STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 000	INITIAL COMMENTS The purpose for this visit was to conduct a re-licensure survey and complaint investigation. There were no deficiencies as a result of the complaint investigation.	L 000		
L 076	.2305(A) QUALITY OF CARE 10A-13D.2305 (a) The facility shall provide necessary care and services in accordance with medical orders, the patient's comprehensive assessment and on-going plan of care. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to: obtain a physician's order to use a seat belt to restrain one sampled resident to her wheel chair (#6); obtain physician's orders prior to administering oxygen therapy for 2 of 4 sampled residents who were reviewed for oxygen therapy (Residents #2 and #5), and; develop care plans for oxygen therapy and pressure ulcer development for 3 of 8 residents whose care plans were reviewed (#1, #4 and #5). Findings included: 1. Resident #6 was admitted to the skilled nursing unit on 8/9/17. There was no order for restraint usage in the skilled nursing unit. Review of the March 2018 physician orders did not include an order to use a Velcro strap to restrain Resident #6's thighs. Resident #6 was observed on 3/15/18 at 1:02 PM with a hook and loop fastener strap applied	L 076	1. Resident #6 *How corrective action accomplished for affected resident: (1) Obtained MD order for restraint (velco belt) for Resident #6 *Identify other residents with potential to be affected: (1) DON reviewed 100% of other residents to identify any other residents with restraints. None identified *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts with restraints to ensure MD order is present. Weekly review of charts starting the week of 3/26/18 and weekly x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with obtaining MD order. (2) Audit/observation to be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/16/18 3/19/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 1 across her thighs. Interview of Nurse Aide (NA)#1 at 1:02 PM on 3/15/18 revealed, "The strap prevents her from falling out of the chair." At 3:56 PM on 3/15/18, NA #2 stated Resident #6 had the hook and loop fastener strap because she would lean and fall over. Resident #6 was observed on 3/16/18 at 8:10 AM in the dining room at a table with the strap applied across her thighs. Nurse #1 was interviewed on 3/16/18 at 10:00 AM. She said the purpose of the hook and loop fastener strap was to remind Resident #6 she should not get up. She said she can take it off on her own. "It is not a restraint." Nurse #1 stated Resident #6 removed it more in the evenings and said she thought she had it in the assisted living unit. Resident #6 was observed on 3/16/18 at 8:10 AM with the Velcro strap applied across her thighs. The Administrator and Director of Nurses (DON) were interviewed on 3/16/18 at 10:30 AM. The Administrator said the seat belt was implemented when Resident #6 was a resident in assisted living and provided a physician's telephone order dated 3/16/17 (prior to her admission to the skilled nursing unit) for a reclining back wheel chair with seat belt. The DON said the purpose of the seat belt was to remind her not to lean forward. The DON said I would think an order would be needed. Physician #1 was interview on March 16, 2018 at 1:47 PM. He said he may have given a verbal	L 076	1. Resident #6 (con't) *How corrective action accomplished for affected resident (1) Staff education completed for staff caring for Resident #6, clarifying that the velco belt is a restraint for resident. (2) Staff education on restraints including: (a) What is a restraint (b) When should restraints be released *Identify other residents with potential to be affected. No other residents with restraints at this time *How will plan be monitored to ensure compliance (1) DON or designee will monitor the nursing documentation to assure that it reflects residents with restraints weekly starting the week of 3/26/18 x four weeks; then every two weeks x two and then monthly x two and randomly thereafter as appropriate to assure ongoing compliance. (2) Audit/observation to be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/19/18 4/2/18 3/19/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 2 order for the use of a Velcro strap and it never got to the chart. Resident #2 was readmitted to the skilled unit on 3/14/18. 