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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted a complaint investigation on June 24, 2015 and June 25, 2015. The county initiated the complaint investigation on May 8, 2015.	D 000		
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: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 3 of 6 sampled residents (#1, #2, and #3) received supervision in accordance with the resident's needs in the areas of fall prevention and prevention of injury due to unpadded bedrails. The findings are: A. Review of Resident #1's current FL2, dated 9/3/2014 revealed: - Diagnoses included vascular dementia-uncomplicated, unspecified cerebrovascular disease, depressive disorder, encephalopathy unspecified. - Resident #1 was noted to be constantly disoriented, total care, and incontinent of bowel and bladder.	D 270		

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Review of the resident register revealed Resident #1 was admitted to the facility on 10/8/14.

Review of Resident #1's Care Plan, dated 4/21/2015 revealed:
- The resident was non-ambulatory.
- The resident was total assist with all ADLs.
- The resident required a wheelchair with cushions.
- The resident was always disoriented.
- The resident had weak communication methods.

Observation of Resident #1 on 5/8/2015 at 4:00pm revealed:
- Resident was lying in bed with the wall on her right side, and a full bed rail on her left side.
- The resident had a skin tear, 4 inches in diameter underneath the right forearm.
- There was a 6 inch bruise on the right forearm.
- There was a 2 inch skin tear on the inside of the elbow, on the right arm.
- There was a 2 inch skin tear below the left elbow, irregular in appearance.
- There were red dots around the right wrist.
- The wounds had not been bandaged or treated.
- There was no protection or padding on the bed rail.

Telephone interview with Administrator-In-Charge (AIC) on 5/8/2015, at 4:00pm revealed she believed that the injury to the resident's right arm was caused by hitting the arm on the bed rail.

Interview with a family member on 5/27/2015, at 11:45am revealed:
- On 5/8/2015 the family member observed bruising on the right arm, and a place that she believed were two fingernail prints on the arm.
- The family member asked staff about the

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bruising on the resident's arm.
- The family member was told by the Supervisor that the bruising was caused by the resident twisting her arms in the bed rail.
- The family member felt that she was lied to by the Supervisor.
- The family member was concerned about abuse due to Resident #1's bruising and skin tears.

Interview with Resident #1's Legal Guardian on 5/28/2015 at 11:40am revealed:
-The Guardian received notification of the incident but did not recall date of notification.
-The Guardian did not know if the Incident Report had been sent to him.
-The Legal Guardian visited the resident monthly.
- The Legal Guardian didn't see anything on prior visits that raised any concerns.
-The Legal Guardian visited the resident on May 12, 2015, and observed the bed rail had been wrapped.

Observation of Resident #1 on 5/29/15 at 2:30pm revealed:
- Resident was lying in bed on right side.
- Unable to view right arm, as the resident was lying on it, and the resident was sleeping.
- Abrasions were observed on the left arm.
- The entire bed rail was wrapped in grey foam.

Interview with Special Care Unit Coordinator (SCC) on 6/1/2015 at 10:45am revealed she did not know why precautions to prevent further injury, such as wrapping bed rails with foam, were not implemented on 5/8/2015.

Per observation on 6/24/15 and 6/25/15, Resident #1 resided in the Special Care Unit (SCU.)

Interview with AIC on 6/1/2015 at 10:50am

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revealed:
- AIC did not know when bruising of the resident's arm was first observed.
- AIC determined on 5/8/2015, that the resident must have sustained bruising by hitting the right arm on the bed rail.
- The facility placed padding on the bed rail and wheelchair on 5/11/2015.

Interview with SCC on 6/3/2015 at 9:15am revealed:
- The resident was "bed bound, or wheelchair bound."
- The resident was unable to turn self in bed.
- The resident was turned by staff every 2 hours.
- The resident was total lift into the wheelchair.

Interview with Administrator on 6/3/2015 at 1:45pm revealed:
- The Administrator was unsure why staff did not implement precautions to prevent further injury to Resident #1 prior to 5/11/2015.
- The Administrator was made aware of the incident on 5/11/2015, and precautions were implemented at that time.

Interview with AIC on 6/25/2015 at 4:30pm revealed:
- On 5/8/2015 at 4:00pm, the AIC decided to wrap the bed rail as precaution against further injury.
- Maintenance staff had already left for the day.
- Maintenance staff was notified on 5/11/2015, and the bed rail and wheel chair were wrapped in foam.
- AIC stated that there are two maintenance persons who rotate on-call on weekends.
- Maintenance staff was not called prior to 5/11/2015 to implement precautions.

Review of Nurses Notes, dated 5/8/2015 revealed

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Resident #1 had "an old scab from a blister on left forearm but has already almost done healing."

