The resident was in bed with rails up during the LHPS evaluation by the nurse.
-The nurse noted the resident had a potential for falls.
-The nurse's recommendation was to continue the current plan of care and follow all protocols for residents with physical restraints.

Interview with a medication aide (MA) on 06/06/19 at 11:40am revealed:
-The resident had not fallen or rolled out of bed to her knowledge.
-The resident had a hospital bed with rails since he was admitted (05/02/19).
-Staff kept the bed rails up while the resident was in bed.
-Staff had used the bed rails since the resident was admitted (05/02/19).
-She thought they were supposed to use the bed rails since she had always seen the rails up.

Observation of Resident #4 on 06/06/19 at 11:55am revealed the resident was in bed with both bed rails in the up position.

Interview with a personal care aide (PCA) on 06/06/19 at 1:50pm revealed:
-She had always put Resident #4's bed rails up when the resident was in bed since he first came to the facility (05/02/19).
-The resident could not stand unless someone was with him.
-Staff used the bed rails to keep the resident from falling out of bed.
-The resident had not rolled out of bed or fallen to her knowledge.

Interview with a second PCA on 06/06/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 63 1:50pm revealed: -She had always put Resident #4's bed rails up when the resident was in bed since he first came to the facility (05/02/19). -Staff used the bed rails to keep the resident from falling out of bed. -The resident had not rolled out of bed or fallen to her knowledge. Interview with a third PCA on 06/06/19 at 5:35pm revealed: -Resident #4 could sit up on the bed and reposition himself. -The resident had a bed alarm but she had never heard the alarm sound -The resident had a hospital bed with rails since he was admitted (05/02/19). -She made sure the bed rails were up when the resident was in bed. -The bed rails had been used since the resident was admitted. -The resident had no falls to her knowledge. Telephone interview with two hospice nurses on 06/06/19 at 4:59pm revealed: -Resident #4 was admitted to hospice services when he was admitted to the facility on 05/02/19. -The resident got a hospital bed with rails upon admission on 05/02/19. -The bed rails were kept up while the resident was in bed for safety. -The bed rails had been used by facility staff since the resident was admitted on 05/02/19. Observation of Resident #4 on 06/07/19 at 2:55pm revealed the resident was in bed asleep with both bed rails in the up position. Interview with Resident #4's family member on 06/07/19 at 2:55pm revealed:	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 64 -Resident #4 was admitted to the facility on 05/02/19 and he started hospice services the same day. -The resident rolled over and moved around in the bed independently. -The resident had a hospital bed with rails since he was admitted on 05/02/19. -Staff wanted to the bed rails to be up when the resident was in bed for "safety reasons". -Staff put the bed rails down when the resident got out of bed. -She remembered signing a form for the facility to use the bed rails when the resident was admitted on 05/02/19. -Staff had always kept the bed rails up when the resident was in bed since he moved into the facility on 05/02/19. Interview with the Personal Care Aide Coordinator (PCAC) on 06/07/19 at 4:00pm revealed: -Resident #4 was admitted to the facility and to hospice services on 05/02/19. -The resident had a hospital bed with rails since admission because he was receiving hospice care. -It was her understanding the resident had falls at home prior to coming to the facility but he had none at the facility to her knowledge. -The resident was combative when he was admitted to the facility. -There was a delay in requesting the physical restraint order because they were not sure if the resident would stay at the facility because of his behavior. -The hospice nurse got some medication for the resident and he eventually calmed down. -She had explained to the PCAs and MAs when Resident #4 was admitted to the facility that they were not supposed to use the bed rails until an order was received from the physician.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 65 -Staff (could not recall who or when) had asked if the bed rail next to the wall could be left in the up position and she had told staff "yes" since that side of the bed was against the wall anyway. -The physician had signed the order for the restraint this week on 06/04/19. -She met with staff on 06/04/19 and told them the order had been received and they could use the bed rails for Resident #4. -She was not aware staff had been using the bed rails since the resident was admitted on 05/02/19. -She thought staff got confused and used the bed rails since they were already installed on the bed and it was "a habit". -There was no specific protocol for checking to see if staff were using the bed rails for Resident #4 prior to receiving the order. -She had checked one day last week and the resident's bed rail beside the wall was in the up position, but the other bed rail was down. -The staff had tried lowering his bed (could not recall when) but could not because the resident would complain of back pain. -She could not recall any other alternatives or interventions prior to the use of the bed rails. -The Director of Resident Services handled the physical restraint assessment and care plan, so she was not sure why the documentation was incomplete. Interview with the DRS on 06/07/19 at 4:15pm revealed: -The resident could sit up and move around independently while in bed. -The resident could self-propel his wheelchair with his feet, but he was very slow. -The resident was admitted to hospice services when he came to the facility on 05/02/19. -The hospital bed was set up by hospice on 05/02/19 and it came with bed rails.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 66 -Resident #4's family member signed consent for use of the bed rails on 05/02/19. -The assessment and care plan for use of the bed rails was completed and signed on 05/02/19. -She did not know where the assessment page was for Resident #4 or why information on the care plan was blank. -The only alternative to the bed rails they had tried for Resident #4 was a bed alarm, but she could not recall when they started using the bed alarm. -She did not send a request to the physician to sign an order for the bed rails until 05/22/19. -There was a delay in sending the request because she did not know if the resident was going to stay at the facility because of his behaviors. -She received the signed restraint order for the bed rails on 06/04/19. -She notified the PCAC they had received the order on 06/04/19. -Staff were not supposed to put the bed rails up until they received a signed order from the physician. -She was not aware staff were putting up the bed rails for Resident #4 prior to the order being received. -She "don't hardly get a chance to go down the hall", so she was not aware staff had been putting the bed rails up since the resident was admitted on 05/02/19. 2. Review of Resident #1's current FL-2 dated 02/11/19 revealed: -Diagnoses included Alzheimer's unspecified, cerebral infarction, general anxiety, urinary tract infection, chest pain unspecified, excessive crying, and dementia without behavioral. -She was semi-ambulatory using a wheelchair.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 67	D 482		

