STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 an annual survey on July 25, 2023.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal service on 05/23/23 from 11:43am to 12:16pm revealed: -The meal consisted of a baked boneless skinless chicken breast with a sauce served over egg noodles, green peas and a roll. -There were 18 place settings with a fork and a spoon, and one place setting with a spoon only; there were no knives on the tables. -One resident used her fingers to hold the chicken breast in place while she used the side of her spoon to cut pieces of the chicken; she only ate 80 percent of her chicken.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 286	Continued From page 1 -A second resident tried but was unable to cut her chicken breast with her fork. She then picked up the chicken breast and ripped it into pieces with her hands and ate the chicken breast with her hands. -A third resident held the chicken breast to the plate with her fingers while she used the side of her fork to cut the chicken. -A fourth resident used her spoon to hold the chicken breast to the plate and cut pieces with the side of her fork; she eventually stopped trying to cut the chicken. -The fourth resident ate 100 percent of everything on her plate but only ate about 25 percent of her chicken. -A fifth resident tried to cut the chicken breast with the side of her fork but after several attempts she gave up and did not eat any of the chicken breast. -A sixth resident picked up the entire chicken breast with her fork and was eating it by taking bites. She then picked up the whole chicken breast with her hand and ate it with her hands. -Several residents stabbed the center of the chicken breast with their forks, picked it up with the fork and took bites of the chicken while holding it on the fork. -One staff assisted a resident after the resident was observed using the side of the spoon to try to cut the chicken breast. -The staff used the spoon to hold the chicken breast to the plate and used the side of the fork to cut the chicken breast as she told the resident the chicken was tender but not tender enough to cut with the spoon. Interview with a resident on 07/25/23 at 4:30 pm revealed: -She did not receive a knife at her place setting. -She was unable to cut the chicken.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 286	Continued From page 2	D 286		

-Having a knife would have made it better to cut the chicken.
-She thought she could get a knife if she requested one.

Interview with the cook on 07/25/23 at 11:56pm revealed:
-They did not give knives to the residents.
-She did not know why they did not give them to the residents, they had them in the kitchen.

Interview with the Dietary Manager (DM) on 07/25/23 at 4:06pm revealed:
-She did not know why they did not provide knives at the place settings for the residents; it had been that way since she started working there a couple of weeks before.
-She had never thought to ask why they did not provide knives for the residents to eat with.
-She assumed the residents could not have knives because they had dementia.
-There were enough knives in the kitchen to give to each resident one; she had seen them.
-She did not watch the residents during the lunch meal on 07/25/23 to see if they struggled with cutting the chicken breast with the side of a fork.
-She was not aware of the rule requiring a full place setting including a fork, knife and a spoon for each resident.

Interview with the Administrator on 07/25/23 at 4:34pm revealed:
-The kitchen staff placed a spoon, a fork, a napkin and a cup for coffee at each resident's seat.
-He instructed the staff not to put knives out for the residents because knives had been an issue in the past when multiple residents were fighting in the dining room with them.
-He was aware of the requirement for a fork, knife

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 286	Continued From page 3 and a spoon at each place setting. -The staff trained each other and the no knives on tables had carried over. -He observed meals in the dining room about every other day if not more often. -He did not recall any of the residents asking for a knife. -The staff knew which residents struggled with cutting their food and would assist them with cutting their food with a knife from the kitchen. -The residents enjoyed being pampered and cutting their food for them at the table was pampering them. -There were enough knives in the kitchen to provide a knife for each resident. -He was not aware some of the residents had to use their bare hands when cutting their food or when eating the chicken breast. Attempted interview with a second resident on 07/25/23 at 4:30 pm was unsuccessful.	D 286		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by:	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 309	Continued From page 4 Based on observations, record review and interviews the facility failed to maintain current listing of residents with physician ordered therapeutic diets for guidance of food service staff. The findings are: Observation of the kitchen on 07/25/23 at 9:43am revealed there was not a list of physicians ordered therapeutic diets posted for staff to reference. Interview with the Dietary Manager (DM) on 7/25/23 at 9:45am revealed: -There was not a list of residents on therapeutic diets posted in the kitchen. -She had been told by the Administrator that there were two residents who were ordered puree diets and there were three residents who were ordered mechanical soft diets. Interview with the cook on 07/25/23 at 4:13pm revealed she was told what diets the residents were ordered; there was not a list in the kitchen to follow. Interview with the Administrator on 07/25/23 at 4:43pm revealed: -He let the kitchen staff know what the diet orders were for the residents. -The residents' diet orders had not changed in a long time. -The only diets residents currently had orders for were puree and mechanical soft; he did not think any of the residents had orders for a no concentrated sweets (NCS) diet. -He was responsible for making the diet list. -He had gotten behind due to staffing shortages and had not made a diet list for the kitchen staff	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 309	Continued From page 5 to follow. -He did not know how long the kitchen staff had been without a current diet list.	D 309		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record.	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 6	D 485		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure an order for a restraint was current as required for 1 of 1 sampled resident (#2) with a padded seatbelt.