Review of Resident #1's Incident Reports revealed:
- 5/4/2015 Supervisor was notified by Personal Care Staff of a blister and small skin tear on Resident #1's right forearm- skin tear happened during transfer. first aid was administered.
-5/5/2015 Area clean, no redness.
-5/8/2015 A family member complained about the resident's arms where blood was drawn and left small bruise and a prior scab from a blister.
-5/11/2015 Checked area on right arm. Area scabbed, bruising on forearm. Maintenance applied foam rolls to bed rail and wheelchair to prevent further bruising or skin tear.

B. Review of Resident #2's current FL2 dated 11/14/2014 revealed:
- Diagnoses of a history of stroke, recurrent falls, hydrocephalus, hypertension, overactive bladder, osteoarthritis, and degenerative joint disease.
- Resident was semi-ambulatory with a walker.
- An admission date of 11/23/2013.

Review of the resident's care plan dated 12/10/14 revealed:
- Resident #2 was oriented with an adequate memory.
- Resident #2 required limited assistance with toileting, ambulation and bathing, and extensive assistance with bathing, dressing, and grooming/personal hygiene.
- The resident was noted as independent with transfer.

Review of a facility fall risk assessment tool for Resident #2 dated 12/13/14 revealed a score of 5 with a score of 10 or more indicating resident was

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D 270	Continued From page 5 a fall risk. Observation of Resident #2 on 6/10/2015 at 11:55am revealed the resident was lying on a stretcher being transported to hospital by emergency medical services (EMS) due to injury from a fall. Interview with Family Member on 6/10/2015 at 3:00pm revealed: - The resident has fallen 8 times recently, and 6 times during the last month. - The resident's falls were discussed with the Administrator-In-Charge (AIC) on several occasions, with the last conversation being after the fall on 6/10/2015. -The AIC explained that the resident could not be restrained, but that a seatbelt would be implemented and an alarm would be placed on the resident's bed. - The family member was upset "it has taken several falls for the facility to implement safety measures." Observation of Resident #2 on 6/11/2015 at 11:00am revealed: - The resident was in the facility living area, sitting in a reclined Geri-Chair . - Resident #1 had a tab alert fastened to the back of her shirt, that would sound an alarm if the resident attempted to get up out of the chair. Observation of Resident #2 on 6/12/2015 at 9:50am revealed: - The resident was lying awake in the bed. - A tab alert was fastened to resident's shirt. - A Geri-chair was located in the resident's room. - A bicycle horn (used in place of a call bell) was sitting on the bedside table.	D 270		

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Observation of Resident #2 on 6/15/2015 at 10:40am revealed:
- The resident was sitting in the hallway, sitting in a reclined Geri-chair
- A tab alert was fastened to the resident's shirt.
- The resident was leaning forward, with her left leg resting in the fold of the Geri-chair and her right leg was over the side of the footrest near the floor.
- The resident was trying to get up out of the reclined Geri-chair, but could not.

Interview with Resident #2 on 6/12/2015 at 9:50am revealed:
-Resident #2 was able to get out of the Geri-Chair independently, if the chair was not in a reclined position.
-The resident was told by staff not to attempt getting out of the Geri-chair independently.
-The resident has a bicycle horn to use (in place of a call bell system) when she needed assistance with getting up out of bed or chair.

Interview with Resident #2 on 6/15/2015 at 10:40am revealed:
- Resident #2 stated that she "hated" the Geri-chair.
- The resident did not like the Geri-chair, because she was unable to get out of it while in a reclining position.
- The resident wanted to be in her wheelchair.

Interview with the AIC on 6/11/2015 at 10:40am revealed:
- Resident #2 had required the use of a wheelchair for ambulation.
- The resident required assistance with transfers and ambulation.
- The resident had a shunt in her head and

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indicated this was not due to the resident's previous falls.
- The resident had fallen several times in the past, primarily during last year (2014). (Per review of progress notes, the physician was aware of the resident falls.)
- The AIC "assumed" that the falls during the last year were caused by a Detrol LA prescription ordered in June 2014. (Detrol LA is a medication used to treat bladder spasms and incontinence.)
- The Detrol LA prescription was discontinued in July 2014. (Record review revealed a physician's order dated 7/10/14 to "d/c Detrol (falls)."
- The resident had fallen less frequently after the medication change.
- The Detrol LA was reordered in February 2015, as insurance would not pay for a replacement medication.
- The AIC "assumed" that the 6/10/2015 fall was once again, caused by the Detrol LA.

-Review of Resident #2's record revealed:
- A telephone order was received on 6/11/2015, by the Physician's Assistant (PA), "D/C Detrol LA - contributes to falls."
- An order for the resident to use a tab alert at all times.
- An order for the resident to use a Geri-Chair.

