STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: _____ B. WING _____	03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing	D 482		

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D 482	Continued From page 1 frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interview and record review, the facility failed to assure an assessment or care planning had been completed prior to the use of a Geri Chair with tray as a restraint for one of one resident. (#6) The findings are: Review of Resident #6's current FL-2 dated 2/3/15 revealed: -Diagnoses included dementia and seizures. -Resident #6 was constantly disoriented. -Resident #6 was non-ambulatory and used a wheelchair. Review of Resident #6's current care plan dated 4/18/14 revealed: -No documentation of an assessment of restraint use for Resident #6. -No documentation of a Geri Chair or restraint use. -Resident #6 had no problems with his upper extremities. -Resident #6 was non-ambulatory and used a wheelchair. -Resident #6 was disoriented and had a significant memory loss.	D 482		

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D 482	Continued From page 2 Review of the facility's restraints' policy (no date) revealed: -The administrator shall assure that each resident with medical symptoms that warrant the use of restraints is assessed and a care plan is developed. -This assessment and care planning shall be completed prior to the resident being restrained, except in emergency situations. -The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible party or legal representative. Review of the physician's order for Resident #6 revealed a Geri Chair was ordered on 12/23/14, but did not include information related to it's use or a tray. Review of a physician's order dated 12/23/14 revealed Geri Chair to replace reclining wheelchair. Review of an incident report for Resident #6 dated 12/21/14 revealed: -Resident fell out of his wheelchair and hit his head on the floor. Observation on 3/17/15 at 10:00 a.m. revealed Resident #6 sitting in his bedroom in a Geri Chair with a tray attached. Interview with Resident #6 on 3/17/15 at 10:00 a.m. revealed he did not know why he was sitting in a Geri Chair with a tray attached. Observation on 3/18/15 at 11:00 a.m. revealed Resident #6 sitting in the dayroom in his Geri	D 482		

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D 482	Continued From page 3 Chair with a tray attached. Observation on 3/18/15 at 12:40 p.m. revealed Resident #6 was sitting in his Geri Chair in dining room with tray attached. Observation on 3/19/15 at 10:30 a.m. revealed: -Resident #6 was lying in his bed. -Half siderails pulled up at the head of the bed. Observation on 3/19/15 at 10:30 a.m. revealed: - Resident #6 was able to grab the half siderail and turned on his right side. -Siderails were used to enhanced the mobility of the resident while in bed. Interview with an Assisted Living (AL) medication aide on 3/18/15 at 4:45 p.m. revealed: -She was aware Resident #6 had a Geri Chair with a tray. -Geri Chair with a tray was used for safety reasons because the resident had seizures. -Resident #6 fell out of his wheelchair over 2 months ago and hit his head. -The wheelchair was replaced with a Geri Chair. Did not know if Resident #6 could remove the tray from the Geri Chair. Interview with a Special Care Unit (SCU) personal care aide on 3/18/15 at 5:10 p.m. revealed: -She was aware Resident #6 had a Geri Chair with a tray. -The Geri Chair with tray was used for safety. Did not know if Resident #6 could remove the tray from the Geri Chair. Interview with the 2nd Special Care Unit (SCU) personal care aide on 3/18/15 at 5:20 p.m. revealed: -She was aware Resident #6 had a Geri Chair	D 482		

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D 482	Continued From page 4 with a tray. - " I put the resident in the Geri Chair with tray top, but no one told me it was used for safety reasons." -The tray was part of the Geri Chair. Did not know if Resident #6 could removed the tray from the Geri Chair. -She had not asked the resident to remove the tray. Interview with the 3rd Special Care Unit (SCU) personal care aide on 3/18/15 at 5:30 p.m. revealed: -He was aware Resident #6 had a Geri Chair with tray. -The Geri Chair with tray top was used for eating. -Resident #6 does not try to get up out of his Geri Chair. Did not know if Resident #6 could remove the tray from the Geri Chair. Telephone interview with Resident #6's Nurse Practitioner (NP) on 3/20/15 at 8:08 a.m. revealed: -Resident #6 had an order dated first week of January 2015 to have a Geri Chair to replace the reclining wheelchair. -Resident #6 fell out of his wheelchair and hit his head on the floor. -This was the reason the wheelchair was replaced by the Geri Chair. -Geri Chair was for safety and comfort and the tray was used for eating and activities. -"I don't think the resident can remove the table top on the Geri Chair." -An assessment should be done on Resident #6's restraint use of tray with Geri Chair because staff did not know if Resident #6 could remove the tray.	D 482		

