STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0649	A. BUILDING: _____ B. WING _____	C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON	740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403

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D 000	Initial Comments A licensure complaint investigation was conducted from 10/02/19 through 10/04/19. A Type A1 Violation was identified at Rule 10A NCAC 13F.0901 (b). The deficient practice associated with the Type A1 Violation began on 10/01/19 and was abated on 10/04/19. During the survey 4 of 8 complaint allegations were substantiated with deficiency.	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 staff interviews and record review the facility neglected to provide activity of daily living (ADL) care to a resident who was incontinent, had a diagnosis of dementia and was unable to make her needs known to staff, by leaving her in her wheelchair all night and not providing incontinence care for 1 of 3 residents reviewed for care, Resident #2. Finding included:	D 269	The following is a Plan of Correction for Bradley Creek Health Center. This Plan of Correction is in regards to the Statement of Deficiencies resulting from the complaint survey on October 1st 2019. This plan of Correction is not to be constructed as and admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as	10/9/19

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D 269	Continued From page 1 Resident #2 was admitted to the facility on 09/02/16 with diagnoses that included dementia, essential hypertension, gastroesophageal reflux disease and a history of venous thrombosis and embolism. She was discharged to another facility on 09/30/19. Review of the Assisted Living service plan dated 9/20/19 for Resident #2 revealed she had an activity of daily living deficit related to cognitive impairment. The resident required hands on assistance with toileting and incontinence care every 2 hours. She also required hands on assistance for bathing, mobility, and dressing. Review of the 5 Day Report filed by the facility on 09/23/19 revealed the allegation of resident neglect related to Resident #2 was substantiated by the facility. The facility investigation documented: "Facility completed interviews with the oncoming staff as well as watched camera footage and resident was left sitting in her wheelchair all night. Aide was witnessed asleep and not making routine rounds. Med tech did not make rounds nor ensure resident was put down." Investigative Actions documented Agency Nurse Aide #2 was removed from the schedule and Med Tech #4 was suspended and had not returned to the facility. In an interview with the facility Administrator on 10/04/19 at 9:26 AM she stated she received a call on 09/14/19 from staff informing her that Resident #2 had been left sitting in her wheelchair all night. At that time she said she notified the Director of Nursing who in turn notified the family. She terminated the Agency Nurse Aide immediately and suspended the facility Med Tech who was also terminated after an allegation of neglect was substantiated by the facility. She	D 269	confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this plan, we have outlined specific actions in response to identified issues. D 269 Corrective Action for Affected Resident Resident #2 was sitting up in her chair on the morning of 9/14/19 when the day shift aide arrived at work. During breakfast service resident was noted to be soiled. Immediately following breakfast, she was assisted to bed, bathed and clothing was changed. Resident remained in bed to rest until lunch. Resident skin integrity was assessed by Director of Nursing on 9/14/19 showing no signs of breakdown. D 269 Corrective Action for Potentially Affected Residents Residents residing in the Assisted Living Community that have ADL needs for incontinence and transfers have the potential to be affected by the alleged non-compliance. On 10/3/2019 walking rounds by the nurse in charge was assigned to be completed between 9 and 11 pm daily. This round is to ensure that all dependent residents have been provided appropriate ADL care and are in bed as appropriate. Any resident found up or without appropriate ADL care for incontinence will be immediately cared for and documentation completed for care provided. The Administrator or DON will be immediately	

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D 269	Continued From page 2	D 269		

stated she had not been able to interview either employee as to why Resident #2 had been left in her wheelchair all night and not provided care. She said that night she had called the facility a couple of times to check on the residents and talk to staff. She commented she had the ability to view camera footage of the facility at her home and was watching to make sure no residents were left in the living room area at bedtime. She stated she did not feel this occurrence was a facility wide problem but rather an isolated incident. She stated because the Agency Nurse Aide and the Med Tech had been terminated the facility now had the proper staffing to address resident needs. She felt because she could monitor the living room on camera from her home no further interventions were needed until her boss called her on 09/25/19 and inquired about what the facility was doing to make sure all residents were laid down each night. She stated she met with the Director of Nursing on that date and started a plan to have a staff member on duty check all the floors between 8:00-9:00 PM each evening to ensure all residents had been put to bed. She stated this plan started on 9/25/19.

In an interview with the Director of Nursing on 10/04/19 at 10:00 AM she stated she went to the facility on 09/14/19 to complete a skin assessment on Resident #2 after learning she had been left up in her wheelchair all night. She arrived at the facility shortly after lunch and found the resident in bed with her legs elevated. She completed a full body assessment and found no reddened skin areas. Her lower extremities were puffy. She commented she notified the family of the assessment findings. She commented she did not complete written documentation of the assessment. On 09/25/19, after meeting with the Administrator, she stated she began to write on

notified if a resident issue is found. Documentation of each round is completed by the nurse on duty.
On 10/11/2019 audits began on all residents that have potential to be affected. The Social worker or designee will monitor using the Abuse Quality Assurance tool for monitoring abuse and care concerns. The monitoring will include reviewing 6 residents for concerns of abuse, neglect or misappropriation of property. This will be completed weekly times 2 weeks then monthly times 3 months or until resolved by the Quality Assurance Committee.
Alert and Oriented residents are interviewed regarding abuse/neglect prevention. Any concerns that the resident voices or the exhibiting behaviors such as tearfulness, withdrawal, bruises or injuries of unknown origin will be immediately communicated to the Administrator or DON.
Non-Interviewable residents will be audited for abuse/neglect prevention. Any concerns that the auditor notes will be immediately communicated to the Administrator or DON. Signs of abuse/neglect in the non-interviewable resident may include withdrawal, tearfulness, skin tears, bruises or incontinent odor.
D 269 Systemic Change
On 10/9/2019 in-servicing was completed for all nurses, medtechs and aides on abuse and neglect.
The in-service defined abuse and discussed the seven different types of abuse. Employees were taught that all types of abuse must immediately be