2. Review of the medical record revealed Resident #2 was readmitted to the skilled unit on 03/14/18 with diagnoses including fracture of the femur and pubis, hypertension, chronic kidney disease, arteriosclerotic heart disease, hypothyroidism, atrial fibrillation, insomnia, non-celiac gluten sensitivity, hypokalemia, malignant neoplasm bronchus or lung, anxiety, pacemaker, vitamin D deficiency and allergies. Review of a Long Term Care Transfer Instruction dated 3/13/18 revealed it did not indicate the need for oxygen administration. A physician's order for oxygen administration was not found on the medical record. According to the vital sign record, Resident #2's oxygen saturation during the period from March 14 through 16, 2018 was in the range of 96 - 100%. Observations of Resident #2 on 3/15/18 at 8:35 AM revealed she was using oxygen via nasal cannula (NC) with the flow meter set at 1.0 liters per minute (LPM). Resident #2 stated she just got the oxygen yesterday. On 3/16/18 at 11:45 AM, the oxygen flow meter was set at one LPM. Nurse #1 was interviewed on 3/16/18 at 11:45 AM and said she could not find an order for oxygen administration. She said there were standing orders for oxygen usage when a resident's oxygen saturation was 88 to 92% and she said	L 076	2. Resident #2 *How corrective action was accomplished for affected resident Received order from MD for oxygen for Resident #2 *Identify other residents with potential to be affected (1) DON reviewed 100% of other residents to identify any other residents with oxygen. Six of seventeen residents were found to have oxygen and presently all have orders. *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have oxygen to ensure MD order is present. Weekly review starting the week of 3/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with obtaining MD order. (2) Audit/observation will be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/16/18 3/20/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 3 Resident #2 was using oxygen prior to going to the hospital. On 3/16/18 at 1:13 PM, the Director of Nursing (DON) said she recalled an updated discharge summary that was not on the chart which was dated 3/13/18 with a status modified at 3:13 PM. It said her oxygen saturation level was 96% on room air at rest. It noted after walking Resident #2 on room air, her oxygen saturation level dropped to 81%. At that point, she was placed on oxygen at 2 LPM via nasal cannula. The oxygen concentration rate was observed in the presence of the DON at this time and the flow meter was set at 1.0 LPM. Physician #2 was interviewed on 3/16/18 at 2:30 PM. She said she thought there was some miscommunication about the need for oxygen from the hospital. She said this was the first time it (no physician's order) happened and she thought it got missed. 3. a. Review of the medical record revealed Resident #5 was admitted 1/12/16 with diagnoses including atherosclerotic heart disease, shortness of breath, and recurrent pneumonia. Review of Resident #5's Physician's orders revealed there was no order for continuous oxygen via nasal cannula (NC). During an initial observation on 03/15/18 at 9:00 AM Resident #5 was sitting in her wheelchair in her room with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set between 1.0 and 1.5 liters per minute (LPM). Subsequent observations on 03/15/18 at 4:02 PM, 03/16/18 at 8:21 AM, and 03/16/18 at 2:00 PM revealed Resident #5 was on continuous oxygen via NC with the oxygen flow meter set	L 076	3a. Resident 5 *How corrective action was accomplished for affected resident Received order from MD for oxygen for Resident #5. * Identify other reisdents with potential to be affected (1) DON reviewed 100% of other residents to identify any other residents with oxygen. Six out of seventeen residents have oxygen and presently all have orders for oxygen *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have oxygen to ensure MD order is present. Weekly review starting the week of 3/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with obtaining MD order. (2) Audit/observations will be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/16/18 3/20/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 4	L 076		

between 1.0 and 1.5 LPM.

During an interview on 03/16/18 at 2:26 PM Nurse #1 stated she thought Resident #5 had to start on oxygen due to a drop in her oxygen saturation but was not sure when that occurred.

An interview was conducted with the Administrator on 03/16/18 at 2:45 PM. The Administrator confirmed Resident #5 was on continuous oxygen but was not sure when it was initiated. The Administrator reviewed Resident #5's medical record and noted there was no Physician's order for the use of continuous oxygen. The Administrator stated oxygen was considered a drug and there should be a Physician's order for it to be administered.

During a follow up interview on 03/16/18 at 3:15 PM the Administrator provided a copy of an email communication between a nurse and the Physician on 01/31/18. The nurse informed the Physician Resident #5 had a bad cough with wheezing and crackles noted in the base of her lungs and continuous oxygen via NC 2 LPM to maintain her oxygen saturation between 93% to 96%. The Administrator stated she thought this was when the continuous oxygen had been initiated but confirmed there was no written Physician's order.

b. Review of the medical record revealed Resident #5 was admitted 1/12/16 with diagnoses including atherosclerotic heart disease, shortness of breath, and recurrent pneumonia.

