STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaints investigation on December 19-21, 2017. The complaints were initiated by the Bladen County Department of Social Services on December 13, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings and floors were kept clean and in good repair for 4 resident rooms (101, 103, 109, 111), 7 resident bathrooms (101/103, 104, 105/107, 108, 109/111, 110, 113) and one common hall bathroom, in the facility's Special Care Unit (SCU). Observation of the bathroom for Resident Room 104 on 12/19/17 at 10:56 a.m. revealed: -There were two patches of white plaster each 3 inches by 3 inches on the wall near the light switch. -The tile flooring had dark gray and black stains in several areas that ranged in sizes from 3 inches to 6 inches in diameter. -The bottoms of the door frames each had a half inch rusted area where the frames met the floor.	D 074		

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D 074	Continued From page 1 Observation of the bathroom for Resident Room 108 on 12/19/17 at 11:09 a.m. revealed: -There were two areas on the wall each 2 inches by 2 inches with chipped plaster and 2 half inch holes in each. -There was a 4 inch by 4 inch patch of white plaster on the wall next to the toilet. -The bottoms of the door frames each had a half inch rusted area where the frames met the floor. Observation of the bathroom for Resident Room 110 on 12/19/17 at 11:20 a.m. revealed: -There were four patches of white plaster each 2 inches by 2 inches on the wall near the light switch. -There was a missing towel bar. -The tile flooring had dark gray and black stains in several areas that ranged in sizes from 3 inches to 6 inches in diameter. -The bottoms of the door frames each had a half inch rusted area where the frames met the floor. Observation of the bathroom for Resident Room 113 on 12/19/17 at 11:26 a.m. revealed: -The wall below the shower head had an area 2.5 feet in length where the paint was buckling and peeling away from the edge of the shower wall. -There was an 18 inches by 18 inches ceiling spot where water had leaked through the ceiling. -The tile flooring had dark gray and black stains in several areas that ranged in sizes from 3 inches to 6 inches in diameter. Observation of Resident Room # 101 on 12/19/17 at 10:46 a.m. revealed: -The heating and air conditioning unit was separating from the wall causing breaks in the paint above the unit. -There was a golf ball sized hole in the wall to the	D 074		

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D 074	Continued From page 2 right of the door. -There was a golf ball sized hole in the wall to the left of the door. -There was an area of peeled paint on the ceiling measuring about the size of a handprint. -There were four gray stains on the ceiling each about the size of a golf ball. Observation of the shared bathroom between Resident Rooms 101 and 103 at 12/19/17 at 10:47 a.m. revealed: -There were two patches of white plaster about the size of a tennis ball to the left of the toilet. -There was a wall to wall tear in the flooring covered in clear tape. -There were cracks in the grout between the sink and the wall. - There was an area surrounding the pipe extending from the wall to the toilet and above the baseboard where paint was buckling and peeling. -There was a missing towel bar on the wall. Observation of Resident Room #103 on 12/19/17 at 10:57 a.m. revealed: -There was a large white plastered area with cracks on the wall to the right of the bed. -There was a quarter sized hole in the wall behind the door. -There was a golf ball size, white patched hole in to the right of the door. Interview with two PCA's on 12/19/17 at 10:58 a.m. revealed: -There was a knob on the bed rail that caused the hole in the wall. -They noticed the area on the wall about a month ago. -The area was patched about three weeks ago. -They were unsure if the area would be repainted.	D 074		

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D 074	Continued From page 3 Observation of the hall bathroom on 12/19/17 at 11:07 a.m. revealed: -There was a two foot area of peeling paint on the ceiling to the right of the door. -There was a foot and a half long area on the ceiling that was unpainted. -There were three, two foot areas of peeling paint on the ceiling above the tub. Observation of the shared bathroom between Resident Rooms 105 and 107 on 12/19/17 at 11:13 a.m. revealed: -There was a foot long area below the bathroom sink where the baseboard was separating from the wall. -There was a missing towel bar on the wall. -The tile flooring was darkened in certain areas that appeared to be black stains. Interview with a PCA on 12/19/17 at 11:17 a.m. revealed: -The floor had those dark areas for about two years. -She believed it might have been caused by past flooding but was not sure. Observation of Resident Room 109 on 12/19/17 at 11:20 a.m. revealed: -There were two dime sized holes on the ceiling near the light fixture. -There was a foot long scratch in the wood on the back of the door. -There was a golf ball sized hole in the wall beneath the ledge of the window. Observation of the shared bathroom between Resident Rooms 109 and 111 on 12/19/17 at 11:21 a.m. revealed: -There was a large unpainted area on the wall behind the toilet.	D 074		

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-There was a two foot area below the sink and above the baseboard that was missing paint.

Observation of Resident Room 111 on 12/19/17 at 11:27 a.m. revealed there were six tennis ball sized gray areas on the ceiling.

Interview with the Medication Aide on 12/19/17 at 11:30 a.m. revealed she was unsure what happened to cause those areas on the ceiling.

Interview with the Maintenance Supervisor on 12/19/17 at 5:20 p.m. revealed:
-The areas on the ceiling in Resident Rooms 101, 109, and 111 were caused by removing an old light fixture.
-He was unaware the ceiling was peeling in the hall bathroom.
-He was unaware of the area in Resident Room 101 where the heating and air conditioning unit was separating from the wall.
-He was unaware of the holes in the walls in Resident Rooms 101, 103, and 109.
-He believed the holes may have been caused by residents or by the doors being pushed into the walls.
-The hole in the wall in Resident Room 103 was caused by the bed hitting the wall.
-The area was plastered about two weeks ago.
-The flooring in the shared bathroom between Resident Rooms 101 and 103 had always had tape over the ripped area.
-He was instructed to tape the area by the contractors who installed it.
-The area of the wall in the shared bathroom between Resident Rooms 101 and 103 was damaged when the pipe was repaired.
-He was aware the baseboard was coming away from the wall in the shared bathroom between Resident Rooms 105 and 107.

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-He was aware the towel bars were missing in the shared baths between Resident Rooms 101 and 103 and 105 and 107.
-He was unsure why the tile in the shared bathroom of Resident Rooms 105 and 107 was darkening.
-This was happening in several bathrooms throughout the facility.
-He was aware the shared bathroom between Resident Rooms 109 and 111 needed some repainting.
-He was unsure when the areas in the shared bathrooms would be repainted
-He also did housekeeping at the facility and did not do major repairs such as painting.
-He reported items that needed to be repaired to the ED so that she could contact contractors.
-The Executive Director (ED) was in the process of having contractors come in and repaint those areas.

Interview with the Resident Care Coordinator (RCC) and the Executive Director (ED) on 12/19/2017 at 5:45 p.m. revealed:
-They were aware of the floor stains, areas of plaster on the walls and ceiling spots in the bathrooms on the SCU.
-The Maintenance Supervisor would report any areas requiring repair to the ED.
-The ED would coordinate getting the repairs completed.
-The ED was working with contractors for repainting the SCU bathrooms.
-The contractors had already completed some repairs in the SCU bathrooms.
-The ED would show the Administrator the rusted areas on door frames and floor stains in the bathrooms.

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D 270	Continued From page 6	D 270		
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, interviews, and record reviews, the facility failed to assure supervision by not implementing interventions to address the current symptoms and assessed needs for 2 of 5 residents sampled (#3, #4) who had a diagnosis of dementia. Resident #3, who had a history of attempting to ambulate without assistance and multiple falls with injuries, sustained multiple facial fractures and a fractured wrist. Resident #4, who had a history of moving excessively in bed and becoming entangled in the bed covers and falling off the bed, was found entangled in the bed covers with her head stuck between the bed and bed rail with her body on the floor. The findings are: 1. Review of Resident #3's FL-2 dated 6/6/17 revealed: - Diagnoses included vascular dementia with behavioral disturbances, heart disease, systolic heart failure, hypertension, and anxiety. -The resident was disoriented constantly and used a walker to assist with ambulation. Review of Resident #3's Resident Register	D 270		

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revealed an admission date of 01/19/16.

Review of Resident #3's care plan dated 01/18/17 revealed:
-The resident required extensive assistance with bathing, dressing and grooming.
-The resident required total assistance with toileting.
-There was no documentation regarding the level of assistance required with ambulation or transfers.

Review of the Resident #3's Licensed Health Professional Support (LHPS) review dated 11/15/17 revealed the resident required assistance with ambulation and transfers.

The LHPS nurse was not available for interview during the survey.

Observation on 12/18/17 at 3:10pm revealed:
- Discolored (yellowish and purplish) bruising on the left side of Resident #3's face from above the left eye down to her left cheek/jaw/nose and on forehead.
-The Resident's left wrist/hand had purplish bruising. Her shoulder had a dark/yellowish bruise
-The resident's left eyebrow had a healing laceration
-The resident was sitting in a Geri chair, the living room, in the special care unit.

Review of an EMS report dated 12/6/17 revealed:
-The county EMS received a non-emergent call from the facility on 12/6/17 at 6:34am.
- EMS arrived at the facility at 6:58am and was informed by facility staff, Resident #3 fell during the night, causing her to have bruises.
-The resident had multiple injuries of the head upper and lower extremities due to fall.