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D 269	Continued From page 3 the working schedules an instruction for a nurse to complete "bed rounds" to ensure all residents had been put in bed each evening. She stated there was no way of knowing if the rounds had actually been conducted because there had not been an audit tool developed to monitor the intervention. In an interview conducted with Facility Nurse Aide #1 on 10/04/19 at 10:45 AM she stated she arrived at work on 09/14/19 at 6:45 AM to find Resident #2 sitting in her wheelchair in the living room watching television. She commented Resident #2 usually slept in bed and did not get up that early in the morning. She said she had cared for Resident #2 for over a year and knew her well. She stated Resident #2 had dementia and was very confused. Her responses did not make sense when she conversed with staff. She remarked Resident #2 was not able to make her needs known. In an interview conducted on 10/04/19 at 11:15 AM with Nurse Aide #3 she stated when she reported to work on 09/14/19 between 5:00-5:15 AM she observed Agency Nurse Aide #2 sitting in a chair asleep. She noticed Resident #2 was sitting in her wheelchair fully dressed in the living room. She stated she asked Agency Nurse Aide #2 at that time if she had gotten Resident #2 up that morning and she said she had. When Nurse Aide #3 sat Resident #2 at the breakfast table at 7:30 AM she noticed both her pants and up the back of her sweater were wet with urine. She stated she and another staff member took the resident to her room and provided ADL care. When she realized Resident #2 was in the same clothes as the day before and that her bed had not been slept in she notified the facility Administrator that she believed the resident had	D 269	reported to the DON and administrator, including resident to resident abuse. The staff was also taught how to recognize and report abuse and any time a resident, family, or visitor says that abuse happened or they suspect abuse it must be reported. 269 Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Monitor for Abuse Reporting. The monitoring will review weekly x 2 week's then monthly x 3 months or until resoled by QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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D 269	Continued From page 4 been left up in her wheelchair all night. She stated she did not notice any reddened areas on the resident's skin but did notice her ankles and feet were swollen. She said after breakfast the resident was laid down in her bed to rest. She commented Resident #2 was not able to make her needs known and was sometimes resistant to care if she did not recognize the caregiver providing her care. An attempt was made to interview Agency Nurse Aide #2 via phone on 10/04/19 at 8:50 AM and 10:14 AM and by text message on 10/04/19 at 10:18 AM with no response. An attempt was made to interview Facility Nurse Aide/Medication Technician #4 via phone on 10/04/19 at 10:17 AM and 12:16 PM with no response. Both staff members had been terminated by the facility for leaving Resident #2 sitting up in a wheelchair all night and not providing care to the resident.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 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: Based on observation, physician interview,	D 270	The following is a Plan of Correction for	10/4/19

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D 270	Continued From page 5 physician assistant interview, facility staff interview, hospice staff interview, and record review the facility failed to check a resident every two hours according to his care plan and lower his bilateral assist bars at 1:43 AM on 10/01/19 after care was provided to 1 of 1 sampled residents (Resident #1) who had just experienced an episode of anxiety and attempted to get out of bed unassisted. Review of camera footage revealed no staff members had entered Resident #1's room between 1:43 AM and 6:42 AM on 10/01/19. The coroner's preliminary primary cause of death to be documented on the resident's death certificate was positional asphyxiation (the state or process of being deprived of oxygen, which can result in unconsciousness or death; suffocation due to the way in which the body was positioned). Based on observation, resident interview, staff interview, and record review the facility failed to identify side rails as a potential hazard for 2 of 2 sampled residents (Resident #5 and Resident #6) who had gaps between the side rails on their beds and their mattresses. Findings included: 1. Record review revealed Resident #1 was admitted to the facility on 11/01/16 with orders for do not resuscitate (DNR). The resident's documented diagnoses included history of falls, benign paroxysmal vertigo, macular degeneration (legally blind), osteoarthritis, long term (current) use of aspirin, and congestive heart failure. The resident's most recent service plan (care plan), dated 12/20/18, identified "The resident is at risk for falls r/t (due to) severe vision impairment, balance problems, intermittent	D 270	Bradley Creek Health Center. This Plan of Correction is in regards to the Statement of Deficiencies resulting from the complaint survey on October 1st 2019. This plan of Correction is not to be constructed as and admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this plan, we have outlined specific actions in response to identified issues. D 270 Corrective Action for Affected Resident Resident #1 had grab bars present on his bed for bed boundaries due to macular degeneration and to assist him with turning from side to side. The grab bar met the standards as established by FDA Guidance on Hospital Bed Dimension and Assessment guidance to Reduce Entrapment. There was not an assessment, physician order, or consent noted in the chart for the grab bars. On 10/01/2019, the resident was cared for by NA #1 at 0143 and incontinence care was given. During this time the resident was noted with an episode of agitation. After care was provided, the resident was positioned in the middle of the bed and was without agitation. Staff did not reenter the room again until 0642. At 0642 the resident was noted by NA #1 with part of his chin above the top of the grab bar. Resident was non-responsive and without	

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D 270	Continued From page 6 confusion, hx (history) of falls, incontinence and has had actual fall, impaired safety awareness" as a problem. Interventions for this problem included "Encourage, remind and assist resident with using the bathroom at more frequent intervals (every 2 hours). Remove any potential causes (of falls) or hazards, if possible. Educate resident and caregivers of potential fall hazards for the resident. Inform the resident/caregivers about safety reminders and what to do if a fall occurs." Resident #1's cardex, not dated other than documenting an admission date of 12/26/18 when Resident #1 moved to his most recent destination in the facility, addressed the resident's safety needs. These needs included, "Encourage, remind and assist resident with using the bathroom at more frequent intervals (every 2 hours)." Review of hospice records revealed Resident #1 was admitted to hospice on 09/12/19 with an admitting diagnosis of late effects of cerebrovascular disease. Admission documents stated, "On assessment, he (Resident #1) is alert and oriented to person only, continuously confused, disheveled, and appears depressed. He has minimal speech and impaired vision. He is bed or chair bound, unable to bear weight for transfer. He requires assistance for ADLs (activities of daily living) of bathing, dressing, transfers, continence, and meal prep. He reportedly has been having hallucinations. He has a wet cough and reportedly has been aspirating, treated for pneumonia twice in the last year. He requires assistance for feeding...and appears to have lost weight. He has urinary and fecal incontinence....Over the past weeks to months, the patient has experienced decline in	D 270	a pulse. Per the medical examiner, the preliminary primary cause of death is positional asphyxiation. Resident #5 had no adverse outcome to a grab bar that did not conform to the FDA Guidance on Hospital Bed Dimension and Assessment guidance to Reduce Entrapment. On 10/2/19 the grab bar was removed with the resident permission. Resident #6 had no adverse outcome to a grab bar that did not conform to the FDA Guidance on Hospital Bed Dimension and Assessment guidance to Reduce Entrapment. On 10/2/19 one on one caregiver was placed with resident until an alternate grab bar system could be obtained. One on one continued until 10/4/19 when a grab bar was installed on his bed that met entrapment guidelines. Assessment, physician order and consent for the grab bar is current on the resident chart. D 270 Corrective Action for Potentially Affected Residents Residents residing in the Assisted Living Community that utilize grab bars or bed rails have the potential to be affected by the alleged non-compliance. On 10/01/2019 the RN Clinical Managers completed Device and Bed Rail Evaluation Forms on all current residents using bed rails or grab bars or other devices. This was accomplished by going into every resident’s room and determining what type of bed rails or grab bar, or device was being used. Once a bed rail or grab bar or device was determined to be attached or adjacent to the resident’s body it was evaluated by the RN Clinical Manager to identify if it restricted the patient’s freedom	

