STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

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D 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation on February 18, 2015, February 19, 2015 and February 20, 2015.	D 000		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Infomation on Home and Resident Register (a) An adult care home administrator or administrator-in-charge shall furnish and review with the resident or responsible person information on the home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the home. The information shall include the following: (1) the resident contract to which the following applies: (A) the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet pursuant to G.S. 131D-2(a1)(4); (C) the contract shall be signed and dated by the administrator or administrator-in-charge and the resident or responsible person, a copy given to the resident or responsible person and a copy kept in the resident's record; (D) the resident or responsible person shall be notified as soon as any change is known, but not less than 30 days before the change for rate	D 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 243	Continued From page 1	D 243		

changes initiated by the facility, of any changes in the contract and be provided an amended contract or an amendment to the contract for review and signature;
(E) gratuities in addition to the established rates shall not be accepted; and
(F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly.
Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure action was taken to correctly charge the room rental rate for 1 of 1 sampled residents (Resident #6) as related to State-County Special Assistance.

The findings are:

Review of Resident #6's record on 2/18/15 revealed:
-She was admitted to the facility on 4/1/11.
-Resident #6 had a Power of Attorney (POA) managing her financial affairs.
-She qualified for Medicaid in September 2011 (Medicaid is funding for medical and health-related services).
-The facility began receiving State-County Special Assistance (SA) funding in September 2011 (SA funding provides a cash supplement to pay for room and board for individuals in assisted living

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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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D 243	Continued From page 2	D 243		

facilities).
-There were copies of Resident #6's Medicaid cards going back to September 2011.
-Resident #6 was approved for Veteran Affairs Aid and Attendance (VA AA) funding on 1/10/12 (VA AA funding is a pension benefit for veterans or survivors who require the aid and attendance of another person).

Review of the admissions contract dated 4/1/11 revealed:
-There was an established rate of $1,900 per month.
-The POA had signed the contract.

Review of the Resident Roster provided by the facility at entrance on 2/18/15 at 10:45am revealed:
-Roster was two pages, one page listed all private pay residents and one page listed all residents receiving Medicaid.
-Resident #6 was listed as private pay.

Phone interview with Henderson County Department of Social Services (DSS) Medicaid Income Maintenance Case Manager (IMC) on 2/19/15 at 9:36am revealed per eligibility rules VA Aid and Attendance was not to be counted as personal income.

Review of the North Carolina Department of Health and Human Services Integrated Eligibility Manual AL 2014-01 on 2/19/15 revealed:
-The manual is used to verify personal and financial information to establish or maintain eligibility.
-Per the manual, VA Aid and Attendance was not to be counted as personal income.

Review of Resident #6's Henderson County DSS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

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D 243	Continued From page 3 Medicaid record on 2/19/15 revealed: -Resident #6 SA funding became "effective on 9/1/11". -Resident #6's POA had called the Income Maintenance Case Manager on 12/3/2014 indicating the facility "was going up on their rates and he could not afford to pay over $2,000 monthly for her (Resident #6) care." -IMC informed the POA facility was only to be paid $1182 for room rental, the amount of Resident #6's social security income and SA benefits. -"Client gets VA Aid and Attendance. This is not a countable income for Medicaid." -A Complaint Intake Report dated 2/5/15 indicated "Facility has charged (Resident #6) a private rate on top of the SA rate". "The facility had this brought to their attention that this is fraudulent". "The facility has been unwilling to reimburse Resident #6 approximately $20K that was overcharged". Review on 2/19/15 of financial records Resident #6's POA had given to Henderson County DSS revealed: -The facility had provided the POA with monthly statements from 4/1/11 to 11/17/14. -POA had met with the Executive Director of the facility 2/12/15 and the Executive Director told POA "The aide and attendance income wouldn't allow Resident #6 to qualify for Medicaid". -POA had reported "the facility didn't cash December's (2014) check and POA didn't receive a statement (bill) for December 2014 or January 2015 after it was brought to the facilities attention Resident #6 is receiving Medicaid SA benefits". -A letter from the facility to the POA dated 4/22/13 indicating the room rental rate would increase from $1,957 to $2,054.85 on 6/1/13. -A letter from the facility to the POA dated 3/13/12	D 243		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 243	Continued From page 4 indicating the room rental rate would increase from $1,900 to $1,957 on 5/1/12. Interview with the Executive Director on 2/18/15 at 11:00am revealed: -The facility's previous office manager had informed him she had spoken with "someone at DSS and VA AA counted as income". -Up until November 2014 it was his understanding Resident #6 was private pay. -"In good faith the facility has not charged the family since November" until this issue is resolved. -"There has been no intent to fraud anyone, it is confusion."	D 243		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure 2 of 3 sampled residents were administered their Humalog sliding scale insulin medication as ordered by the physician (Residents #5 and #7). The findings are: A. Review of Resident #5's current FL2 dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

