STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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, follow up survey, and complaint investigation on 08/23/23 to 08/25/23.	D 000		
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 provide supervision for 1 of 6 sampled residents (#3) as evidenced by a resident who resided in the Special Care Unit (SCU) with cognitive disorder and disorientation being allowed to smoke unsupervised and sustained burns which resulted in the resident being admitted to a hospital burn center and placed on a ventilator. The findings are: Observation of the bulletin board in the nurses station of the Special Care Unit (SCU) on 08/23/23 at 3:00pm revealed there was a yellow posting which read, "Attention all staff, Residents, and Visitors: The only area that smoking is allowed is the front designated smoking area. Smoking is not allowed in any other areas."	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 1 Observation of the exit door on SCU on 08/24/23 at 10:01am revealed there was a paper taped to the door window that read, " The 'designated smoking area' is located at the front of the building. Once you exit the building turn to your right and proceed to the patio located immediately the the right. All other areas are to be free of smoking. This is required by the State of North Carolina and the local health department. No smoking is to be within 15 feet of any exit or doorway." and was dated 03/15/23. Observations of the side yard out from the Special Care Unit (SCU) on 08/24/23 at 9:51am -10:01am and 12:43pm-12:45pm and 08/25/23 at 8:57am-9:01am revealed: -There was an employee seated on the far corner of the sidewalk smoking a cigarette and using their cell phone. -There was a 7 inch drop at the end of the sidewalk and a 6 inch drop to the side of the sidewalk to the ground where the staff had been seated. -The sidewalk width straight out the SCU door to the edge of the sidewalk was 11 feet 3 inch with a 2.5 inch drop from the edge of the sidewalk to the ground which could lead to someone falling. -There was not a fence to enclose the area of the facility's property. -There was a chain link fence with 3 rows of rusted barbed wire at the top. -This fence separated the one side of the facility's property from the neighboring storage unit facility's property only. -There was an opening in the fence from the top of the chain link down to the ground that was large enough for a full-grown adult to get through to the property next door. -The opening in the fence measured 62 inches in height, 6 inches in width at the top of the opening	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 2	D 270		

and 32 inches in width at the base of the opening nearest the ground.
-The area behind the facility property leads to highway 211, which was a busy 2 lane road.
-The speed limit was 45 miles per hour on the stretch of road directly behind the facility property.
-There was a convenience store/gas station located on the opposite side of the highway from the facility.
-Directly behind the facility was a building which the laundry area and maintenance storage areas were located.
-On the side of the building was a diamond shaped National Fire Protection Association placard that contained 4 colored diamonds (blue, red, yellow, and white) with numbers in each that were within the diamond.
-The blue diamond represents Health Hazard with 0 being Normal Material, 1 being slightly hazardous, 2 being hazardous, 3 being extreme danger, and 4 being deadly.
-The red diamond represents Fire Hazard Flash Point with 0 Will not burn, 1 Above 200° (degrees) F (Fahrenheit), 2 Below 200°F, 3 Below 100°F, and 4 Below 73°F.
-The yellow diamond represents Instability Hazard with 0 being Stable, 1 being Unstable if heated, 2 being Violent Chemical Change, 3 being Shock and Heat May Detonate, and 4 being May Detonate.
-The white diamond represents Specific Hazard with ACID, ALK (Alkali), COR (Corrosive), OX (Oxidizer), radioactive symbol (Radiation Hazard) and W (with a strike thru) (Use no Water).
-The door to the laundry was unlocked and partially open.
-The door to the maintenance storage was unlocked.
-The maintenance storage had numerous cans and buckets of paint in various sizes , numerous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 3	D 270		

tubes of caulking, numerous cans of spray paint, cans of polyurethane, 1 gallon spray container of bug stop home barrier and various tools, ladders, levels, and hammers.

Review of the facility's Policy for the Use of Tobacco Products revealed:
-Residents who smoke must use designated smoking areas.
-Staff will supervise residents who smoke as needed.

Review of the facility's new employee training manual (date unknown) revealed staff would supervise residents who smoke when it was determined during their quarterly Registered Nurse assessment they were not competent to continue to smoke unsupervised.

Review of Resident #3's current FL2 dated 01/25/23 revealed:
-Diagnoses included unspecified dementia, schizophrenia, chronic static encephalopathy and history of falls.
-There was documentation Resident #3 had a history of wandering behaviors.
-She was constantly disoriented.

