

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2024
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NAME OF PROVIDER OR SUPPLIER CHILTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 135 TURNER FARM LANE REIDSVILLE, NC 27320
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(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 survey on 08/07/24.	C 000		
C 175	<p>10A NCAC 13G .0506 Training On Physical Restraints</p> <p>10A NCAC 13G .0506 Training On Physical Restraints</p> <p>(a) A family care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.</p> <p>(b) Training shall be provided by a registered nurse and shall include the following:</p> <ol style="list-style-type: none"> (1) alternatives to physical restraints; (2) types of physical restraints; (3) medical symptoms that warrant physical restraint; (4) negative outcomes from using physical restraints; (5) correct application of physical restraints; (6) monitoring and caring for residents who are restrained; and (7) the process of reducing restraint time by using alternatives. <p>This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 3 of 3 staff (A, B, and C) were trained on the use of alternatives to physical restraints and on the care of residents who were physically restrained.</p> <p>The findings are:</p>	C 175		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 175	<p>Continued From page 1</p> <p>1. Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 01/23/23. -There was an undated licensed health professional support (LHPS) skills/competency evaluation. -There were different dates beside some of the LHPS tasks indicating that the Staff A had been checked off for those LHPS tasks. -There was no documentation Staff A had been checked off or satisfactorily completed the LHPS task of application and monitoring of restraints or alternative care practices to restraint use.</p> <p>Attempted telephone interview with Staff A on 03/07/24 at 3:33pm was unsuccessful.</p> <p>Refer to the interview with the Administrator on 08/07/24 at 3:07pm.</p> <p>2. Review of Staff B's, medication aide (MA)/Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 03/30/21. -There was a licensed health professional support (LHPS) skills/competency evaluation dated 03/30/21. -There was no documentation Staff B had been checked off or satisfactorily completed the LHPS task of application and monitoring of restraints or alternative care practices to restraint use.</p> <p>Interview with Staff B on 08/07/24 at 3:46pm revealed: -She had not had any training on the use of restraints at the facility. -There were 2 residents whom she placed a gait belt or wheelchair seatbelt on when they were in</p>	C 175		

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C 175	<p>Continued From page 2</p> <p>their wheelchairs eating their meals.</p> <p>Refer to the interview with the Administrator on 08/07/24 at 3:07pm.</p> <p>3. Review of Staff C's, medication aide (MA)/Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 02/19/21. -There was a licensed health professional support (LHPS) skills/competency evaluation dated 02/19/21. -There was no documentation Staff C had been checked off or satisfactorily completed the LHPS task of application and monitoring of restraints or alternative care practices to restraint use.</p> <p>Interview with Staff C on 08/07/24 at 3:39pm revealed: -She placed belts on 2 residents when they were up in their wheelchairs. -She was not sure if she had training on the use of restraints at the facility.</p> <p>Refer to the interview with the Administrator on 08/07/24 at 3:07pm.</p> <p>Interview with the Administrator on 08/07/24 at 3:07pm revealed: -She was a Registered Nurse and completed staffs' LHPS Skills/Competency Evaluation. -Staff were not checked off on the LHPS Skills/Competency Evaluation for restraints because she did not think that the residents' belts were considered restraints.</p>	C 175		
C 456	10A NCAC 13G .1301(d) Use of Physical Restraints and Alternatives	C 456		

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C 456	<p>Continued From page 3</p> <p>10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES</p> <p>(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:</p> <p>(1) The order shall indicate:</p> <p>(A) the medical need for the restraint;</p> <p>(B) the type of restraint to be used;</p> <p>(C) the period of time the restraint is to be used; and</p> <p>(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.</p> <p>(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.</p> <p>(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.</p> <p>(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.</p> <p>(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.</p> <p>(6) The restraint order shall be kept in the resident ' s record.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an order for a physical restraint was obtained prior to the application of the restraint for 2 of 3 sampled residents (#1 and #2) related to a gait belt used</p>	C 456		