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D 358	Continued From page 5 2/9/15 revealed: -Diagnoses including insulin dependent type 2 diabetes, chronic kidney disease, cerebrovascular disease (status post stroke), anemia and coronary artery disease. -No concentrated sweets (NCS), low salt and low fat diet. Further review of Resident #5's current FL2 revealed orders for: -Humalog insulin 17 units before breakfast and lunch (Humalog is a fast-acting insulin used to treat diabetes). -Humalog insulin 28 units after supper. -Humalog insulin sliding scale before meals as follows: 151-200 = 2 units. 201-250 = 4 units. 251-300 = 6 units. 301-350 = 8 units 351-400 = 10 units. -Humalog insulin sliding scale at bedtime as follows: 151-200 = 0 units. 201-250 = 2 units. 251-300 = 4 units. 301-350 = 6 units 351-400 = 8 units. Review of Resident #5's FL2 dated 12/22/14 revealed orders for: -Humalog insulin 17 units before breakfast and lunch. -Humalog insulin 26 units after supper. -Humalog insulin sliding scale before meals as follows: 151-200 = 2 units. 201-250 = 4 units. 251-300 = 6 units. 301-350 = 8 units	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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D 358	Continued From page 6 351-400 = 10 units. -Humalog insulin sliding scale at bedtime as follows: 151-200 = 0 units. 201-250 = 2 units. 251-300 = 4 units. 301-350 = 6 units 351-400 = 8 units. Review of Resident #5's record revealed a physician's order dated 1/7/15 to increase the after supper Humalog insulin from 26 to 28 units. Observation of Staff D, MA, during the noon medication pass on 2/18/15 from 11:18am until 11:25am revealed: -At 11:18am, Staff D correctly performed finger stick blood sugar (FSBS) testing for Resident #5. -Resident #5's FSBS was 396. -At 11:25am, Staff D was observed to administer Humalog insulin 8 units to Resident #5 in her left abdomen using appropriate technique. Interview with Staff D, MA, on 2/19/15 at 9:20am revealed: -Resident #5's blood sugar "usually doesn't run that high." -Staff D stated when she had looked at the insulin sliding scale for the resident she had mistakenly looked at the 301-350 range dose which was 8 units, when the resident per the scale should have received 10 units of insulin. -Staff D stated the resident had received the correct dose of scheduled Humalog 17 units after lunch and so the resident's FSBS had been 144 at the 4:30pm check on 2/18/15. -She stated the documented FSBS for the resident on 2/18/15 at 8:00pm was 133. Review of Resident #5's Medication	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 7 Administration Record (MAR) and blood sugar readings documentation for December 2014 beginning from the FL2 dated 12/22/14 revealed: -Resident #5 was out of the facility from dinner time on 12/24/14 and returned by the lunch meal time on 12/29/14. -FSBS range from 72-257. -Humalog insulin sliding scale was documented as administered correctly for 4 out of 6 opportunities. -Computer generated sliding scales on the MAR coincided with the physician's orders. -The bedtime sliding scale parameters were located on the MAR directly below the mealtime sliding scale parameters. Review of Resident #5's MAR and blood sugar readings documentation for January 2015 revealed: -FSBS range from 50-458. -Humalog insulin sliding scale was documented as administered correctly for 49 out of 64 opportunities. -Computer generated sliding scales on the MAR coincided with the physician's orders. -The bedtime sliding scale parameters were located on the MAR directly below the mealtime sliding scale parameters. Review of Resident #5's MAR and blood sugar readings documentation for February 2015 revealed: -FSBS range from 62-526. -Humalog insulin sliding scale was documented as administered correctly for 25 out of 36 opportunities. -Hand-written sliding scales on the MAR coincided with the physician's orders. Telephone interview with 2nd shift MA on 2/20/15	D 358		