Review of Resident #3's Memory Care Functional and Health/Medication Assistance Assessment date 06/16/23 revealed:
-There was documentation this assessment was Resident #1's quarterly SCU assessment.
-There was documentation Resident #3 was not oriented to person, time and place.
-Resident #3 was to be supervised when leaving the facility.
-Resident #3 required staff supervision when smoking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 4	D 270		

Review of Resident #3's Incident/Accident Report dated 08/12/23 revealed:
-Resident #3 went outside on the North Hall to smoke a cigarette at 4:00pm.
-The lighter Resident #3 used to light the cigarette burst and her hair caught fire.
-A personal care aide (PCA) put out the fire with water.
-Resident #3 was sent to the local emergency department (ED) and, from there, was sent to a burn center at another hospital.
-Who was present at the time of the incident was documented as "Res".

Review of the Internal Investigation Report dated 08/14/23 revealed:
-There was documentation the incident occurred on 08/12/23 at 3:57pm.
-There was documentation a PCA let Resident #3 out of the side door of the North Hall of the SCU to smoke in a non-smoking area.
-The PCA returned to the nurses station and did not supervise Resident #3.
-Resident #3 set her hair on fire when she tried to light her cigarette.
-Another resident on the SCU, who was looking through the door window, alerted the PCA, who went with water from the medication cart and put out the fire.
-There was documentation the PCA on duty reported she let Resident #3 out of the end door when instructed by the supervisor to let Resident #3 smoke; she did not stay with Resident #3.

Review of the Investigation Report for incident occurring on 08/12/23 and dated 08/22/23 revealed:
-The incident occurred outside of the SCU North Hall on 08/12/23 at 4:00pm.
-A PCA working on the SCU for dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 5	D 270		

residents let Resident #3 out of the unit door and did not stay with her.
-Resident #3 was burnt with a cigarette lighter and transported to the local ED and then to the burn center at another hospital.
-Resident # was burned on the left side of her head and shoulder.
-There was documentation the PCA did not stay with Resident #1 who was to have supervision.
-There was documentation Resident #3 was not in a designated smoking area at the time of the incident.

Interview with Resident #3's primary care provider (PCP) on 08/23/23 at 11:45am revealed staff should always be present and supervise residents from the SCU when they were outside the locked unit to keep them safe.

Interview with a resident on the SCU on 08/24/23 at 12:35pm revealed:
-Staff would take him outside the SCU to smoke sometimes but they were not supposed to.
-He kept his cigarettes and lighter on him until recently.
-Staff kept his cigarettes and lighter now and would light his cigarette for him.

Telephone interview with a PCA on 08/24/23 at 9:08am revealed:
-She was the only PCA working on the floor at the time of the incident that occurred on 08/12/23 because the other PCA was on break.
-The medication aide (MA) was the supervisor and was going to let Resident #3 go to smoke but she offered to do it because the supervisor was busy at the medication cart.
-She let Resident #3 outside the door on the SCU to smoke and she went to the nursing station.
-She was not able to see Resident #3 from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 6	D 270		

nurses station.
-Resident #3 had her own lighter to light her cigarette and she was not aware the residents on SCU were not supposed to have a lighter until after the incident on 08/12/23.
-Resident #3 was outside alone for 5-10 minutes and another resident told her Resident #3 was on fire.
-Resident #3 and a second resident on the SCU that smoked was let out the side door of the SCU to smoke by staff often.
-Staff always stayed outside with residents while they smoked when they were taken to the designated smoking area in front of the building but not when they smoked outside the door of the SCU.
-She was not aware Resident #3 had a history of wandering behaviors.
-Staff were supposed to take residents to the front of the building to the designated smoking area, light their cigarette for them and stay with them while they smoked and staff were trained on smoking procedures upon hire.
-Staff were supposed to supervise residents who resided on the SCU when they were outside the locked unit to keep an eye on them for safety.
-The Special Care Unit Coordinator (SCC) was aware staff would let residents on SCU smoke outside alone and would tell them they were not suppose to do it.