The findings are:

Observation of Resident #2 on 07/25/23 at 9:21am revealed she was sitting in a wheelchair in the living room with a blue, soft belt restraint around her waist.

Review of Resident #2's current FL2 dated 12/06/22 revealed:
-Diagnoses included dementia with agitation, muscle waste and atrophy, abnormality of gait and altered mental status.
-The resident was non-ambulatory with a wheelchair.
-The resident was constantly disoriented.
-The resident required assistance with bathing, feeding and dressing.

Review of Resident #2's Resident Register dated 12/08/23 revealed she was admitted to the facility on 12/07/23.

Review of Resident #2's most recent consent for physical restraint dated 12/07/23 revealed:
-The consent was signed by Resident #2's primary care provider (PCP), the facility manager and a family member.
-The medical reason for the restraint was documented as the resident's family requested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 7	D 485		

the restraint to prevent injury to the resident when she tried to get up on her own; the resident was very unsteady and non-weight baring.
-The type of restraint documented was a soft seatbelt.
-The time period the restraint was to be used was documented for when [she] was in her wheelchair during the day.
-The restraint was to be checked every two hours.
-The restraint was to be released for 15 to 30 minutes at the two-hour checks.

Review of Resident #2's Nursing Assessment dated 12/7/22 revealed:
-She required assistance when getting up.
-She was mobile with a wheelchair.
-She had limited range of motion.
-She was always disoriented.
-There was documentation for a soft seatbelt when up in a wheelchair.
-The assessment was not signed by the PCP.

Review of Resident #2's Care Plan dated 01/24/23 revealed:
-She was totally dependent and required total assistance with ambulation, transfers, bathing dressing, toileting, eating and grooming.
-She was ambulatory with a wheelchair.
-There was no documentation about the use of a soft seatbelt as a physical restraint.

Review of Resident #2's most recent Licensed Health Professional support (LHPS) task dated 07/13/23 revealed:
-There was a task checked off for ambulation with an assisted device.
-There was a task checked off for care of residents who were physically restrained.
-There was documentation of the use of a lap

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 8	D 485		

belt.
-There was a task checked off for transferring semi-ambulatory or non-ambulatory residents.
-There was documentation of the use of a Hoyer lift (an assistive device used to lift residents from the bed to the chair or from a chair to a bed).

Telephone interview with Resident #2's family member on 07/25/23 at 3:34pm revealed:
-She and another family member had requested Resident #2 wear the soft seatbelt when Resident #2 was seated in her wheelchair.
-She was aware the soft seatbelt was considered a restraint and she was fine with it.
-She did not want Resident #2 to fall from the wheelchair also the soft seatbelt prevented Resident #2 from getting out of the wheelchair and falling.
-She visited with Resident #2 at the facility about once a week or more.
-Resident #2 had the soft seatbelt on when she was in the wheelchair; if not she would request to have staff put it on Resident #2.
-She thought the consent for the restraint was signed when Resident #2 was admitted to the facility.