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D 270	Continued From page 8 -EMS was unable to assess the resident's left pupil due to swelling of the left eye. -The resident was noted to have several injuries to include an old bruise to the center of her forehead, a laceration approximate 1 inch in length to her left outer upper orbital area, her left eye was swollen shut, swelling noted to entire left side of face, and to her left jaw area, her lips were swollen and bruised black and blue, old and new bruising to her left outer shoulder cap area (yellow, black and purple), swelling and slight deformity noted to her left forearm/wrist area with bruising and swelling noted throughout the wrist area and to her left hand, old bruising and swelling noted to left knee, same was hot to touch. Interview with a local emergency medical technician (EMT) on 12/19/17 at 9:15am revealed: -On 12/6/17 at 6:34am, the facility called emergency medical service (EMS) for non-emergency transport of a resident residing in their Alzheimer's unit. -When the EMTs arrived at the facility, they found Resident #3 in the dayroom on the couch (in the Alzheimer's unit). -The resident was lying in a fetal position and looked like "someone had beat the crap out of her". -A staff informed the EMTs, the resident had fallen on 2nd shift on 12/5/17. Staff had contacted the family and the hospice nurse, but the resident was not transported to the hospital. -A staff (whom the EMT did not know the name) stated the resident fell again on 3rd shift (12/6/17). She was found on the floor, but no injuries were noted because the light in the resident's room was not turned on. -The resident's left eye was swollen shut with a 1	D 270		

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D 270	Continued From page 9 inch laceration at the outer socket near the left eyebrow. -The resident's left jaw was swollen and the left side of her lips were swollen with purple bruising. -The resident's left outer shoulder had a brownish/yellowish bruise. -The resident's left forearm and left hand was bruised with deformity at the wrist. -Even though the resident's records documented the resident ambulated with a walker, a walker was not at the couch. The staff informed the EMTs, the resident was carried to the couch. -The resident moaned and groined in pain when the EMTs transferred her to the stretcher and was in obvious pain. Review of facility Incident/Accident reports revealed: -On 12/5/17 at 4:15pm, Resident #3 was lying on the chair (in the SCU living room). She got up without saying nothing and fell on her left side and cut her left eye. The hospice nurse was notified. "we put her in her bed so she would be on an alarm [bed alarm]. -On 12/3/17 at 5:30pm, all staff was in the dining room [on the SCU] feeding resident. Resident #3 was on the couch [in the living room] and stood up and fell down and hit her face on the floor. Her nose was bleeding and she busted her lip. She had a bruise on the left side of her face and on her left shoulder. The hospice nurse was notified. (No other interventions were documented). -On 9/27/17, Resident #3 was in her bedroom and [attempted] to get up [without assistance]. She appeared to be weak and fell, hit her wrist on the night stand. The resident had 2 skin tears on the right wrist and the wrist was swollen and had a hematoma. the resident did not lose consciousness and was transported to a local ER by the local EMS. (No other interventions were	D 270		

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documented).
-On 9/22/17 at 2:00pm, Resident #3 was sleeping when [staff] heard "help me help me". [Staff] went to the resident's room and she was on the floor, on the left side of the bed. The resident got herself off the floor and onto the bed after [staff] told her to stay down. The resident stated her left knee hurt but she was fine. The resident refused to go to the hospital and since she "put up a fuss" the staff left her alone. (No other interventions were documented).

Review of documentation on facility "Nurses Notes" revealed:
-On 8/31/17 at 4:45pm, [Resident #3] got up out of bed, was walking without her walker, fell and hit the floor and cut above her left eye. [The resident] was sent out to [a local hospital] for treatment.
-On 9/3/17, [staff from local hospital] "called with update on [Resident #3]. She has post-concussion syndrome from her fall on 8/31/17.EMS used Narcan and ammonia capsules on the way to the hospital and both were ineffective".
-On 9/3/17, [the resident] "was in her room lying in the bed calling for help, when we got to the room, she was out [non-respnsive]. The CNA cleaned her up and put her back to bed and then she went out [non-responsive] again. 911 [EMS] was called and took her to [local hospital].
-On 9/22/17, [Resident #3] "fell off her bed, looks like she might have rolled off. She refused to go to the hospital, said her knee hurt, but then said she was fine. She went back to sleep. [Staff checked resident] every 15 minutes".
-On 11/14/17, the resident's hospice nurse documented, "received call from [medication aide (MA)] stating that patient was agitated and had a fall. And on arrival, patient was lying in bed. She

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had a knot on left forehead".
-On 11/21/17 at 7:40pm, the resident's hospice nurse documented, "she has several bruises that are healing to arms bilaterally.
-On 12/03/17 at 7:00pm, the resident's hospice nurse documented, "prn visit. The patient had a fall and hospice [was] called. Daughter did not want patient sent to the hospital. The left side of face swollen. Staff reports that patient had bloody nose. No bleeding at this time".
-On 12/6/17, the SCU supervisor documented, "the hospital called back and gave report on resident. They stated that resident had multiple fractures to include facial fractures, and old fracture of left shoulder.
-On 12/06/17, the special care unit (SCU) supervisor documented "late entry, got a phone call last night on 12/5/17 that resident [#3] had fallen. Her daughter was notified and also hospice nurse was notified. Her daughter requested that she not be sent out. So staff [followed] orders that hospice had given which were to put her back to bed and give morphine".
-On 12/06/17, the SCU supervisor documented, "received phone call from med tech on 3rd shift, stating that resident was black and blue from fall on 12/5/17, 2nd shift, with a bruise on shoulder and wrist, with wrist being swollen. She wanted to send the resident out and I agreed".

Review of local hospital emergency room (ER) reports revealed:
-On 12/06/17, Resident #3 was treated at a local ER in another county and was diagnosed with multiple left facial bone fractures which included left orbital floor fracture and left lateral orbital wall fracture, fracture of the anterior wall and posterior wall of the left maxillary sinus, diffuse soft tissue swelling, impaction fracture of the distal radial metaphysis and oblique fracture of the distal ulna

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(left wrist). The resident "presents after a fall at a nursing facility. Patient placed in volar splint for her wrist. All fractures are nonsurgical at this time. Patient will be sent back to nursing facility.
-On 8/31/17, Resident #3 was transported by EMS to a local ER in another county after a fall at the facility. The resident was alert but drifts off to sleep. CT scan of the head revealed no intracranial bleeding or fracture. There is left frontal and left periorbital soft tissue swelling.
-On 9/3/17, Resident #3 was transported by EMS to a local ER for complaints of unresponsiveness. The resident arrived to the ER not responding to verbal, tactile or painful stimuli. EMS found the resident unresponsive. The resident had significant bruising noted to left eye/side of face and left collar bone from fall 4 days ago. The resident was diagnosed with post-concussion syndrome.
-On 9/27/17, Resident #3 was transported by EMS to a local ER in another county after a fall at the facility with a bruise, swelling and skin tear to the right hand/wrist. X-rays were negative for fracture or dislocation. The resident was discharged with a dressing to the wound.

Interview with a nursing assistant (NA) on 12/19/17 at 3:15pm revealed.
-The NA worked on the SCU on 2nd shift.
-Resident #3 had several falls within the last few months because she walked with a walker but always attempted to walk without her walker and has fallen a few times.
-The resident was checked every 1 to 2 hours when she was in her room, but when she was on the couch, in the living room, staff was always in the room and watched the residents.
-The NA did not know if the resident had ever been placed on 30 minute checks or any different supervision before the fall on 12/5/17.

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D 270	Continued From page 13 -A staff always monitored the resident since her last fall on 12/5/17 by sitting in a chair across from the resident's room when the resident was in her room. -Staff always supervised the residents in the living room. Interview with a MA on 12/19/17 at 3:20pm revealed: -She was working on the SCU (2nd shift) when Resident #3 fell on12/3/17 and 12/5/17. -The resident was not sent to the hospital per family's request and hospice was called after the falls. -The resident was sent to the hospital on 12/6/17 due to the new bruising found the next morning. -The resident was checked every 2 hours when she was in her room and the staff always supervised the residents when they were in the living room. -After the resident's last fall on 12/05/17, a staff member was always monitoring the resident when she was in her room. A staff member was required to sit in a chair across from the resident's room when she was in her room. Interview with the SCU Supervisor on 12/19/17 at 3:30pm revealed: -Resident #3 was always restless, especially at night and sometimes refused to go to bed. -She was not in her bed the morning of 12/6/17 when EMS transported her to the ER. -The resident had fallen on 12/6/17 and 12/3/17 (on 2nd shift). The staff called the hospice nurse who came to the facility and checked the resident. -The resident was always supervised when up in her wheelchair or Geri chair. A staff sat in chair across from the resident's room when the resident was in bed after the last fall (on 12/5/17).	D 270		

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The resident had a bed/chair alarm, which the staff responded to immediately if sounded.

Interview with Resident #3's hospice nurse on 12/19/17 at 11:30am revealed;
-The resident was admitted to hospice on 10/13/17. The resident has declined and was totally dependent for all ADLs including transfers, feeding and bathing.
-The resident was ambulating with a walker but due to increased falls, she recommended the use of a wheelchair for ambulation after she fell on 12/3/17.
-The hospice nurse has taught the staff to use the bed alarm/chair alarm at all times and not to leave the resident alone when she was in the living room.
-The resident has a Geri chair to use for comfort and even though the resident may be able to get out of the chair, she will not be able to get up as quickly.
-She did not know how often the staff checked on the resident.

