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	HAL025035	A. BUILDING: _____ B. WING _____	01/07/2016

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D 000	Initial Comments The Adult Care Licensure Section and the Craven County Department of Social Services conducted an annual survey and complaint investigation on January 5,6, and 7, 2016. The complaint investigation was initiated by Craven county on December 21, 2015.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure the water temperatures at the facility ranged from 100-116 degrees for sinks that were used by the residents in their rooms and in common bathrooms for 11 out of 19 fixtures (sinks) checked. The findings are: Observation of a sink in room 79 of the facility on 01/05/16 at 10:45 AM revealed a hot water temperature of 98 degrees. Observation of a sink in room 65 of the facility on 01/05/16 at 10:50 AM revealed a hot water temperature of 98 degrees.	D 113		

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D 113	Continued From page 1 Observation of a sink in room 55 of the facility on 01/05/16 at 11:00 AM revealed a hot water temperature of 98 degrees. Observation of a sink in a common bathroom on the blue hall on 01/05/16 at 11:05 AM revealed a hot water temperature of 96 degrees. Observation of a sink in room 47 of the facility on 01/05/16 at 11:12 AM revealed a hot water temperature of 98 degrees. Observation of a sink in room 43 of the facility on 01/05/16 at 11:16 AM revealed a hot water temperature of 98 degrees. Observation of a sink in a common bathroom on the red hall on 01/05/16 at 11:17 AM revealed a hot water temperature of 96 degrees. Observation of a sink in the common bathroom on the red hall on 01/06/15 at 3:25 PM revealed: -The water temperature was 96 degrees. -The water temperature taken by the maintenance staff was 92 degrees. -The Maintenance staff was using a meat thermometer to check the water temperature. Interview with the maintenance man on 01/06/15 at 3:22 PM revealed: -The maintenance man checks the water temperatures in the building once a week. -He has been checking the water temperature once a week and has not had any problems. -The water temperatures are checked by a housekeeper in the facility when he can't be there or there is a problem. -Some weeks the housekeeper and he both would check the water temperatures.	D 113		

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D 113	Continued From page 2 -He was not aware that he was using the wrong thermometer. -He was not sure what the temperature range should be on all the faucets. -He does not check all fixtures every week when he checks water temperatures. Observation of a sink in room 43 of the facility on 01/06/16 at 3:28 PM revealed a hot water temperature of 92 degrees. Observation of a sink in a community bathroom on the blue hall on 01/06/16 at 3:29 PM revealed a hot water temperature of 104 degrees. Observation of a sink in room 45 of the facility on 01/06/16 at 3:30 PM revealed a hot water temperature of 98 degrees. Review of the facility logs for water temperatures at the facility revealed: -The logs doumented what the ranges should be. -The logs said that water temperatures should be checked twice per day and placed on the log. -The log did not specify how many fictures should be checked. -There were only six to ten fixtures beings checked each week. -There were some of the logs that had some temperatures that were out of range. -There was no documentation that those temperatures were reported. Interview on 1/06/15 at 3:10 pm with a Personal Care Aide revealed: - A few months ago the water temperatures in the facility were too hot, and a plumber was called in, and the water temperature was turned down at the water heater (did not know what the high and low temperatures were).	D 113		

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D 113	Continued From page 3 - Recently (does not remember exactly when), some residents complained that the water was too cold to take a shower and would wait for the temperature to rise to bathe. Interview with Maintenance Supervisor on 01/07/16 at 10:15 AM revealed: -The maintenance staff believes there are mixing problems with the cold and hot water. -The plumber would be back to recheck the unit again on 01/08/16. -He believes that when the laundry and the kitchen are operating at the same time its messing up the water mixture. -He was unaware that there were any problems with water temperatures. -He was unaware that his maintenance staff were using a meat thermometer to check water temperatures. Interview with the Administrator on 01/05/16 at 4:08 PM revealed: -The maintenance staff check the water temperatures once a week on Friday and documents those temperatures. -There is a housekeeping staff that does some random checks on the water temperatures. -If the water temperatures are not normal they are to be reported to the Administrator or the Business Office Manager. -There have not been any problems with the water temperatures that have been reported to her. -There are no other water temperatures checks done other than the ones the maintenance staff and the housekeeping staff have done. -She was unaware that the maintenance staff was using the wrong thermometer to check the water temperature. -They have already contacted the plumbers and	D 113		