Review of a physician's order for Resident #1 revealed:
-There was a seat belt restraint order from a physician dated 03/27/19 with instructions for the resident to be checked every 30 minutes and restraints released every 2 hours.
-There was a second seat belt restraint order from a nurse practitioner dated 03/28/19 with instructions for the resident to be checked every 30 minutes and restraints released every 2 hours.

Observation of Resident #1 on 06/04/19 at 9:44am revealed:
-The resident came in the dining room in a wheelchair with a mesh type velcro fastened seat belt around her abdomen.
-There was a chair alarm attached to the back of the wheelchair.

Observation of Resident #1 on 06/05/19 at 9:20am revealed:
-She was seated in her wheelchair in the tv room.
-Resident #1's wheelchair seat belt restraint was fastened.

Observation of Resident #1 on 06/06/19 at 9:40am revealed:
-The resident was seated in her wheelchair with the velcro seat belt restraint fastened.
-The Medication Aide (MA) prepared Resident #1 for an activity and relocated her wheelchair at a table in the tv room.

Observation of Resident #1 on 06/06/19 at 10:00am revealed:
-Another PCA relocated the resident to the dining room for a BINGO activity.
-Resident #1's wheelchair seatbelt restraint remained fastened and was not released.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 68	D 482		

Observation of Resident #1 on 06/06/19 between 10:00am and 1:00pm revealed:
-Resident #1 remained in the dining room playing BINGO from 10:15am - 11:15am.
-At 11:35am, Resident #1 was eating her lunch meal in the dining room.
-At 12:10pm, Resident #1 self-propelled herself in the wheelchair into the hallway. A PCA instructed the resident to "come this way" and the resident continued to self-propel the wheelchair in the hall. The wheelchair seatbelt remained fastened and had not been released by staff.
-At 12:18pm, the MA transported the resident to the tv room in her wheelchair. The wheelchair seatbelt was not released.
-At 12:27pm, Resident #1 was seated in her wheelchair in front of the dining room. The wheelchair seatbelt remained fastened.
-At 12:31pm, Resident #1 was assisted to the tv room by staff. The staff returned to the dining room area within 10-15 seconds.
-At 12:43pm, Resident #1 was assisted by the MA to the bathroom after releasing the velcro seatbelt restraint. The MA instructed Resident #1 to stand up from the wheelchair and sit on the commode.

Observation of Resident #1 on 06/06/19 at 12:59pm revealed she was back in the tv room in her wheelchair with the seat belt restraint fastened.

Interview with the Personal Care Aide on 06/06/19 at 1:20pm revealed:
-She was supposed to release the wheelchair seatbelts for 30 minutes when doing every two-hour checks.
-She had not had a chance to release the resident's seatbelt restraints.
-Staff were supposed to be with the resident because of danger for falls, when the seat belt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 69	D 482		

restraint was released.

Interview with the Special Care Unit Coordinator on 06/07/19 at 10:30am revealed:
-Staff got training on restraints which included releasing of restraints every 2 hours and checking the resident with restraints every 30 minutes.
-She had not read a restraint policy.
-She noticed on 06/06/19 the residents wheelchair seat belts were not released for 30 minutes every two hours by personal care aides.
-Staff have a lot to do "like showers."
-She had not talked to anybody about the amount of work staff had to do.

