STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039004	A. BUILDING: _____ B. WING _____	R 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE GARDENS ADULT CARE	6016 PINE TOWN ROAD OXFORD, NC 27565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on March 14, 2019.	{D 000}		
{D 482}	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident	{D 482}		

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{D 482}	Continued From page 1 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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to assure physical restraints were used only after an assessment, care and team planning, use of alternatives were tried and documented for 1 of 1 sampled resident related to resident (#1) who had full bed rails attached to both sides of her bed. The findings are: Review of Resident #1's current FL-2 dated 07/18/18 revealed: -Diagnoses included hypertension, B12-deficiency, dementia, osteoporosis and post-menopausal. -The resident was ambulatory. -There was no physician's order for bed rails.	{D 482}		

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{D 482}	Continued From page 2 Review of Resident #1's Resident Register revealed an admission date of 07/24/18. Review of Resident #1's assessment and care plan dated 06/19/18 revealed: -The resident was sometimes disoriented. -The resident had a rolling walker with a seat, but she did not used it. -The resident needed extensive assistance with toileting, bathing, dressing and grooming. -The resident needed supervision with ambulation. -There was no documentation for the use of bed rails for Resident #1 Review of Resident #1s Licensed Health Professional Support (LHPS) review dated 08/13/18 revealed there was no documentation for the use of bed rails for Resident #1. Attempted telephone interview with the LHPS nurse on 0314/19 at 12:26pm was unsuccessful. Review of the physician's order dated 02/07/19 revealed: -Resident #1 needed bedrails at night for safety. -She had a diagnoses of dementia and osteoporosis. Review of the physician's order dated 03/14/19 revealed: -Resident #1 needed bedrails at night to prevent her from falling out of the bed. -Resident #1 should use full bedrails while in bed. -Resident #1 had a diagnoses of osteoporosis and dementia. Review of Resident #1's record revealed: -There was no documentation of an assessment	{D 482}		

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{D 482}	Continued From page 3 or care planning for the use of restraints for the resident. -There was no documentation of the use of alternatives to restraints for the resident. Observation on 03/13/19 at 11:00am in Resident #1's bedroom in room #15 revealed: -A bed with full bed rails attached to both sides of the bed. -The bed rails were in a downward position. Observation on 03/13/19 at 11:48am of Resident #1 revealed: -The resident was walking with 1-person assistance to the dining room. -She sat in a chair at the table in the dining room. Telephone interview with Resident #1's physician's nurse on 03/13/19 at 3:44pm revealed: -Resident #1 should use bedrails at night to prevent her from rolling out of the bed. -Resident #1 had the diagnoses of osteoporosis and dementia. Interview with the supervisor-in-charge (SIC)/medication aide (MA) on 03/13/19 at 4:28pm revealed: -Resident #1 needed to use the bed rails for safety and to prevent her from falling out of the bed. -No least restrictive alternatives had been used to provide safety for Resident #1. Interview with the Owner/Supervisor on 03/13/19 at 4:45pm revealed: -Resident #1 needed to use the bedrails at night to prevent her from falling out of the bed. -No least restrictive alternatives had been used prior to the use of the bedrails.	{D 482}		

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{D 482}	Continued From page 4 -Resident #1's family member gave a verbal consent for the use of full side rails. Attempted telephone interview with Resident #1's family member on 03/13/19 at 3:53pm and 03/14/19 at 11:33am were unsuccessful. Observation on 03/14/19 at 11:50am of Resident #1 revealed: -The resident was walking with 1-person assistance to the dining room. -She sat in a chair at the table in the dining room. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	{D 482}		