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D 113	Continued From page 4 they are trying to fix the hot water pumps outside.	D 113		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walk-in cooler, food storage area, ice machine, reach-in cooler, kitchen walls, and the dining room floors, ceilings, and walls were clean and protected from contamination. The findings are: Observation of one of the dining rooms on 01/05/16 at 11:22 AM revealed: -There were black stains and peeled paint on 4 out of 4 walls. -There were 16 out of 26 chairs in the dining room that had scratched/scuffed wood and black stains in the seats. -There were 6 dried up orange stains on the ceiling. -There were dried up brown food particles on the floor of the dining room. Observation of a second dining room on 01/05/16 at 11:26 AM revealed: -There were 4 out of 4 walls that had black stains and peeled paint. -The entry doorway had some sticky black stains and cracked paint.	D 282		

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D 282	Continued From page 5 -There were dried up brown food particles on the floor of the dining room. Observation of the dry food storage area on 01/05/16 at 3:03 PM revealed: -There were dried up white and black particles on the storage container that was labeled brown sugar. -Dried up brown food particles on top of some of the cans in the dried food storage area. -There was a serving cart that had dried up yellow food particles and brown liquid all over the top and bottom of the cart. Observation of the kitchen area on 01/05/16 at 3:08 PM revealed there were white and brown stains on the floor under the sink where the dishes were washed. Observation of the ice machine on 01/05/16 at 3:10 PM revealed: -There were brown and orange rust spots on the outside of the ventilation system of the ice machine. -There were dried up white and brown particles on the inside lid of the ice machine. -There were dried up white and brown stains on the outside door of the ice machine. Observation of a preparation table in the kitchen on 01/05/16 at 3:12 PM revealed: -The tea maker had dried up brown stains all over it. -There was brown liquid all over the top of the table. -There was dried up white and brown stains all over the racks that hold the clean cups on the bottom shelf of the table. Observation of the reach in cooler on 01/05/16 at	D 282		

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D 282	Continued From page 6 3:17 PM revealed: -There were dried up white stains on the outside of the cooler doors. -There was brown and orange rust spots all over the outside of the cooler. -There was a carton of milk that was dated 01/04/16 and it was about half way full used. -There was dried up white and brown particles all over the bottom inside of the cooler. -There 3 boxes of butter that were opened but did not have a date or time on them. Observation of the reach in freezer on 01/05/16 at 3:20 PM revealed: -There were dried up white particles on the outside of the freezer doors. -There were dried up brown dirt and white food particles all over the inside bottom of the reach in freezer. Observation of a second reach in freezer on 01/05/16 at 3:22 PM revealed: -There were dried up white and brown particles in the bottom of the freezer. -There were green and brown rust spots on the inside bottom of the freezer. -There was a sticky yellow substance on the inside doors of the freezer. Observation of the walk in cooler on 01/05/16 at 3:20 PM revealed: -There were 3 heads of lettuce on the shelf that were rotten and wilted. -There was black sticky grime all over the floor in the walk in cooler. -There was a container in the cooler that was labeled tuna but had several dates on the outside of the bowl. -There was a yellow sticky substance on the floor underneath the racks on the floor of the cooler.	D 282		

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D 282	Continued From page 7 Observation of the oven in the kitchen on 01/05/16 at 3:30 PM revealed there were brown, orange, and black caked up grease spots all of the side and back side of the oven. Observation of the air conditioning units in the dining room on 01/06/16 at 10:14 AM revealed: -There were dried up white and brown stains on the inside of the vent system. -There was a dead roach in the inside of one of the two air conditioning units in the dining room. Interview with a cook on 01/05/16 at 3:40 PM revealed: -The cook had said there are always 3 dietary staff on during the day and 2 staff in the evenings. -She said the cook cleans the oven/stove and all the dishes used to cook the meals with after each meal. -The other dietary staff in the kitchen does all the other cleaning in the kitchen after each meal. -The dining room staff cleans the dining room after each meal. Interview with a dietary staff member on 01/07/16 at 9:21 revealed: -The cook cleans the stove and all the dishes used to cook after each meal. -The dietary staff responsible for dishes clean the rest of the kitchen after each meal. -The dining room staff cleans the dining room after each meal. -The staff would swept and mopped the floor, cleaned the tables and chairs. -She said the coolers, freezers, ice machine, and dry food storage areas are cleaned by all the dietary staff. -She said there use to be a staff member that came in and just did the cleaning once a week.	D 282		