Telephone interview with Resident #2's Hospice Nurse on 07/26/23 at 1:09pm revealed:
-Resident #2 had been under hospice care since January 2023.
-She visited with Resident #2 once a week to provide care, but she was in the building almost every day.
-Someone from the facility had asked her about renewing the order for the soft seatbelt physical restraint but she could not remember when because it had been a while.
-The hospice group she worked for did not agree with the use of physical restraints and would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 9	D 485		

write a new order for the soft seatbelt.
-She did not know if Resident #2 had a current order for the physical restraint; the facility was going to pursue an order from a secondary physician.
-Resident #2 continued to wear the soft seatbelt after she refused to provide a new order from hospice.
-The facility put the soft seatbelt on Resident #2; it was their decision to use the physical restraint.
-Resident #2 had the soft seatbelt on if she was in her wheelchair when she visited every week.
-She had seen Resident #2 on 07/25/23 and she had the soft seatbelt on.

Interview with a personal care aide (PCA) on 07/25/23 at 3:46pm revealed:
-He worked with Resident #2 on second shift.
-Resident #2 wore a soft, blue restraint when she was up in the wheelchair.
-He would release Resident #2's restraint every 2 hours for 15 minutes.
-Resident #2's restraint was applied each morning she got out of bed by the PCAs.

Interview with a second PCA on 07/25/23 at 4:01pm revealed:
-She typically worked third shift and would get Resident #2 out of the bed in the mornings.
-She would place the soft, blue restraint on Resident #2 each morning when she transferred Resident #2 to the wheelchair.
-If Resident #2 did not have the restraint on, she would stand up and fall.

Interview with a third PCA on 07/25/23 at 6:06pm revealed:
-She worked first shift from 7:00am to 3:00pm.
-She had placed the soft seatbelt on Resident #2 that morning, 07/25/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 10	D 485		

-She had removed it after the hospice nurse told her on 07/25/23 to remove it because Resident #2's order was not renewed.
-She put the soft seatbelt on Resident #2 each time she got her out of the bed during the day.
-If she did not put the soft seatbelt on then another PCA did.
-She saw Resident #2 with the soft seatbelt on every day.
-Resident #2 had to have the soft seatbelt on to prevent her from falling.
-The Resident Care Coordinator (RCC) nor the Administrator had ever told her to take the soft seatbelt off Resident #2 when they saw it.
-Today, 07/25/23 was the first time she had been told to take the soft seatbelt off Resident #2.

Interview with the RCC on 07/25/23 at 6:54pm revealed:
-She was told by the hospice nurse that hospice would not sign an order for a physical restraint for residents.
-The family wanted the soft seatbelt for Resident #2 to prevent her from falling.
-Resident #2 would lean forward in her wheelchair or try to stand and the family was afraid she would fall.
-Resident #2 had declined and was not trying to stand up like she once did.
-She could not recall the last time she had seen the soft seatbelt on Resident #2 or if she had seen the soft seatbelt on Resident #2 after the order was not renewed by hospice.
-If she had seen the soft seatbelt on Resident #2, she would have told the staff to remove it.
-The family had not complained to her about the soft seatbelt not being on.
-She had the discussion with the family about not having a renewed order for the physical restraint when the new order was due sometime in March

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 11 2023 or April 2023. Interview with the Administrator on 07/25/23 at 5:51pm revealed: -The family requested the use of the soft seatbelt when Resident #2 was admitted to prevent her from trying to stand and falling. -Resident #2 went under the care of hospice in on 01/23/23. -The hospice nurse and the physician for hospice would not renew the order for the soft seatbelt in March 2023. -He considered the order expired because a new order was not signed. -The family was aware the order had expired because the facility had told them. -He thought the family still wanted the soft seatbelt to be worn and depending on the family member who visited they would insist the staff put the physical restraint on Resident #2. -Facility staff were instructed not to put the soft seatbelt on Resident #2 after the order expired. -He had not seen the soft seatbelt on Resident #2 since sometime in April 2023. -If he had seen the soft seatbelt on Resident #2, he would have instructed the staff to remove it. -He thought only the medication aides (MA) put the soft seatbelt on Resident #2. -He was not aware the soft seatbelt was on Resident #2 this morning. -One of the PCAs probably took it off her. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 485		