3. Review of Resident #2's current FL-2 dated 02/11/19 revealed:
-Diagnoses included Alzheimer's disease, altered mental status, diabetes mellitus type 2, hypertension, migraines, vitamin D deficiency, dementia, hypercholesterolemia, osteoarthritis, chronic lymphedema, hiatal hernia, and iron deficiency anemia.
-She was semi-ambulatory using a wheelchair.

Review of a physician's order for Resident #2 dated 05/17/19 revealed a restraint order with instructions for the resident to be checked every 30 minutes and restraints released every 2 hours.

Review of Resident #2's care plan dated 09/19/18 revealed Resident #2 required extensive to total assistance from staff for transferring.

Observation of Resident #2 on 06/04/19 at 10:30am revealed resident #2 was coming out of the community shower in a wheelchair with a seat belt fastened around her lower abdomen.

Observation of Resident #2 on 06/04/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 70 5:15pm revealed Resident #2 remained seated in her wheelchair with the seat belt fastened. Interview with a Personal Care Aide (PCA) on 06/04/19 at 5:15pm revealed: -Sometimes the resident did not won't anyone to touch her but when she talked to the resident she would allow her to provide care. -Resident #2 was supposed to have the seat belt on because she liked to get up. -The PCA took the seat belt off every time she took the resident to the bathroom. Observation of Resident #2 on 06/06/19 at 9:40am revealed: -She was seated in her wheelchair in the tv room. -Resident #2's wheelchair seat belt restraint was fastened. Observation of Resident #2 on 06/06/19 at 9:45am revealed: -Resident #2's wheelchair seat belt restraint remained fastened. -The Medication Aide (MA) approached Resident #2, told her to wake up and relocated her wheelchair at a table in the tv room. Observation of Resident #2 on 06/06/19 at 10:00am revealed: -Another PCA relocated the resident to the dining room for a BINGO activity. -Resident #2's wheelchair seatbelt restraint was not released. Observation of Resident #2 on 06/06/19 between 10:00am and 1:00pm revealed: -Resident #2 remained in the dining room playing BINGO from 10:15am - 11:15am. -At 11:20am the MA took Resident #2 to the medication room and checked the resident's	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 71	D 482		

finger stick blood sugar and administered the resident an injection of Novolog (used to treat diabetes) insulin and returned the resident to the dining room. Resident #2's wheelchair seatbelt restraint was not released.
-At 11:35am, Resident #2 was served her lunch meal in the dining room.
-At 12:12pm, Resident #2 remained in the dining room eating her lunch meal. The wheelchair seatbelt restraint was not released.
-At 12:42pm, the MA transported the resident to the tv room in her wheelchair. The wheelchair seatbelt was not released.
-At 12:58pm, Resident #2 was seated in her wheelchair in the tv room. The wheelchair seatbelt restraint remained fastened. There was no staff present in the tv room.

Observation of Resident #2 on 06/06/19 at 1:16pm revealed:
-The resident was assisted to her bedroom by the PCA.
-The PCA released the seatbelt restraint and provided incontinence care.

Interview with the Personal Care Aide on 06/06/19 at 1:20pm revealed:
-She was supposed to release the wheelchair seatbelts for 30 minutes when doing every two-hour checks.
-She had not had a chance to release the resident's seatbelt restraints.
-Staff were supposed to be with the resident because of danger for falls, when the seat belt restraint was released.

Interview with the Special Care Unit Coordinator on 06/07/19 at 10:30am revealed:
-Staff got training on restraints which included releasing of restraints every 2 hours and checking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 72 the resident with restraints every 30 minutes. -She had not read a restraint policy. -She noticed on 06/06/19 the residents wheelchair seat belts were not released for 30 minutes every two hours by personal care aides. -Staff have a lot to do "like showers." -She had not talked to anybody about the amount of work staff had to do.	D 482		
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	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 73	D 485		

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:
TYPE B VIOLATION

Based on observations, interviews and record reviews the facility failed to provide appropriate care and services for 1 of 1 resident (Resident #1) by restraining her in the wheelchair with a gait belt without having an order for a restraint and by not notifying her physician within 24 hours that an emergency restraint had been used.

The findings are:

Review of the facility's physical restraint policy revealed emergency restraints would only be used in temporary situations and the physician would be notified within 24 hours.