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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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D 358	Continued From page 8 was unsuccessful prior to exit. Phone interview with facility's FNP for Resident #5 on 2/20/15 at 12:10pm revealed: -Resident #5 saw an endocrinologist for her sliding scale insulin. -"We follow what they tell us." Phone interview with nurse at endocrinologist's office on 2/20/15 at 2:12pm revealed: -"It is worse to give too much than too little" sliding scale insulin. -"Two less units are not detrimental." -The sliding scale errors "have not been detrimental" to Resident #5, but "could be if it continues." -It is important for the facility to provide close oversight of Resident #5's diabetic care. Refer to Interview with RCC on 2/20/15 at 3:30pm. Refer to interview with the Executive Director (ED) on 2/20/15 at 4:45pm. B. Review of Resident #7's current FL2 dated 11/26/14 revealed: -Diagnoses including renal stone status post fracture of stones, urinary tract infection (UTI). -No concentrated sweets (NCS) therapeutic diet. Review of Resident #7's medication physician's orders dated 12/9/14 revealed: -Humalog insulin sliding scale before meals as follows: 151-200 = 2 units. 201-250 = 4 units. 251-300 = 6 units. 301-350 = 8 units 351-400 = 10 units.	D 358		

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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 9 Greater than 400 call the doctor. -Humalog insulin sliding scale 30 minutes before bedtime as follows: 150 and below = 0 units. 151-199 = 0 units. 200-249 = 1 units. 250-299 = 2 units. 300-349 = 3 units 350 and above = 4 units. Review of Resident #7's MAR and blood sugar readings documentation for December 2014 revealed: -FSBS range from 102-447. -Humalog insulin sliding scale was documented as administered correctly for 66 out of 78 opportunities. -Hand-written sliding scales on the MAR coincided with the physician's orders. -The bedtime sliding scale parameters were located on the MAR directly below the mealtime sliding scale parameters. Review of Resident #7's MAR and blood sugar readings documentation for January 2015 revealed: -FSBS range from 78-384. -Humalog insulin sliding scale was documented as administered correctly for 59 out of 61 opportunities. -Computer generated sliding scales on the MAR coincided with the physician's orders. -The bedtime sliding scale parameters were located on the MAR directly below the mealtime sliding scale parameters. Review of Resident #7's MAR and blood sugar readings documentation for February 2015 revealed: -FSBS range from 90-436.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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D 358	Continued From page 10 -Humalog insulin sliding scale was documented as administered correctly for 91 out of 100 opportunities. -Computer generated sliding scales on the MAR coincided with the physician's orders. -The bedtime sliding scale parameters were located on the MAR directly below the mealtime sliding scale parameters. Telephone interview with 2nd shift MA on 2/20/15 was unsuccessful prior to exit. Interview with Resident #7's Primary Care Provider on 2/20/15 at 4:27pm revealed: -The facility staff were good to inform her of high and low blood sugar readings for Resident #7 to get information and how to best care for the resident under these circumstances. -When made aware of the sliding scale insulin errors that had occurred for the resident from December 2014 to February 2015, she stated since the resident did not experience extreme highs or lows as a result of the occurrences of incorrect dosing she did not feel the errors were detrimental to the residents' health. -She stated in some cases the resident receiving a higher bedtime dose of insulin actually helped to keep the blood sugar within a more normal range. -She stated she would look at Resident #7's bedtime sliding scale the next time she was in the facility and see if the resident needed an increase in the bedtime scale. Refer to Interview with RCC on 2/20/15 at 3:30pm. Refer to interview with the Executive Director (ED) on 2/20/15 at 4:45pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

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D 358	Continued From page 11 Interview with RCC on 2/20/15 at 3:30pm revealed: -The facility's FNP reviews the sliding scale readings. -The RCC checks glucometer readings to assure they match MAR documentation. -There is "no one checking" the sliding scale insulin scale as related to number of insulin units administered. Interview with the Executive Director on 2/20/15 at 4:45pm revealed: -The Medication Aides were responsible for ensuring the correct insulin dosages before administering the medication to residents. -The RCC would be responsible for "spot checking" MAR's randomly to make sure the Medication Aides were administering sliding scale insulin correctly.	D 358		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

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D 485	Continued From page 12	D 485		

than the resident's physician, the facility shall notify the resident's physician of the order within seven days.
(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.
(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.
(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.
(6) The restraint order shall be kept in the resident's record.

This Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to assure 2 of 2 sampled residents with orders for restraints (Resident #2 and #4) were checked every 30 minutes and released every 2 hours and at mealtimes as ordered by the physician.

The findings are:

A. Review of Resident #2's current FL2 dated 8/5/14 revealed:
-Diagnoses included: dementia, psychosis, anxiety, and chronic renal insufficiency.
-Resident was documented as constantly disoriented, semi-ambulatory, and incontinent of bladder and bowel.