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D 270	Continued From page 7 clinical status as evidenced by weakness, weight loss, confusion, decreasing exercise tolerance, and increasing ADL dependence." A 09/19/19 3:13 AM progress note documented, "Resident was found lying on the floor by CNA (certified nursing assistant). Resident said he got up to go to the bathroom and fell." A 09/19/19 hospice note documented, "Pt (patient) fell last night--rolled out of bed (with) no injury. Requested fall mats be placed..." Hospice records documented a 09/19/19 12:00 PM triage call, "Patient had a fall last night and thought to be without injury, however today he has a large hard 'hematoma' on his thigh." A 09/24/19 8:05 AM progress note documented, "Resident found on the floor at the bedside, resident slid to floor while trying to get oob (out of bed) to chair." A 09/24/19 hospice coordination of care note documented, "...update (family member) on fall last night that occurred around the same time as fall last week. Geri-chair discussed to encourage pt to get out of bed and expend energy during the day, hopefully making him less restless at night...." A 09/24/19 physician's order started Resident #1 on Haldol (antipsychotic medication) 0.25 milliliters (ml) or 0.5 milligrams (mg) by mouth at bed time. A 09/25/19 Fall Risk assessment identified Resident #1 at being high risk for falls due to age, intermittent confusion, elimination with assistance, history of multiple falls, poor hearing	D 270	of movement or normal access to the patient's body, determined if the patient could use the bed rail or grab bar, or if it the device presented as a restraint and/or hazard to the patient. Bed rails or grab bars or device that were considered a restraint were then reviewed for medical necessity by the evaluating clinical team. If the bed rail or grab bar or device was identified as a restraint and not medically indicated a reduction plan was established by the care planning team. If it presented as a risk for injury to the resident a reduction plan was established by the care planning team. This review was completed by 10/01/2019. No bed rails or grab bars were identified as a restraint. 13 out of 25 bed rails/grab bars were identified as not utilized by the resident or not meeting FDA specifications and were discontinued. No other devices were identified. This was completed on 10/02/2019. Patients that utilize bed rails or grab bars or device were assessed by the Director of Nursing and support nurse for injuries such as skin tears or bruises. This was completed on 10/01/2019. No injuries or bruises were identified related to bed rail/grab bar use. Patients who did not have a previously signed consent for bed rails or grab bars were contacted or their R/P's (for those patients unable to consent) and were educated on the risk of utilizing a bed rail or grab bar and consent was obtained to utilize the device. This was completed by the Clinical RN's by 10/01/2019. Patients, families and/or responsible parties were notified beginning on 10/1/19 if the bedrail that they had currently	

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D 270	Continued From page 8 and poor vision, confined to bed, loss of balance while standing, decrease in muscular coordination, and two or more high risk medications. On 09/25/19 documentation gathered to update Resident #1's Service Plan revealed, "Day and night incontinence care to/from bathroom or total incontinence care and positioning/skin monitoring, frequent verbal and tactile cueing redirection and/or reassurance as needed, hands on assistance with entire bathing process, reminders and encouragement for meal time and 'check by' supervision, total 'hands on' assistance of one with transfer and sit to stand, hands on assistance with entire dressing and grooming process, 15 or more medications administered." During an interview with Facility Nurse #2 on 10/04/19 at 10:30 AM she stated Resident #1's cognition varied from alert and oriented x 1 (aware of person only) to alert and oriented x 2 (aware of person and place only). She reported in the last month the resident had lost a lot of strength in his lower extremities, but she had witnessed him on several occasions throwing his feet and legs off the bed in an attempt to transfer to the bathroom unassisted. She commented she was not sure whether the resident could still use his assist bars to turn and reposition and aide with transfers, but he had other interventions in place such as the bed in the lowest position, a mat on the floor at bedside, and furniture moved away from the bed to help keep him safe. According to Facility Nurse #2, she felt it was important to assess Resident #1 when he became agitated and restless, trying to figure out the source of his agitation, and putting interventions in place to help keep the resident safe.	D 270	installed on their bed met criteria for entrapment zone safety. Those that did not meet criteria were removed by 10/2/19. Alternative grab bar options or changing to a facility provided hospital bed that met criteria for entrapment zones were presented as options to residents who wished to utilized grab bars. Patients who utilize a bed rail or grab bar had their MD contacted or Medical Director to receive an order for the bed rail or grab bar in use. This was completed by the Clinical RN's on 10/01/2019. Patients who utilize a bed rail or grab bar had their service plan updated to include the use of the grab bar or bed rail device. This was completed by the Nurse Consultant on 10/01/2019. Maintenance personnel measured each grab bar that was care planned to remain in use to determine compliance with FDA standards for entrapment zones. Devices that did not meet compliance were removed from the facility. D 270 Systematic Changes On 10/01/2019, the Clinical Nurse Consultant in-serviced all nurses managers (Director of Nursing, ALF unit director, and MDS nurse on restraints. Topics included: • Many devices can be a restraint for a patient. For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move. Other examples include: bed rails, grab bars, geri-chair, or broda	

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D 270	Continued From page 9 During an interview with Facility NA #1 on 10/04/19 at 10:54 AM she stated Resident #1 experienced intermittent confusion, restlessness, and decreased comprehension in the late evenings and early mornings. She reported she considered the resident a fall risk because he was very weak in his lower extremities, he tried to compensate by flopping his upper body over in one jerking movement, and he had poor perception of where he was in the bed because of his poor eyesight. She commented the resident could still hold onto the assist bars, and they still set bed boundaries for the last two or three weeks, but she did not think the resident could actually use them to help maneuver himself in bed. According to NA#1 , when the resident was on her assignment lately she tried to check on him hourly to make sure he was not attempting to get up unassisted. She stated if the resident's behavior elevated from restlessness to agitation, she notified the nurse so the nurse could figure out a plan to calm the resident down. During a telephone interview with Hospice Nursing Assistant (NA) #1 on 10/03/19 at 9:12 AM she stated she cared for Resident #1 multiple times on first and second shifts. She stated the resident was restless, resisted care sometimes, and was incontinent of bowel and bladder. She reported facility staff informed her that the resident used the urinal at one time, but that had changed, and a brief was used since the resident was on a containment program now. She commented she had found the resident's legs and feet off the bed multiple times. According to this NA, Resident #1 was no longer able to use the call bell, and needed to be checked on frequently. She stated she lowered the assist bars on the resident's bed when providing care,	D 270	chair. • Device and bed rail evaluation UDA's must be completed on all patients on admission, readmission, every 3 months and with significant changes in condition. The device evaluation is used to assess the device or bed rail/grab bar in use for the potential of it being a restraint or having risk for injury to the patient. • Additionally any time a resident has a fall or injury where a device or bed rail/grab bar was utilized the device must be evaluated to ensure that it does not pose a hazard to the patient. • The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint. If the device is considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. Reduction plans should be reviewed every week during the daily clinical meeting to ensure that the restraint is being reduced. This must continue until the restraint is discontinued. • If a bed rail or grab bar is utilized then an MD order must be obtained for the use of the bed rail or grab bar and consent must be obtained from the patient or R/P using form MP5476. • If a restraint is utilized then an MD order must be obtained for the use of the restraint and consent must be obtained from the patient or R/P using the BRIGGS form for restraint consent. • In addition to this the definition of a restraint was discussed. See the	