Review of Resident #2's May and June 2015 MARs revealed:
- An entry for Detrol LA 4mg. 1 by mouth daily.
- Detrol LA 4mg was documented as administered every day in May 2015, at 12:00 noon.
- The order for Detrol LA 4 mg, 1 by mouth daily was discontinued on 6/11/2015.
- Detrol LA 4mg was documented as administered every day, June 1 through June 10 at 12:00 noon.

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D 270	Continued From page 8 Interview with AIC on 6/15/2015 at 12:50 revealed: - A verbal order had been received for the Geri-Chair. - AIC did not view Geri-Chair as a restraint, believed it was "OK because of the doctor's order." Interview with Administrator on 6/18/2015 at 9:30 am revealed: - The resident had cut the tab alert with a pair of scissors, on 06/17/15. - The resident required more care than the facility could offer due to noncompliance and falls. - The resident was to be assessed by a Skilled Nursing Facility for possible admission. Interview with Personal Care Aid (PCA) on 6/25/2015 at 10:38am revealed: - The use of the Geri-Chair for the resident was "to keep the resident from getting up." - PCA stated "It takes the resident longer to try to get out of the Geri-chair than the wheelchair", giving staff more time to respond. Telephone Interview with the resident's Physician on 6/25/2015 at 4:05 pm revealed: - The resident had dementia and "does what she feels like." - The resident had a history of falls. - The Geri-Chair was ordered to minimize falls. - The physician stated: "It takes her awhile to get out of the chair (Geri-chair), giving staff time to get to her." - The physician stated that the order for the Geri-chair was discontinued on 6/15/2015, because the "county social workers twisted my arm," i.e. concerns by the county social workers the Geri-Chair was being used as a restraint.	D 270		

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D 270	Continued From page 9 Review of Resident #2's record revealed the resident sustained falls on the following dates: - 3/15/2014, Resident stood up to answer phone, lost balance and fell, no complaints of pain, bruising, or skin tears. - 5/16/2014, Resident #2 lost balance and fell in hallway, bumping head against handrail, resulting in a small "pump knot" on head, sent to ER for evaluation, no new orders, follow-up with primary care doctor on 5/29/14. - 5/17/2014, no incident report noted. A physician's order for an x-ray of left hand was noted due to pain and swelling. - 5/25/2014, resident self reported fall, hit her head on the sink, sent to ER for evaluation, diagnosis of contusion, follow up with primary care doctor on 5/29/14. - 5/27/2014, no incident report noted. - 6/18/2014, no incident report noted. - 7/3/2014, resident tripped over roommate's wheelchair and hit back of head on nightstand, no open wounds, send to ER for evaluation, no diagnosis noted on incident report. - 7/7/2014, no incident report noted. - 4/9/2015, resident was found on bedroom floor, stated she was on her way to the bathroom without turning on light, bumped into roommate's bed and fell, no scrapes or bruising noted, monitor. (A follow-up note on 4/10/15 indicated Resident #2 was started on an antibiotic for a urinary tract infection with no other falls reported.) - 6/10/2015 12:30am, resident lying on floor of bathroom, stated her legs keep giving out and her left thigh hurts, no bruising, cuts, or knots noted, Resident #2 being monitored for falls throughout the day, tab alert secured, gave bicycle horn. - 6/10/15 11:45am, resident fell while MD was in facility, open area to right forehead, sent to ER for evaluation and treatment, new order to d/c Detrol	D 270		

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LA, use GeriChair and tab alert at all times. (A 6/11/15 Nurses Note indicated forehead wound required stitches, and Detrol LA was d/c due to increased falls.)

Review of Resident #2's Licensed Health Professional Support (LHPS), dated 3/12/2015 revealed:
- The resident required assistance with ADL's.
- The resident required fall precautions.
- The resident required the use of a walker for ambulation.
- The resident requires staff assistance occasionally.
- Noted recommendations for stand-by assist.

Review of Resident #2's LHPS, dated 6/14/2015 revealed:
- The resident required assistance with ADL's
- The resident required fall precautions.
- The resident required the use of a walker for ambulation.
- The resident required one person stand-by assistance occasionally.

Review of the Physician's progress note, dated 6/15/2015 revealed:
- Resident was re-evaluated after fall with head contusion.
- Resident "Remains high risk for further falls or fractures likely inevitable as she's had multiple falls previously."
- "Really little to offer as we do not feel that chemical or physical restraints as likely in her best interest."
- Also stated "further falls and fractures likely inevitable."
- Recommended physical therapy (PT) evaluate in an effort to minimize falls.
- Recommended to wean resident off of Pamelor

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as it may be contributing to falls. (Pamelor is an antidepressant and can cause dizziness and drowsiness.)