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C 456	<p>Continued From page 4</p> <p>as a restraint (#1) and a wheelchair seatbelt used as a restraint (#2); and failed to document alternatives, type of restraint, medical symptoms, times, care provided and behavior of the restrained residents.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 02/21/24 revealed: -Diagnoses included Alzheimer's disease, endometrial carcinoma, and edema. -Resident #1 was non-ambulatory and constantly disoriented. -Resident #1 required total care.</p> <p>Review of Resident #1's care plan dated 02/23/24 revealed: -Resident #1 was non-ambulatory and needed total assistance with all activities of daily living (ADLs) except for eating. -There was no documentation of the use of the gait belt for Resident #1 when she was in her wheelchair.</p> <p>Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 07/10/24 revealed: -There was no documentation of the use of the gait belt for Resident #1 when she was in her wheelchair. -There was no documentation the LHPS task for care of resident who were physically restrained and the use of care practices as alternatives to restraints had been provided or that staff's competency had been validated for restraints.</p> <p>Review of Resident #1's record revealed: -There was no documentation of an order for a restraint for Resident #1.</p>	C 456		

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C 456	<p>Continued From page 5</p> <ul style="list-style-type: none"> -There was no documentation of an assessment for a restraint. -There was no documentation Resident #1's responsible party was informed, accepted, or declined the use of a restraint. <p>Observation of the facility on 08/07/24 at various times between 9:08am and 3:45pm revealed:</p> <ul style="list-style-type: none"> -At 9:08am, Resident #1 was seated at the dining room table in a wheelchair. -The wheelchair was pushed all the way to the dining room table and there was a gait belt wrapped around the back of the wheelchair and around the front of Resident #1. -The buckle of the gait belt was plastic and had a push release on both sides. -The buckle of the gait belt was at the back of the wheelchair. -At 10:09am, Resident #1 was seated at the dining room table in her wheelchair with the gait belt in place around her and the wheelchair. -At 11:43am, Resident #1 was seated at the dining room table in her wheelchair with the gait belt in place around her and the wheelchair. -At 12:32pm, Resident #1 was seated at the dining room table in her wheelchair and was eating her lunch meal; the gait belt was in place around her and the wheelchair. -At 2:25pm, Resident #1 was seated at the dining room table eating a snack; the gait belt was in place around her and the wheelchair. -At 2:48pm, Resident #1 was seated at the dining room table in her wheelchair with the gait belt in place around her and the wheelchair. -At 3:45pm, Resident #1 was seated in a recliner chair in the living room with her feet elevated. <p>Interview with a medication aide (MA)/Supervisor-in-Charge (SIC) on 08/07/24 at 9:09pm revealed:</p>	C 456		

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C 456	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Resident #1 had a tendency to get up and she would fall if she got up by herself. -Resident #1 had her gait belt for about a year and the gait belt was placed on her anytime she was in her wheelchair. -There were no scheduled times to remove the gait belt from Resident #1. <p>Telephone interview with a second MA/SIC on 08/07/24 at 3:46pm revealed:</p> <ul style="list-style-type: none"> -There were no restraints at the facility. -Resident #1 had a gait belt fastened around her and her wheelchair when she was in her wheelchair eating meals. -The gait belt was in place for safety purposes, but it was not fastened tightly. -Resident #1 would lean forward and fall on the floor if she did not have the gait belt. -Either staff placed the gait belt on her when she was in her wheelchair or she had to stay in the bed. -Resident #1 could not unfasten the gait belt. -She never thought of the gait belt as a restraint. <p>Telephone interview with Resident #1's responsible party on 08/07/24 at 2:39pm revealed:</p> <ul style="list-style-type: none"> -She was aware staff used a belt for Resident #1 when she was up in her wheelchair. -Staff had use the belt for Resident #1 for a month or longer. -She had not signed any documents acknowledging the use of the belt or to accept or deny the use of the belt. -Resident #1 had the belt because of her diagnosis of Alzheimer's disease and her trying to stand up; the belt was to keep her from falling. -She did not necessarily agree with the use of the belt, but she did not want Resident #1 to fall. -"Nobody likes the idea of their [family member] 	C 456		

