

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL039014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2015
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NAME OF PROVIDER OR SUPPLIER SUMMIT COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 904 RALEIGH STREET OXFORD, NC 27565
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D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record review, interviews and observations, the facility failed to provide adequate supervision for 2 of 2 sampled residents who smoked cigarettes inside the facility. (Residents #1, #6). The findings are:</p> <p>1. Review of Resident 1's current FL-2 dated 4/15/15 revealed: - The resident's diagnoses included chronic obstructive pulmonary disease (COPD), generalized weakness, alcohol and nicotine abuse, and falls risk. - The resident was ambulatory with the use of a walker.</p> <p>Record review of the latest Cardiology Consult dated 4/22/15, For Resident #1 included documentation of "current smoker".</p> <p>Observation on 7/16/15 at 10:30 am of the 100 Hall during the tour revealed: - The hallway just outside the door of Resident #1 had a very strong odor of fresh cigarette smoke. - After knocking and upon entrance to the room, Resident #1 was observed holding a partially smoked cigarette in her hand and was in the</p>	D 270		

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

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D 270	<p>Continued From page 1</p> <p>process of putting the cigarette into the open drawer of the bedside table.</p> <ul style="list-style-type: none"> - The resident's room had a strong fresh cigarette odor. -The resident stated she "had not noticed any cigarette smoke smell and did not smoke in her room". - The resident also stated she "had not placed a cigarette into the bedside table drawer". - Resident #1 pointed to the open pack of cigarettes laying in the drawer and stated her cigarettes were in the pack and said she only smoked outside. - A partially smoked cigarette, having approximately a 1/2" length of grey ash at the tip, was laying beside the open package of cigarettes. <p>Interview on 7/16/15 at 10:40 am with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - One time, a few months back, several staff smelled (cigarette) smoke at Resident #1's door. - The Assistant Administrator (AD) went in and talked with the resident and staff did not smell the smoke afterward. - Today is the first day I have smelled the (cigarette) smoke since. - Resident #1 usually smokes outside. <p>Interview on 7/16/15 at 3:00 pm with a resident who smoked on the "back porch" revealed:</p> <ul style="list-style-type: none"> - The resident had seen and heard about Residents #1 and another resident smoking inside the building in their rooms, especially at the 2nd to 3rd shift changes (around 10:30 pm to 11:00 pm and a little after). - At shift change, staff did not pay as much attention to residents. - Residents smoked in their rooms every day at any time and some staff would tell on residents 	D 270		

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D 270	<p>Continued From page 2</p> <p>who smoked inside and some would not. - Other residents who smoked would not tell on the ones who smoked in the building.</p> <p>Interview on 7/16/15 at 3:50 pm with the 2nd shift medication aide (MA) revealed staff had not smelled cigarette smoke or knew of any residents smoking in their rooms during this staff's shifts.</p> <p>Confidential interview revealed: - Residents and staff were allowed to smoke on the "back porch" and the gazebo only. - The staff was not aware of residents signing a facility policy on smoking. - A resident told the staff of another resident who smoked in their room, but did not say whom, just "her". - Staff was to notify a MA if someone was smoking in their room and the MA would notify the AD. - Staff could not take away cigarettes from residents who had purchased them. - The staff did not know of any consequences to residents who were caught smoking inside the building. - The staff did not know of any warnings given to residents who were caught smoking inside the building. - The staff did not know of any residents who had been discharged for smoking inside the building.</p> <p>Interview on 7/17/15 at 12:25 pm with a 1st shift PCA revealed: - Resident #1 smoked in her room and was told by staff to not do so. - Resident #1 had been "warned by administration". - Staff A heard Resident #6 went to the shower rooms usually in the evenings and nights after the</p>	D 270		

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D 270	<p>Continued From page 3</p> <p>doors were locked for the night.</p> <p>Interview on 7/17/15 at 2:45 pm with a 1st shift MA revealed:</p> <ul style="list-style-type: none"> - All residents who smoke go the "back porch". - One PCA was supposed to stay with residents until they finished their cigarettes. - Supervision inside the building for all residents was 30 minute checks (Staff C); with other staff it varies, maybe around an hour or so. - There was no difference in the supervision for residents who smoke. - There was one resident who smoked inside and was caught by staff by smelling the cigarette smoke coming from the resident's room. - The resident was asked if she was smoking and the reply was "no". - There was no facility system in place to supervise residents who smoke. - Staff had a meeting with the Administrator two weeks ago and the aides brought up the topic of residents smoking in the building. - Staff was "instructed to watch for signs of residents smoking". <p>Interview on 7/17/15 at 4:20 pm with a 2nd shift PCA revealed:</p> <ul style="list-style-type: none"> - When residents who smoke went to the "back porch" to smoke, they went on their own without staff; they can go in and out, staff needs to cover the halls. - Residents who went out are reliable and could be outside smoking without staff present. - If a resident needed to be supervised, staff would go. - Residents knew not to smoke inside; when residents come to the facility, they knew they were not to smoke (inside), but did not know how residents are told. - Staff had sometimes smelled smoke or a 	D 270		