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D 270	Continued From page 10 and raised them when the care was completed. She reported she had observed no problems with the stability of the side bars or their positioning in relation to the mattress. The NA commented Resident #1 was vision impaired, and the assist bars set bed boundaries for the resident who could also hold on to them. During a telephone interview with Hospice Nurse #1 on 10/02/19 at 11:54 AM she stated the last time she observed and assessed Resident #1 was on 09/26/19 which was a follow-up visit related to an aspiration event, two recent falls, and toleration of Haldol. She reported staff informed her the resident slept better the night before, possibly related to the initiation of a mild dose of Haldol in the evenings, and the resident did not appear to be sedated or lethargic related to the introduction of the Haldol. According to the hospice nurse, Resident #1 was alert to person, could answer yes and no questions, and could carry on a conversation, but was never oriented to time. She explained the resident frequently talked about things that occurred in the past as if they were currently happening. She reported Resident #1 began experiencing nightly restlessness on 09/23/19 as evidenced by trying to get up unassisted to urinate. She commented she observed Resident #1 with bilateral assist bars in place on his bed, and also observed staff guiding the resident's hand to the grab bars during care. However, she stated even though the resident could grasp the bars, she did not feel like the resident had enough strength to actually use them to help in turning and repositioning himself, as evidenced by the nursing assistants (NAs) having to use a draw sheet to roll the resident over on his side so he could be changed. She also commented the resident had to be transferred using a lift. The nurse reported she	D 270	education packet. On 10/01/2019 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA, MT both full time and part time regarding the use of devices and bed rails or grab bars. The Director of Nursing will ensure that any employee who have not received this training by 10/01/2019 will not be allowed to work until the training is completed. Training will also be provided for all agency nurses and CNA's prior to beginning work at the facility. As of 10/4/2019 100% of employees have received this training. This in-service included the following topics: • There are lots of reason why we should not use a restraint. Studies have shown that restraints do not prevent falls and can actually cause harm to a patient. This harm can include fractures, skin injuries, or even death by strangulation. The survey guidelines that regulate nursing facilities also include regulations that protect the resident's right against being restrained. • Restraints can include a physical restraint or chemical restraint (medications). For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move. • Definition and types of restraints • If you notice a patient with a change in condition such as decline in ability to use the bed rail or grab bar, new confusion or agitation, or new injury from the device	

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D 270	Continued From page 11 thought the assist bars set bed boundaries for Resident #1 who suffered from macular degeneration. She stated she never saw any operational problems with the side rails, always being stable and flush against the mattress. She explained the facility was responsible for conducting assist bar/grab bar/side rail assessments and determining the appropriateness of their use. During an interview with the Regional Director for Senior Living and the Assisted Living Director on 10/02/19 at 5:08 PM they stated that there was no order, consent, or assessment for the assist bars on Resident #1's bed. They also reported that it could not be determined when the assist bars were installed on the resident's bed. They stated assisting living (AL) assessments such as the service plans, device evaluations, and licensed health professional support forms had not been completed per corporate scheduling because of changes, vacancies, and inconsistencies in the AL management team. The Assisted Living Director reported use of these forms helped capture changes in resident condition and needs. She reported she thought the assist bars were beneficial to Resident #1 because they functioned as his "comfort blanket", making the resident feel more secure since he suffered from severe macular degeneration. However, she commented that these assist bars caused more harm than good when the resident began to experience restless in the evenings and was getting out of bed unassisted. During an interview with Facility Nurse #1 on 10/02/19 at 1:13 PM she stated she cared for Resident #1 on the evening of 09/30/19 into the morning of 10/01/19 (from 7:00 AM until 7:00 PM). She reported during the last two weeks of	D 270	then you must notify the hall nurse or nurse manager. • If a patient uses one of these devices we need to ensure that the device is not a hazard for the patient. If you notice the patient throwing their legs over the side rails or gerichair or trying to get up from a gerichair or around a side rail, notify the charge nurse immediately. The charge nurse should ensure that the nurse manager is notified. The nurse manager will need to complete a device or bed rail evaluation to ensure that the device is still medically necessary or they will need to make efforts to remove the device. • As you can see there are very few situations where restraints should be used. • In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include active listening, provide reassurance, provide activities, modify the environment, find other outlets for the patient and check yourself ensuring your approach is calm and reassuring. • Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient’s service plan or care plan will include interventions that should be used to try to calm the patient. • The physician should also be notified so that medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician	

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the resident's life he was much weaker, no longer sitting up on the side of the bed or trying to use the urinal, becoming bedbound. She commented in the last week there were problems with the resident trying to get out of bed unassisted and seeming restless. She reported Resident #1 was up out of bed when she began her shift on 09/30/19 with the resident being confused and talking about things in the past as if they were currently happening.

During an interview with Agency NA #1 on 10/02/19 at 3:01 PM, she stated she worked from 7:00 PM on 09/30/19 until 7:00 AM on 10/01/19, and was assigned to care for Resident #1. She reported one facility nurse and three agency NAs were assigned to care for residents on Resident #1's floor. She commented one of the agency NAs felt very uneasy because it was her first time in the building so the nurse suggested that this NA be paired with her. According to NA #1, she had about 14 residents on her assignment, and the other NA had about the same number on her assignment. She explained that on rounds she and the other NA alternated checking on/ providing care to residents on one another's assignments. NA #1 remarked that this slowed down their progress, and unfortunately did not allow her to check on her residents as frequently as she would have liked. According to NA #1, there was a lot of confusion about assignments for the night so the first time she saw Resident #1 was between 8:00 PM and 8:30 PM when he was in a geri-chair in the television room on the unit. She reported the resident was "antsy" and restless, not aware that he was in the facility and stating that he was in a hurry because he had to get to the store.

During an interview with Facility Nurse #1 on

cannot provide additional directions, then notify the DON or administrator.
• In addition to the above interventions, resident dignity is very important. Checking residents frequently and toileting incontinent residents promotes the resident by allowing him/her to retain a sense of dignity despite incontinence issues. Peaking in on a resident is not considered rounding on a resident. You must enter the room and make contact with the resident to see what care or safety needs may be needed.

The Administrator prepared a letter that was hand delivered to all Assisted Living residents and mailed to Assisted Living responsible parties on 10/4/19 stating:

Bradley Creek Health Center is committed to providing excellent patient care in the safest possible environment. Your assistance is needed to ensure we maintain a safe environment.
Assistive devices such as bedrails, raised toilet seats, beside commodes, wheelchairs, rollators and walkers must be checked by facility staff and approved to ensure their safety before resident use.
If you are considering bringing your loved one of the above mentioned items, please speak to the administrative team for guidance and approval before delivering to the resident.

