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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 11/25/2024 through 11/26/2024. Event ID# Y9W611. The following intakes were investigated NC00222672, NC00224445, and NC00224547. 2 of the 6 complaint allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.12 at tag F604 at a scope and severity of G.	F 000		
F 604 SS=G	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, and responsible party (RP), staff, nurse practitioner (NP), and physician assistant (PA) interviews, the facility failed to protect a resident's right to be free of physical restraints for 1 of 3 residents (Resident #1) reviewed for restraints. Resident #1 was found to have his wrists restrained using a pillowcase wrapped in a figure eight patten and then covered with a top sheet. The reasonable person concept was applied as no reasonable person would expect to have their wrists restrained with a pillowcase, restricting their movement, unable to use their call bell for assistance, and making the person feel restricted and/or belittled. Findings included: A review of the facility's "Abuse and Neglect Policy" and "Use of Restraints Policy" dated 03/28/2023 stated residents have the right to be free from abuse including physical restraints imposed for purposes of discipline or staff convenience. Physical restraints were defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Physical restraints shall only be used for the safety and well-being of the resident(s) and	F 604	Past noncompliance: no plan of correction required.	

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only after other alternatives have been tried successfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience.

Resident #1 was admitted to the facility on 07/17/2024 and discharged on 10/03/2024 with diagnoses that included multiple sclerosis (MS), left-side hemiplegia (partial or complete paralysis on the left side of the body), left-side hemiparesis (muscle weakness or partial paralysis on the left side of the body), and cerebral infarction (when blood flow to the brain is blocked, causing the brain tissue to die).

Review of the admission Minimum Data Set (MDS) dated 07/26/2024 indicated that Resident #1 had moderate cognitive impairment, required total assistance with all activities of daily living (ADL) and displayed no behaviors during the 7-day assessment period. The MDS revealed Resident #1 had no use of physical restraints.

Review of Resident #1's care plan dated 07/30/2024 revealed Resident #1 was care planned for ADL deficits related to disease processes and cognitive deficits with interventions to converse with resident while providing care, be aware of the resident's need for assistance and that additional staff support may fluctuate from day to day and hour to hour. Resident #1's care plan also reflected limited physical mobility related to bilateral upper and lower extremity contractures with interventions to provide gentle range of motion as tolerated with daily care. Resident #1 was also care planned for being resistant to care including personal care, medication, treatments, and lab work with interventions to allow resident to have freedom of

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choice, and to attempt to determine the reason for non-compliance. Resident #1's care plan also indicated behavioral problems including hitting, kicking, cursing staff and using racial slurs with interventions to explain all procedures to Resident #1 before providing care, approach and speak in a calm manner, divert attention, monitor behavior episodes and attempt to determine the underlying cause and document, and praise any indication of Resident #1's improvement in behavior.

Review of the facility's initial abuse investigation report dated 10/02/2024 at 11:30 AM revealed Resident #1 was found to have upper extremity range of motion restricted in linen. The report also indicated that the linen was removed immediately. Resident #1 was assessed by the Director of Nursing (DON) and the Medical Director (MD). The physical assessment revealed discoloration on the top of Resident #1's wrists. Resident #1 denied pain or discomfort and had no mental injury of harm noted upon psychosocial assessment. The report also revealed the incident was reported to local law enforcement and the Department of Social Services on 10/02/2024 at 10:30 AM. The report indicated that Nurse Aide (NA) #1 and NA #2 were suspended pending the conclusion of the investigation.

Review of the incident report dated 10/02/2024 at 9:30 AM revealed upon staff rounding, Resident #1 was noted to have upper extremity range of motion restricted in linen. Linen immediately straightened and removed allowing Resident #1 normal range of motion. Resident #1 was assessed by the DON and MD with discoloration noted to top of both wrists. Resident #1 denied

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pain or discomfort.

Review of the MD's acute visit progress note dated 10/2/2024 at 10:50 AM revealed Resident #1 was seen after he was found by nursing staff restrained at the wrists with a pillowcase. Physical examination revealed mild superficial bruising noted on the top of the left and right wrists. No edema was present and Resident #1 had no pain with palpation or movement of the left and right wrists. The MD's plan revealed clinically Resident #1 appeared stable and without fracture but given the mild bruising will obtain STAT (immediate) x-rays of both wrists. Resident #1 elicited no pain with examination.

Review of the physician's orders revealed STAT bilateral wrist x-rays were ordered 10/2/224 at 10:45 AM.