Review of Resident #1's current FL-2 dated 01/05/19 revealed:
-Diagnoses included Alzheimer's unspecified, cerebral infraction, general anxiety disorder, urinary tract disorder, chest pain unspecified, excessive crying of child, long term use of antithromb and dementia without behavioral.
-Resident #1 was constantly disoriented.
-Resident #1 ambulated with a wheelchair.

Review of Resident #1's care plan dated 01/03/19 revealed:
-Resident #1 required limited assistance with toileting, ambulation/locomotion, dressing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 74	D 485		

grooming/personal hygiene and transferring.
-Resident #1 required no assistance with eating,
-Resident#1 required extensive assistance with bathing.

Review of Resident #1's record revealed there was no documentation that a physician had been notified that an emergency restraint (gait belt) had been used to restrain the resident.

Telephone interview on 06/05/19 at 9:15am with a Supervisor revealed:
-Resident #1 did not want to lay down or get in her wheelchair.
-Resident #1 kicked and screamed while she and a PCA placed the resident into the wheelchair.
-No other alternatives had been used before Resident #1 was restrained with the gait belt.
-She had placed the gait belt around Resident #1 and tied it to the back of the wheelchair to prevent the resident from falling.
-Resident #1 had been restrained from 2:30am till about 4:00am.
-She had not utilized Resident #1's prn Ativan (used to treat anxiety).
-Resident #1 was offered food and something to drink while she was restrained.
-Resident #1 was not released from the restraint during that time.
-She was aware Resident #1 did not have a restraint order.
-She had not told anyone she had restrained Resident #1 with the gait belt.
-She had not known there was an emergency restraint policy.
-She had not been trained on emergency restraints.

Telephone interview with a Personal Care Aide (PCA) on 06/06/19 at 11:47am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 75	D 485		

-When Resident #1 was restrained with the gait belt on the 10pm to the 6am shift on 03/27/19 she and the Supervisor where the only employees working in the special care unit.
-When Resident #1 was put to bed, the resident kicked, screamed and yelled.
-She or the Supervisor was with Resident #1 the entire time she was restrained.
-Resident #1 was restrained from 2:30am to 4:00am.

Telephone interview with another Supervisor on 06/06/19 at 5:49am revealed:
-She had gone to the laundry room and observed Resident #1 had been restrained to a wheelchair with a gait belt.
-She could not tell how the gait belt was tied in the back.
-She was concerned because she had never seen a resident restrained with a thick white belt before.
-She had informed the Resident Care Coordinator Supervisor (RCCS) of the incident at the change of shift that morning.

Telephone interview with Resident #1's PCP on 06/06/19 at 2:42pm revealed:
-Resident #1 had severe vascular dementia.
-On 03/27/19 and on 03/29/19 the facility faxed him a request for a seatbelt order to help reduce the risk of falls.
-He signed the seatbelt order for Resident #1 on 03/27/19.
-The PCP was not notified that an emergency restraint had been used on Resident #1.

Interview with the RCCS on 06/07/19 at 10:16am revealed:
-She was informed by a personal care aide (PCA) on 03/27/19 that a 3rd shift supervisor had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 76	D 485		

restrained Resident #1 to the wheelchair with a belt.
-She was not sure what kind of belt had been used to restrain Resident #1; therefore, she asked the business office manager to show her the footage from the facilities video cameras.
-The video camera showed the supervisor had gone into the medication room and came out of the room with the gait belt that was used to restrain Resident #1 to the wheelchair.
-The supervisor went back into Resident #1's room once she had the gait belt.
-When the Supervisor, the PCA and Resident #1 came out the room, the gait belt was already around Resident #1.

Interview with the Special Care Unit Coordinator (SCUC) on 06/07/19 at 10:36am revealed:
-She was informed that Resident #1 had screamed, yelled and kicked at the Supervisor and PCA; the Supervisor didn't know what to do so she restrained her with the gait belt.
-She had not conducted an internal investigation when Resident #1 was restrained with a gait belt to the wheelchair.
-Resident #1's PCP signed the seatbelt order on 03/27/19.
-She had not informed the PCP that an emergency restraint was used on Resident #1.
-She was not aware she needed to contact Resident #1's PCP about the use of an emergency restraint.
-She had not been trained on the use of emergency restraints.

