STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045127	A. BUILDING: _____ B. WING _____	01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME # 22	41 TORE'S DRIVE EAST FLAT ROCK, NC 28726

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 01/03/20.	C 000		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family 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	C 453		

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C 453	Continued From page 1	C 453		

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:
Based on observations, interviews and record reviews, the facility failed to ensure bed rails were used only after a written physician order, a team assessment and care planning process, and alternatives were tried prior to the restraint that would provide safety to the resident for 1 of 1 sampled residents (#3), who had bed rails to keep the resident from getting out of bed.

The findings are:

Observation during the initial tour on 01/03/20 at 8:23am revealed:
-Resident #3 was sitting up in bed with her breakfast in front of her.
-There were full length bed rails in the up position on each side of the bed.

Review of Resident #3's current FL2 dated 12/26/19 revealed:
-Diagnosis included Alzheimer's dementia, spinal stenosis, osteoporosis, and closed fracture of the left and right hip.

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C 453	Continued From page 2 -There was documentation that Resident #3 was constantly disoriented and semi ambulatory. -There was no order for bed rails. Interview with the Supervisor In Charge (SIC) on 01/03/20 at 11:28am revealed: -Resident #3 had been a resident of the facility for a "long time". -Resident #3 had fallen and broken her hip and was sent to the hospital. -Resident #3 returned from the hospital on 12/26/19 after hip surgery. -The bed rails had been placed on the bed to prevent the Resident from getting out of bed on her own and falling. -The SIC had not been working as the SIC when the bed rails were placed on the bed. -The Supervisor on call should have notified Resident #3's Physician before the bed rails were placed on the bed. Review of Resident #3's physician's orders revealed there was no order for bed rails. Review of a Restraint Assessment and Care Plan for Resident #3 dated 07/01/19 revealed documentation that Resident #3 had not required the use of restraints. Review of a Restraint Assessment and Care Plan for Resident #3 dated 12/23/19 revealed documentation that Resident #3 had not required the use of restraints. Interview with the Supervisor on call on 01/03/20 at 12:09pm revealed: -The bed rails had been placed on Resident #3's bed on 12/26/19. -Resident #3's Physician had telephoned her on 12/26/19 and she had informed him of the need	C 453		

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C 453	Continued From page 3 for the bed rails. -The Physician would be in to assess the Resident at a later date and write the order for the bed rails. Telephone interview with Resident #3's Physician on 01/03/20 at 11:20am revealed: -He did not remember a telephone conversation regarding bed rails for Resident #3. -The facility "usually" faxed restraint orders for him to sign. -He had not been into the facility to assess the Resident since her readmission. Interview with the Property Manager on 01/03/20 at 12:35pm revealed: -The Physician should be notified immediately when the use of bed rails was required. -The Care Plan would be updated after the Physician gave the order. -The Restraint Assessment and Care Plan dated 12/23/19 was an error because the Resident had been in the hospital at that time. -She did not know why the Physician had not been notified and an order received.	C 453		
C 454	10A NCAC 13G .1301(b) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative	C 454		

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C 454	Continued From page 4 may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use. Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to receive informed consent from the legal representative prior to the use of restraints for 1 of 1 sampled residents (#3) who had bed rails to keep the resident from getting out of bed. The findings are: Observation during the initial tour on 01/03/20 at 8:23am revealed: -Resident #3 was sitting up in bed with her breakfast in front of her. -There were full length bed rails in the up position on each side of the bed. Review of Resident #3's current FL2 dated 12/26/19 revealed: -Diagnosis included Alzheimer's dementia, spinal stenosis, osteoporosis, and closed fracture of the left and right hip. -There was documentation that Resident #3 was constantly disoriented and semi ambulatory.	C 454		

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C 454	Continued From page 5	C 454		

Telephone interview with Resident #3's Power of Attorney (POA) on 01/03/20 at 11:11am revealed:
-She had not been aware of the need for bed rails for Resident #3.
-She had seen the bed rails on the bed during visits to the facility.
-Staff had not notified her or discussed the need for the bed rails for Resident #3.

Interview with the Supervisor In Charge (SIC) on 01/03/20 at 11:28am revealed:
-Resident #3 had been a resident of the facility for a "long time".
-Resident #3 had fallen and broken her hip and was sent to the hospital.
-Resident #3 returned from the hospital on 12/26/19 after hip surgery.
-The bed rails had been placed on the bed to prevent the Resident from getting out of bed on her own and falling.
-The SIC had not been working as the SIC when the bed rails were placed on the bed.
-The SIC did not know if Resident #3's POA had been notified.

Review of Resident #3's record and charting notes revealed there was no documentation that Resident #3's POA had been notified and consent received for the use of the bed rails.

Interview with the Supervisor on call on 01/03/20 at 12:09pm revealed:
-The bed rails had been placed on Resident #3's bed on 12/26/19.
-It was the SIC's responsibilty to notify the POA and get consent for the bed rails.

Interview with the Property Manager on 01/03/20 at 12:35pm revealed:
-The physician should be notified immediately

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C 454	Continued From page 6 when the use of bed rails was required. -The Care Plan would be updated after the physician gave the order and consent received from the POA. -She did not know why the POA had not been notified of the bed rails.	C 454		