Interview with another NA on 12/20/17 at 10:50am revealed:
-Resident #3 continued to attempt to get out of her wheelchair and bed.
-The resident had a bed/chair alarm which sounded if she attempted to get up.
-The resident had more falls on 2nd shift and the NA usually checked the resident every 1 and ½ to 2 hours and assisted her to the bathroom and provided incontinent care.
-When the resident was in bed, a staff sat in a chair across from her room since the last fall on 12/5/17.

Interview with another MA on 12/20/17 at 11:15am revealed:

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-On 12/6/17 she came to work at 6:50am, and Resident #3 was on the living room couch covered with a blanket. She was alert and disoriented.
-The left side of the resident's face was swollen with dark bruising on the left side of her face.
-The staff was waiting on the EMS to arrive to take her to the ER. The 3rd shift MA reported the resident had fallen on 2nd shift and the hospice nurse had checked on her.
-The resident could get out of bed, out of a chair fast and needed to be supervised at all times.
-The staff should check on her every 30 minutes and staff sat in a chair across the hall from the resident's room since last her fall on 12/5/17.
-Before the last fall, staff checked on the resident every 1-2 hours when she was in bed and there were always staff present when the resident was in the SCU living room.

Interview with Resident #3's primary health care provider on 12/20/17 at 2:50pm revealed:
-He was aware of 1 fall which occurred at night, but did not know the date of the fall.
-He was aware the resident had multiple facial fractures and fracture of her wrist from the fall.
-He was aware of previous falls but did not order any changes in the resident's supervision or care.
-A Geri chair was ordered for use in December, 2017 to help decrease falls, but the resident would need one to one supervision to prevent falls.

Interview with the SCU Supervisor on 12/20/17 at 6:00pm revealed:
-On 10/3/17 a Fall Prevention Assessment was completed after a fall.
-The resident should have been using her walker with all ambulation/transfers, but she would often get up and attempt to walk without her walker.

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-The staff should have assisted the resident with transferring or ambulating if they observed her getting up or walking without her walker.
-The staff encouraged resident to use her call light when in bed but she did not because of her forgetfulness.
-A bed/chair alarm was in use after last fall on 12/5/17, to alert the staff when the resident attempted to get up.

Interview with the Resident Care Coordinator on 12/20/17 at 7:00pm revealed:
-Since the last fall on 12/5/17, staff was to sit in a chair across the hall from the resident's room when she was in bed.
-When the resident was up in her wheelchair, in the living room, staff was to supervise area at all times.
-A bed/chair alarm was used to alert staff if the resident attempted to get up without assistance.
-On 12/3/17, Resident #3 was lying on the couch in the living room, while the staff was assisting the other residents with supper.
-The staff could see the resident on the couch, while in the dining room.
-The MA turned around to check on the resident and observed the resident standing up and falling on the floor hitting the left side of her face. The resident's nose was bleeding and a bruise was on the left side of her face.
-The resident was not sent to the ER, but they watched the resident closer after the fall.

Interview with a third MA on 12/21/17 at 10:45am revealed:
-She worked 3rd shift after Resident #3 fell on 2nd shift on 12/05/17.
-The 2nd shift MA reported the resident had fallen and hospice nurse came to the facility and checked the resident and instructed the staff to

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keep an eye on her.
-Around 3:30am, the MA checked on the resident and she was awake and restless.
-The MA assisted the resident to the living room on the couch and observed bruises on her face and a red spot on her left shoulder.
-By 6:30am, the bruises were dark. When the staff provided incontinent care and rolled her over on the couch, the resident grabbed her wrist which was swollen and bruised.
-The MA called the RCC and reported injuries. The RCC instructed her to call EMS to transport her to the ER for evaluation.
-The 3rd shift staff check on the residents every 2 hours and walk through the hallway every 30 minutes to make sure the residents are in bed and breathing.
-A staff sat in a chair near Resident #3's room at all times, when the resident was in bed, since the last fall on 12/5/17.

Interview with the Executive Director (ED) on 12/21/17 at 1:50pn revealed:
-When a resident was assessed to be a fall risk or have a history of repeated falls, the facility would use bed/chair alarms to alert the staff if resident attempt to get up without assistance, fall mats were used at bedsides.
-The staff was to put their eyes on the residents as much as they can. Normally the staff do 30 minute checks and walk the floor every 15 minutes.
-Since Resident #3's last fall, the resident sat in a wheelchair or Geri chair, when out of bed, with alarms.
-The ED was not aware the resident sustained multiple facial fractures from her last fall on 12/5/17, only aware of left wrist fracture and old healed shoulder fracture.
-There were no supervision changes until after

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last fall on 12/5/17.

Resident #3's family was not available for interview during the survey.

Based on observation, record review and interviews, Resident #3 was confused and was not interviewable.

2. Review of Resident #4's FL-2 dated 07/19/17 revealed:
-Diagnoses included Alzheimer's disease, weakness, hypertension, osteoarthritis, and Vitamin D deficiency.
-The resident was constantly disoriented and wandered.
-The resident was semi-ambulatory with the use of a wheelchair.
-The resident was incontinent of bowel and bladder.
-The resident required personal care assistance with bathing, feeding, and dressing.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 06/20/17.
-The resident required assistance with dressing, bathing, nail care, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, eating, positioning/turning, scheduling appointments, and orientation to time and place.
-The resident had significant memory loss.

Review of Resident #4's assessment and care plan dated 08/09/17 revealed:
-The resident was admitted on 06/20/17 to the assisted living side of the facility but she tried to leave, wandering up and down halls saying she

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needed to get out.
-The resident was ambulatory with a wheelchair.
-The resident had limited range of motion in her upper extremities.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #4's nurses' notes revealed:
-09/20/17 (4:30 p.m.): The resident was sent out to the hospital after getting out of her wheelchair and falling on the floor. She was complaining of her left leg hurting.
-09/29/17 (no time noted): The resident was wrapped up in the sheets on the bed and rolled off onto the floor onto her right side.

Review of an incident/accident report dated 09/29/17 at 9:05 a.m. for Resident #4 revealed:
-The resident was wrapped up in sheets on bed and rolled off onto the floor onto her right side.
-The resident did not lose consciousness and there were no visible injuries.
-The resident refused vital signs.
-Staff checked the "no" blocks indicating bed rails were not ordered and bed rails were not present.

Review of an incident/accident report dated 12/06/17 at 7:20 a.m. for Resident #4 revealed:
-The location of the incident/accident was the resident's room.
-The resident's condition before the incident/accident was noted to be normal.
-The section of the form asking if bed rails were ordered was left blank.
-The section asking if bed rails were present was checked yes and noted to be in the up position.
-The section asking if a restraint was in use was

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checked no.
-A medication aide documented walking in the residents' room.
-The resident "was on the floor with her head caught between the bed rail and bed".
-The resident "was on the floor tangled up in her covers and her head was caught between the bed and the bed rail, her head was just sitting in the rail facing the wall".
-The diagram to indicate the location of injury had the head circled.
-The type of injury was left blank.

Review of an Emergency Medical Services (EMS) dispatch detail report dated 12/06/17 revealed there was an incoming call to 911 from the facility on 12/06/17 at 7:39 a.m. for Resident #4.

Interview with a medication aide (MA) on 12/20/17 at 12:44 p.m. revealed:
-She got to the facility for first shift about 6:50 a.m. on 12/06/17.
-She clocked in and went to the special care unit (SCU).
-There was a resident on the couch in the living room that staff was getting ready to send out to the hospital.
-Third shift staff gave her a verbal shift report.
-Two personal care aides (PCAs) were taking care of bed alarms that were sounding in residents' rooms.
-The other MA was working on the medication cart.
-She decided to take the second medication cart but that medication pass did not start until 8:30 a.m.
-She decided to go down the hall and help the two PCAs get residents up.
-They always started at the far end of the hall and worked their way back toward the nurses' station.