Review of Resident #2's incident report, dated 6/10/2015 revealed:
- The Resident was found lying in floor of bathroom at 12:30am.
- The resident complained of legs "giving out" and left thigh pain.
- No bruises, cuts or knots noticeable.
- Documented facility provided a horn and secured tab alert.
- The resident sustained a second fall at 11:45 am.
- The resident suffered an open area on right forehead.
- The resident was transported to the hospital for evaluation and treatment.
- Verbal Order was received to discontinue the Detrol LA, use Geri-chair, and use tab alert at all times.

Review of Nurses Notes, dated 6/10/2015 revealed:
- The resident had fallen and hit her head.
- The family had been notified.
- The resident had been transported to the emergency room.

Review of Nurses Notes, dated 6/11/2015 revealed:
- Received order for Geri-chair and tab alert at all times.
- Discontinued Detrol LA due to falls.
- Facility had given the resident a horn, and educated her on the use of horn, in place of a call bell system.

Review of Nurses Notes, dated 6/15/2015

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revealed:
- PT intervention to evaluate for falls and gait.
- The resident was added to fall risk list.

C. Review of Resident #3's prior FL2 dated 8/5/2014 revealed:
- Diagnoses of dementia, pneumonia, anxiety, osteopenia, and gastroesophageal reflux disease.
- Disoriented intermittently.
- Assistance with bathing and dressing.
- Ambulatory.

Review of Resident #3's current FL2 dated 1/12/2015 revealed:
- Diagnoses of: dementia, left hip fracture.
- Disoriented constantly.
- Total care.
- Non-ambulatory.
- Incontinent bowel and bladder.
- Home Health order for Physical Therapy.

Observation of Resident #3 on 6/12/2015 at 9:45am revealed emergency medical services (EMS) was at the facility preparing to transport Resident #3 to the emergency room for evaluation due to a fall.

Interview with the Supervisor on 6/12/2015 at 9:45am revealed:
- The resident fell on the floor that morning, while trying to get up.
- The resident hit her head.
- The Supervisor stated there was a "pool of blood on the floor" from hitting her head.
- The Supervisor called 911.

Interview with a family member on 6/17/2015 at 9:00am revealed:
- Resident #3 has had numerous falls at the facility, resulting in bruising, black eyes, hip

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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fracture, and stitches.
- The resident fell out of a chair on 6/12/2015, and needed stitches.
- The resident fell out of bed in March 2015 and suffered a broken hip.
- Family was concerned that the residents of the facility had been neglected resulting in falls causing injuries due to the number of residents with bruising.

Interview with same family member on 6/17/2015 at 3:15pm revealed:
- Resident #3 fell several months ago and suffered a broken hip (1/8/2015).
- The resident received "rehabilitation" and was able to walk.
- The resident fell again, shortly after the first fall, but did not suffer any injuries or fractures.
- After the second fall, the resident was unable to get up independently or feed herself.
- Resident #3 fell out of her chair on 6/12/2015, and was transferred to the hospital.
- Resident required stitches above her left eye.
- The family member had taken pictures of bruising on the resident's face on 6/16/2015.
- The family member stated it was "questionable if caused by falls," due to extensive bruising.
- The resident had dementia and requires assistance with transfers, toileting and feeding.

Observation of Resident #3 on 6/18/2015 at 3:00pm revealed:
- The resident was lying in bed asleep.
- The resident's face had bruising around both eyes.
- The resident had 6 stitches above her left eye.

Continued interview with family member on 6/22/2015 at 11:00am revealed:
- The resident was taken to the family member's

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home on 6/21/2015 at 5:30pm.
- Upon preparing the resident for a bath on the morning of 6/22/2015, the family member observed the resident leaning to the left, with weakness in her left arm and left leg.
- The family member called 911.
- The resident was transported to the hospital.

Interview with family member on 6/22/2015 at 2:09pm revealed:
- The family member stated that the hospital informed the family, the resident had a "brain bleed on both sides of her head, possibly due to her most recent fall."
- The resident was transferred to another hospital for an evaluation.

Observation of Resident #3 on 6/25/2015 at 8:47 am revealed:
- The resident was in the dining room in the special care unit (SCU).
- The resident was sitting in a wheelchair.
- The resident had a tab alert on the wheelchair affixed to her clothing.

Review of Resident #3's Fall Assessment Tool dated 12/14/2014 revealed:
- No needs for gait and balance assessment.
- The fall assessment tool was updated on 1/8/2015, with intervention of wheelchair protocol."

Review of Resident #3's Care Plan dated 2/27/2015 revealed:
- The resident was ambulatory with walker.
- The resident required assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.
- Physical Therapy (type, time and duration not specified.)