Review of Resident #5's care plans revealed there was no plan of care for the use of continuous oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 5 During an initial observation on 03/15/18 at 9:00 AM Resident #5 was sitting in her wheelchair in her room with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set between 1.0 and 1.5 liters per minute (LPM). Subsequent observations on 03/15/18 at 4:02 PM, 03/16/18 at 8:21 AM, and 03/16/18 at 2:00 PM revealed Resident #5 was on continuous oxygen via NC with the oxygen flow meter set between 1.0 and 1.5 LPM. An interview with Physician #1 on 03/16/18 at 1:55 PM revealed he considered oxygen a drug and thought a plan of care was important so the staff would know how to assess, monitor, and manage residents who used continuous oxygen. During an interview on 03/16/18 at 2:33 PM the Director of Nursing (DON) stated oxygen use should be care planned and she could not explain why Resident #5 did not have a care plan in place for the use of continuous oxygen. The interview further revealed care plans were typically updated quarterly during care plan meetings. 4. Review of the medical record revealed Resident #5 was admitted on 02/25/12 with diagnoses including chronic airway obstruction, emphysema, and rheumatic mitral valve disease. Review of Resident #4's March 2018 Physician's orders revealed an order for continuous oxygen at 1.0 to 2.0 liters per minute (LPM) to keep oxygen saturation greater than or equal to 92%. Review of Resident #4's care plans revealed there was no plan of care for the use of continuous oxygen. During an initial observation on 03/15/18 at 8:47	L 076	3b. Resident #5 *How corrective action was accomplished for affected resident Care plan was updated to include use of oxygen *Identify other residents with potential to be affected (1) DON reviewed 100% of other residents with oxygen and verified that oxygen use was on care plan. Six out of seventeen residents have oxygen and presently they all have care plans that reflect oxygen usage. *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have oxygen to ensure that oxygen usage is on care plan. Weekly review starting the week of 3/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with care planning oxygen usage. (2) DON or designee will update care plans as resident condition changes (3) Audit/observations will be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/19/18 3/20/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 6 AM Resident #4 was resting in bed with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set at 2.0 liters per minute (LPM). Subsequent observations on 03/15/18 at 11:55 AM, 03/16/18 at 10:00 AM, and 03/16/18 at 3:00 PM revealed Resident #4 was on continuous oxygen via NC with the oxygen flow meter set at 2.0 LPM. An interview with Physician #1 on 03/16/18 at 1:55 PM revealed he considered oxygen a drug and thought a plan of care was important so the staff would know how to assess, monitor, and manage residents who used continuous oxygen. During an interview on 03/16/18 at 2:33 PM the Director of Nursing (DON) stated oxygen use should be care planned and she could not explain why Resident #4 did not have a care plan in place for the use of continuous oxygen. The interview further revealed care plans were typically updated quarterly during care plan meetings. 5. Review of the medical record revealed Resident #1 was admitted on 04/27/17 with diagnoses including adult failure to thrive, dementia, and atherosclerotic heart disease. Review of the medical record revealed a Physician's order written on 01/22/18 to apply a liquid film-forming dressing to both heels twice a day and to keeps heels floated. An order was written on 01/28/18 to make Hospice aware of the area on Resident #1's right heel on Monday and to follow the protocol for pressure injury. Review of a nurse's note dated 03/01/18 revealed the wound on Resident #1's right heel had opened up and was approximately 2.0 cm (centimeters) round. The nurse documented a	L 076	4. Resident #4 *How corrective actions was accomplished for affected resident Care plan was updated to include use of oxygen *Identify other residents with potential to be affected (1) DON reviewed 100% of other residents with oxygen and verified that oxygen use was on the care plan. Six out of seventeen residents have oxygen and presently they all care plans that reflect oxygen usage. *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have oxygen to ensure that oxygen usage is on the care plan. Weekly review starting the week of 2/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with care planning oxygen usage. (2) DON or designee will update care plans as resident condition changes. (3) Audit/observations will be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/20/18 3/19/18 4/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 076	Continued From page 7 protective foam dressing had been applied. On 03/09/18 the nurse noted a black area on the 2nd toe on Resident #1's right foot and had informed the Hospice nurse. Continued review of Physician's orders revealed on 03/09/18 a culture of right heel drainage and an oral antibiotic was ordered. In addition, an new treatment order was written for the pressure ulcers on Resident #1's right heel and the 2nd toe on his right foot. Review of Resident #1's care plans revealed there was no care plan in place that addressed the pressure ulcers or any interventions. An interview with the Director of Nursing (DON) on 03/15/18 at 11:10 AM revealed the area on Resident #1's right heel started as a purple area about a month ago and the area on the 2nd toe was just identified a week ago. During an interview on 03/16/18 at 10:28 AM the DON stated the pressure ulcers should probably be care planned and she could not explain why Resident #1 did not have a care plan in place for the pressure ulcers. The interview further revealed care plans were typically updated quarterly during care plan meetings.	L 076	5. Resident #1 *How corrective action was accomplished for affected resident Care plan was updated to include care of pressure ulcer *Identify other residents with potential to be affected (1) DON reviewed 100% of other residents with pressure ulcers to ensure care plan included care of pressure ulcer. No others residents met criteria *Measures to be put in place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have pressure ulcers to ensure that care of pressure ulcer is on the care plan. Weekly review starting the week of 3/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with care planning pressure ulcers. (2) DON or designee will update care plans as resident condition changes. (3) Audit/observations will be presented/discussed at monthly QAPI meetings x one year with revisions as necessary.	3/19/18 3/19/18 4/2/18