Review of the bilateral wrist x-ray reports dated 10/02/2024 revealed bilateral wrist x-rays were completed 10/02/2024 at 7:45 PM and results released at 10/03/2024 at 12:51 AM. The results read:

1. Right wrist - minimally displaced fracture of the scaphoid (small bone on the thumb side of the wrist) bone.
2. Left wrist - No obvious acute osseous (bone) or soft tissue abnormality. Further evaluation with Computerized Tomography (CT) (medical imaging procedure that uses x-rays to create 3D cross-sectional pictures) may be considered if clinically indicated.

Review of the facility's Nurse Practitioner's (NP) acute visit note dated 10/03/2024 at 8:00 AM. Physical examination revealed Resident #1 was

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F 604	Continued From page 5 lying bed in no acute distress. Resident #1 endorsed no pain or complaints of pain. Review of bilateral wrist x-rays which showed displaced fracture of the scaphoid bone of right wrist and left wrist showed no acute osseous or soft tissue abnormality however further evaluation with CT may be considered if clinically indicated. NP's plan revealed Resident #1 was to be transferred to the Emergency Department (ED) for further evaluation and treatment and possible CT of left wrist. Resident #1 was sent to the ED on 10/03/2024 at 8:47 AM. Review of the ED physician assistant notes dated 10/03/2024 at 10:15 AM revealed Resident #1 had bilateral wrist x-rays taken at his nursing facility on 10/02/2024 which showed an assumed scaphoid fracture of the right wrist and unclear if there were any fractures of the left wrist. Resident #1 denied pain and when asked if his hands hurt, Resident #1 responded "no". Physical examination revealed no traumatic deformity present but contractures of all 4 extremities were present with the left side being the worst. No bruising of the extremities was observed during the examination. The ED note revealed Resident #1 was placed in a thumb spica (device used to immobilize a limb) splint of the right wrist and a CT scan of the left wrist was ordered. Review of the left wrist CT scan results dated 10/03/2024 revealed the examination was degraded by demineralization (bones that have lost minerals that are essential for bone strength which makes bones more likely to fracture). There were findings suspicious for a triquetral	F 604		

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fracture (a break in a small wedge-shaped bone in the wrist) and a questionable fracture through the tip of hamate (small bone in the wrist) versus more likely vascular groove (type of indent or furrow in bone surfaces).

Review of the facility 5-day investigation report dated 10/04/2024 submitted to the state agency indicated staff interviews were conducted with NA #1 who had applied the restricting technique to Resident #1's wrists for combative behavior. The report also revealed NA #1 reported no intent of harm or intent of abuse but identified these techniques as "behavioral management" which she had learned from NA #2. The facility also conducted an interview with NA #2 who stated that she was not going to lie; she had placed Resident #1's hands inside his shirt when changing him so that Resident #1 would not hit her. NA #2 stated that she did not think she was doing anything wrong by placing Resident #1's hand inside his shirt. NA #1 and NA #2's employment with the facility was terminated effective 10/04/2024. The facility's root cause analysis determined the staff required education on behavioral management during personal care which did not include the use of restrictive devices.

Review of statement provide by NA #1 dated 10/02/24 at 4:30 PM read, NA #1 revealed she only tied Resident #1's wrists together with a pillowcase this one time. NA #1 stated that Resident #1 would hit and kick staff during care. NA #1 stated she had seen NA #2 do something like this before; NA #2 would put Resident #1's arms inside his shirt so Resident #1 would not hit her when she changed him. NA #1 stated that NA #2 would take his arms out when she was

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done with the care. NA #1 was asked if there were other residents these techniques were used on, NA #1 replied "no".

An attempt to conduct a phone interview with NA #1 on 11/25/2024 at 11:10 AM was unsuccessful. The phone number was no longer in service.

A statement provided by NA #2 dated 10/02/24 at 7:00 Pm read, NA #2 stated that she was not going to lie; she had placed Resident #1's hands inside his shirt when changing him so that Resident #1 would not hit her. NA #2 stated that she did not think she was doing anything wrong by placing Resident #1's hand inside his shirt.

A telephone interview was conducted with NA #2 on 11/25/2024 at 11:25 AM. NA #2 stated that she had never used linen or anything else to tie a resident down with. She further explained that she had never tied a resident's hands, arms, legs, or body down and she had never seen any staff member tie a resident to the bed or a wheelchair. She further revealed she "did not understand why she was involved in this investigation because she had not worked a shift at the facility since 09/29/2024 and was not working when the incident occurred". She also stated that "she did not understand how her name got brought up with this investigation". She further stated that she had never shown another NA how to restrain a combative resident so that care could be provided easily, and she had never placed a Resident #1's arms inside his shirt to keep him from hitting her.