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D 270	Continued From page 21 -The heavier care residents had rooms closest to the nurses' station. -She looked at the clock and it was 7:20 a.m. -She decided to see if Resident #4 wanted to get up for breakfast. -Resident #4's door was open but the room was dark. -Resident #4's bed was the bed closest to the door. -There was a little light shining in the room from the hallway. -She saw bed covers on the floor and the resident was not in bed so she assumed the resident was on the floor. -She called for the other MA, stepped back and turned on the light. -Resident #4's body was on the floor wrapped in bed covers from her chest area to her feet. -The resident's head was between the bed and the bed rail with her chin on the lower bar of the bed rail. -The resident was facing the wall toward the door. -The resident's eyes were closed and the skin on her forehead was pale gray. -She called the resident's name but the resident did not answer. -She checked for a pulse on the left side of the resident's neck for about 3 to 4 seconds but she could not feel a pulse. -The resident's skin felt "lukewarm". -She could not check a pulse on the resident's wrist because the resident's arms were tangled in the covers and she did not want to move the resident. -She called the other MA a second time. -The other MA came in the room and she told the other MA that she did not think the resident was alive. -The other MA ran for help and called for the Special Care Unit Supervisor (SCUS) who was	D 270		

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outside with EMS for a different resident.
-Then the SCUS and the Assisted Living Shift Supervisor (ALSS) came to Resident #4's room and took over the scene.
-She was not sure who called 911 because she was very upset and crying.
-Staff had to loosen the bed rail from the bed to release the resident's head.
-She did not recall seeing any marks on the resident's face or head.
-She helped the Resident Care Coordinator (RCC) and the Transporter move the resident's body to the bed.
-The resident's legs were "cool to the touch" and her arms and legs were pale.
-The RCC and the Transporter checked again for a pulse but could not get a pulse.
-It was not like Resident #4 not to respond, "She was a hollerer".
-She did not hear the resident holler prior to discovering the resident in her room.
-She did not recall Resident #4 having a bed alarm.
-The resident could sit up on the bed by herself if she pulled on the bed rail.
-She felt the resident could sit up and swung her legs to the side of the bed if she had scooted down past the bed rail.
-The resident could bear weight with staff standing beside her and the resident could hold onto the wheelchair while staff changed her incontinence brief.
-It was not unusual to see the resident trying to get out of bed.
-The resident was a "rough sleeper" because she rolled around a lot.
-It was not unusual for the resident to get tangled in the bed covers on a daily basis with half her body including her legs hanging off the bed.
-She would have to help the resident get

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untangled from the covers.
-The resident got a hospital bed about a month ago but she continued to get tangled in the covers.
-She was not aware of anything being done to prevent the resident from getting tangled in the covers.
-SCU staff did routine 30 minute checks on all residents at that time.
-Since the incident on 12/06/17 with Resident #4, they had a hall person doing 15 minute checks.
-SCU staff did incontinence checks every 2 hours.
-Resident #4's roommate was not in the room on 12/06/17 during the incident.

Interview with a second MA on 12/20/17 at 1:45 p.m. revealed:
-Resident #4 would get tangled in the bed covers every day because she rolled in the bed.
-The resident was "a mover and a shaker" and she was at risk for falls.
-The resident got tangled in the bed covers in September 2017 and fell out of bed but she had no injuries.
-The resident's family member wanted the resident to have a hospital bed with rails because he thought the resident would be safer to keep her from falling off the bed again.
-She was not sure how long the resident had the hospital bed with half rails but she though it was "about a month".
-SCU staff did routine 30 minute checks for all residents and 2 hour incontinence checks.

Telephone interview with a third MA on 12/21/17 at 12:12 p.m. revealed:
-Resident #4 would twist and turn and get bed covers tangled.
-The resident would need help to get untangled

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from the covers.
-It was not unusual for the bed covers to be wrapped around the resident during the night.

Telephone interview with a PCA on 12/21/17 at 10:55 a.m. revealed:
-Resident #4 would scoot down in the bed sometimes.
-The resident had previously rolled off of the bed tangled in the bed covers in September 2017 when she had a regular bed prior to getting the hospital bed.
-The resident's family member and other staff had told her the resident would get tangled in the covers.
-She did not recall seeing the resident tangled in bed covers.

Attempts to contact the other PCA (who worked third shift on 12/05/17 11:00 p.m. - 12/06/17 7:00 a.m.) on 12/21/17 starting at 11:22 a.m. were unsuccessful.

Interview with a second PCA on 12/20/17 at 2:10 p.m. revealed:
-Resident #4 tossed and turned in bed and she would get tangled in the sheets every day.
-Staff would have to help untangle the resident from the sheets.
-She could not recall how long the resident had the bed rails.
-SCU staff did 30 minute routine checks on all residents and 2 hour incontinence checks.

Interview with a third PCA on 12/21/17 at 1:10 p.m. revealed:
-Resident #4 could sit up in a chair and she could roll in the bed.
-The resident would roll over and the bed covers would fold around and over her.

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WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

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-The resident required two staff for transferring and toileting.
-SCU staff did 30 minute checks to physically locate all residents.
-Both third shift and first shift were supposed to document a 30 minute check at 7:00 a.m.
-He did not always do a physical check for the 30 minute log sheet at 7:00 a.m.
-He would sometimes document whatever third shift had noted on their log for the 7:00 a.m. check.

Interview with the facility's Transporter on 12/21/17 at 11:50 a.m. revealed:
-She also worked as a MA and PCA at times.
-Resident #4 would sometimes try to get out of bed or the wheelchair.
-When staff would go to change the resident, she would be tangled up in the bed covers.
-The resident could not untangle herself.
-She had observed the resident roll over in bed by herself.

Interview with the Special Care Unit Supervisor (SCUS) on 12/20/17 at 5:15 p.m. revealed:
-Resident #4 got the hospital bed with rails "about 2 weeks ago" for repositioning.
-The resident moved a lot in the bed and it was not unusual for the resident to get tangled in the bed covers.
-They limited the resident to a sheet and a blanket but the resident still continued to get tangled in the bed covers.
-The resident got tangled in the sheets and fell off the bed in September 2017 but she had no injuries.
-She was not aware of any other interventions to prevent the resident from getting tangled in the bed covers.
-SCU staff did 30 minute checks on all residents.

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-They also tried to have one of the SCU staff in the hall at all times checking on all residents about every 15 minutes.
-Staff did incontinence checks every 2 hours.

Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 6:10 p.m. revealed:
-Resident #4 would try to get up out of the wheelchair and out of bed.
-She was not aware the resident was getting tangled in the bed covers daily.
-She was aware of one incident in September 2017 when the resident was tangled in the sheets and fell out of the bed.
-Staff should have reported to her that the resident was getting tangled in the bed covers daily.
-If she had been aware, she would have contacted the resident's PCP.

Interview with the Executive Director (ED) on 12/21/17 at 1:50 p.m. revealed:
-She was not aware the resident had been getting tangled in the bed covers.
-Staff should have reported to the SCUS or the RCC that the resident was getting tangled in the bed covers.
-The 30 minute checks in the SCU were supposed to physical checks of the location of the residents.

Interview with Resident #4's primary care provider (PCP) on 12/20/17 at 3:00 p.m. revealed:
-He was notified the resident got tangled in the sheets and fell out of bed in September 2017.
-The resident got combative around August 2017 so he started her on some Xanax for anxiety as needed.
-The combativeness could have contributed to her getting tangled in the sheets.

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-He did not recall being notified the resident was getting tangled in the sheets on a daily basis.
-He recalled the resident had an order for hospital bed with bed rails in June 2017 but he did know when the resident actually got the hospital bed with rails.
-The resident was short and would need to scoot down in the bed to get around the half bed rails.
-He could not recall if the resident was physically able to get out of bed independently.
-He was at the facility on the afternoon of 12/06/17 and facility staff reported Resident #4 was found half out of bed and deceased.

Telephone interview with a family member of Resident #4 on 12/19/17 at 3:15 p.m. revealed:
-The resident was admitted to the facility about 6 months ago.
-The resident was moved to the SCU about 3 months ago because staff said she was going into other residents' rooms.
-The resident never got tangled in the bed sheets when she lived at home.
-The resident deteriorated quickly after moving to the SCU.
-Another family member was the resident's power of attorney (POA).
-The POA was contacted on 12/06/17 about the resident's death.

Interview with Resident #4's family member (power of attorney) on 12/21/17 at 12:00 p.m. revealed:
-The resident required total assistance in every aspect including getting in and out of bed.
-The resident was confined to a wheelchair.
-The resident could self-propel the wheelchair with her arms and legs if she really wanted to.
-The resident got a hospital bed with rails about one month ago to keep her on the bed.

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-The resident had strength in her arms and he thought it was possible that she might could pull on the bed rail to sit up on the side of the bed.
-The resident would move around a lot some nights when lying in bed.
-He was aware of one episode of the resident being combative about 2 months ago.
-He was informed by the facility once of the resident having a fall from the wheelchair.
-He was not aware of the resident getting tangled in the bed covers prior to 12/06/17.
-He got a phone call from the RCC on 12/06/17 around 7:30 a.m.
-The RCC told him that the resident had slid off the bed, covers wrapped around her, and head lodged in bed rail.
-The RCC told him the resident "did not make it".
-He went to the facility immediately.
-The resident was back in bed, covered perfectly with straight bed linens, and two towels rolled and placed under her chin.

Review of Resident #4's certificate of death revealed:
-The resident's date of death was 12/06/17.
-The manner of death was an accident.
-The description of how injury occurred was "fall from bed, head in bed rail".
-The time of injury was noted as 12/06/17, "07:" (the minutes was not specified).
-The cause of death was "asphyxiation, entrapment in bed rail, slid off bed, head entrapped".

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The facility failed to provide supervision in accordance with the needs for Resident #3, who sustained multiple falls with injuries including multiple facial fractures, post-fall concussion, fracture of wrist, facial laceration and massive

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facial bruises; and Resident #4 who had dementia, a history of getting tangled in the bed covers, falling off the bed, and was found without a pulse with her head stuck between the bed and the bed rail and her body on the floor tangled in the covers. This failure constitutes a Type A1 Violation for serious physical harm and neglect.