Interview with a second PCA 08/25/23 at 10:18am revealed:
-She was assigned to the SCU on 08/12/23 but was assisting on the assisted living (AL) side at the time of the incident that occurred on 08/12/23.
-After being on the AL side of the building for 25-30 minutes, the other PCA assigned waved for her to go to the SCU.
-When she responded, Resident #1 was inside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 7	D 270		

the unit and was burned.
-Residents kept their cigarettes on the SCU but she did not know if they kept a lighter.
-She would borrow a lighter from a staff member and light the cigarette for them when she took residents to smoke.
-There was only one designated smoking area for the facility that was located in front of the building.
-She never saw staff take residents outside the SCU to smoke or leave the resident unsupervised.
-If there was only one staff on the unit when a resident wanted to go smoke, she would ask the resident to wait or call for staff to return to the unit.
-She was not aware of a written smoking policy but she was informed of the expectations for resident smoking procedure during orientation to the SCU.
-Staff were expected to stay with residents from the SCU when they were outside the unit because they had dementia and needed to be kept safe.

Interview with a third PCA on 08/24/23 11:50am revealed:
-Staff routinely took residents out of the side door of the SCU to smoke but usually they stayed with them.
-Residents were not suppose to have a lighter on the SCU and the staff that took them to smoke would light the cigarette for them.
-Staff were suppose to take residents to the designated smoking area in front of the building but they did not do what they were supposed to most of the time.

Interview with a fourth PCA on 08/25/23 at 10:06am revealed:
-Residents on the SCU were allowed to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 8	D 270		

cigarettes and lighter on them until the incident occurred on 08/12/23.
-Cigarettes and lighters were taken up while she was off and she was not sure who gave the staff instructions to take and secure cigarettes and lighters.

Interview with the MA/Supervisor on 08/24/23 at 2:49pm revealed:
-It was common practice for staff to take residents from the SCU out the side door of the SCU to smoke because it took a long time to take residents to the designated smoking area in front of the building.
-She reported to the SCC that staff were taking residents out the side door to smoke in the past but nothing was done so she stopped reporting.
-The supervisor was suppose to get the resident's cigarettes from the medication room when it was time to smoke.
-Resident #3 kept her cigarettes with her but not a lighter however, Resident #3 did have her cigarettes and lighter on 08/12/23; she did not know how she got it.
-She was not on the unit at the time the incident occurred on 08/12/23.
-There was one PCA on the SCU and one PCA on the AL unit at the time of the incident.
-She was outside getting something from her car when the PCA that was on the AL unit yelled to her that a Resident #3 was burned.
-Resident #3 was sitting inside the building when she arrived and she could smell burnt skin and hair when she entered the SCU.
-Resident #3's lighter was in a lot of pieces and she (supervisor) picked up the pieces and threw them in the dumpster.
-She knew the PCA was taking Resident #1 to smoke but she did not know she left her unsupervised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 9	D 270		

-It was not safe to leave residents from the SCU outside alone.
-Resident #3 did get agitated and curse at staff sometimes but she had not seen any wandering behaviors.
-Smoking was covered in monthly staff meetings and specifically mentioned not to leave the residents unattended while smoking.
-She told the Administrator that staff were taking residents outside the SCU to smoke and was told by the Administrator that as the supervisor, she should not let them.
-She told staff in the past not to take the residents outside the SCU to smoke but they did not listen and she gave up trying to tell them.
-Policies, including the smoking policy, were reviewed by staff every 6 months.

Interview with the Special Care Unit Coordinator (SCC) on 08/25/23 at 10:10am to 11:10am revealed:
-She was not aware residents on the SCU were allowed by staff to keep cigarettes and lighter on them.
-She caught staff smoking outside the SCU but never saw residents taken out the side door to smoke.
-Staff were expected to take residents to smoke in the designated smoking area in the front of the building, light their cigarette for them and supervise them while they smoked.
-She believed staff frequently took residents to smoke outside the SCU because the staff was too comfortable in doing so on 08/12/23 for it to not be a common practice.
-During a COVID-19 outbreak, staff were allowed to take residents out of side door in the SCU to smoke to prevent the spread of infection by taking them through the AL to the designated smoking area but that was stopped in April or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 10	D 270		

May of 2023.
-Staff were informed of the changes during staff meetings and postings on the doors.
-The Administrator had meetings to address smoking in the designated area with the last one being about 1 week prior to the incident.
-Staff were expected to notify the supervisor when taking residents out the smoke.
-Supervision of SCU residents was important because of safety concerns related to memory loss and dementia.