An interview was conducted with the DON on 11/25/2024 at 11:45 AM. The DON stated that she was coming down the hall on 10/02/2024 and that Nurse #1 and NA #3 asked her to come to

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Resident #1's room at approximately 9:30 AM. She explained that NA #3 was serving Resident #1's breakfast tray and noticed his linen was tangled and found Resident #1's wrists tied together with linen. Resident #1 was covered with his sheet and when the DON removed the top sheet, she noted Resident #1's wrists were bound together and secured with a pillowcase which was tucked in a figure-8 around both wrists. The DON stated she removed the pillowcase and observed redness to the top of both wrists. The DON further added that Resident #1 denied pain or discomfort. The DON explained she went to the MD who was in the facility and explained to him what happened and ask the MD to see Resident #1. The DON revealed the MD ordered STAT (immediate) x-rays of Resident #1's bilateral wrists which were taken 12/02/2024 at 7:45 PM and resulted on 12/03/2024 at 12:51 AM. The DON stated the x-ray report was placed in the physician's box for review because the report was not flagged as critical and did not indicate an acute fracture. The DON further explained that it was unknown exactly how long Resident #1's wrists were bound by the pillowcase. The DON also revealed that Resident #1 was difficult to care for and he would often resist care. The DON explained Resident #1 would be combative, and he would hit and kick staff. She also stated that when she reviewed the night shift staffing grid, NA #1 was assigned to care for Resident #1. The DON stated that when she interviewed NA #1, NA #1 stated this was the only time she had ever placed a pillowcase around Resident #1's wrists so Resident #1 would not hit her while she provided care.

An interview was conducted with NA #3 on 11/25/2024 at 12:25 PM. The NA stated that

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Resident #1 was tangled up in his linen and when she pulled the top sheet back, she observed Resident #1's wrists tied together with linen. NA #3 called for Resident #1's nurse (Nurse #1) and the DON who came to the room immediately.

Multiple attempts to contact Nurse #1 were made and were unsuccessful.

Several attempts to contact the MD were made from 11/25/2024 to 11/26/2024. The attempts were unsuccessful and there were no return calls from the MD.

An interview was conducted with the facility's Nurse Practitioner (NP) on 11/25/2024 at 2:57 PM. The NP stated that she did not see the pillowcase tied around Resident #1's wrists and further added that a fracture occurring from a pillowcase wrapped around the wrists was unlikely but not impossible. She also explained that it would not be appropriate to restrain any resident because the restraint itself may result in harm and/or injury to the resident.

An interview was conducted with Resident #1's responsible party (RP) on 11/25/2024 at 3:05 PM. The RP stated that the facility notified him that a staff member had bound Resident #1's wrists together and Resident #1 had broken wrist. The RP also stated that he was not happy with the care provided to Resident #1 at the facility and did not want him to return to the facility.

A telephone interview was conducted on 11/26/2024 at 9:02 AM with the Physician Assistant (PA) who cared for Resident #1 on 10/3/2024 in the ED. The PA stated that they were unable to determine the age of the wrist

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fractures due to the demineralization of Resident #1's bones. The PA further explained that they could not tell if the fracture(s) were acute or chronic in nature. The PA explained that the fractures could be a chronic condition related to the severity of Resident #1's hand/wrist contractures.

A joint interview was conducted with the Administrator and the DON on 11/26/2024 at 1:45 PM. The DON stated Resident #1 was found restrained with his wrists bound together with a pillowcase. The DON explained Resident #1 was assessed by nursing and the MD with x-rays ordered. The Administrator stated the facility reported the incident with the 24-hour initial report and the 5-day investigation report and the facility substantiated the use of the pillowcase as a restraint. The DON also stated that both NAs involved were suspended and ultimately terminated on 10/04/2024.

The facility provided the following corrective action plan with a completion date of 10/04/2024.

Address how corrective actions will be accomplished for those residents to have been affected by the deficient practices:

On 10/02/2024, pillowcase was removed from Resident #1's hands by licensed nurse.
On 10/02/2024, Resident #1 assessed by licensed nurse for any injury with none noted.
On 10/02/2024, Resident #1 was assessed by physician with new orders for x-ray given.
On 10/02/2024, Resident #1 assessed for psychosocial harm by licensed nurse with no ill effects noted.
On 10/02/2024, Resident #1's responsible party

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was notified of incident by licensed nurse.
On 10/02/2024, NA #1 and NA #2 staff reporting use of restraints were suspended pending investigation by the director of nursing.
On 10/02/2024, 1:1 education provided verbally by director of nursing to two staff (NA #1 and NA #2) reporting use if restraints regarding restraint-free facility policy and reporting behaviors to charge nurse.
On 10/02/2024, Resident #1's care plan updated by licensed nurse to include two person assist for personal care
On 10/03/2024 Resident #1 was transferred to the Emergency Room.