Interview with Resident #1's family member/Power of Attorney (POA) on 06/04/19 at 4:57pm revealed:
-The POA visited with her family member three times a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 77 -Resident #1 had a history of combative behavior. -Resident #1's PCP had been notified of the resident's combative behaviors. -The POA was informed that Resident #1 had been restrained in a wheelchair with a gait belt. -The Supervisor on duty on the 10pm to 6am shift [03/26/19-03/27/19] could not get Resident #1 to stay in the bed or the wheelchair. -The gait belt was used to restrain Resident #1 in the wheelchair to prevent her from falling. Review of Resident #1's record revealed there was no documentation that a physician had been notified that an emergency restraint (gait belt) had been used to restrain Resident in the wheelchair. Interview with the Administrator on 06/07/19 at 8:43am revealed: -She had been informed on 04/02/19 that the 3rd shift supervisor had used a gait belt to restrain Resident #1 in the wheelchair. -The Supervisor knew she had to check on other residents so Resdient #1 was restrained in the wheelchair with a gait belt so, resident would not fall. -She did not see what the problem was and the Supervisor made an emergency call and did what was best to protect Resident #1. The facility failed to notify Resident #1's physician within 24 hours that an emergency restraint had been used by staff. The noncompliance was detrimental to the health, safety, and welfare of the resident. The noncompliance constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on June 7, 2019. THE CORRECTION DATE FOR THIS TYPE B	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 485	Continued From page 78 VIOLATION SHALL NOT EXCEED July 22,2019.	D 485		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, use of physical restraints and alternatives, and health care personnel registry. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#5, #6) who had multiple falls that resulted in multiple injuries and visits to the local emergency department (ED). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure allegations of	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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
D912	Continued From page 79 suspected physical abuse and any facility investigation was reported to Health Care Personnel Registry (HCPR) within the 24 hour and 5-day requirements for allegations of 1 of 1 sampled staff (Staff C) restraining a resident (Resident #1) in a wheelchair using a gait belt, without any physician orders for restraints. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 3. Based on observations, interviews and record reviews the facility failed to provide appropriate care and services for 1 of 1 resident (Resident #1) by restraining her in the wheelchair with a gait belt without having an order for a restraint and by not notifying her physician within 24 hours that an emergency restraint had been used. [Refer to Tag 485, 10A NCAC 13F .1501(d)(5) Use of Physical Restraints and Alternatives (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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
D934	Continued From page 80 Commission pursuant to G.S. 131D-4.5	D934		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 3 of 6 Medication Aides (MA) sampled (Staff A Staff C, and Staff E), who had been employed at least one year, completed the state-mandated infection control training annually.

The findings are:

1. Review of Staff A, medication aide's (MA) personnel record revealed:
-Staff A was hired on 04/13/18.
-There was documentation Staff A completed the state infection control training course on 04/26/18.
-There was no additional documentation of infection control training for Staff A.

Refer to interviews with the Business Office Manager on 06/07/19 at 11:40 am and 4:45 pm.

Refer to interview with the Administrator on 06/07/19 at 5:05 pm.

2. Review of Staff C, medication aide's (MA) personnel record revealed:
-Staff C was hired on 01/12/17 as a personal care aide (PCA), and MA and supervisor.
-There was documentation Staff C completed the state infection control training course on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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
D934	Continued From page 81 05/03/18. -There was no additional documentation of infection control training for Staff C. Refer to interviews with the Business Office Manager on 06/07/19 at 11:40 am and 4:45 pm. Refer to interview with the Administrator on 06/07/19 at 5:05 pm. 3. Review of Staff E, medication aide's (MA) personnel record revealed: -Staff E was hired on 11/07/16 as a MA. -There was documentation Staff E completed the state infection control training course on 05/23/18. -There was no additional documentation of infection control training for Staff E. Refer to interviews with the Business Office Manager on 06/07/19 at 11:40 am and 4:45 pm. Refer to interview with the Administrator on 06/07/19 at 5:05 pm. _____ Interviews with the Business Office Manager (BOM) on 06/07/19 at 11:40 am and 4:45 pm revealed: -She was responsible for personnel records. -She had been responsible of personnel files and training schedules. -The MAs were responsible for completing their annual infection control training. -She had a spreadsheet to keep track of staff CEUs. -She kept a spreadsheet of when each staff members were due for annual training as well as new hires and posted training on the bulletin board.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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
D934	Continued From page 82 -There was training she was aware of being overdue. -She was in the process of scheduling needed annual trainings with the nurse consultant. Interview with the Administrator on 05/07/19 at 5:05 pm revealed: -She was aware there were some staff who were overdue for their annual infection control training. -TheBusiness Office Manager had been working to get those scheduled. -The Business Office Manager was responsible for the personnel records. -The Business Office Manager was responsible for making sure the MAs had completed their annual infection control training. -The Business Office Manager assigned the training, scheduled training, sent reminders for training and audited the training records. -She did not audit personnel records; she expected the Business Office Manager to keep the personnel records in order. -She expected the MAs to complete their required training.	D934		