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D 270	Continued From page 15 Review of Resident #3's LHPS dated 3/7/2015 revealed: - The Registered Nurse (RN) recommended staff to use fall precautions. - One staff member required for transfers. - The resident completed PT on 3/4/2015. - Ambulation with walker and one person standby assist. Review of Resident # 3's LHPS dated 6/11/2015 revealed: - The RN recommended the staff to use fall precautions. - One staff person required for transfers. - Ambulation with walker. Review of Resident #3's Incident Report dated 1/8/2015 revealed: - At 8:00am the resident complained of left leg pain. - The resident told Special Care Unit Coordinator (SCC) that she fell the evening before, got up on her own, and did not tell anyone. - X ray of left hip ordered. - Mobilex was notified for Xray. - Wheelchair ordered as needed. - At 10:00am still awaiting results of X ray. - At 11:00 am Mobilex had not arrived, the doctor was notified, and orders were received to "send to ER to eval +tx." - The resident was admitted to the hospital with a hip fracture. Review of Resident #3's Incident Report dated 6/1/15 revealed: - Resident #3 was walking in hallway when a friend tripped on Resident #3's walker causing Resident #3 to fall.	D 270		

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- Resident #3 bumped her head causing a small "pump knot" on her head.
- Applied ice, and will monitor.
- Intervention noted, "educated staff on assisting resident with ambulation."

Review of Incident Report dated 6/12/2015 revealed:
- Supervisor was notified by nursing assistants that resident #3 tried to get up and fell and hit her head.
- Supervisor assessed the situation.
- Supervisor called 911.
- When the Supervisor looked at the resident's head, she had "about a 1 ½ to 2 inch laceration on her left eye."
- Resident #3 complained of "rib area hurting."

Review of Nurses Notes in Resident #3's record dated 6/12/2015 revealed:
- Resident #3 had fallen in the dining room at 9:30am while trying to get out of her chair.
- The resident "busted a spot on L forehead open."
- The resident was sent to the emergency room (ER).
- The resident returned to the facility at 2:30pm.
-.The resident received 6 stitches.
- An order was received for a wheelchair and tab alert at all times.

Review of Nurses Notes in Resident #3's record dated 6/13/2015 revealed the family visited the resident and "was not happy that she fell."

Review of Nurses Notes in Resident #3's record dated 6/15/2015 revealed Medical Doctor wrote an order for PT.

Review of Nurses Notes in Resident #3's record

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D 270	Continued From page 17 dated 6/16/2015 revealed "resident ambulatory in wheelchair and & tab alert in place." Review of Physician Order dated 6/15/2015 revealed "PT for gait/falls." Review of Resident #3's medical records dated 6/22/2015 revealed: - Resident #3 received a computerized tomography (CT) Scan of the head. - Results of the CT Scan showed no hemorrhage or recent infarction of the head. Review of Resident #3's medical records dated 6/24/2015 revealed: - Left sided weakness likely related to pain. - MRI did not show any acute ischemia. - Likely patient was not moving her left leg due to pain from prior hip fracture. _____ On 6/11/15, the facility provided the following plan of protection: - In the case of Resident #1, bed rails were padded to keep the resident from further injuries. The resident care director (RCD) continues to follow-up with routine checks or resident and padding. - Incident reports was updated to include interventions and follow-up. - The RCD or designee on call is contacted immediately following any incident. - An immediate assessment is completed to determine immediate interventions as well as long term interventions. - The RCD then completes follow up to assess whether interventions continue to keep residents	D 270		

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D 270	Continued From page 18 safe. - All documentation is being added to charts as well. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 25, 2015.	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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect residents by not investigating allegations of neglect for 2 residents (#2 and #3) and injuries of unknown source for one resident (#1) and not reporting to the Health Care Personnel Registry. The findings are: A. Review of Resident #1's current FL2 dated 9/3/2014 revealed: - Diagnoses of vascular dementia, type 2 diabetes, depression, and a history of encephalopathy. - A medication order for Xarelto 20mg daily with evening meal. (Xarelto is a medication used to prevent blood clots and can cause bruising as a side effect.)	D 438		