Interview with the Administrator on 08/25/23 at 12:08pm revealed:
-There was no designated smoking area on the SCU.
-She expected staff to take residents on the SCU to smoke to the designated smoking area and supervise them during smoking.
-When COVID-19 was in the building, SCU residents were allowed to smoke off the SCU with staff supervision to prevent the spread of infection but notices were put up to stop the practice in March 2022 and reiterated the practice was no longer allowed again in September 2022..
-Supervision at the time of the incident would not have prevented the lighter from exploding but interventions could have been implemented quicker.
-Resident #3 had wandered away from a sister facility prior to admission to the SCU 2 years prior but was not aware of any wandering behaviors since.
-She had a meeting with the staff of the SCU, SCC and the Supervisor about 1 week before the incident after she caught staff taking residents from the SCU out of the side door to smoke.
-SCU residents were not supposed to have cigarettes or lighters and she did not know Resident #3 had a lighter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 270	Continued From page 11 -Cigarettes and lighters were confiscated and secured after the incident. -Staff were trained on the expectations and smoking procedure during orientation but there was no written smoking policy specific to the SCU. _____ The facility failed to provide supervision for a resident that resided on the Special Care Unit (#3) that was allowed outside the building in an undesignated, unsecured side yard to smoke unsupervised, resulting in the resident catching her hair and clothes on fire which lead to extensive burns to her head and face and being hospitalized in a burn center and placed on a ventilator. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2023.	D 270		
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.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 12	D 358		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#8, #7) observed during the medication pass including errors with a thyroid medication (#8) and an acid reflux medication (#7).

The findings are:

The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 07/19/23.

1. Observation of the 8:00am medication pass on the Special Care Unit (SCU) on 08/24/23 revealed:
-At 7:39am, the medication aide (MA) prepared Resident #8's medication from the medication cart outside the dining room door.
-There was an entry on the electronic medication administration record (eMAR) computer screen indicating levothyroxine sodium 50mcg tablet take 1 tablet 30 minutes before breakfast was scheduled to be administered at 8:00am for Resident #8.
-The MA took a cup of water and the paper soufflé cup with Resident #8's medications (which included his levothyroxine 50 mcg) scheduled at 8:00am into the SCU dining room.
-Resident #8 was seated at the dining room table with his breakfast at 7:40am.
-Resident #8 had eaten ½ of his toast and ½ of his eggs.
-The MA proceeded to administer Resident #8's medications including the levothyroxine.
-Resident #8 took his medications with the water provided and continued to eat his breakfast once he had swallowed his medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 13	D 358		

Review of the Personnel Policies and Employee Handbook dated Revised 01/17/17, 02/13/17, 07/14/17, and 08/08/17 revealed medications, prescription and non-prescription, and treatments would be administered in accordance with the prescribing practitioner's orders.

Review of Resident #8's FL2 dated 02/14/23 revealed:
-Diagnoses included hypothyroidism, dementia, neurocognitive disorder with Lewy bodies, and non-traumatic intracerebral hemorrhage.
-There was an order for levothyroxine sodium 25mcg tablet (used to treat hypothyroidism) take one tablet 30 minutes before breakfast.

Review of Resident #8's thyroid stimulating hormone (TSH) bloodwork order dated 02/24/23 revealed:
-The normal range for TSH was 0.46 - 4.68 per the laboratory performing the bloodwork.
-His TSH level was 5.50 (H), which indicated the levothyroxine dose was too low.

Review of a signed physician's order dated 03/01/23 revealed there was an order for levothyroxine sodium 25mcg tablet take 1 ½ tablet (37.5mcg) 30 minutes before breakfast.

Review of Resident #8's thyroid stimulating hormones (TSH) bloodwork order dated 03/30/23 revealed:
-The normal range for TSH was 0.46 - 4.68 per the laboratory performing the bloodwork.
-His TSH level was 7.32 (H), which indicated the levothyroxine dose was too low.

Review of a signed physician's order dated 04/10/23 revealed there was an order for levothyroxine sodium 50mcg tablet take one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 14	D 358		

tablet 30 minutes before breakfast.