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D 282	Continued From page 8 -There is no schedule to clean the larger areas in the kitchen such as the freezer, coolers, ice machine or dry food storage area. -She said there was no log of cleaning the kitchen or dining room. -She felt that the dining room and kitchen were not cleaned as often as they should be. -The dietary staff said the facility had cut back hours and it was hard to get all the work done in a short amount of time. -The walls in the dining room were only cleaned if there was a spill or they needed to be cleaned. -She said that the maintenance man did come in a few weeks ago and did some painting to the base boards on the walls. -The dietary person had said that she had never seen the ceilings cleaned. Interview with a second dietary staff on 01/07/16 at 9:29 Am revealed: -The cook cleans the stove and all the dishes used to cook after each meal. -She was not sure who responsibility it was to clean the walls and ceilings. -She had been working here for 3 months. -She had not seen anyone clean the coolers, freezers, ice machine, or the dry food storage area since she had been there. -The dining room staff swept and mopped the floor as well as cleaning the table. -She has never seen the dining room staff clean the chairs. -She was not sure who put the dates and times on the food. -The dietary staff said that she did not clean any of the coolers, freezers, ice machine, or the dry food storage area. Interview with the dietary manager on 01/05/16 at 11:30 AM revealed:	D 282		

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D 282	Continued From page 9 -She said the kitchen and dining rooms were cleaned after every meal. -She said that during the day she had 3 dietary staff and 2 dietary staff in the evening. -The dietary manager said it was the cook ' s responsibility to clean the stove and all the dishes used to cook. -She said dining room staff were responsible for cleaning the dining rooms after each meal. -The dining room staff cleaned the tables, the chairs, buss the tables, swept and mopped the floors. -The dietary manager said that the dish person was responsible for cleaning the dishes and all other areas in the kitchen that the cook does not clean. -The larger areas such as the freezer, coolers, and dry food storage areas only get cleaned when they are dirty. -There are no schedules or logs to clean these areas. Interview with the Administrator on 01/07/16 at 9:54 AM revealed: -The dining room staff are responsible for cleaning the dining room area. -She said there use to be a deep cleaning person that come in once a week to clean. -The Administrator said she has had the housekeeping staff go in and assist with cleaning the dining room area. -She said the housekeeping staff has been helping out 1-2 times per month with deep cleaning. -The larger areas like the coolers, freezers, ice machine, and dry food storage areas are to be cleaned weekly. -She was not aware of any log that was being done to clean these areas.	D 282		

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D 282	Continued From page 10 -She said it was the dietary managers to follow up and make sure these areas are clean.	D 282		
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 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.	D 485		

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D 485	Continued From page 11 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to obtain orders before using restraints and failed to document alternatives, type of restraint, medical symptoms, times, care provided and behavior of resident for 4 of 6 residents (Residents #1, #2, #3, #5). The findings are: 1. Review of Resident #1's current FL-2 dated 08/12/15 revealed the diagnoses included pelvis fracture, dementia with behavioral disorder, insulin dependent diabetes and pernicious anemia. Review of Resident #1's Resident Register revealed an admission date of 03/21/15. Review of Resident #1's Restraint Assessment dated 11/30/15 revealed: - Specific type of restraint is blank. - "The team has found Resident #1's use does not meet the criteria as a restraint due to positioning and turning." - Assessment signed by RCC but signature space for Administrator and Regional Director is blank. Interview with the Resident Care Coordinator on 01/07/16 at 12:00pm revealed: - It was the RCC's responsibility to train other staff on restraints and how to use them. - Staff used the bed rails for Resident #1 "in order for staff to position and turn her". - The RCC stated that for all residents who had falls, signs were posted above their bed for bed	D 485		