The Residency Letter of Agreement and Resident Handbook were both updated on 10/4/19 to include the following statement:

Assistive devices including but not limited

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D 270	Continued From page 13 10/02/19 at 1:13 PM she stated Resident #1 was still out of bed when she administered his nightly Haldol between 8:45 PM and 9:00 PM on 09/30/19. During an interview with Agency NA #1 on 10/02/19 at 3:01 PM, she stated a couple of hours after initially checking on Resident #1, she and the NA she was working with used a lift to place the resident in bed. (Camera footage revealed the two NAs were in Resident #1's room between 10:03 PM and 10:20 PM). NA #1 commented Resident #1 appeared to have calmed down some by the time he was put to bed. She reported Resident #1 had no clean pajama bottoms so she put him in an over-sized T-shirt and left him in his brief. During an interview with Facility Nurse #1 on 10/02/19 at 1:13 PM she stated she checked on Resident #1 twice after administering his Haldol. (Camera footage revealed Nurse #1 entered the resident's room at 12:03 AM and 1:20 AM, staying 1 - 2 minutes both times). Nurse #1 reported the first time she entered the room the resident seemed to be resting well or was asleep. She commented the second time the resident seemed a little restless, and she noted movement of his legs and feet. During an interview with Agency NA #1 on 10/02/19 at 3:01 PM, she stated she responded to a call light in Resident #1's room around 2:00 AM (camera footage revealed NA #1 was in the resident's room between 1:31 AM and 1:43 AM). She reported she found the resident very restless, trying to get out of bed, with all his blankets on the floor and the resident diagonal in the bed, his feet and ankles hanging off the bed, and "urine everywhere." She commented the	D 270	to bedrails, raised toilet seats, beside commodes, wheelchairs, rollators and walkers are not permitted without prior approval. The AL Area Director or designee will complete A Device and Bedrail Review UDA upon admission, quarterly and with significant change in resident's condition. The Maintenance Director will monitor weekly for any new devices x 8 weeks then monthly x 2 months to ensure that all enabler devices in use have been inspected and approved by the facility meeting established safety standards. D 270 Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Monitor for devices, bed rails or grab bars. The monitoring will review weekly x 8 week's then monthly x 3 months bed rails to monitor for safety, risk, MD orders, consent, and care planning. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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resident had ripped his brief off, and his right arm was out of his T-shirt. She stated she asked the resident what was wrong, and he replied he was cold. The NA asked him why he was taking clothes off if he was cold, and the resident stated, "I did what I thought I was supposed to do." She reported she provided incontinent care, and "tucked" the resident back in bed. She stated she raised the bed to a working height when she provided care, but placed it back in the lowest position when she left the room. She also commented bilateral assist bars were up when she left the room, and the resident seemed to have calmed down a lot. According to NA #1, it was a hectic night with another resident on her assignment trying to exit the unit and setting off alarms, and working with the other NA to check and/or change residents on both their assignments. Therefore, she reported that she did not have a chance to inform Facility Nurse #1 about Resident #1's agitation and apparent attempt to get out of bed unassisted which she witnessed at 1:31 AM on 10/01/19. She stated at approximately 4:45 AM on 10/01/19 she began her last round, but it was after 6:00 AM by the time she got to Resident #1's room. (Camera footage revealed NA #1 entered Resident #1's room at 6:42 AM). She reported she found Resident #1 off the right side of the bed with his upper extremity still in the bed but his legs and feet off the bed and on the floor. She commented the resident was on his left side with his neck hyperextended and his head cocked up to the side in an unnatural position. NA #1 stated although the resident definitely appeared to be dead, she checked for pulse (and there was none), did an external rub, and called the resident's name with no response. She commented the resident's head was "so wedged into the side rail" that it was difficult for the

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nursing staff to remove it. She reported risk management asked her to recreate the way in which she found the resident which took 3 - 5 minutes, and her neck was hurting after that short of a time period. According to NA #1, part of the resident's chin was over the top of the side rail and part was just under the top of the side rail because of the unnatural position of the resident's head and neck. She stated there was purple bruising on the resident's chin, under his chin, and around his Adam's apple (which was confirmed from viewing post mortem pictures). The NA reported she went in search of Facility Nurse #1 after she determined the resident was non-responsive and without a pulse.

During an interview with Facility Nurse #1 on 10/02/19 at 1:13 PM she stated when she entered Resident #1's room (determined to be at 6:50 AM per camera footage) on 10/01/19 the bed was in the low position, the bilateral assist bars were up, and the resident's bilateral lower extremities were off the bed and onto the floor. She commented the resident had apparently scooted down in the bed because his head and neck were down near the level of the assist bars. She reported the resident was off the right side of the bed, his neck was hyperextended with the resident on his left side. Nurse #1 positioned herself in the the resident's bed as she found him on 10/01/19, originally with the bottom of her chin resting on the top of the right assist bar, but then adjusting herself so that only part of her chin was over the top of the bar.

At 10:47 AM on 10/02/19 Resident #1's room was observed, reported by the Director of Nursing (DON) to be untouched since the resident's death. The resident had a low air loss mattress on his bed, and bilateral assist bars were up and

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flush against the mattress. The assist bars were installed per manufacturer's guidelines and illustrations. The assist bars extended approximately 14 inches above the beginning of their base which was level with the bottom of the mattress. The assist bars became wider as they extended upward with their width ranging from approximately 5 inches to approximately 8 1/2 inches. The head of the bed was elevated by about 20 degrees.

During an interview with the Administrator on 01/03/19 at 12:50 PM she stated that it was appropriate to use assist bars if a resident could use them to position themselves and steady themselves during care. However, she reported assist bars should not have been put back up on Resident #1's bed after he was found in an agitated state at 1:31 AM on 10/01/19. She commented it was not acceptable that there was no order, consent, or assessments for Resident #1's assist bars. She also stated that NA #1 should have notified Facility Nurse #1 after she found Resident #1 in an agitated state at 1:31 AM on 10/01/19, giving the nurse the chance to assess the cause of the resident's agitation and determining an intervention to lessen that agitation. According to the Administrator, five hours should not have elapsed between Resident #1 being checked on by staff members (between 1:43 AM and 6:42 AM on 10/01/19), especially with his cardex and service plans documenting he was to be checked every two hours.

During a telephone interview with Resident #1's primary physician on 10/03/19 at 3:57 PM she stated assist bars were acceptable when they could be used by residents for positioning and mobility. She reported Resident #1's assist bars were enablers, not restraints, and she had never

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witnessed such an outcome related to enablers before. She commented after reviewing re-enactment photos it appeared Resident #1 slid down in bed, and threw his legs over the bed, apparently attempting to get out of bed. According to the physician, Resident #1 was very weak and had a physical decline warranting hospice services. She stated device assessments were important to determine if devices were warranted for specific residents based on a risk versus benefit rationale. The physician reported, per the coroner, the preliminary primary cause of death to be documented on the resident's death certificate was positional asphyxiation.