Review of Resident #2's Care Plan dated 1/4/15 revealed:
-The resident was totally dependent upon staff for

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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 485	Continued From page 13	D 485		

toileting, ambulation/locomotion, bathing, grooming/personal hygiene, and transferring.
-The resident "suffers from severe dementia."

Review of Resident #2's restraint order dated 2/11/14 revealed:
-The medical reason for restraints was for fall risk.
-Type of restraint to be used was a wheelchair safety belt.
-Time period for restraints was 99 months.
-Time intervals the restraint must be checked was every 30 minutes.
-The restraint was to be removed every 2 hours.
-The restraint was to be released at meal times.
-The restraint was to be recertified every 30 days.
-The order was signed by the resident's primary care provider (PCP).

Record review revealed Resident #2's restraint of wheelchair safety belt use had been recertified by the physician on the following dates 3/4/14, 5/4/14, 6/4/14, 7/4/14, 8/7/14, 9/19/14, 9/30/14, 11/18/14, and 12/20/14.

Review of Resident #2' current restraint order dated 1/18/15 revealed:
-Recertification for wheelchair safety belt.
-The restraint was to be checked every 30 minutes and released every 2 hours.
-The restraint was to be released at mealtimes.
-The order was signed by the resident's PCP.

Continuous observation of Resident #2 in the dining room on 2/20/15 at 8:00am until 8:53am revealed:
-The resident was eating breakfast seated in a wheelchair with the wheelchair safety belt fastened.
-The wheelchair safety belt remained fastened

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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2015

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CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 14 during the entire meal. -At 8:53am, staff assisted resident to the living room in the wheelchair. Observation of Resident #2 on 2/20/15 from 9:00am until 9:42am revealed: -The resident remained seated in the wheelchair with safety belt fastened. -At 9:10am, the resident remained seated in wheelchair safety belt attempting to talk to another resident but was mumbling. -At 9:15am, the resident was observed to pick and pull at safety belt, but could not release it; then tried to push safety belt down around her hips, but was unsuccessful. -At 9:25am, the resident was seated in living room in wheelchair safety belt in place with her head in her hand leaning to the right. The television was on. Staff were in and out of the living room asking other residents to let them take them to the bathroom, however no staff approached Resident #2 since she had been brought to the living room by staff. -At 9:30am, staff member came and took Resident #2 to her room and closed the door. Could hear one staff ask the resident to brush her teeth. A second staff member also in the room was heard encouraging the resident to brush her teeth. -At 9:37am, a third staff member entered the resident's room. -At 9:38am, staff were heard to inform the resident that they were done brushing the resident's teeth. The resident's door opened and one staff wheeled the resident in the wheelchair with safety belt fastened. Interview with Staff A, Medication Aide/Personal Care Aide (MA/PCA), on 2/20/15 at 9:42am revealed:	D 485		

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D 485	Continued From page 15 -Resident #2 had been taken to her room for oral care. -No other care had been provided by staff besides brushing the resident's teeth. Continued observation of Resident #2 from 9:42am until 10:10am revealed: -At 9:43am, the resident remained in the wheelchair with safety belt fastened sitting in front of the television in the living room. -At 9:49am, two personal care staff came to the living room door, but there was no interaction with the resident. -At. 10:02am, the resident remained in the wheelchair with safety belt fastened. -At 10:10am, the resident was given a white bowl containing fruit for snack. Resident ate fruit with fingers. Remained seated in the wheelchair with safety belt fastened. Refer to confidential interviews with five direct care staff during the survey. Refer to interview with the Resident Care Coordinator (RCC) on 2/20/15 at 11:45am. Refer to interview with the facility Licensed Health Professional Support (LHPS) Nurse Consultant on 2/20/15 at 12:10pm. Refer to interview with the RCC on 2/20/15 at 2:15pm. Refer to interview with the Executive Director on 2/20/15 at 4:45pm. B. Review of Resident #4's current FL2 dated 12/24/14 revealed: -Diagnoses included dementia, hypertension, degenerative joint disease with chronic back pain,	D 485		

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D 485	Continued From page 16	D 485		

transient with psychotic features, history of diverticulitis, and dysphagia.
-Resident was documented as intermittently disoriented, non-ambulatory, and incontinent of bladder and bowel.

Review of Resident #4's Care Plan dated 2/2/15 revealed the resident was totally dependent upon staff for toileting, ambulation/locomotion, bathing, grooming/personal hygiene, and transferring.