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D 485	Continued From page 12 rails to be used at all times to prevent falls. Observation by Craven County Department of Social Services Adult Home Specialist (AHS) on 12/21/15 at 8:30pm revealed: - One side of Resident #1's bed was against the wall. - A full rail was up on the other side of the bed. - A sign stating "Please raise the rails anytime a resident is in bed falls don't happen just at night" was posted on the wall above Resident #1's bed. Interview with the Resident Care Manager (RCM) on 01/05/16 at 11:00am revealed it is the responsibility of the Resident Care Coordinator (RCC) to take care of everything pertaining to restraints since she is a nurse. Telephone interview with Resident #1's primary care physician's (PCP) nurse on 01/06/16 at 9:35 revealed an order for rails had never been signed and they were not aware rails were being used. Interview with Resident #1's POA on 01/06/16 at 12:45pm revealed: - She was aware that bedrails are being used on Resident #1's bed to help prevent falls. - She is not aware of alternatives to rails being used. - Resident #1 is not able to utilize the rails to assist with mobility. - She has informed the Administrator that she does not mind rails being used on Resident #1's bed but she wanted frequent checks to be completed to prevent injury. - The Administrator contacted her in	D 485		

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D 485	Continued From page 13 September, 2015 to request verbal permission to use rails for Resident #1 but she had not signed anything regarding the use of rails. - She observed a sign on Resident #1's door after rails began to be used for 15 minute checks but it was taken down after a month. - She was told by the Administrator that checks were no longer necessary but not given a reason for the change. Interview with the Medication Aide on 01/07/16 at 1:15pm revealed: - The facility does use restraints on any residents. - The rails on Resident #1's bed are not restraints because the staff uses them to turn and reposition resident. - She was not aware of any resident in the facility that could lower their own bedrails. - She had been an employee since 2014 and has received no restraint training. - She had been told that staff would receive restraint training sometime this year. Interview with the Executive Director (ED) on 12/21/15 at 9:15 pm revealed: - The RCC used to use the restraint information documents provided by the state. - In October 2015, corporate informed the RCC that she should no longer use the documents. - Rails were used to prevent falls and were not considered restraints since the residents that utilize them were not ambulatory. Interview with Regional Director of Operations (DOO) and the RCC on 01/06/16 at 10:20 am revealed:	D 485		

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(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 - The RCC used to use restraint form tools provided by the state. - In October 2015, the RCC was told by their corporate office to no longer utilize forms. - The RCC was a registered nurse and had always been taught that bedrails were a form of restraint but was told that was not the case if residents were not ambulatory. - All residents with bedrails should have an order to utilize rails in their resident record. 2. Review of Resident #2's current FL-2 dated 03/22/15 revealed diagnosis include Dementia, Diabetes Mellitus, Hyperlipidemia, Osteoarthritis, Degenerative Disc Disease, and Renal Insufficiency. Review of Resident #2's resident register revealed the Resident was admitted to the facility on 03/22/15. Observation of Resident #2 on 01/05/16 at 10:48 Am revealed: -The resident was lying in her bed with both side rails up. -The resident has a wheel chair in her room. -The resident was unable to grab the side rail and move or turn herself at this time. Attempted interview with Resident #2 on 01/05/16 at 10:49 AM revealed the resident was uninterviewable. Review of the restraint order in Resident #2's record revealed: -The resident has an order for usage of restraints dated 04/23/15.	D 485		

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D 485	Continued From page 15 -The order was the side rails were to be up when the resident was in the bed. -The order said the restraint device will be monitored every 15 minutes and included checking and making sure the restraint is applied properly. -The order included restraints should be released every 2 hours. Review of Resident #2's record revealed: -There was no other documentation in the chart that the resident had been assessed or checked on every 15 minutes. -There was no documentation that the restraints had been released every 2 hours. Interview with the Resident Care Coordinator (RCC) on 01/06/16 at 10:14 AM revealed: -She had said there were no orders to use restraints on any of the residents. -She had said the side rails that were being utilized were being used for safety purposes. -She thought that if a resident was non-ambulatory then the side rails could not be considered a restraint. -She had said that the residents were using the side rails for turning and repositioning in the bed. Interview with a Medication Aide (MA) on 01/06/16 at 12:50 PM revealed: -The facility is using restraints but they have an order to use them. -She said they are to check on the residents with restraints every 30 minutes. -The MAs are to assess the resident for bruising or injury and document. -She was not sure where the restraint documentation was done. -She had not done any of the documentation on the residents who had restraints.	D 485		