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Review of the facility's Plan of Protection dated 12/21/17 revealed:
-The Executive Director (ED) and Resident Care Coordinator (RCC) will train (including immediate in-service beginning 12/22/17) and maintain staff to provide appropriate personal care and supervision through the following:
-At least one staff member will supervise the special care unit (SCU) corridor when resident(s) are in the individual resident bedroom(s).
-Conduct 30 minute checks by visually observing each resident.
-Place residents in rooms according to resident abilities and considering distance from living room, dining room, bathroom, etc.
-Train all staff (housekeeping, maintenance, transportation, dietary, activities) to monitor and report residents' activities, condition, symptoms, etc.
-The RCC will be responsible for preparing a plan of care to attend to residents' care needs and other personal care needs that residents may be unable to attend to for themselves.
-The ED and RCC will train and maintain staff to provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms.
-The ED and RCC will train and maintain staff to immediately respond to a resident involved in an accident or incident involving a resident to provide appropriate care and intervention.

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D 270	Continued From page 30 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 20, 2018.	D 270		
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 observations, interviews, and record review, the facility failed to keep the kitchen doors, floors, walls, sinks, 2 plate storage carts, the walk-in cooler/freezer, deep fryer, and toaster clean and free of contamination. The findings are: Observation on 12/21/17 at 9:00 a.m. of the kitchen entry way door revealed: -There were yellow brown stains on the surface of the door frame. -Paint was scraped off the lower 1-1/2 feet of the door frame. -There was a build-up of dark brown greasy dust around the lower edges of the door frame. -There were dark brown smudges on the surface of the door. -There scrape marks and black ½ inch horizontal lines across the door. -The metal frame of the 2 feet by 6 inches vertical door window was tarnished and had a gray-green substance. -There were yellow and dark brown stained	D 282		

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smudges on the metal kick plate at the base of the door.

Observation on 12/21/17 at 9:13 a.m. of the wall and floor on the right side of the ice machine revealed:
-There were dried yellow and dark brown spatters on the wall 2-1/2 feet above tile floor molding.
-There were black, dark brown, and tan stains on the top and bottom edges of the tile floor molding.
-The tile molding surface was covered with dark brown and tan stains.

Observation on 12/21/17 at 9:20 a.m. of the kitchen tile flooring and corners revealed:
-There were yellow-brown stains on the top edges of the tile floor molding in the room.
-There were dark brown and black stains on the bottom edges of the tile in the room.
-There was a build-up of dark brown greasy dust in the corners on the room.
-There was a heavy coating of greasy dark brown and tan dust on the 4 inches x 4 inches x 2 inches standing metal outlet case positioned on the floor at the end of the prep table.

Observation on 12/21/17 at 9:21 a.m. of the rolling, stand-alone deep fryer revealed:
-The temperature control panel on the top back of the fryer was covered with a yellow and black build-up of a greasy substance.
-Both sides of the fryer were coated with yellow, dark-brown, and black greasy residue from the top to the bottom edges.
-There were several icicle shaped grease droppings hanging from the lower right side of the fryer.
-The wheel on the right side of the fryer was thickly coated with a build-up of black grease.
-There were drops of yellow oil on the floor tiles

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beside the fryer.

Observation on 12/21/17 at 9:25 a.m. of the standing toaster revealed:
-There were dark yellow-brown smudges around the circular indented handles.
-There were dark tan and brown crumbs on the inside of the indented handles.

Observation on 12/21/17 at 9:40 a.m. of 2 tall metal storage carts revealed:
-The wheeled carts had 3 levels of slots being currently used for the vertical storage of clean serving plate covers.
-There were numerous spots of a yellow-brown substance on the horizontal and vertical bars of the cart.
-The metal wheel covers were coated with dust and a yellow and dark brown sticky substance.
-The 4 wheels of each cart were coated with a build-up of dirt and crumbs.
-The plate covers, on the lower level, were positioned on the rack 2 inches above the wheels of the carts.

Observation on 12/21/17 at 9:25 a.m. of the large double wash sink revealed:
-There were spots of yellow stains on the wall above the double sinks.
-There was a build-up of yellow and brown sticky dust on the top edge of the backsplash of the double sinks.

Observation on 12/21/17 at 9:26 a.m. of the walk-in cooler/freezer floor area revealed:
-The tile wall molding, at the right side of the cooler, was separated from the wall, and had a black substance on each side and top of the tile.
-On the right side of the cooler was a green and black substance on the pipe that was attached to

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the door of the cooler and to a drain in the floor.

Observation on 12/21/17 at 9:28 a.m. of the walk-in cooler/freezer revealed:
-There were black and dark brown smears over the entire door.
-There was a continuous line of a black substance on both outer edges and base of the door.
-There was a black substance in the grooves of the door gasket.
-There was a build-up of a black substance along the edges of the threshold strips on the floor.
-There were light tan, brown, and black stains on the cooler floor.
-The metal storage shelves were rusty and had a build-up of dust.

Observation on 12/21/17 at 9:31 a.m. of the food service doorway entrance revealed:
-The interior door, door frame, and side wall were spattered with yellow-brown stains.
-There was a build-up of black grime, on the floor, at the base of the door and the top and bottom of the tile molding at the wall.
-There was yellow and light brown dust build-up on the face plate and flip switches of the wall electrical outlet.

Interview on 12/21/17 at 9:35 a.m. with the Dietary Supervisor revealed:
-Dietary had a staff of 3, herself, the cook, and an aide; all were responsible for cleaning the kitchen.
-Staff swept the floors after each meal; a deep cleaning of the kitchen was done on Thursdays or Fridays and weekends.
-There was a daily kitchen cleaning task check-off list posted in the kitchen for staff to date and initial when the assigned cleaning tasks were

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done.
-The outlet on the floor had not been used since she had been at the facility (September or October 2016).
-The steam table was cleaned after each meal.
-The walk-in cooler and freezer were cleaned daily.
-Deep cleaning is scrubbing the top of the stove and grill using a steel wool pad, lemon juice, and water.
-The fryer was cleaned 2 times a week when the oil was changed.
-The walls were cleaned daily with a steel wool pad after breakfast and after dinner.
-The fryer was cleaned last week (did not remember when); she used a butter knife and steel wool pad to scrape off the grease.
-A professional liquid cleaner, Clorox water, soap and water and let sit, was used to clean the tiles and door frames.

Observation on 12/21/17 at 10:00 a.m. of the posted dietary check off cleaning list revealed:
-On 12/15/17, the tasks of wiping down the oven - inside and out, and wiping down the flat top grill sides and backsplash were initialed as done
-On 12/16/17, the tasks of wiping down the fryer sides and back splash and wiping the wall around the hand sink were initialed as done.
-On 12/19/17, the tasks of wiping down the stove top and backsplash and cleaning the porch area were initialed as done.

Interview on 12/21/17 at 10:10 am with the Administrator revealed:
-Dietary staff were to do regular cleaning of all surfaces.
-He had not gone through the kitchen often enough; it had been at least a year since the kitchen had a good deep cleaning; they never had

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D 282	Continued From page 35 a professional steam cleaning, they used institutional cleaners. -None of the institutional cleaning products were very effective for cleaning in the kitchen. -He should have done more "walk-throughs" to determine what needed to be done. -There would be a cleaning party this weekend (12/23-24/17) to address the concerns in the kitchen.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a Calcium and Vitamin D supplement (#7) and a lubricant eye drop for moderate to severe dry eyes (#6); and 1 of 5 residents (#1) sampled who missed doses of an antibiotic being used to treat a lung infection. The findings are: 1. The medication error rate was 6% as	D 358		

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evidenced by the observation of 2 errors out of 29 opportunities during the 9:30 a.m. medication pass on 12/20/17.

A. Review of Resident #6's current FL-2 dated 10/15/17 revealed:
-Diagnoses included seizure disorder, mental retardation, edema, cholelithiasis, gastroesophageal reflux disease, osteoporosis, and acid reflux.
-There was an order for Systane Balance eye drops, instill 2 drops in each eye 3 times a day. (Systane Balance is used to restore moisture to the eyes for moderate to severe symptoms of dry eyes.)

Observation of the medication pass on 12/20/17 at 8:39 a.m. revealed:
-The medication aide (MA) attempted to put Systane Balance eye drops in Resident #6's eyes.
-The resident was sitting down with her head facing straight forward.
-The MA tried to lift the top lid of Resident #6's left eyelid but the resident kept blinking her eyes and tilting her head forward.
-No drops went in the resident's left eye.
-The MA tried to lift the top lid of the resident's right eyelid but the resident kept blinking her eyes and tilting her head forward.
-One drop of Systane Balance landed on the resident's top eyelid of the right eye and the MA took her gloved finger and pushed the drop toward the opening of the resident's eye.
-About half of the drop went into the resident's right eye and the rest of the drop rolled down the resident's face.
-The MA did not ask the resident to tilt her head back or did not attempt to pull down on the resident's lower eye lids to form a pocket (proper

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D 358	Continued From page 37 technique). -The resident did not receive 2 drops in each eye as ordered. -The MA documented the Systane Balance eye drops as administered on the electronic December 2017 medication administration record (MAR). Review of Resident #6's December 2017 MAR revealed: -There was an entry for Systane Balance eye drops, instill 2 drops in each eye 3 times daily. -Systane Balance was scheduled to be administered at 9:30 a.m., 3:30 p.m., and 9:30 p.m. -Systane Balance was documented as administered from 12/01/17 - 12/20/17 (9:30 a.m.) Interview with the MA on 12/20/17 at 10:50 a.m. revealed: -She had trouble administering Resident #6's eye drops because the resident would close her eyes and would not tilt her head back. -She did not know why she did not instruct the resident to tilt her head back. -She had not tried pulling on the resident's lower eyelid to form a pocket for the drops. -She had to push drop into the resident's eye with her finger because the resident kept closing her eyes. -Some of the other MAs can get the resident to open her eyes better when trying to administer the eye drops. -She was not sure if the resident would lay down to make it easier to instill the drops. -The resident had a recliner in her room and she could try using the recliner to tilt the residents head back for the eye drops.	D 358		

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Interview with Resident #6 on 12/20/17 at 11:45 a.m. revealed:
-When the resident was asked if her eyes were dry, the resident pointed to her eyes and nodded her head up and down, indicating her eyes felt dry.
-She did not answer any other questions.

Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 1:38 p.m. revealed:
-The MAs had been trained on proper technique for instilling eye drops.
-The MAs were supposed to have the resident tilt their head back and the MA should pull the lower lid to form a pocked to instill the drops.
-The MAs should notify her and the physician if they were having difficulty administering eye drops to a resident.
-She was not aware the MA was having trouble administering eye drops to Resident #6.

B. Review of Resident #7's current FL-2 dated 12/05/17 revealed:
-Diagnoses included Alzheimer's disease, dementia without behaviors disturbance, fracture of femur, essential hypertension, and malignant neoplasm.
-There was an order for Calcium chewable 500mg take 4 by mouth daily. (Calcium is a supplement used to treat and prevent osteoporosis.)
-There was an order for Vitamin D3 5,000IU take 1 by mouth daily. (Vitamin D is a supplement used to treat low levels of Vitamin D and used to help with the absorption of Calcium.)

Review of Resident #7's December 2017 medication administration record (MAR) revealed:
-There was an entry for Calcium chew 500mg give 4 tablets (=2,000mg) by mouth every day.

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-Calcium chew 500mg was scheduled to be administered at 9:30 a.m.
-Calcium chew was documented as administered from 12/01/17 - 12/20/17.
-There was an entry for Vitamin D3 5,000IU take 1 capsule by mouth every day.
-Vitamin D3 5,000IU was scheduled to be administered at 9:30 a.m.
-Vitamin D3 5,000IU was documented as administered from 12/01/17 - 12/20/17.

Observation of the 9:30 a.m. medication pass on 12/20/17 revealed:
-The medication aide (MA) administered Vitamin D3 5,000IU to Resident #7 at 8:58 a.m. along with several other medications scheduled at that time.
-The MA then administered 4 Calcium chew 500mg with Vitamin D tablets to the resident at 9:01 a.m.
-The resident was not administered plain Calcium chew 500mg tablets as ordered.

Observation of medications on hand for Resident #7 on 12/20/17 revealed:
-There was a supply of Calcium chew 500mg plus D that was dispensed on 12/12/17.
-The label did not indicate how much Vitamin D was in each tablet.

Interview with the MA on 12/20/17 at 11:15 a.m. revealed she had not noticed the label on the Calcium chew tablets did not match the order or the MARs.

Interview with the Special Care Unit Supervisor (SCUS) on 12/20/17 at 11:08 a.m. revealed:
-She had not noticed the label on the Calcium chews had Vitamin D listed on it.
-She also administered medications and she had

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D 358	Continued From page 40 not noticed the label for the Calcium chews did not match the MARs. -If something did not match, the MAs were supposed to stop and call the pharmacy or the physician to clarify the orders. -She would contact the pharmacy about the Calcium chews with Vitamin D. Telephone interview with a pharmacist at the primary pharmacy on 12/20/17 at 11:17 a.m. revealed: -They had an order on file dated 02/17/17 for Calcium 2,000mg and Vitamin D 2,000IU per day. -There was also an order in June 2017 for Calcium 2,000mg and Vitamin D 5,000IU per day. -He was not sure how much Vitamin D was in the Calcium chews with Vitamin D that were dispensed on 12/12/17. -He would pull the bottle and find out. A second telephone interview with a pharmacist at the primary pharmacy on 12/20/17 at 11:55 a.m. revealed: -He checked the manufacturer's label and the Calcium chews with D that were dispensed to Resident #7 had 500mg of Calcium and 100IU of Vitamin D in each tablet. -The resident was getting an extra 400IU of Vitamin D each day. -There appeared to have been some changes with the NDC number of the Calcium product in their computer system in August 2017, which resulted in the Calcium chew with Vitamin D being dispensed. -No one from the facility had contacted the pharmacy about the Calcium not matching the order prior to today, 12/20/17, to his knowledge. Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 1:40 p.m. revealed:	D 358		

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-The MAs were supposed to notify the RCC if a medication label and the MARs did not match.
-They should not administer the medication if the label and the MAR did not match.
-She was not aware Resident #7's was receiving the wrong Calcium chew tablets.
-They would notify the physician and clarify the orders.

Review of Resident #7's labwork in the record revealed no documentation of any Vitamin D levels.

Review of a clarification order from the primary care provider (PCP) dated 12/20/17 for Resident #7 revealed:
-The resident should continue receiving Vitamin D3 5,000IU once daily.
-The resident should receive Calcium 500mg take 4 tablets daily.

2. Review of Resident #1's current FL2 dated 08/24/17 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD)
-There was an order for Avelox 400mg daily for 5 days written on 10/27/17. (Avelox is an antibiotic used to treat bacterial infections.)

Review of Resident #1's Medication Administration Records (MARs) for October 2017 through November 2017 revealed:
-Avelox 400mg was documented as being administered on 10/29/17, 10/31/17, and 11/01/17.
-Avelox 400mg was documented as not being administered on 10/30/17, reason for not being administered was documented as medication not in facility.

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Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 12:39 p.m. revealed:
-The facility used a backup pharmacy for resident #1's Avelox prescription.
-The facility received 5 doses of Avelox on 10/30/17 from resident #1's backup pharmacy.
-She does not know why it is documented as being administered on 10/29/17 when the facility received the medication on 10/30/17.
- RCC said currently there is not a process in place to assure antibiotics are completed per the prescriber's orders.
-RCC said currently she asks the staff if the medication was given.
-RCC said the physician was not aware of the missed doses because she was not aware of the missed doses.

Telephone interview with pharmacist from resident #1's backup pharmacy on 12/20/17 at 9:03 a.m. revealed:
-Avelox 400mg was picked up from the pharmacy on 10/30/17 at 1:44 p.m.
-Five tablets were dispensed.

Review of Resident #1's pharmacy packing slip and drugs returned to pharmacy form on 12/21/17 at 8:30 a.m. revealed:
-Avelox 400mg 5 tablets dispensed to facility on 10/28/17
-Avelox 400mg 6 tablets returned to pharmacy on 11/06/17.

Second interview with RCC on 12/21/17 at 8:50 a.m. revealed:
-She did not know why 6 tablets of Avelox were returned to resident #1's Pharmacy.
-"I don't know how many doses the resident received".

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D 358	Continued From page 43 Interview with first shift staff, Medication Aide (MA) on 12/20/17 at 9:56 a.m. revealed: -On 10/30/17 the Avelox dose was not available when she administered morning medications. -She gave resident #1 one dose of Avelox on 10/31/17. Telephone Interview with Staff D on 12/20/17 at 10:21 a.m. revealed: -She did not remember anything about the order for Avelox for Resident #1. -The RCC went into the electronic MAR system and accepted the orders and the order would be put on the MAR.	D 358		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.	D 482		

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(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 A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure bed rails were used only after an assessment and care planning process had been completed through a team process for 2 of 5 residents sampled (#3, #4) including a resident with bed rails who had a history of getting tangled in the bed covers due to excessive movement in the bed and resulted in the resident's head being stuck between the bed and the half bed rail and her body tangled up in

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the bed covers (#4); and a resident who had been recently observed more than once attempting to climb over bed rails (#3).

The findings are:

1. Review of Resident #4's FL-2 dated 07/19/17 revealed:
-Diagnoses included Alzheimer's disease, weakness, hypertension, osteoarthritis, and Vitamin D deficiency.
-The resident was constantly disoriented and wandered.
-The resident was semi-ambulatory with the use of a wheelchair.
-The resident was incontinent of bowel and bladder.
-The resident required personal care assistance with bathing, feeding, and dressing.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 06/20/17.
-The resident required assistance with dressing, bathing, nail care, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place.

Review of an incident/accident report dated 09/29/17 at 9:05 a.m. for Resident #4 revealed:
-The resident was wrapped up in sheets on bed and rolled off onto the floor onto her right side.
-The resident did not lose consciousness and there were no visible injuries.
-The resident refused vital signs.
-Staff checked the "no" blocks indicating bed rails were not ordered and bed rails were not present.

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-Staff documented the resident's family was notified at 9:39 a.m.
-The area of the form to document notification of the physician had "N/A" (not applicable) written in the block.

Review of Resident #4's nurses' notes dated 09/29/17 (no time noted) revealed the resident was wrapped up in the sheets on the bed and rolled off onto the floor onto her right side.