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C 456	<p>Continued From page 7</p> <p>being tied to a chair," but she knew Resident #1 would fly out of the wheelchair if the belt was not around her.</p> <p>-She did not know how long the belt was in place for Resident #1 throughout the day, but she assumed Resident #1 had the belt in place from the time staff placed her in the wheelchair until the time they took her out of the wheelchair.</p> <p>-Resident #1 was usually in her wheelchair with the belt in place when she visited her at the facility, but there were times, when she was in a recliner chair in the living room with her feet elevated to keep her feet from swelling.</p> <p>Interview with the Administrator on 08/07/24 at 3:07pm revealed:</p> <p>-Resident #1's family member asked her to put the gait belt on her when she was up in her wheelchair for safety.</p> <p>-Resident #1 used to have a chair alarm in her wheelchair, but she would constantly get up and down from the chair.</p> <p>-Resident #1's family used to have a sitter come to the facility for a few hours 3 days a week.</p> <p>-The wheelchair alarm, the camera, and the sitter helped, but if she was going to get up, she would just get up out of the wheelchair.</p> <p>-Resident #1 was now non ambulatory.</p> <p>-She had been wearing the gait belt for about 3 months and she was not able to unfasten the gait belt herself.</p> <p>-Resident #1 did not have a physician's order for a restraint.</p> <p>-She thought if Resident #1's family member requested the gait belt and facility staff were watching her, then an order was not needed.</p> <p>-Resident #1's family member told her to do whatever needed to be done.</p> <p>-The gait belt was to keep Resident #1 safe by preventing her from getting up and trying to walk</p>	C 456		

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C 456	<p>Continued From page 8</p> <p>when she wanted to; the gait belt was not to keep her from falling.</p> <p>Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/07/22 at 12:55pm was unsuccessful.</p> <p>Refer to the interview with the Administrator on 08/07/24 at 3:07pm.</p> <p>2. Review of Resident #2's current FL2 dated 05/23/24 revealed: -Diagnoses included dementia, paroxysmal atrial fibrillation, hypertension, acute kidney disease, left sided weakness, frequent falls, and lumbar compression fracture, closed. -Resident #2 required limited assistance with ambulation and dressing, maximum assistance with bathing, and was independent with feeding.</p> <p>Review of Resident #2's care plan dated 03/04/24 revealed: -Resident #2 was ambulatory with a walker and wheelchair. -She required total assistance with incontinence care and bathing, extensive assistance with ambulation and dressing, limited assistance with grooming and transferring, and she was independent with eating. -There was no documentation of the use of a wheelchair seatbelt for Resident #2 when she was in her wheelchair.</p> <p>Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 07/10/24 revealed:</p>	C 456		

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C 456	<p>Continued From page 9</p> <ul style="list-style-type: none"> -There was no documentation of the use of a wheelchair seatbelt for Resident #2. -There was no documentation the LHPS task for care of resident who were physically restrained and the use of care practices as alternatives to restraints had been provided or that staff's competency had been validated for restraints. <p>Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> -There was no documentation of an order for a restraint for Resident #2. -There was no documentation of an assessment for a restraint. -There was no documentation Resident #2's responsible party was informed, accepted, or declined the use of a restraint. <p>Observation of the facility on 08/07/24 at various times between 9:08am to 12:32pm revealed:</p> <ul style="list-style-type: none"> -At 9:08am, Resident #2 was seated at the dining room table in a wheelchair. -The wheelchair was pushed all the way to the dining room table and there was a wheelchair seatbelt in place around Resident #2. -The plastic buckle of the wheelchair seatbelt fastened in the front Resident #2. -At 10:29am, Resident #2 was in her room in a recliner chair with her legs elevated and the wheelchair seatbelt was connected to the wheelchair. -At 11:43am, Resident #2 was seated at the dining room table in her wheelchair with her wheelchair seatbelt in place. -At 12:32pm, Resident #2 was seated at the dining room table in her wheelchair and was eating her lunch meal; the wheelchair seatbelt was in place. <p>Interview with Resident #2 on 08/07/24 at 3:39pm revealed:</p>	C 456		