During a 10/03/19 4:17 PM telephone interview with Physician Assistant (PA) #1, who cared for Resident #1, she stated hospice services were initiated for the resident because of progression of his congestive heart failure (CHF), increasing weakness exacerbated by a couple of bouts of pneumonia, trouble swallowing, increased agitation, and a slower cognitive decline. She reported she thought the resident's assist bars were being utilized as a fall intervention, to help keep the resident from rolling out of the bed and discouraging him from getting out of the bed unassisted. She commented she was unsure if the resident could still use the assist bars for positioning in the bed. According to PA #1, she stated it was important to assess devices such as assist bars at least quarterly to make sure they were still appropriate, and she though the facility was doing such. She reported Resident #1 had rolled out of bed and had several falls related to getting up unassisted prior to 10/01/19. She reported the resident could no longer use his urinal, and he needed to have incontinent checks every couple of hours due to ongoing problems

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D 270	Continued From page 18 with yeast in his groin area. The Administrator, Director of Nursing, Regional Director for Senior Living, and Quality Assurance Nurse Consultant were notified of a Type A1 Violation on 10/04/19 at 10:27 AM. On 10/04/19 at 3:00 PM the facility provided an acceptable credible allegation for abating the Type A1 Violation that included the following: Resident #1 had grab bars present on his bed for bed boundaries due to macular degeneration and to assist him with turning from side to side. There was not an assessment, physician order, or consent noted in the chart for the grab bars. On 10/01/2019, the resident was cared for by NA #1 at 1:43 AM and incontinence care was given. During this time the resident was noted with an episode of agitation. After care was provided, the resident was positioned in the middle of the bed and was without agitation. Staff did not reenter the room again until 6:42 AM. At 6:42 AM the resident was noted by NA #1 with part of his chin above the top of the grab bar. Resident was non-responsive and without a pulse. Per the medical examiner, the preliminary primary cause of death is positional asphyxiation. Residents residing in the Assisted Living Community that utilize grab bars or bed rails have the potential to be affected by the alleged non-compliance. On 10/01/2019 the RN Clinical Managers completed Device and Bed Rail Evaluation Forms on all current residents using bed rails or grab bars or other devices. This was accomplished by going into every resident's room and determining what type of bed rails or grab bar, or device was	D 270		

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D 270	Continued From page 19 being used. Once a bed rail or grab bar or device was determined to be attached or adjacent to the resident's body it was evaluated by the RN Clinical Manager to identify if it restricted the patient's freedom of movement or normal access to the patient's body, determined if the patient could use the bed rail or grab bar, or if it the device presented as a restraint and/or hazard to the patient. Bed rails or grab bars or device that were considered a restraint were then reviewed for medical necessity by the evaluating clinical team. If the bed rail or grab bar or device was identified as a restraint and not medically indicated a reduction plan was established by the care planning team. If it presented as a risk for injury to the resident a reduction plan was established by the care planning team. This review was completed by 10/01/2019. No bed rails or grab bars were identified as a restraint. 13 out of 25 bed rails/grab bars were identified as not utilized by the resident or not meeting FDA specifications and were discontinued. No other devices were identified. This was completed on 10/02/2019. Patients that utilize bed rails or grab bars or device were assessed by the Director of Nursing and support nurse for injuries such as skin tears or bruises. This was completed on 10/01/2019. No injuries or bruises were identified related to bed rail/grab bar use. Patients who did not have a previously signed consent for bed rails or grab bars were contacted or their R/P's (for those patients unable to consent) and were educated on the risk of utilizing a bed rail or grab bar and consent was obtained to utilize the device. This was completed by the Clinical RN's by 10/01/2019. Patients who utilize a bed rail or grab bar had	D 270		

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their MD contacted or Medical Director to receive an order for the bed rail or grab bar in use. This was completed by the Clinical RN's on 10/01/2019.

Patients who utilize a bed rail or grab bar had their service plan updated to include the use of the grab bar or bed rail device. This was completed by the Nurse Consultant on 10/01/2019.

The action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring.

On 10/01/2019, the Clinical Nurse Consultant in-serviced all nurses managers (Director of Nursing, ALF unit director, support nurse and MDS nurse on restraints. Topics included:

Many devices can be a restraint for a patient. For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move. Other examples include: bed rails, grab bars, geri-chair, or broda chair.

Device and bed rail evaluation User Defined Assessments must be completed on all patients on admission, readmission, every 3 months and with significant changes in condition. The device evaluation is used to assess the device or bed rail/grab bar in use for the potential of it being a restraint or having risk for injury to the patient.

Additionally any time a resident has a fall or injury where a device or bed rail/grab bar was utilized the device must be evaluated to ensure that it does not pose a hazard to the patient.

The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint. If the device is

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considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. Reduction plans should be reviewed every week during the daily clinical meeting to ensure that the restraint is being reduced. This must continue until the restraint is discontinued.

If a bed rail or grab bar is utilized then an MD order must be obtained for the use of the bed rail or grab bar and consent must be obtained from the patient or R/P using form MP5476.

If a restraint is utilized then an MD order must be obtained for the use of the restraint and consent must be obtained from the patient or R/P using the BRIGGS form for restraint consent.

Definition of a restraint was discussed.

On 10/01/2019 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA, MT both full time and part time regarding the use of devices and bed rails or grab bars. The Director of Nursing will ensure that any employee who has not received this training by 10/01/2019 will not be allowed to work until the training is completed. Training will also be provided for all agency nurses and CNA's prior to beginning work at the facility. As of 10/02/2019 approximately 75 % of employees have received this training.

This in-service included the following topics:

There are lots of reason why we should not use a restraint. Studies have shown that restraints do not prevent falls and can actually cause harm to a patient. This harm can include fractures, skin injuries, or even death by strangulation. The survey guidelines that regulate nursing facilities also include regulations that protect the resident's right against being

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restrained.

Restraints can include a physical restraint or chemical restraint (medications). For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move.

Definition and types of restraints

If you notice a patient with a change in condition such as decline in ability to use the bed rail or grab bar, new confusion or agitation, or new injury from the device then you must notify the hall nurse or nurse manager.

If a patient uses one of these devices we need to ensure that the device is not a hazard for the patient. If you notice the patient throwing their legs over the side rails or gerichair or trying to get up from a gerichair or around a side rail, notify the charge nurse immediately. The charge nurse should ensure that the nurse manager is notified. The nurse manager will need to complete a device or bed rail evaluation to ensure that the device is still medically necessary or they will need to make efforts to remove the device.

As you can see there are very few situations where restraints should be used.

In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include active listening, provide reassurance, provide activities, modify the environment, find other outlets for the patient and check yourself ensuring your approach is calm and reassuring.

Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient's service plan or care plan will include interventions that should be used to try to calm the patient.

The physician should also be notified so that

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medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide additional directions, then notify the DON or administrator.

Supervision: In addition to the above interventions, resident dignity is very important. Checking residents frequently and toileting incontinent residents promotes the resident by allowing him/her to retain a sense of dignity despite incontinence issues. Peaking in on a resident is not considered rounding on a resident. You must enter the room and make contact with the resident to see what care or safety needs may be needed

In conclusion: Restraints do not provide safety for our patients and should only be used in extreme emergencies.

Restraints can be both physical and chemical.