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D 438	Continued From page 19 - A requested level of care of a special care unit (SCU). Review of the resident's register revealed an admission date of 10/8/2014. Review of Resident #1's care plan dated 4/2120/15 revealed: - Resident resides in the SCU and had a history of wandering. - Resident hasn't wandered at this facility. - Resident was non-ambulatory with use of a wheelchair. - Resident was total assist with all activities of daily living (ADL). Review of a facility incident report completed by the facility Administrator in Charge (AIC) revealed: - The incident happened on May 4, 2015. - Staff brought to my attention Resident #1 had a blister and small skin tear on the right forearm. - This skin tear happened during transfer from resident's bed to chair. - The blister finished draining when the AIC removed the bandage. - The area was "sterilized" and tegaderm bandages with Neosporin was applied. - On 5/11/2015, checked areas on right arm, area scabbed, bruising on forearm. Maintenance applied foam to bed rail and wheelchair to prevent any further bruising or skin tears. Interview with family member of Resident #1 on 5/27/2015 at 11:45am revealed: - On 5/8/2015 the family member observed the resident to have bruising on the right arm, and a place that she was convinced were two fingernail prints on the arm.	D 438		

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D 438	Continued From page 20 - The family member inquired about the bruising on the resident's arm. - The family member was told by the Supervisor that the bruising was caused by the resident twisting her arms in the bed rail. - The family member felt that she was lied to, by the Supervisor. - The family member was concerned about abuse due to bruising and skin tears on Resident #1. Interview with Administrator-In-Charge on 6/1/2015 at 10:58am revealed: - Administrator-In-Charge did not know when bruising of Resident #1's arm was first observed. - Administrator-In-Charge determined on 5/8/2015, that Resident #1 must have sustained bruising by hitting the right arm on the bed rail. Interview with the Administrator on 6/3/2015 at 1:45pm revealed: - On 5/11/2015,the Administrator was made aware of the 5/8/2015 incident involving Resident #1 Interview with the AIC on 6/25/2015 at 3:45pm revealed: - She had not reported the above incident to the HCPR because she believed the injuries to be caused by the bedrails and not of unknown origin. - The injuries were found by care staff and brought to the AIC's attention late on 5/8/2015, a Friday. - Maintenance staff are off on weekends, but padding was placed on the bedrails on 5/11/2015. - The resident received no further injuries from 5/8/2015 to 5/11/2015. B. Review of Resident #2's current FL2 dated 11/14/2014 revealed:	D 438		

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D 438	Continued From page 21 - Diagnoses of a history of stroke, recurrent falls, hydrocephalus, hypertension, overactive bladder, osteoarthritis, and degenerative joint disease. - Resident was semi-ambulatory with a walker. - An admission date of 11/23/2013. Review of the resident's care plan dated 12/10/2014 revealed: - Resident was oriented with an adequate memory. - Resident #2 required limited assistance with toileting, ambulation and bathing, and extensive assistance with bathing, dressing, and grooming/personal hygiene. - The resident was noted as independent with transfer. Review of a facility fall risk assessment tool for Resident #2 dated 12/13/2014 revealed a score of 5 with a score of 10 or more indicating resident was a fall risk. Review of the Resident #2's facility records revealed: - An incident report dated 4/9/2015 noted the resident fell going to the bathroom with no injuries noted. (The resident was noted to have a urinary tract infection at that time which was treated with antibiotics.) - An incident report dated 6/10/2015 noted Resident #2 was found lying in the floor of the bathroom at 12:30am with no injuries noted. - On that same incident report, another fall was noted at 11:45am with an open are on the forehead with resident sent to a local emergency room for evaluation and treatment. (Resident's primary care physician noted to be in the facility at the time of the fall.) - A physician's order dated 6/11/2015 for Resident #2 to wear a tab alert at all times, discontinue	D 438		

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Detrol LA- contributes to falls. (Detrol is a medication used to treat urinary incontinence), use a GeriChair, remove stitches in 7 days.
- The resident's other falls were in 2014 with the most recent on 7/7/2014.

Interview with family member of Resident #2 on 6/10/2015 at 3:00pm revealed:
- The resident has fallen 8 times recently, and 6 times during the last month.
- The resident's falls were discussed with the Administrator-In-Charge (AIC) on several occasions, with the last conversation being after the fall on 6/10/2015. (On 6/11/15 Resident #2's physician ordered d/c of Detrol LA-contributes to falls, use a GeriChair, and use of a tab alert at all times.)
- The family member was upset that "it has taken several falls for the facility to implement safety measures."

Interview with the AIC on 6/25/15 at 3:45pm revealed she had not reported anything to the Health Care Personnel Registry (HCPR).

C. Review of Resident #3's current FL2 dated 1/12/2015 revealed:
- Diagnoses of dementia and a left hip fracture.
- Resident #3 was constantly disoriented.
- Resident #3 was non-ambulatory
- Resident #3 needed assistance with bathing, dressing, feeding, and was total care.
- Resident #3 was incontinent of bowel and bladder.

Review of the prior FL2 dated 8/5/2014 noted additional diagnoses of anxiety, osteopenia, and gastroesophageal reflux disease.