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D 485	Continued From page 16 -She had got training when she started at the facility. -Her training was done by the LHPS nurse who was also the facilities Resident Care Coordinator. -The Corporation does in-services on a regular basis. -She was not sure when the last time she had some training on restraint usage. Interview with a second Medication Aide (MA) on 01/06/16 at 3:00 PM revealed: -There were some residents that had side rails that were being used for safety but not restraints. -She said if a resident had a restraint they had to be checked every 15 minutes and released the restraint. -She had said that the Resident Care Coordinator had told her that the facility was not allowed to use restraints any more. -The MA had said if there were restraints used the staff would have to document in the record when they checked and released the restraints. -She had said that Resident #5 only got their rails up when they are in the bed at night for safety and prevention of falls. -She said she gets restraint training once a year from the Resident Care Coordinator. -The Corporation does an in-service once every 3 months about restraint usage from an outside in-service company. -She said they facility had cut back on the amount of staff and it had increased the workload for the staff. Interview with a third Medication Aide (MA) on 01/06/16 at 3:49 PM revealed: -None of the residents are using restraints. -The side rails were used for turning and repositioning of the resident in the bed. -Some of the resident's use the restraints for	D 485		

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safety so they do not fall out of bed.
-She said she gets training once a year on the use of restraints.
-She was not sure who was the one doing the training at the facility.
-She was not sure how to manage the use of a restraints because she had not used one in a while.

Interview with a fourth Medication Aide on 01/07/16 at 9:08 AM revealed:
-None of the residents in the facility were using restraints.
-She was unsure of how often Resident #2's side rails were up.
-She had some training and in-services on the use of restraints.
-The last training was done last year as an in-service on restraint usage.
-The LHPS nurse signed her off for the use of restraints when she started working at the facility.
-There should be an order to use the restraint.
-The MA's should be checking on the resident with a restraint every hour.
-She said the restraint should never be released unless they need to assist the resident with personal care needs.

Interview with the Administrator on 01/07/16 at 9:54 AM revealed:
-She did not feel anyone in the facility was using restraints.
-She was not aware that the side rails were being used as restraints.
-She had said that the Personal Care Aides try to keep the residents out of the bed as much as possible.
-If there were a resident with restraints they should be using the least restrictive restraint possible.

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D 485	Continued From page 18 -She said the Resident Care Coordinator (RCC) should assess the residents for restraint usage. -The facility has been trying to be restraint free. -She said there must be an order for the use of restraints. -The Administrator had said that the RCC had done all the training on the use of restraints. -She said there was a clinical team that come in around August and did some training on the use of restraints. -She said if the resident had restraints then the staff should be checking on them every 15 minutes and releasing the restraint. -The facility does notify the family if the resident has to be placed in restraints. -She is not aware of how often the order for restraint usage should be renewed. -She said the RCC knows more about the use of restraints and getting orders from the medical doctor. Interview with Resident Care Coordinator (RCC) on 01/07/16 at 11:35 AM revealed: -The RCC had said there has to be an order from the medical doctor (MD) for the use of restraints. -She had said once the order is in the record it never has to be renewed. -She had said they get the equipment in and apply it to the resident per MD orders. -She had said that a sign was placed on the wall that when the resident was in bed the side rails should be up. -She had said the resident should be rounded on every hour to assess the restraint. -The RCC had said the restraints are never released because they do not use wrist restraints in this facility. -She said there is no additional documentation needed with restraint usage other than the order.	D 485		

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Telephone Interview with a fifth Medication Aide (MA) on 01/07/16 at 1:18 PM revealed:
-The MA had said there were no residents in the facility that had restraints.
-She said all the residents in the facility get 2 hour checks.
-The residents do not get any special checks when they have restraints.
-She said she usually rounded behind the Personal Care Aides and checked on the residents herself when she worked.
-She said restraints should only be released if the resident has to go to the bathroom or needs to be changed.
-If the resident has restraint orders they should only be used according to the medical doctors orders.
-She said that she had never received any training on restrains since she has worked in this facility.
-She said she got her restraint training from her previous employment.
-The MA said there have been so many in-services that she can ' t recall if there has been one on restraints.