Review of Resident #8's thyroid stimulating hormones (TSH) bloodwork order dated 05/11/23 revealed:
-The normal range for TSH was 0.46 - 4.68 per the laboratory performing the bloodwork.
-His TSH level was 5.04 (H), which indicated the levothyroxine dose was too low.

Review of Resident #8's thyroid stimulating hormones (TSH) bloodwork order dated 06/22/23 revealed:
-The normal range for TSH was 0.46 - 4.68 per the laboratory performing the bloodwork.
-His TSH level was 6.40 (H), which indicated the levothyroxine dose was too low.

Review of Resident #8's August 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for levothyroxine sodium 50mcg tablet take 1 tablet 30 minutes before breakfast and scheduled for administration at 7:00am.
-Levothyroxine sodium 50mcg was documented as administered on 08/01/23 - 08/24/23 at 7:00am.

Observation of Resident #8's medications on hand on 08/24/23 at 7:38am revealed there were 4 of 30 levothyroxine sodium 50 mcg tablets available for administration dispensed on 07/29/23.

Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable.

Interview with a medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 15 08/25/23 at 1:30pm revealed: -She was aware there were residents who had medication that required them to be administered 30 minutes before meals such as breakfast. -The order directions were on the medication cards for any "special" things that needed to be followed. -She was not sure how any of the MAs would have administered Resident #8's levothyroxine sodium without seeing the instructions of "30 minutes before breakfast" since it was on the medication card and on the computer for the electronic medication administration record (eMAR). -The MAs were all supposed to do their 3 checks when they pulled the medication from the cart. -The three checks included making sure the medication on the card matched the medication on the computer screen and what was on the screen matched the medication card and then again when they documented the medication as administered. -Resident #8's medications were given within the correct time except the levothyroxine should not have been given since he was eating. -Breakfast was scheduled to be served on the SCU at 7:30am. Telephone interview with Resident #8's primary care provider (PCP) on 08/25/23 at 10:42am revealed: -She was not aware that Resident #8's levothyroxine sodium was being administered while he was eating breakfast. -Levothyroxine needed to be administered on an empty stomach to allow proper absorption. -She had been titrating his medication dosages based on the bloodwork results of his TSH levels. -She expected the facility to administer medications as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 16 -The TSH levels were elevated because the medication was not being administered before breakfast as ordered and therefore not absorbed properly. Interview with the Executive Director (ED) on 08/25/23 at 12:00pm revealed: -She was not aware Resident #8 was receiving his levothyroxine during breakfast. -MAs were responsible to administer medications as ordered. -She knew levothyroxine was supposed to be given on an empty stomach so it would be absorbed, and food would interfere with the absorption. -The MAs were trained to read the medication card and follow the directions on the card and on the computer (eMAR). 2. Observation of the 8:00am medication pass on the assisted living hall (AL) on 08/23/23 revealed: -At 9:13am, the medication aide (MA) prepared Resident 7's medication from the medication cart outside the resident's door. -There was an entry on the electronic medication administration record (eMAR) computer screen for omeprazole DR 20mg take one capsule daily 30 minutes before breakfast at 8:00am. -The MA took a cup of water and the paper soufflé cup with Resident #7 medications (which included her omeprazole DR 20mg) scheduled at 8:00am into the resident's room. -Resident #7 was seated on the side of her bed drinking her shake. -Resident #7 had eaten breakfast. -The MA proceeded to administer Resident #7's medications including the omeprazole DR 20mg. -Resident #7 took her medications with the water provided and continued to drink her shake once she had swallowed her medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 17 Review of Resident #7's current FL2 dated 01/25/23 revealed: -Diagnoses included gastroesophageal reflux disease (GERD) without esophagitis and dysphagia (difficulty swallowing). -There was an order for omeprazole DR 20mg take one capsule daily 30 minutes before breakfast. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole DR 20mg take one capsule daily 30 minutes before breakfast at 8:00am. -There was documentation for omeprazole DR 20mg was not administered 9 of 23 opportunities from 08/01/23 through 08/23/23 with reason documented as "resident refused". Observation of Resident #7's medications on hand at the facility on 08/23/23 at 9:14am revealed: -There was omeprazole DR 20mg available for administration. -Omeprazole DR 20mg was filled and dispensed by the facility's pharmacy on 07/29/23 for 30 capsules. -There were 14 tablets of omeprazole DR 20mg remaining. Interview with Resident #7 on 08/23/23 at 10:15am revealed: -She had some stomach pain, like burning. -The facility's Primary Care Provider (PCP) ordered her some medication for her stomach. -She did not always take it if she did not need it (have the burning) -She did not remember if she took it before or	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 358	Continued From page 18 after breakfast. Interview with Resident #7's primary care provider (PCP) on 08/23/23 at 11:45am revealed: -She ordered Resident #7's omeprazole 20mg DR 1 capsule every morning 30 minutes before breakfast to allow for better absorption. -She was not aware the resident was not being administered omeprazole 20mg DR as ordered nor that she had refused it on several occasions. -She was at the facility yesterday and saw Resident #7. -Resident #7 had not complained about reflux or stomach pain.	D 358		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented 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. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 484	Continued From page 19 of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment for the use of bedrails prior to the use of restraints for 1 of 2 sampled residents (#5) with half bedrails. The findings are: Review of the census in the assisted living (AL) side of the facility revealed a census of 49 residents.	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 484	Continued From page 20 Observations of the AL side of the facility on 08/23/23 between 8:30am -9:30am revealed: -Resident #5 was in bed with both half rails up on the left and right sides of the bed. -There was a fall mat noted on the floor on the right side of the bed. Review of Resident #5's current FL2 dated 03/22/23 revealed: -Diagnoses included cerebral infarction, left sided hemiplegia, major depressive disorder, diabetes mellitus type 2, hypertension, heart failure, and general anxiety disorder. -He was semi-ambulatory and used a wheelchair. -He was intermittently disoriented. Review of Resident #5's care plan dated 03/22/23 revealed: -Resident #5 was semi-ambulatory and used a wheelchair. -He was intermittently disoriented. -Resident #5 had extensive dependence upon staff to assist him with toileting, bathing, dressing, and transferring; he required limited assistance with eating and ambulation. Review of Resident #5's physician's order dated 06/07/23 revealed an order for a hospital bed with half rails when in bed due to fall risk. Based on observations, record reviews and interviews, it was determined Resident #5 was not interviewable. Interview with a personal care aide (PCA) on 08/23/23 at 3:58pm revealed: -Resident #5 required assistance with all activities of daily living (ADLs) and he was a 1-2 person assist. -Resident #5 did not use the bedrails to assist	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 484	Continued From page 21	D 484		