L 078	.2305(C) QUALITY OF CARE 10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure	L 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 078	Continued From page 8 that the least restrictive means of restraint have been initiated on patients requiring restraints. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to determine whether the least restrictive means of restraint were used since implementation of a hook and loop strap to restrain the thighs of Resident #6 to her to the wheel chair. Resident #6 was the only resident in the skilled unit who used a physical restraints. Findings included: A physician's telephone order dated 3/16/17 (prior to her admission to the skilled nursing unit) indicated, Order reclining back wheel chair with seat belt. Resident #6 was admitted to the skilled nursing unit on 8/9/17. There was no order for restraint usage in the skilled nursing unit. A care plan for falls dated 8/1/17 included a problem for "potential for injury as a result of falls related to lack of safety awareness, muscle weakness, unsteady gait, diagnosis of spinocerebellar degeneration and arthritis." On 11/6/17 an approach was added to the falls care plan. Anti-tippers to w/c with Velcro seat belt. On 9/4/17, a physical restraint elimination assessment form was completed. Resident #6 was determined to be a "Good Candidate" for restraint elimination, but was marked "No" for restraint reduction or elimination program. There was no documentation of any attempted unrestrained observation periods or explanation for the decision not to go forward with the	L 078	Resident #6 *How corrective action accomplished for affected resident (1) Staff education completed for staff caring for Resident #6 that the velco belt is a restraint. 3/19/18 (2) Staff education on restraints including 4/2/18 (a) What is a restraint (b) When should restraints be released (3) MD order obtained for restraint (velco belt) 3/16/18 (4) Education completed for Administrator and DON on correctly completing the quarterly "Physical Restraint Elimination Assessment" 3/28/18 *Identify other residents with potential to be affected. No other residents with restraints at this time *How will plan be monitored to ensure compliance (1) DON or designee will monitor the nursing documentation (including the Resident Collection Data Tool & Physical Restraint Elimination Assessment) to ensure documentation is correct for residents with restraints. 4/2/18 (2) Random inquires to staff to ensure understanding of what is a restraint and when it should be released. Weekly review of charts and staff interviews starting the week of 3/26/18 x four; then every two weeks x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with documentation and staff understanding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 078	Continued From page 9 reduction or elimination program. On 12/5/17, a physical restraint elimination assessment form was completed. Resident #6 was determined to be a "Good Candidate" for restraint elimination, but was marked "No" for restraint reduction or elimination program. There was no documentation of any attempted unrestrained observation periods or explanation for the decision not to go forward with the reduction or elimination program. A physician's progress note dated 1/16/18 indicated, in part, " ...unfortunately she fell out of her wheelchair; reaching forward. Velcro belt released and she fell face forward; has a large intraorbital hematoma below right eye with a contused lip." The Resident Status Collection Tools dated 1/30/18 and 2/16/18 indicated restraints were not used on Resident #6. Review of the March 2018 physician orders did not include an order to use a Velcro strap to restrain Resident #6's thighs. On 3/7/18, a physical restraint elimination assessment form was completed. Resident #6 was determined to be a "Good Candidate" for restraint elimination, but was marked "No" for restraint reduction or elimination program. There was no documentation of any attempted unrestrained observation periods or explanation for the decision not to go forward with the reduction or elimination program. Resident #6 was observed on 3/15/18 at 1:02 PM with a Velcro strap applied across her thighs.	L 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 078	Continued From page 10 Interview of NA #1 at 1:02 PM on 3/15/18 revealed, "The strap prevents her from falling out of the chair." At 3:56 PM on 3/15/18, NA #2 stated Resident #6 had the hook and loop fastener strap because she would lean and fall over. Resident #6 was observed on 3/16/18 at 8:10 AM with a Velcro strap applied across her thighs. She was in the dining room at a table with three other residents and one staff member who was assisting another resident with breakfast. Nurse #1 was interviewed on 3/16/18 at 10:00 AM. She said the purpose of the Velcro strap was to remind Resident #6 she should not get up. She said she can take it off on her own. "It is not a restraint." She said Resident #6 will remove it more in the evenings and said she thought she had it in the assisted living unit. She said if it is irritating to her, we take it off. Resident #6 was observed on 3/16/18 at 8:10 AM with the Velcro strap applied across her thighs. In the presence of Nurse #1, Resident #6 was asked what the belt was and when asked to remove it, she could not. When Nurse #1 cued Resident #6 by tapping the belt and asked her to take the seat belt off, then Resident #6 was able to unfasten the belt. She was also able to close it loosely with cueing. The Administrator and Director of Nurses (DON) were interviewed on 3/16/18 at 10:30 AM. The Administrator said the Velcro belt was implemented when Resident #6 was a resident in assisted living. She had fallen forward and hurt her nose. The Administrator said we do think it is a restraint. The DON said the purpose was to	L 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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
L 078	Continued From page 11 remind her not to lean forward. Both the Administrator and DON confirmed the Resident Collection Data Tool marking for no restraint was not correct and Physical Restraint Elimination Assessment did not include any documented attempts to initiate restraint reduction or elimination even though Resident #6 was determined to be a "Good Candidate."	L 078		