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D 482	Continued From page 5 Telephone interview with Resident #6's family member on 3/20/15 at 12:19 p.m. revealed: -He was not aware Resident #6 had a Geri Chair with a tray top. -The Staff had not notified him Resident #6 had a Geri Chair with a tray. -Resident #6 probably would not be able to remove the tray. Interview with the Resident Care Coordinator (RCC) on 3/20/15 at 11:30 a.m. revealed: -She was aware Resident #6 had a Geri Chair with a tray. -The purpose of the tray was for eating and activities. -She did not do an assessment pertaining to the use of Geri Chair with tray as a restraint. -She did not think about a Geri Chair with tray as a restraint. -She did not know if Resident #6 could remove the tray. -She was responsible for doing an assessment on restraint use. Observation on 3/20/15 at 11:50 a.m. in resident's room revealed Resident #6 was not able to remove the tray from the Geri Chair. Interview with the Administrator on 3/20/15 at 11:50 a.m. revealed: -She was aware Resident #6's Geri Chair had a tray. - " It did not cross my mind about a tray being a restraint." -The Geri Chair is safer than the wheelchair. -The tray was a part of the Geri Chair. -No assessment had been done on the Geri Chair with a tray. - "I guess nobody thought of it." -Resident #6 can not remove the tray.	D 482		

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D 482	Continued From page 6 -RCC was responsible for doing an assessment on restraint use. Observation on 3/20/15 at 8:10 am of Resident #6 revealed: -The resident was seated in a Geri Chair with the tray attached in the dining room for the breakfast meal. -The resident's Geri Chair was aligned beside a crescent shaped table used for residents with wheelchairs to pull up to the table to eat. -The resident was being fed from a bowl on the Geri Chair's tray by a medication aide (MA)who was seated between the resident and the table. Interview on 3/20/15 at 8:38 a.m. with the 2nd medication aide revealed: -Resident #6 had the Geri Chair since January 2015. -The MA did not know why Resident #6 had a Geri Chair instead of some other type of wheelchair and that Hospice had ordered it for him. Interview with the Hospice nurse on 3/19/15 at 10:30 a.m. revealed the Geri Chair was ordered by Hospice. Interview on 3/20/15 at 9:00 am with the Activity Director revealed: -Resident #6 regularly came to Church and music activities, performance activities, movies, and sometimes had 1:1 time. -The resident was a passive participant in activities; he listened and observed. -The resident did not work on crafts. -The resident never stood or walked and could only stand with assistance. -The resident usually rode around with the tray attached to the Geri Chair.	D 482		

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D 482	Continued From page 7 -The Activity Director did not know if the resident could remove the tray from the chair. Interview on 3/20/15 at 10:30 a.m. with the 4th Special Care Unit (SCU) personal care aide (PCA) revealed: -Resident #6 used a regular wheelchair prior to having the Geri Chair. -The resident was not able to walk unassisted. -The SCU PCA "had no idea why he got a Geri Chair" and "thought the tray was to be used for meals." -"Other staff would remove the tray and push him up to the table for meals, but usually when (this staff) saw him, the tray was in place." -Resident #6 got the chair about 4 months ago, but did not know why the change in wheel chairs or who got the Geri Chair. -The SCU PCA did not think Resident #6 could remove the tray because the release buttons were in the front of the tray. -The SCU PCA 'had always seen the tray attached except when the resident went to the dining room." -Resident #6 "did not fall out of the regular wheelchair, and I did not think he needed to use the chair with the tray." Interview on 3/20/15 at 11:25 am with an assisted living (AL) personal care aide (PCA) revealed: -The AL PCA stated Resident #6 was not ambulatory but could stand and pivot with assistance. -The tray (on the Geri Chair) was to be used for meals. -The Resident's food would be closer to him with the tray as opposed to pushing him up to the table. -The AL PCA did not know why the resident specifically got a Geri Chair, but it was more	D 482		

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D 482	Continued From page 8 comfortable. -"[Resident #6] did not necessarily need the tray except at meals; the resident could feed himself." -"The tray was used to keep [Resident #6] safe." -"If [Resident #6] was not using the tray for eating, it didn't make sense for him to have the tray." -"The way the tray was designed, I don't think he could take it off." The Administrator provided a "Plan of Protection" for residents. Effective 3/20/15 the Geri Chair table tray was discontinued per the Nurse Practitioner. All DME (durable medical equipment) ordered or entering the facility for any resident would be assessed by the Resident Care Coordinitor (RCC) or Administrator to assure attachments or equipment could be used to restrain a resident unless necessary orders, assessments were in place. Additional training will be provided to staff on restraints. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents	D912		

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D912	Continued From page 9 received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to restraint use for residents. The findings are: Based on observations, interview and record review, the facility failed to assure an assessment or care planning had been completed prior to the use of a Geri Chair with tray as a restraint for one of one resident. [Refer to Tag D 482 10 A NCAC 13F .1501(a) (Type B Violation)].	D912		