Interview with a Personal Care Aide (PCA) on 01/07/16 at 3:44 PM revealed:
-The PCA said none of the residents were using restraints.
-She said the side rails were used for safety and to help prevent falls.
-She said if a resident was getting restraints she would check on the resident about every 15-20 minutes.
-She would then document that she had checked on them in the chart.
-She said that restraints should never be released off of the resident.
-She only got training on restraints when she first

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D 485	Continued From page 20 started working for the facility. 3. Review of Resident #5's current FL-2 dated 07/06/15 revealed: Diagnosis of Dementia, Alzheimer's, anxiety disorder, Schizophrenia, Hypothyroidism, Hallucination, major depressive disorder, macular degeneration, hearing loss, recurrent falls, abnormality of gait, and muscle weakness. Review of Resident #5's resident register revealed the Resident was admitted to the facility on 07/06/15. Observation of Resident #5 on 01/07/16 at 8:20 AM revealed: -The resident had side rails on her bed. -The resident was lying in bed and both side rails were up. - The resident was unable to grab the side rail and move or turn herself at this time Review of the restraint order in Resident #5's chart revealed: -The resident has an order for usage of restraints dated 07/08/15. -The order said the side rails were to be up when the resident was in the bed. -The order said the restraint device will be monitored every 15 minutes to include checking and making sure the restraint is applied properly. -The order said the restraints should be released every 2 hours. Review of Resident #5's chart revealed: -There was no other documentation in the chart that the resident had been assessed or checked on every 15 minutes. -There was no documentation that the restraints had been released every 2 hours.	D 485		

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D 485	Continued From page 21 Interview with Resident #5 on 01/06/16 at 11:30 PM revealed that Resident #5 was not interview-able due to cognitive reasons. Interview with a Medication Aide (MA) on 01/06/16 at 12:50 PM revealed: -The MA had said the facility is using restraints but they have an order to use them. -She said they are to check on the residents with restraints every 30 minutes. -The MA ' s are to assess the resident for bruising or injury and document. -She was not sure where the restraint documentation was done. -She had not done any of the documentation on the residents who had restraints. -She had got training when she started at the facility. -The MA had said her training was done by the LHPS nurse who was also the facility's Resident Care Coordinator. -The Corporation does in-services on a regular basis. -She was not sure when the last time she had some training on restraint usage. Interview with a second Medication Aide (MA) on 01/06/16 at 3:00 PM revealed: -She had said there were some residents that had side rails that were being used for safety but not restraints. -She said if a resident had a restraint they had to be checked every 15 minutes and released the restraint. -She had said that the Resident Care Coordinator had told her that the facility was not allowed to use restraints any more. -The MA had said if there were restraints used the staff would have to document in the chart	D 485		

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when they checked and released the restraints.
-She had said that Resident #2 and Resident #5 only get there rails up when they are in the bed at night for safety and prevention of falls.
-She said she gets restraint training once a year from her Resident Care Coordinator.
-The Corporation does an in-service once every 3 months about restraint usage from an outside in-service company.
-She said they facility had cut back on the amount of staff and it had increased the workload for the staff.

Interview with a third Medication Aide (MA) on 01/06/16 at 3:49 PM revealed:
-She said none of the residents are using restraints.
-The MA had said the side rails were used for turning and repositioning of the resident in the bed.
-She said that some of the resident ' s use the restraints for safety so they do not fall out of bed.
-She said she gets training once a year on the use of restraints.
-She was not sure who was the one doing the training at the facility.
-She was not sure how to manage the use of a restraints because she had not used one in a while.

Telephone Interview with Resident #5's responsible person on 01/06/16 at 5:00 PM revealed:
-She felt that Resident #5 needed more care than she was receiving due to her diagnosis of Dementia.
-She said that Resident #5 used to be in a Special Care Unit but was moved due to the facility closing down.
-She said Resident #5 has had 3 falls since she

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was admitted to the facility.
-The facility does notify her of falls when the resident has one.
-She was aware that the bed rails were placed and being used when the resident was in the bed.
-She said she requested that the facility put the bed rails up to help prevent falls.
-She was not aware of anything other than the side rails that the facility had done to help prevent the falls.

Interview with a fourth Medication Aide on 01/07/16 at 9:08 AM revealed:
-The MA had said none of the residents in the facility were using restraints.
-She was unsure of how often Resident #5's side rails were up.
-she said she had some training and in-services on the use of restraints.
-The last training was done last year as an in-service on restraint usage.
-she said that her LHPS nurse signed her off for the use of restraints when she started working at the facility.
-There should be an order to use the restraint.
-The MA's should be checking on the resident with a restraint every hour.
-She said the restraint should never be released unless they need to assist the resident with personal care needs.