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D 438	Continued From page 23 Review of a facility incident report dated 1/8/2015 revealed: - Resident fell on the evening of 1/7/2015, but got herself up and didn't tell anyone she had fallen. - Resident complained of leg pain on the morning of 1/8/2015 and the primary care physician (PCP) was called. - The PCP ordered an x-ray of the hip and the mobile x-ray service was called. A wheelchair was ordered for Resident #3 as needed. - At 11:00am on 1/8/2015 the mobile x-ray had not arrived, the PCP was called again, and the resident was sent out the the emergency room for evaluation and treatment. - Resident was admitted to the hospital with a hip fracture. Review of an incident report dated 6/1/2015 revealed: - Resident #3 fell when another resident tripped on Resident #3's walker. - The resident bumped her head causing a small "pump knot" on her head. - Ice was applied and resident was monitored. - Family member was called, and no other treatment was required. - Intervention noted was to educate staff in assisting with ambulation and remind resident to use walker. Review of an incident report dated 6/12/2015 revealed: - Resident #3 tried to get up and fell and hit her head. - 911 was called immediately and the family was called. - The resident had a 1 and 1/2 inch to 2 inch laceration on left eye and complained of pain in the rib area.	D 438		

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D 438	Continued From page 24 Review of nursing notes revealed: - On 6/12/2015 at 9:30am, Resident #3 fell trying to get out of a chair in the dining room and sustained a laceration to left forehead. - Resident was sent out the the emergency room, and returned at 2:50pm with 6 stitches to the laceration. - The PCP was called at this time for an order for a wheelchair with a tab alarm to be worn at all times. - On 6/15/2015 the PCP ordered home health to evaluate Resident #3 for physical therapy. Interview with a family member of Resident #3 on 6/17/2015 at 9:00am revealed: - The resident has had numerous falls resulting in bruising, black eyes, hip fracture, and stitches - There was concern by the family member that the residents are being neglected leading to falls and result in injury to the resident. Interview with same family member of Resident #3 on 6/17/2015 at 3:15 pm revealed: - The family member took pictures of bruising on the resident on 6/16/2015. - The family member stated that it was "questionable if caused by falls" due to extent of bruising. Interview with the AIC on 6/25/2015 at 3:45pm revealed she had not reported anything to the HCPR. _____ On 6/29/2015 the facility provided the following plan of protection:	D 438		

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D 438	Continued From page 25 - Educated all medication aides and supervisors on reporting any incident and documentation. - Resident in question, padding has been added to bedrail and wheelchair on 5/11/2015 with no further bruising noted. - When an incident is reported, the Supervisor will immediately assess resident and incident form. - Upon incident, intervention will immediately be placed and documented on the incident form and chart. - The nursing supervisor will follow up with primary care physician to assure intervention is appropriate. - Schedule future training for staff. - Any unknown source of injury will be immediately be reported to nursing supervisor for reporting to HCPR immediately. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 25, 2015.	D 438		
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	D 482		

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D 482	Continued From page 26 (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure a Geri-Chair was used only after an assessment and care planning process had been completed and used	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014014	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

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D 482	Continued From page 27	D 482		

only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and only with a physician's written restraint order for 1 of 2 sampled residents with restraints. (Resident #2.)

The findings are:

Review of Resident #2's current FL2 dated 11/14/2014 revealed:
- Diagnoses of a history of stroke, recurrent falls, hydrocephalus, hypertension, overactive bladder, osteoarthritis, and degenerative joint disease.
- Resident was semi-ambulatory with a walker.
- An admission date of 11/23/2013.

Review of the resident's care plan dated 12/10/2014 revealed:
- Resident was oriented with an adequate memory.
- Resident #2 required limited assistance with toileting, ambulation and bathing, and extensive assistance with bathing, dressing, and grooming/personal hygiene.
- The resident was noted as independent with transfer.

Review of a facility fall risk assessment tool for Resident #2 dated 12/13/2014 revealed a score of 5 with a score of 10 or more indicating resident was a fall risk.

Observation of Resident #2 on 6/11/2015 at 11:00am revealed the resident was in the facility living area, sitting in a reclined Geri-Chair.

Observation of Resident #2 on 6/12/2015 at 9:50am revealed a Geri-Chair was located in the resident's room.

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D 482	Continued From page 28	D 482		

Observation of Resident #2 on 6/15/2015 at 10:40am revealed:
- The resident was sitting in the hallway, sitting in a reclined Geri-Chair.
- The resident was leaning forward, with her left leg resting in the fold of the Geri-Chair and her right leg was over the side of the footrest near the floor.
- The resident was trying to get up out of the reclined Geri-Chair.