Physical restraints may be items not typically thought of as a restraint such as a sheet or chairs.

It depends on how the device is used and why we are using it.

If you are caring for an agitated patient who is trying to get up unassisted please refer to the care plan for interventions to minimize the agitation. If they do not work contact the physician. One on one supervision may also be necessary for patient safety.

Type A1 Violation abatement date: 10/04/19

Validation:

The Type A1 violation was abated on 10/04/19 at 4:10 PM. Validation of the credible allegation for the Type A1 Violation abatement was completed

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as evidenced by interviews with seven nurses and 10 nursing assistants/med techswho received in-servicing about restraints and resident safety. Any staff members not receiving the in-servicing prior to the abatement were not allowed to clock in for work again until receiving the in-servicing. Interviews were also conducted with three nurse managers who received in-servicing on restraints. In addition, the following information was reviewed and verified: device and bed rail reviews for 17 residents, side rail consents completed for 17 residents, updated care plans for 17 residents with assist bars/side rails, mattress and bed rail assessments for 61 residents, and body audits completed for 24 residents.

2. Record review revealed Resident #6 was admitted to the facility on 02/20/17. The resident's documented diagnoses included dementia, hypertension, chronic gout, and convulsions.

Record review revealed Resident #6 had a history of actual falls with the last fall sustained on 05/03/19 without injury.

Resident #6's 07/18/19 Licensed Health Professional Support (LHPS) form documented the resident was pleasantly confused with a history of "intermittent aggression with physical contact made with staff", ambulated with a walker, required assistance to/from the bathroom, and often experienced lethargy.

Resident #6's 09/18/19 Level of Care assessment documented his level of care was 6 on a 1 (lightest care) to 6 (heaviest care) scale.

During initial tour of the facility with the

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D 270	Continued From page 25 Maintenance Director on 10/02/19, beginning at 10:48 AM, a side rail was observed on Resident #6's bed. The Maintenance Director reported he was unaware of the side rail, and it was not a facility-installed device. The Maintenance Director commented he would remove the side rail because it did not meet safety standards. He explained the gap between the rail and the bed was not acceptable and posed safety risks. During a follow-up observation on 10/02/19 at 11:07 AM there was a side rail on the right side of Resident #6's bed which was 13 1/2 inches long and 38 1/2 inches tall. There was a one inch gap between the rail and the mattress. During an interview with the Maintenance Director on 10/03/19 at 8:35 AM he stated through his research he had learned that Resident #6's side rail was installed by his family. He reported he completed his own full audit of side rails/assist bars in the facility on the afternoon of 10/02/19. He explained a second person had been involved in an initial audit of side rails/assist bars in the building on 10/01/19, but he had not had access to that person's data, so that was the reason he did not know about Resident #6's side rail during initial tour of the facility on the morning of 10/02/19. According to the Maintenance Director, he did safety rounds in the building annually in the spring before Life Safety surveys, and at that time he would address devices that did not meet facility safety standards like Resident #6's side rail. He commented family members were supposed to obtain permission before bringing in devices so the devices could be evaluated for safety. The Maintenance Director reported he was not sure if family members had been informed of this policy or not.	D 270		

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D 270	Continued From page 26 During an interview with Facility Nursing Assistant (NA) #1 on 10/04/19 at 10:54 AM she stated Resident #6 was incontinent of bowel and bladder, and was known to attempt unassisted transfers even though staff had educated him that such was not safe. She reported the resident used his side rail when getting in and out of bed. She commented the resident had some balance issues, experienced some confusion, and experienced some random frustration and anger. According to Facility NA #1, she stated she considered Resident #6 to be at risk for falls and to have poor safety awareness because of his history of unassisted transfers, finding the resident with his torso on the bed and his feet thrown off the bed and onto the floor, and the resident's tendency to flop full force into his bed rather than slowly lowering himself down on the bed. During an interview with Med Tech/Facility NA #2 on 10/04/19 at 2:22 PM she stated Resident #6 had dementia, and experienced more confusion in the late afternoons and at night. She reported the resident resisted some care, could get aggressive with staff at night, and needed to be checked on every 30 minutes to hour. She commented she would consider Resident #6 to be at risk for falls because of poor balance, unsteadiness, a history of falls in the facility without injury, and rarely using the call bell lately when he needed assistance. According to Facility NA #2, she thought the resident had a family-installed side rail on his bed for close to a year. During an interview with the Regional Director for Senior Living on 10/04/19 at 2:40 PM she stated currently there was not anything in the admission packet or handbook about family members	D 270		

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having to get facility approval before installing devices. She also reported the facility's device policy addressed facility installation, but not family installation of devices such as assist bars and side rails.

During an interview with the Administrator on 10/04/19 at 3:55 PM she stated family members should have written guidance about devices they wished to install or have installed, and the facility would be developing a policy and information to include in the admission packet once the facility found assist bars/side rails that met facility safety regulations that could be recommended if family members did not want facility-installed assist bars or hospital beds when they felt residents were unsafe when transferring in and out of bed.

3. Record review revealed Resident #5 was admitted to the facility on 01/10/19. The resident's documented diagnoses included history of falls, gout, hypertension, congestive heart failure, diabetes, and chronic pain syndrome.

Record review revealed Resident #5 had a history of actual falls with the last fall sustained on 06/12/19 when the resident slid out of his wheelchair without injury.

Resident #5's 08/11/19 Level of Care assessment documented the resident self-toileted, was alert but had periods of confusion and/or agitation, could be resistant to care, and exhibited inconsistent use of ambulation devices. The assessment also documented the resident's level of care was 4 on a 1 (lightest care) to 6 (heaviest care) scale.

During initial tour of the facility with the Maintenance Director on 10/02/19, beginning at

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D 270	Continued From page 28 10:48 AM, a side rail was observed on Resident #5's bed. The Maintenance Director reported he was unaware of the side rail, and it was not a facility-installed device. The Maintenance Director commented he would remove the side rail because it did not meet safety standards. He explained the gap between the rail and the bed was not acceptable and posed safety risks. During a follow-up observation on 10/02/19 at 11:07 AM there was a side rail on the left side of Resident #5's bed which was 19 inches long and 31 inches tall. There was a four inch gap between the rail and the mattress. The resident stated he used the side rail to help get in and out of bed. He stated a family member installed the rail about two months ago. During an interview with the Maintenance Director on 10/03/19 at 8:35 AM he stated through his research he had learned that Resident #5's side rail was installed by his family. He reported he completed his own full audit of side rails/assist bars in the facility on the afternoon of 10/02/19. He explained a second person had been involved in an initial audit of side rails/assist bars in the building on 10/01/19, but he had not had access to that person's data, so that was the reason he did not know about Resident #6's side rail during initial tour of the facility on the morning of 10/02/19. According to the Maintenance Director, he did safety rounds in the building annually in the spring before Life Safety surveys, and at that time he would address devices that did not meet facility safety standards like Resident #6's side rail. He commented family members were supposed to obtain permission before bringing in devices so the devices could be evaluated for safety. The Maintenance Director reported he was not sure if family members had been	D 270		