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C 456	<p>Continued From page 10</p> <ul style="list-style-type: none"> -She had her seatbelt in place when she was in her wheelchair. -She did not know if she could release the seatbelt or not. <p>Interview with a medication aide (MA)/Supervisor-in-Charge (SIC) on 08/07/24 at 9:09pm revealed:</p> <ul style="list-style-type: none"> -Staff used Resident #2's wheelchair seatbelt when she was up in her wheelchair. -Resident #2 had her wheelchair with the seatbelt for less than a year, but she did not know how long. -There were no scheduled times to remove the seatbelt from Resident #2. <p>Telephone interview with a second MA/SIC on 08/07/24 at 3:46pm revealed:</p> <ul style="list-style-type: none"> -There were no restraints at the facility. -Resident #2 had a seatbelt on her wheelchair and she fastened it when she was in her wheelchair eating meals. -The wheelchair seatbelt was in place for safety purposes, but it was not fastened tightly. -Resident #2's wheelchair seatbelt was fastened when she was in the wheelchair because she would slide down in the chair and onto the floor without it. -She thought Resident #2 might be able to unfasten her wheelchair seatbelt, but she had not seen her try to unfasten it. -She never thought of the wheelchair seatbelt as a restraint. <p>Telephone interview with Resident #2's responsible party on 08/07/24 at 1:19pm revealed:</p> <ul style="list-style-type: none"> -He knew the staff fastened Resident #2 into her wheelchair seatbelt, but he had not signed any documents confirming his knowledge of or 	C 456		

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C 456	<p>Continued From page 11</p> <p>consent for the use of the seatbelt.</p> <ul style="list-style-type: none"> -Resident #2 had a wheelchair with a seatbelt for about 3 years, but she broke the buckle on the wheelchair and recently replaced it with a new wheelchair with a seatbelt. -The seatbelt was used for Resident #2 because she had back problems, favored one side, and slipped down in her chair. -Resident #2's wheelchair seatbelt was fastened every time she was up in the wheelchair. <p>Interview with the Administrator on 08/07/24 at 3:07pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 asked for the seatbelt on the wheelchair to be put on when she was in the wheelchair because she scooted down in the wheelchair. -Resident #2's seatbelt was attached her wheelchair and she brought the wheelchair with her when she was admitted to the facility in February 2024. -She did not have to have the seatbelt in place; she just asked for it when she was in her wheelchair. -Staff had not tried any other interventions with Resident #2 other than the seatbelt because she really did not need the seatbelt. -Resident #2 was able to walk with staff pulling her wheelchair behind her so that she could sit when she got ready. -She thought Resident #2 could unbuckle the seatbelt when she wanted to, but she had not seen her do it. -Resident #2's family was aware that staff placed the seatbelt on her when she was in the wheelchair, but they did not sign any documents related to the restraint. -Resident #2 did not have a physician's order for the seatbelt and there had not been an assessment for use of a restraint. 	C 456		

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(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 456	<p>Continued From page 12</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/07/22 at 12:55pm was unsuccessful.</p> <p>Refer to the interview with the Administrator on 08/07/24 at 3:07pm.</p> <p>Interview with the Administrator on 08/07/24 at 3:07pm revealed:</p> <ul style="list-style-type: none"> -She did not know that belts fastened around residents in a wheelchair were considered restraints. -She did not know she needed an order for the belts or that an assessment needed to be completed for restraints for the residents. 	C 456		