Review of an incident/accident report dated 12/06/17 at 7:20 a.m. for Resident #4 revealed:
-The location of the incident/accident was the resident's room.
-The resident's condition before the incident/accident was noted to be normal.
-The section of the form asking if bed rails were ordered was left blank.
-The section asking if bed rails were present was checked yes and noted to be in the up position.
-The section asking if a restraint was in use was checked no.
-A medication aide documented walking in the residents' room.
-The resident "was on the floor with her head caught between the bed rail and bed".
-The resident "was on the floor tangled up in her covers and her head was caught between the bed and the bed rail, her head was just sitting in the rail facing the wall".
-The diagram to indicate the location of injury had the head circled.
-The type of injury was left blank.

Review of a fax to Resident #4's primary care provider (PCP) dated 06/19/17 revealed:
-A request for an order for a hospital bed with half rails for positioning and a wheelchair for ambulation was made by the facility.

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D 482	Continued From page 47 -The PCP signed the request but did not write a date beside his signature. Review of a note signed by the Resident Care Coordinator (RCC) (no date) in Resident #4's record revealed: -On admission to the facility, Resident #4 was in a hospital bed at home. -The resident's family member asked if the facility could get a hospital bed for the resident to use at the facility. -The RCC told the family member it would be half rails because a whole rail was like a restraint. -The family member was okay with the half rails. -The family member tried to get the hospital bed company the resident used at home to take the resident's hospital bed to the facility. -The note was signed by the RCC but not dated. Review of Resident #4's assessment and care plan dated 08/09/17 revealed: -The resident was admitted on the assisted living side of the facility but she tried to leave, wandering up and down halls saying she needed to get out. -The resident was ambulatory with wheel chair. -The resident had limited range of motion in her upper extremities. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -There was no documentation regarding the use of bed rails. Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 10/12/17 revealed: -The resident had an occupational therapy	D 482		

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D 482	Continued From page 48 evaluation completed. -Range of motion and physical therapy were discontinued. -Staff assisted with ambulation and transfers using wheelchair. -Falls were noted but no lasting injuries were documented. -The recommendation was to continue current physician's orders. -There was no documentation regarding the use of bed rails. Interview with a medication aide (MA) on 12/20/17 at 12:44 p.m. revealed: -Resident #4 could not walk on her own. -The resident could sit up on the bed by herself if she pulled on the bed rail. -The resident could do more for herself some days than others. -The resident could bear weight with staff standing beside her and the resident could hold onto the wheelchair while staff changed her incontinence brief. -It was not unusual to see the resident trying to get out of bed. -She felt the resident could sit up and swung her legs to the side of the bed if she had scooted down past the bed rail. -The resident had half rails on both sides of the bed that were always up when the resident was in bed. -The resident's half rails started about 1 foot from the head of the bed and went just beyond the center of the length of the bed. -Resident #4's family member wanted the resident to have the bed rails. -The resident was a "rough sleeper" because she rolled around a lot. -It was not unusual for the resident to get tangled in the bed covers on a daily basis.	D 482		

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-It was not unusual to walk by the resident's room and see her tangled in the covers with half her body including her legs hanging off the bed.
-She had to help the resident get untangled from the covers.
-The resident got a hospital bed about a month ago but she continued to get tangled in the covers.
-She was not aware of any other alternatives used to prevent the resident from getting tangled in the covers.

Interview with a second MA on 12/20/17 at 1:45 p.m. revealed:
-Resident #4 would get tangled in the bed covers every day because she rolled in the bed.
-The resident was "a mover and a shaker" and she was at risk for falls.
-The resident got tangled in the bed covers in September 2017 and fell out of bed but she had no injuries.
-The resident's family member wanted the resident to have a hospital bed with rails because he thought the resident would be safer to keep her from falling off the bed again.
-She was not sure how long the resident had the hospital bed with half rails but she though it was "about a month".
-The resident had a lot of strength when she was combative.
-The resident was short and she would have to scoot down to get around the half bed rails.

Telephone interview with a third MA on 12/21/17 at 12:12 p.m. revealed:
-She did not know how long Resident #4 had bed rails.
-Resident #4 would twist and turn and get bed covers tangled.
-The resident would need help to get untangled

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from the covers.
-It was not unusual for the bed covers to be wrapped around the resident during the night.

Interview with a personal care aide (PCA) on 12/20/17 at 2:10 p.m. revealed:
-Resident #4 was confined to a wheelchair and needed assistance with transferring.
-The resident could sit up if she tried.
-The resident tossed and turned in bed and she would get tangled in the sheets every day.
-Staff would have to help untangle the resident from the sheets every day.
-She could not recall how long the resident had the bed rails.
-Both bed rails were up when the resident was in bed.
-If the resident was lying more toward the head of the bed, she would have to scoot down to get around the bed rails.

Interview with a second PCA on 12/20/17 at 5:59 p.m. revealed:
-The resident had enough strength to pull on the bed rail and sit up and she could she swing her legs to the side of the bed.
-Resident #4 was "really short" and she would scoot down in the bed to get around the bed rail.

Telephone interview with a third PCA on 12/21/17 at 10:55 a.m. revealed:
-Resident #4 could not bear weight but she could sit up in the wheelchair.
-She did not know if the resident could sit up in bed.
-The resident had previously rolled off of the bed tangled in the bed covers when she had a regular bed prior to getting the hospital bed with rails.
-The resident's family member and other staff had told her the resident would get tangled in the

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D 482	Continued From page 51 covers. -She did not recall seeing the resident tangled in bed covers. Interview with a fourth PCA on 12/21/17 at 1:10 p.m. revealed: -When Resident #4 first moved to the SCU, she would stand but she declined and could not stand. -The resident could sit up in a chair and she could roll in the bed. -He never saw the resident try to sit up in bed. -The resident had the hospital bed with rails for "a few weeks". -The resident would roll over and the bed covers would fold around and over her. Interview with the facility's Transporter on 12/21/17 at 11:50 a.m. revealed: -She was the Transporter but she also worked as a PCA and MA at times. -Resident #4 could sit up in a wheelchair. -Staff had to assist the resident with dressing and transferring. -The resident would sometimes try to get out of the bed or the wheelchair. -When staff would go to change the resident, she would be tangled up in the bed covers. -The resident could not untangle herself. -She had observed the resident roll over in bed by herself. -The resident had the bed rails "about 1 week or so, not long". -The family was concerned about the resident rolling out of bed. Interview with the Special Care Unit Supervisor (SCUS) on 12/20/17 at 5:15 p.m. revealed: -Resident #4 had a regular bed when she was first admitted to the SCU.	D 482		

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-She thought Resident #4's family member had requested a hospital bed.
-The resident got the hospital bed with rails "about 2 weeks ago".
-The bed rails were for repositioning.
-She had not assessed the resident's use of the bed rails and no assessment had been done to her knowledge.
-They did not use restraints at the facility; they were "restraint free".
-She never saw the resident try to get up while in bed.
-The resident moved a lot in the bed.
-The resident did not have a bed or chair alarm.
-It was not unusual for the resident to get tangled in the bed covers.
-They limited the resident to a sheet and a blanket but she still continued to get tangled in the bed covers.
-She was not aware of any other interventions or alternatives being used to prevent the resident from getting tangled in the bed covers.
-The resident was combative at times.
-The resident could sit up by pulling on the bed rails but she was not sure if the resident could swing her legs to the side of the bed.
-The resident was short and she would need to scoot down in the bed to get around the bed rails.
-The resident got tangled in the sheets and fell off the bed in September 2017 but she had no injuries.

Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 6:10 p.m. revealed:
-Resident #4 would try to get up out of the wheelchair and out of bed.
-The resident could probably swing her legs around to the side of the bed.
-The resident had a hospital bed at home before she came to the facility.

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D 482	Continued From page 53 -The family had requested the resident have a hospital bed at the facility. -There was a delay in getting the hospital bed with rails because the family was trying to bring the one from home. -There was a problem with the insurance and medical equipment company and the family could not bring the hospital bed from home. -She took one of the facility's hospital beds with half rails and had it put in Resident #4's room about 1 to 2 months ago. -She did not recall anyone assessing the resident for the use of the bed rails. -The facility policy was to let the physician make the decision if a bed rail was a restraint. -She had not discussed the bed rail with Resident #4's PCP. -She was not aware the resident was getting tangled in the bed covers daily. -She was aware of one incident in September 2017 when the resident was tangled in the sheets and fell out of the bed. -Staff had not reported to her that Resident #4 was getting tangled in the bed covers every day but they should have reported it. -If she had been aware, she would have contacted the resident's PCP. Interview with the Executive Director (ED) on 12/21/17 at 1:50 p.m. revealed: -The facility could not have full rails because they were a restraint free facility. -They had half rails in the facility. -There were no procedures to assess residents' use of half rails. -There was no system to assess bed rails for restraints. -She was not aware the resident had been getting tangled in the bed covers. -Staff should have reported to the SCUS or the	D 482		

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RCC that the resident was getting tangled in the bed covers.

Interview with the Administrator on 12/21/17 at 3:50 p.m. revealed the facility did not have a restraint policy because they did not have restraints.

Interview with Resident #4's primary care provider (PCP) on 12/20/17 at 3:00 p.m. revealed:
-He was notified the resident got tangled in the sheets and fell out of bed in September 2017.
-The resident got combative around August 2017 so he stared her on some Xanax for anxiety as needed.
-The combativeness could have contributed to her getting tangled in the sheets.
-He did not recall being notified the resident was getting tangled in the sheets on a daily basis.
-He recalled the resident had an order for hospital bed with bed rails in June 2017 but he did know when the resident actually got the hospital bed with rails.
-The resident was short and would need to scoot down in the bed to get around the half bed rails.
-He could not recall if the resident was physically able to get out of bed independently.
-He was at the facility on the afternoon of 12/06/17 and facility staff reported Resident #4 was found half out of bed and deceased.