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D 270	Continued From page 29 informed of this policy or not. During an interview with Facility Nursing Assistant (NA) #1 on 10/04/19 at 10:54 AM she stated Resident #5 used a side rail to get in and out of bed and to hold onto when transferring into his wheelchair. She reported the resident had good safety awareness and took notice of his surroundings. However, she commented she considered Resident #5 to be at risk for falls due to significant weakness in his lower extremities. According to Facility NA #1, the resident used his call bell, and was vocal about needing assistance. She reported the resident was mostly continent of bowel and bladder with occasional incontinent episodes. During an interview with Med Tech/Facility NA #2 on 10/04/19 at 2:22 PM she stated Resident #5 was alert and oriented x 3 most of the time, but occasionally became emotional and refused care. She reported the resident was a one-person staff assist, but tried to do some very challenging tasks on his own. Therefore, she commented she considered him to be at fall risk. Facility NA #2 stated Resident #5 had pretty good balance when transferring as long as he used the side rail to hold onto. She commented she thought the resident's family has installed a bed rail almost six months ago. During an interview with the Regional Director for Senior Living on 10/04/19 at 2:40 PM she stated currently there was not anything in the admission packet or handbook about family members having to get facility approval before installing devices. She also reported the facility's device policy addressed facility installation, but not family installation of devices such as assist bars and side rails.	D 270		

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D 270	Continued From page 30 During an interview with the Administrator on 10/04/19 at 3:55 PM she stated family members should have written guidance about devices they wished to install or have installed, and the facility would be developing a policy and information to include in the admission packet once the facility found assist bars/side rails that met facility safety regulations that could be recommended if family members did not want facility-installed assist bars or hospital beds when they felt residents were unsafe when transferring in and out of bed.	D 270		
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: Based on observation, family interview, staff interviews and record review the facility failed to report a missing ring to the Health Care Personnel Registry Section within 24 hours of staff becoming aware of the allegation and failed to report the results of the investigation within five days of the notification for 1 of 3 residents reviewed (Resident #3). Findings included: The facility Abuse Prohibition Policy dated March	D 438	The following is a Plan of Correction for Bradley Creek Health Center. This Plan of Correction is in regards to the Statement of Deficiencies resulting from the complaint survey on October 1st 2019. This plan of Correction is not to be constructed as and admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to	10/11/19

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D 438	Continued From page 31 1, 2000 was reviewed regarding misappropriation of property and stated: "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or misappropriation of resident property, to facility management." Resident #3 was admitted to the facility on 06/24/16 with diagnoses that included Alzheimer's disease and dementia. Review of the Service Plan for Resident #3 revealed she required continuous verbal and tactile cueing redirection and reassurance. She ambulated independently. In an interview with Private Sitter #1 on 10/03/19 at 5:00 PM she stated she had discovered Resident #3 was missing her wedding ring on the Saturday after the hurricane (09/07/19) while giving the resident a shower. She commented she reported to Nurse Aide #3 that the ring was missing and had asked the aide to help her look for it. In an interview with Nurse Aide #3 on 10/04/19 at 11:00 she reported she had helped Private Aide #1 look for the ring that belonged to Resident #3. She stated they searched the resident's room but did not find the missing ring. She said she did not report the missing jewelry to administration. She commented she had an abuse in-service a couple of months prior to this incident and realized she should have reported to the Nursing Supervisor or someone in administration that the ring was missing on 09/07/19 but had not. The facility sent an Initial Allegation Report to the	D 438	comply with statutory and regulatory requirements. In this plan, we have outlined specific actions in response to identified issues. D 438 Corrective Action for Affected Resident Resident #3 was reported to have a missing wedding ring on 9/7/19. The facility Administrator began an investigation on 9/10/19, the day Administrator was made aware of the missing item. The investigation was turned over to the local police department. The investigation is ongoing. D 438 Corrective Action for Potentially Affected Residents Residents residing in the Assisted Living Community that have personal property have the potential to be affected by the alleged non-compliance. All staff were in-serviced beginning on 10/4/2019 and completed on 10/9/2019. In-service education was presented on the grievance policy – specifically on how to handle reports of abuse, neglect and misappropriation of resident property. Employees were educated that they must report complaints and suspicions immediately to their supervisor for investigation. On 10/11/2019 audits began on all residents that have potential to be affected. The Social worker or designee will monitor using the Abuse Quality Assurance tool for monitoring abuse and care concerns. The monitoring will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0649	A. BUILDING: _____ B. WING _____	C 10/04/2019

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D 438	Continued From page 32 State for the misappropriation of Resident #3's property on 09/10/19 at 4:35 PM. On 09/20/19 the facility sent an Investigation Report substantiating the allegation to the State of North Carolina, 10 days after the initial report. In an interview with the facility Administrator on 10/03/19 at 12:45 PM she stated an initial report of resident property misappropriation was to be made to the State within 24 hours of gaining knowledge of the event (except when it occurred on a weekend then a report was filed on the following Monday) and an Investigation Report was to be sent within five days following the initial report. She did not know why the Investigation Report for the misappropriation of Resident #3's property had not been sent to the State until ten days after the Initial Report. She commented she learned of the missing jewelry on 09/10/19 when a family member reported it to the receptionist. She did not know why staff who had knowledge of the missing item prior to 09/10/19 had not reported it sooner. She stated staff were trained to report any misappropriation of resident property immediately. She provided an audit of video surveillance she had reviewed during the investigation showing the ring went missing from Resident #3's hand on 09/05/19. The survey team met with a family member of Resident #3 on 10/03/19 at 10:25 AM who provided pictures and conversation regarding the missing jewelry. She stated she became aware of the missing ring when the private sitter texted her on 10/07/19. An observation of Resident #3 on 10/02/19 at 3:30 PM revealed she was walking independently in the hallway near her room. She was not	D 438	include reviewing 6 residents for concerns of abuse, neglect or misappropriation of property. This will be completed weekly on 6 different residents times 2 weeks then monthly times 3 months or until resolved by the Quality Assurance Committee. Alert and Oriented residents are interviewed regarding abuse, neglect and misappropriation prevention. Any concerns that the resident voices or the exhibiting behaviors such as tearfulness, withdrawal, bruises or injuries of unknown origin will be immediately communicated to the Administrator or DON. Non-interviewable residents will have family/responsible party interviews for abuse, neglect and misappropriation prevention. Any concerns that the auditor notes will be immediately communicated to the Administrator or DON. D 438 Systematic Changes Facility staff will take immediate action on claims of abuse, neglect or misappropriation received upon receipt. Administrator will conduct 24-hour reports of initial claim and timely 5-day working reports of investigating findings. The administrator will notify the regional consultant of all reports and forward a copy for her review. Regional consultant will audit timeliness of reporting.	

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D 438	Continued From page 33 wearing any rings on either hand. Attempting to converse with Resident #3, she answered the word "no" to every greeting and inquiry.	D 438		