How will the facility identify other residents having the potential to be affected by the same deficient practice:
All residents are at risk of this practice.
On 10/02/2024, all other residents were assessed by a licensed nurse for use of restraint with no other residents affected.
On 10/02/2024, all other residents were assessed by a licensed nurse for any injury or new skin area with no concerns noted
On 10/02/2024, all residents with a BIMS score of 10 or greater were interviewed by a nurse unit manager to ensure no other concerns for restraint or other abuse with no additional concerns noted.
On 10/02/2024, all facility staff were interviewed by the DON to ensure no other incidents of restraint use were known with no additional concerns noted.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:
On 10/02/2024, all staff were re-educated in person and/or by telephone to the facility's

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restraint-free policy by director of nursing or other nurse management. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education.
On 10/02/2024, all staff educated in person and by telephone to abuse policy by facility director of nursing or other member of nurse management including types of abuse, reporting, and response. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing the education.
On 10/02/2024, staff were educated in person and/or by telephone to notification & intervention for combative and agitated behaviors by director of nursing or other nurse management. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur:
Beginning on 10/02/2024, the DON, or other nurse manager/leader, administrator or social worker will observe (on alternating shifts to include 3rd shift) five residents per week for four weeks, and then 3 residents per week for four weeks to ensure no restraints, or other restriction of normal movement or range of motion are in place.
Beginning on 10/02/2024, the DON, administrator, or other nurse manager/leader, administrator or social worker will interview 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks for any safety, abuse, or restraint concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345415	A. BUILDING ______ B. WING ______	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

(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) COMPLETION DATE
F 604	Continued From page 13	F 604		

Beginning on 10/02/2024, the DON, administrator, or nurse manager/leader will interview 5 staff members (on alternating shifts to include 3rd) weekly x 4 weeks, then 3 staff weekly x 4 weeks to identify concerns of abuse or restraint use.

The Facility Administrator will review the audits to identify patterns/trends and will adjust the plan to maintain compliance.
The Facility Administrator will review the plan during the October 3rd, 2024, ad hoc QAPI meeting and the audits will continue at the discretion of the QAPI committee.

Date of compliance: 10/04/2024

The facility's corrective action with a correction date of 10/04/2024 was validated onsite by record reviews and interviews with the Administrator, DON, and staff.

Facility staff interviews revealed that they had received education on Abuse and Neglect and the Use of Restraints policies. Staff also received education on notification and interventions for combative and agitated resident behaviors. No employees were allowed to return to work until they had completed the training on Abuse and Neglect, Use of Restraints education and Behavior Management.

Review of the assessment sheets revealed residents were assessed for the use of restraint devices with no other residents identified or affected. Residents were also assessed for injury and for the presence of new skin impairments with no concerns identified. Residents who were cognitively intact were interviewed to ensure no

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F 604	Continued From page 14 additional concerns for restraint or other forms of abuse were verbalized. Review of the facility staff interview sheets to ensure no other incidents of restraint use were being utilized by staff and no additional concerns were found. Administrative staff interviews revealed they had completed the education with all staff and interviews with the staff revealed they had been educated on the Abuse and Neglect, Use of Restraints policies, and Behavior Management. The education included the use of any physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Staff were also able to verbalize that restraints were never used for staff convenience. Review of the audit records revealed the Administrative staff observed five residents per week for four weeks, then 3 residents per week for four weeks to ensure no restraints, or other restriction of normal movement or range of motion was in place. Review of the audits also revealed the Administrative staff interviewed 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks for any safety, abuse, or restraint concerns. Review of the audits further revealed the Administrative staff interviewed 5 staff members on alternating shifts weekly for 4 weeks, then 3 staff members weekly for 4 weeks to identify concerns of abuse or restraint use. The Administrator reviewed the audits to identify patterns/trends and reported the auditing results to the monthly QAPI (Quality Assurance and Performance Improvement) committee. The quality improvement monitoring schedule would	F 604		

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	345415	A. BUILDING ______ B. WING ______	C 11/26/2024

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F 604	Continued From page 15 be modified if needed based on the findings of the audits. Interviews with the Administrator and the DON revealed the facility launched an educational program related to Abuse and Neglect which included the use of restraints immediately after the incident to re-educate all facility staff. The Administrative staff observed residents to ensure no restraints, or other restriction of movement or compromised range of motion was in place, interviewed residents to ensure no safety, abuse, or restraint concerns were present, and interviewed staff to ensure no concerns of abuse or restraint use was in place. The Administrator and the DON stated the interventions were successful as the facility did not have any further incidents of restraint usage. The compliance date of 10/04/2024 was validated.	F 604		