Telephone interview with a family member of Resident #4 on 12/19/17 at 3:15 p.m. revealed:
-The resident was admitted to the facility about 6 months ago.
-Upon admission, the resident walked independently with a walker but within about 2 weeks she deteriorated and needed a wheelchair.
-The resident needed some assistance getting in and out of bed.

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D 482	Continued From page 55 -The resident was moved to the special care unit (SCU) about 3 months ago because staff said she was going into other residents' rooms. -The resident deteriorated quickly after moving to the SCU. -He had not noticed if the resident's bed had bed rails. -The resident never got tangled in the bed sheets when she lived at home. Interview with Resident #4's family member (power of attorney) on 12/21/17 at 12:00 p.m. revealed: -The resident required total assistance in every aspect including getting in and out of bed. -The resident was confined to a wheelchair. -The resident could self-propel the wheelchair with her arms and legs if she really wanted to. -The resident got a hospital bed with rails about one month ago to keep her on the bed. -He was aware of the use of the bed rails. -He had not been asked to sign for consent of the use of bed rails. -He was in agreement with the use of the hospital bed with rails because if no rails she could fall out of bed at any time and injure herself. -The resident had strength in her arms and he thought it was possible that she might could pull on the bed rail to sit up on the side of the bed. -The resident would move around a lot some nights when lying in bed. -He was not aware of the resident getting tangled in the bed covers prior to 12/06/17. -He got a phone call from the RCC on 12/06/17 around 7:30 a.m. and was told the resident had slid off the bed, covers wrapped around her, and head lodged in bed rail. -The RCC told him the resident "did not make it". -He went to the facility immediately.	D 482		

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Based on interviews and record review for Resident #4:
-Resident #4 had a hospital bed with half rails that were used in the up position when the resident was in bed.
-There had been no assessment for the use of the bed rails.
-At least 3 staff reported that Resident #4 would try to get out of bed and out of the wheelchair.
-The resident would move around excessively in bed and get tangled in the bed covers on a daily basis.
-The resident got tangled in the bed covers and fell off the bed in September 2017 (prior to getting the hospital bed with rails) .
-The resident continued to get tangled in the bed covers daily after the use of the hospital bed with rails.
-Staff had to help the resident get untangled from the bed covers because she could not untangle herself.
-There were no alternatives or interventions implemented prior to or after the use of the bed rails.
-Resident #4 was found without a pulse with her head stuck between the bed rails and the bed and her body tangled in the bed covers lying on the floor on the morning of 12/06/17.

2. Review of Resident #3's FL-2 dated 6/6/17 revealed:
- Diagnoses included vascular dementia with behavioral disturbances, heart disease, systolic heart failure, hypertension, and anxiety.
-There was an order for a hospital bed with half bedrails for positioning.
-The resident was disoriented constantly and used a walker to assist with ambulation.

Review of Resident #3's Resident Register

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revealed an admission dated of 01/19/16.

Review of Resident #3's care plan dated 01/18/17 revealed no assessment for assistance with transfers or ambulation.

Review of Resident #3's LHPS Review dated 11/15/17 revealed no assessment for the use of bedrails.

Observation of Resident #3 on 12/19/17 at 11:40 a.m. revealed:
-The resident was lying in a hospital bed with an air mattress.
-The resident was asleep and both half rails on the bed were in the up position.
-There was a fall mat on the floor between the two beds in the room.

Interview with a medication aide (MA) on 12/19/17 at 11:40 a.m. revealed:
-Resident #3 had a walker but had not used the walker in about 1 and half months because the resident started falling more.
-The resident currently used a wheelchair.
-The resident could use her upper body strength to sit up on the side of the bed and she could usually swing her legs around and hang them on the side of the bed.
-The resident had a bed alarm because she would try to get up on her own.
-The resident was a fall risk.

Interview with a medication aide (MA) on 12/20/17 at 6:02 p.m. revealed:
-She usually worked first shift as a MA in the special care unit.
-Yesterday (12/19/17) during first shift, Resident #3 had both of her legs over the top rail of the half bed rail while lying in bed.

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D 482	Continued From page 58 -The resident's bed alarm did not sound because the resident's back was still on the bed. -That was the first time she had seen Resident #3's legs over the rails. Observation of Resident #3 on 12/20/17 at 8:10 a.m. revealed: -Resident #3 was lying in bed with both half rails in the up position. -Two staff entered the room and one staff helped the resident sit up on the side of the bed. -Both staff helped the resident stand up from the bed and both staff, one on each side, held onto the resident as she walked to the geri-chair. -Both staff assisted the resident in sitting down in the geri-chair. Observation on 12/21/17 at 10:10am revealed: -Resident #3 was awake, alert and confused. -The half rails positioned at the head of the hospital bed was in the up position. -The resident attempted to get out of the right side of the bed with her legs positioned on the left side of the rails. -The MA assisted the resident back in the bed but the resident attempted to get out of the bed a 2nd time with the rails up. The resident attempted to put her legs over the rails. Interview with another MA on 12/21/17 at 10:20am revealed: -Two days ago, she observed Resident #3 with her legs thrown over the half rails. The resident was attempting to get out of bed. -The MA did not inform the SCU supervisor or the RCC of her observations. -The MA did not report observations to the resident's primary medical provider. Interview with Resident #3's primary medical	D 482		

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D 482	Continued From page 59 provider on 12/20/17 at 2:50pm revealed: -The hospital bed and half bedrails were ordered to assist the resident with positioning in bed, not as a restraint. -The resident should be able to get in and out of bed without problems. -He was not aware the resident was able to get out of bed while the bedrails were in the up position. -He expected the facility to assess the use of the bedrails and report changes to the hospice nurse or him. Interview with the RCC on 12/20/17 at 7:00pm revealed: -She was aware half bedrails were used to assist Resident #3 with positioning when she was in bed. -She had observed the resident getting out of bed using the bedrails several times before the last 2 falls. -She was not aware the resident had recently attempted to climb over the half bedrails. -The facility did not have a system/policy to assess for the use of bedrails. -The staff who observed the resident attempting to climb over the bedrails should have reported to the RCC. Interview with the ED on 12/21/17 at 1:50pm revealed: -The facility did not have a procedure/policy for assessing use of bedrails/restraints. -The ED was not aware Resident #3 had recently attempted to climb over the half bedrails. Based on interviews and record review for Resident #3: -Resident #3 had a hospital bed with half rails that were used in the up position when the resident	D 482		

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was in bed.
-There had been no assessment for the use of the bed rails.
-At least 2 staff reported that Resident #3 would try to climb over the half rails while in the up position and staff assisted the resident back in the bed.
-The resident was observed by surveyor attempting to climb over the half rails while in the up position.
-There were no alternatives or interventions implemented prior to or after the use of the bed rails.

____

The facility failed to implement an assessment and care planning process and try alternatives prior to using half bed rails as physical restraints for 2 residents including Resident #4 who had dementia and was found without a pulse with her head stuck between the bed and the half bed rail with her body on the floor and tangled up in bed covers from her chest down to her feet and Resident #3 who was observed attempting to climb over bed rails. This failure of the facility resulted in death and serious physical harm and neglect to the residents and constitutes a Type A1 Violation.

____

Review of the facility's Plan of Protection dated 12/21/17 revealed:
-The Executive Director (ED) and Resident Care Coordinator (RCC) will on 12/22/17 perform and document an assessment of each resident's ability to properly and safely use the previously ordered half-rail bed rails.
-The ED and RCC will perform and document an assessment of each resident's ability to properly and safely use bed rails before the bed rails are

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D 482	Continued From page 61 installed. -The ED and RCC will assess if the bed rails are the least restrictive option of physical restraints or alternatives. -The RCC will continuously (at least monthly) assess and document the resident's ability to continue to use bed rails properly and safely. -The ED and RCC will implement the assessment and care planning process for restraints through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident, and the resident's responsible person or legal representative. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 20, 2018.	D 482		
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, record reviews, and interviews, the facility failed to provide the services necessary to maintain the residents' physical health as related to personal care and supervision and the use of physical restraints and alternatives. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure supervision by not implementing interventions to address the current symptoms and assessed needs for 2 of 5	D914		

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residents sampled (#3, #4) who had a diagnosis of dementia. Resident #3, who had a history of attempting to ambulate without assistance and multiple falls with injuries, sustained multiple facial fractures and a fractured wrist. Resident #4, who had a history of moving excessively in bed and becoming entangled in the bed covers and falling off the bed, was found entangled in the bed covers with her head stuck between the bed and bed rail with her body on the floor. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to assure bed rails were used only after an assessment and care planning process had been completed through a team process for 2 of 5 residents sampled (#3, #4) including a resident with bed rails who had a history of getting tangled in the bed covers due to excessive movement in the bed and resulted in the resident's head being stuck between the bed and the half bed rail and her body tangled up in the bed covers (#4); and a resident who had been recently observed more than once attempting to climb over bed rails (#3). [Refer to Tag D482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)].