Telephone Interview with a fifth Medication Aide (MA) on 01/07/16 at 1:18 PM revealed:
-The MA had said there were no residents in the facility that had restraints.
-She said all the residents in the facility get 2 hour checks.
-The residents do not get any special checks when they have restraints.
-She said she usually rounded behind the

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Personal Care Aides and checked on the residents herself when she worked.
-She said restraints should only be released if the resident has to go to the bathroom or needs to be changed.
-If the resident has restraint orders they should only be used according to the medical doctors orders.
-She said that she had never received any training on restrains since she has worked in this facility.
-She said she got her restraint training from her previous employment.
-The MA said there have been so many in-services that she can't recall if there has been one on restraints.

Interview with a Personal Care Aide (PCA) on 01/07/16 at 3:44 PM revealed:
-The PCA said none of the residents were using restraints.
-She said the side rails were used for safety and to help prevent falls.
-She said if a resident was getting restraints she would check on the resident about every 15-20 minutes.
-She would then document that she had checked on them in the chart.
-She said that restraints should never be released off of the resident.
-She only got training on restraints when she first started working for the facility.

Interview with Resident Care Coordinator (RCC) on 01/07/16 at 11:35 AM revealed:
-The RCC had said there has to be an order from the medical doctor (MD) for the use of restraints.
-She had said one the order is in the chart in never has to be renewed.
-She had said they get the equipment in and

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apply it to the resident per MD orders.
-She had said that a sign was placed on the wall that when the resident was in bed the side rails should be up.
-She had said the resident should be rounded on every hour to assess the restraint.
-The RCC had said the restraints are never released because they do not use wrist restraints in this facility.
-She said there is no additional documentation needed with restraint usage other than the order.

Interview with the Executive Director on 01/07/16 at 9:54 AM revealed:
-She did not feel anyone in the facility was using restraints.
-She was not aware that the side rails were being used as restraints.
-She had said that the Personal Care Aides try to keep the residents out of the bed as much as possible.
-If there were a resident with restraints they should be using the least restrictive restraint possible.
-She said the Resident Care Coordinator (RCC) should assess the residents for restraint usage.
-The facility has been trying to be restraint free.
-She said there must be an order for the use of restraints.
-The Administrator had said that the RCC had done all the training on the use of restraints.
-She said there was a clinical team that come in around August and did some training on the use of restraints.
-She said if the resident had restraints then the staff should be checking on them every 15 minutes and releasing the restraint.
-The facility does notify the family if the resident has to be placed in restraints.
-She is not aware of how often the order for

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restraint usage should be renewed.
-She said the RCC knows more about the use of restraints and getting orders from the medical doctor.

4. Review of Resident #3's current FL-2 dated 01/07/15 revealed:
Diagnosis of Pic's disease, dementia with behavior dist., diabetes mellitus, hypertension.

Review of Resident #3's resident register revealed the resident was admitted to the facility on 11/24/09.

Review of Resident #3's record revealed:
-There was not a signed doctor's order for restraint use.
-There was a signed Restraint Assessment form by the registered nurse stating the use of bedrails does not meet the criteria for a restraint.
-There was not a signed doctor's order for bedrails to be used as a safety/support device.
-There was not a signed guardian consent for restraints, safety/support devices, bedrails, or chair alarm use.

Interview with the Registered Nurse (RN) / Resident Care Coordinator (RCC) for Resident #3 on 01/06/16 at 10:08 a.m. revealed:
-The RN/RCC said there were no orders for restraint use in any of the residents' records.
-The resident did not have an order for bedrails because she was non-ambulatory.
-She said a doctor's order for bedrails was not needed for any resident who was non-ambulatory.
-The RN/RCC was in the process of placing Restraint Assessment forms in all residents' records signed by her who were not ambulatory.
-The RN/RCC said bedrails were being used for

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safety reasons and did not consider these to be a restraint.

Interview with a Medication Aide (MA) for Resident #3 on 01/06/16 at 3:00 p.m. revealed:
-Residents with bedrails are not able to pull them up or down but need staff to do this for them.
-Bedrails were being used for safety and positioning of residents.
-The MA said bedrails and restraints are used only with those residents who had a doctor's order.
-MA said resident had a doctor's order for bedrails.
-MA said resident had a wheelchair with a positioning device, along with the bedrails, in place since her falls in July 2015 for support.
-The MA was not sure when she had received training on restraints and bedrail use.
-The MA receives training from the RN/RCC when needed.

Observation of Resident #3 on 1/06/16 at 3:15 p.m. revealed:
-The resident was asleep in her wheelchair with chair alarm attached while in the small day room.
-The chair alarm was on the right side of the resident's wheelchair attached with a clip to the collar of the resident's shirt.
-The resident was considered by facility staff to not be interviewable due to her cognitive and mental status.