Review of Resident #4's restraint order dated 2/25/14 revealed:
-The medical reason for restraints was for fall risk.
-Type of restraint to be used was a wheelchair safety belt.
-Time period for restraints was 99 months.
-Time intervals the restraint must be checked was every 30 minutes.
-The restraint was to be removed every 2 hours.
-The restraint was to be released at meal times.
-The restraint was to be recertified every 30 days.
-The order was signed by the resident's primary care provider (PCP).

Observation of Resident #4 in the dining room during breakfast on 2/20/15 from 8:00am until 8:25am revealed the wheelchair safety belt remained fastened during the entire meal.

Refer to confidential interviews with five direct care staff during the survey.

Refer to interview with the Resident Care Coordinator (RCC) on 2/20/15 at 11:45am.

Refer to interview with the facility Licensed Health Professional Support (LHPS) Nurse Consultant on 2/20/15 at 12:10pm.

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D 485	Continued From page 17 Refer to interview with the RCC on 2/20/15 at 2:15pm. Refer to interview with the Executive Director on 2/20/15 at 4:45pm. _____ Confidential interviews with five direct care staff during the survey revealed: -There were currently four residents in the facility who had orders for restraints. -Intervals for restraint checks and releases were documented in the Medication Administration Record (MAR) for each resident who had an order for restraints. -2 of 4 staff interviewed who worked on shifts during mealtimes knew to release restrained residents during mealtimes. -2 of 5 staff interviewed knew to check restrained residents at least every 30 minutes to ensure the restraints were applied correctly and were not getting to tight. -5 of 5 staff interviewed stated restrained residents were released every 2 hours for toileting or incontinent care. -5 of 5 staff interviewed denied any current skin problems for Resident #2 and #4. -One staff stated the restraints had to be taken off restrained residents for "an hour a shift." -The one hour release "usually" occurred after lunch when staff provided toileting or incontinent care to the restrained resident and then laid them down for a nap. -A second staff stated they would release restrained residents "every hour when she walked by them." She would stand them up or reposition them, and toilet them or provide incontinent care if needed. The staff was very conscientious about releasing restrained residents, because the staff	D 485		

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D 485	Continued From page 18	D 485		

stated they wouldn't want to have to remain seated for 2 to 3 hours without moving because it made your bottom "hurt" and get "sweaty."
-When checking restraints, the staff stated they would place a hand through the restraint to make sure it was not too tight.
-"Can have fluid build up" making a restraint get to tight over time.
-"Restraints are used to keep residents safe, not to tie them down."
-A third staff stated they were trained to check restrained residents for skin tears and other changes in their skin.

Interview with the Resident Care Coordinator (RCC) on 2/20/15 at 11:45am revealed the facility policy on restraints was a copy of the state regulation that care staff were required to sign.

Interview with the facility Licensed Health Professional Support (LHPS) Nurse Consultant on 2/20/15 at 12:10pm revealed:
-She was responsible for restraint training in the facility.
-Restraint training was included on the initial LHPS checkoff for each type of restraint with all care staff before the staff were allowed to work with residents.
-"We printed out the state regulation [concerning restraints] and had every employee sign it."
-Restraint training included: types of restraints, types of restraints used in the facility, correct application of restraints, releasing restraints every 2 hours and at every meal, checking restraints every 15 to 30 minutes.
-When residents were released staff were taught not to just take the restraint off, but to reposition the resident, walk the resident, and take the resident to the bathroom. "Do something with the resident that moves them."

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D 485	Continued From page 19 -She stated she reminded staff bedrails and medications, could under certain circumstances, be considered restraints. -She went over possible negative outcomes of restraint use with staff. -She required return demonstration of correct application of restraints. Interview with the RCC on 2/20/15 at 2:15pm revealed: -Staff were to release restrained residents every 2 hours and at meal times. -Staff were to check restrained residents every 30 minutes to ensure the restraint was still applied correctly and that it was not too tight. -Staff were trained "when they first come in" by the LHPS Nurse Consultant concerning restraint use. -The facility did not have a written policy on restraints, however the policy was to follow the state regulations on restraint use. Interview with the Executive Director on 2/20/15 at 4:45pm revealed: -All staff had received the proper restraint training, before they were allowed to work with the residents. -Restraint training was renewed annually. -It would be the RCC responsibility to ensure staff were checking residents at least every 30 minutes and releasing restrained residents every 2 hours.	D 485		