Interview with Resident #2 on 6/12/2015 at 9:50am revealed the resident was able to get out of the Geri-Chair independently, if the chair was not in a reclined position.

Interview with Resident #2 on 6/15/2015 at 10:40am revealed:
- The resident stated that she "hated" the Geri-Chair.
- The resident did not like the Geri-Chair, because she was unable to get out of it independently, while in a reclining position.
- The resident wanted to be in her wheelchair.

Review of Resident #2's record revealed:
- A physician's telephone order dated 6/11/2015 for the resident to use a Geri-Chair.
- The order contained no other information regarding how frequently the resident was to be checked while in the Geri-Chair or when the resident was to be released from the Geri-Chair.

Interview with Administrator-In-Charge (AIC) on 6/15/2015 at 12:50pm revealed:
- A verbal order had been received for the Geri-Chair
- The AIC did not view the Geri-Chair as a restraint, and believed it was "ok because of the doctor's order."

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D 482	Continued From page 29 Interview with a Personal Care Aid (PCA) on 6/25/2015 at 10:38am revealed: - The use of the Geri-Chair for Resident #2 was "to keep the resident from getting up." - The PCA stated "It takes the (named Resident #2) longer to try to get out of the Geri-Chair than the wheelchair giving staff more time to respond." Telephone interview with Physician on 6/25/2015 at 4:05pm revealed: - The Geri-Chair was ordered for Resident #2 to minimize falls. - "It takes her (Resident #2) longer to get out of the chair (Geri-Chair), giving staff time to get to her." - The physician stated that the order for the Geri-Chair was discontinued on 6/15/2015, because the "county social workers twisted my arm," i.e. concerns by the county social workers the Geri-Chair was being used as a restraint. Review of Incident Report for Resident #2 dated 6/10/2015 revealed - Resident #2 had a fall on 6/10/2015 because "her legs keep giving out." - A verbal order was received to use a Geri-Chair. Review of Resident #2's record on 6/11/2015, 6/12/2015, and 6/24/2015 revealed: - There was no documentation of an assessment prior to implementation of a restraint. - There was no documentation of a restraint care plan. - There was no documentation of a consent for a restraint signed by the resident or legal representative. - The order for the Geri-hair did not include: medical need for the restraint, period of time	D 482		

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D 482	Continued From page 30	D 482		

restraint is to be used, times restraint is to be checked and released.
- There was no documentation of use of alternatives to restraints.
- There was no documentation of the use of restraints.

Review of the facility's Restraint Protocol, Policies and Procedural Guidelines revealed:
- Orders must indicate the specific restraint type, purpose, and time period of use, and alternative methods to restrain implementation before use.
- Restraints will only be used with the consent from the resident, physician, and/ or responsible person.
- Practices that are not permitted included: Placing a resident in a chair that prevents the resident from out of chair.
- An assessment team including resident and responsible person develops and maintains a comprehensive care plan for the resident.
- Informed consent for the restraint will be obtained from the resident or responsible party.

On 6/25/2015 the facility provided the following plan of protection:
- Resident #2's Geri-Chair has been removed.
- Facility had order from MD and a family verbal consent.
- A wheelchair with tab alert has been ordered, resident was given a horn (as call bell substitute.)
- Staff educated immediately not to contact MD for Geri-Chair without notifying administration first, and administrator will contact MD for any orders that may be considered a restraint so necessary paperwork can be implemented.
- Staff educated immediately on use of other means to prevent falls.

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D 482	Continued From page 31 THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 9, 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, record reviews, and interviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the area of failure to assess and care plan a restraint. The findings are: Based on observation, interview and record review, the facility failed to assure a Geri-Chair was used only after an assessment and care planning process had been completed and 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 only with a physician's written restraint order for 1 of 2 sampled residents with restraints. (Resident #2.) [Refer to Tag D 482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives, (Type B Violation.)]	D912		

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D914	Continued From page 32	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect related to investigating allegations of neglect and injuries of unknown sources and reporting to the Health Care Personnel Registry and supervision. The findings are: A. Based on observations, record reviews, and interviews, the facility failed to assure 3 of 6 sampled residents (#1, #2, and #3) received supervision in accordance with the resident's needs in the areas of fall prevention and prevention of injury due to unpadded bedrails. [Refer to Tag D 270, 10A NCAC 13F .0901 Personal Care and Supervision, (Type A1 Violation).] B. Based on observations, interviews, and record reviews, the facility failed to protect residents by not investigating allegations of neglect for 2 residents (#2 and #3) and injuries of unknown source for one resident (#1) and not reporting to the Health Care Personnel Registry. [Refer to Tag D 438, 10A NCAC 13F .1205 Health Care Personnel Registry. (Type A2 Violation.)]	D914		