with care or transfers.
-She did not think Resident #5 was physically able to raise or lower the bedrails and she did not know if he would have enough strength to free himself if he became entangled in the bedrails or between the bedrails and the mattress.

Interview with the facility's RN Consultant (RNC) on 08/24/23 at 3:39pm revealed:
-The former Resident Care Coordinator (RCC) had set up a meeting with Resident #5's Power of Attorney (POA) on 09/27/22.
-The POA had attended the meeting and signed the paperwork for the meeting on 09/27/22.
-The POA had signed the paperwork for consent to use the bedrails for Resident #5 on 09/27/22.
-The physical restraint assessment form was blank but signed by the former RCC, the POA and her (RN Consultant) on 09/27/22.
-The RCC had told her that he did not know how to complete the assessment form and asked for her assistance.
-She had assisted the RCC on how to complete the assessment and the assessment form.
-She was not sure why she signed a blank form and regretted signing it since the RCC failed to complete the form.
-The blank assessment form with the RCC's signature, the POA's signature and her signature remained in Resident #5's record at the facility.

Telephone interview with Resident #5's POA on 08/24/23 at 3:42pm revealed:
-She knew Resident #5 had bedrails and she had signed the blank assessment form that the previous RCC was supposed to complete.
-Resident #5 was paralyzed on the left side and the bedrails were used to keep him from rolling out of bed.
-She had given verbal consent for the RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 484	Continued From page 22 Consultant to complete another assessment form for Resident #5. -She had been at the meeting on 09/27/22 and had signed the forms then. -She was not sure why the assessment form she signed was blank, but she had signed it. Interview with the Administrator on 08/24/23 at 4:00pm revealed: -Resident #5's POA had previously consented to the use of siderails for him. -The former RCC should have done the assessment for Resident #5 before the meeting, and no one should have been asked to sign a blank assessment form. -The RNC had completed an assessment today and contacted the POA regarding consent.	D 484		