Interview with the Resident Care Manager (RCM) for Resident #3 on 1/06/16 at 3:18 p.m. revealed:
-The RCM was aware that the resident had bedrails.
-The resident's bedrails were used for safety and positioning while in bed.
-She was not aware that the resident had a chair

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	HAL025035	A. BUILDING: _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BERN HOUSE	2915 BRUNSWICK AVENUE NEW BERN, NC 28562

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alarm on her wheelchair.
-The chair alarm was probably being used to alert staff when she tries to get up.

Telephone interview with the Physician for Resident #3 on 1/06/16 at 5:05 p.m. revealed:
-There was not a signed order for restraints in the resident's record.
-Bedrails were ordered for use for the resident's safety and positioning.
-There was no signed order for bedrails for safety purposes in the resident's record.
-The physician was aware that the resident had a chair alarm but he did not order it.
-The physician said the hospice nurse recently ordered the chair alarm about a week ago.

Telephone interview with Responsible Person for Resident #3 on 1/07/16 at 11:18 a.m. revealed:
-The responsible person for resident was aware she has bedrails.
-She said bedrails may be considered as restraining but feels these are used to help keep her safe while in bed.
-Responsible person was not asked or offered to sign a consent for restraints or bedrail use.
-Responsible person was aware of the resident had a chair alarm.
-She said the chair alarm was recently put in place by the hospice nurse about a week ago.
-The responsible person said that it was important to her that the hospice nurse train facility staff on the proper use of the chair alarm.
-The responsible person for resident was not asked or offered to sign a consent form for the chair alarm use.

Interview with second Medication Aide (MA) for Resident #3 on 1/07/16 at 1:13 p.m. revealed:
-MA said bedrails are for safety and positioning of

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residents.
-She is not aware of any resident getting up or attempting to and getting injured.
-She follows the resident protocols and orders for restraint use.
The MA said she received training from the registered nurse/resident care coordinator last year.

Telephone interview with the third Medication Aide (MA) for Resident #3 on 1/07/16 at 3:50 p.m. revealed:
-The MA said she only uses bedrails when there is a doctor's order in place for use.
-Bedrails are used for safety of the residents while in bed.
-She does feel bedrails are restraining for residents.
-MA was not aware resident had a chair alarm in place.
-MA received training a year and a half ago from the RN/RCC.

Interview with the Executive Director (ED) on 01/07/16 at 3:35 p.m. revealed:
-The administrator said bedrails were used for safety purposes and for positioning.
-She does not view bedrails or chair alarms as restraints.
-The Resident Care Coordinator (RCC/RN) monitors the residents for restraint use.
-The RCC/RN trains facility staff on restraints at least once a year or more if deemed necessary.
-The ED said there should be orders in the resident's records for restraints.

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D 485	Continued From page 30 The Executive Director provided a "Plan of Protection" for all residents effective 1/07/16. "The ED will immediately have 2 RNs assess all residents to determine of bed rails or any other devise meets the criteria of a restraint by 1/31/2016. If deemed a restraint, alternative devices will be utilized in lieu of bed rails or other restrictive device. The RN will follow the restraint guideline as outlined by the state regulations to ensure compliance with the rule area. For any device meeting the criteria of a restraint staff will be educated on the proper use of the device. All staff will be trained on the use of alternatives to physical restraint use and on the care of residents whom are physicially restrained by care managers, RN, ED, or other designee. Staff will be trained by an RN or other designee and shall include the following: alternatives to physicial restraints, types of physicial restraints, medical symptoms that warrant physical restraint, negative outcomes from using physicals, correct application of physical restraints, monitoring and caring for residents who are restrained, and the process of reducing restainr time by using alternatives, This will be completed by 1/31/2016." CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 21, 2016.	D 485		
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	D912		

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D912	Continued From page 31 regulations. This Rule is not met as evidenced by: The findings are: Based on observations, record reviews, and interviews, the facility failed to obtain orders before using restraints and failed to document alternatives, type of restraint, medical symptoms, times, care provided and behavior of residents for 4 of 6 residents having bed rails (Residents #1, #2, #3, #5). [Refer to tag D 485 10A NCAC 13F .1501(d) (Type B Violation)].	D912		