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D 270	<p>Continued From page 4</p> <p>resident would tell staff they had smelled smoke around Resident #1's room.</p> <ul style="list-style-type: none"> - So far there had not been any consequences to the resident who smoked inside. - No one had instructed staff to make any supervision changes for residents smoking. - "Normal supervision for me is at report and every hour and after meals." - Resident #1 was very popular with staff; "they just loved her"; it may affect the reporting of her smoking inside. - Not aware of any consequences to Resident #1 for smoking inside the building. - Not aware of a facility policy on resident smoking. <p>Record review for Resident #1 revealed:</p> <ul style="list-style-type: none"> - No documentation on the resident's current Care Plan dated 04/15/15 that the resident smoked. - No documentation in the Nurse's Notes reviewed from April 2015 to July 17, 2015 that Resident #1 smoked, or staff had smelled smoke in the area around her room or caught her smoking inside the building or had meetings with administration about smoking inside the facility. <p>Refer to Town Meeting on 7/16/15 at 2:30 pm.</p> <p>Refer to Review of the facility "Community Policies".</p> <p>Refer to interview on 7/16/15 at 5:25 pm with the Administrator.</p> <p>Refer to interview on 7/17/15 at 10:45 am with the Administrator.</p> <p>2. Review of the current FL-2 dated 8/15/14 for Resident #6 revealed:</p>	D 270		

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D 270	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Diagnoses of Alzheimer's Disease, Diabetes Mellitus Type II, Seizure disorder, Chronic Pain and Peripheral Neuropathy. - Review of the Resident Register for Resident #6 dated 8/11/06 revealed a personal habit of smoking. - There was no information related to disorientation listed. <p>Review of the Assessment and Care Plan dated 8/11/14 for Resident #6 revealed:</p> <ul style="list-style-type: none"> - There was no documentation of a resident social history of smoking. - The resident was sometimes disoriented. - The resident was listed as independent with activities of daily living. <p>Review of Resident #6's facility notes dated 10/23/13 revealed:</p> <ul style="list-style-type: none"> - The resident has a history of bronchitis. - The report of a bronchoscopy indicated the resident should be encouraged to quit smoking. <p>Review of a facility contract with no date listed for Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident had signed the contract. - The smoking policy listed smoking was allowed in designated area. - Smoking was allowed with staff supervision. - No other information was provided. <p>Interview on 7/16/15 at 2:50 p.m. with a personal care aide revealed:</p> <ul style="list-style-type: none"> - Staff members had passed along to the shifts that Resident #6 had been caught smoking a few weeks ago in the residents' bathroom on the back hall. - Resident #6 would smoke in the bathroom back there especially at evening and night after the doors were locked. 	D 270		

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D 270	<p>Continued From page 6</p> <ul style="list-style-type: none"> - There had not been any fires in the facility due to smoking in the building. - Staff are to tell administration if residents are caught smoking. - The resident was to be warned to put it out and stop smoking in the building. <p>Observation on 7/16/17 at 2:50 p.m. of the bedroom of Resident #6 revealed:</p> <ul style="list-style-type: none"> - There was no visible smoke. - There was no odor of smoke. - There were no cigarette butts, ashes or burn holes. <p>Interview on 7/17/15 at 2:55 p.m. with Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident said she did not smoke in her room. - Residents were not to smoke in the building. - There was a no smoking sign in the facility on a door with oxygen use. - Staff did not supervise residents smoking outside in the smoking area. - The management would not put up with smoking in the facility. - Residents were to sign a contract for no smoking in the facility. - The resident said some residents smoke in their rooms such as Resident #8. - Resident #1 smoked in her room. - The smoke from Resident #1 would come across the hall to her room and she did not like it. - She told management about 2-3 months ago about Resident #1 smoking in her room. - There had not been any fires in the building from smoking. - Resident had participated in fire drills. <p>Based on review of the facility shift notes for the months of May 2015, June 2015 and July 2015,</p>	D 270		

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D 270	<p>Continued From page 7</p> <p>there was no documentation of Resident #6 smoking in the building.</p> <p>Refer to interview on 7/17/15 at 3:40 p.m. with the Administrator</p> <p>Refer to interview on 7/17/15 at 10:45 a.m. with the Administrator.</p> <p>Refer to interview on 7/16/15 at 5:25 p.m. with the Administrator.</p> <p>Refer to Meeting with residents who smoked cigarettes on 7/16/15 at 2:30 p.m.</p> <hr/> <ul style="list-style-type: none"> - Meeting on 7/16/15 at 2:30 pm on the "back porch" with 12 residents who smoked cigarettes revealed: - The large concrete covered back porch area was the main place residents went to smoke. - Residents could come outside at 6:00 am to smoke and the door stayed unlocked until 10 pm. - Residents could not smoke outside after 10 pm. - The facility policy said smoking was allowed only on the back porch or at the gazebo in the back yard. - All residents sign a "sheet" at admission to abide by the rules which include a smoking rule. - "If you smoke other than outside, you get a warning; after 3 warnings you would have to go to another place." - Smoking is dangerous, you can catch the facility on fire. - If we saw someone smoking inside, we should tell (the staff). - Sometimes we had smelled cigarette smoke inside the building, but had not seen them (residents). - There were some residents who smoked in their 	D 270		

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D 270	<p>Continued From page 8</p> <p>rooms every day.</p> <ul style="list-style-type: none"> - A resident saw Resident #1 smoke in her room. - Several residents reported Resident #1 smoked in her room and Resident #6 smoked in the shower room especially in the evenings. - Smoking in the rooms would burn us all up. - Staff did not usually come on the porch with residents who smoked. - No staff were present on the porch with smoking residents at the start of the meeting or came during the meeting to check on residents. <p>Review of the facility "Community Policies" under the heading "Cigarettes, Pipes, Cigars, Snuff, Chewing Tobacco" revealed:</p> <ul style="list-style-type: none"> - "Residents who smoke must use our designated smoking areas; no smoking is allowed in residents' bedrooms. - Staff will supervise residents who smoke as needed. - (the facility) reserves the right to confiscate smoking materials if a resident fails to abide by this policy, which is designed to insure the safety of the resident and others in our community." <p>Interview on 7/16/15 at 5:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> - He was aware of "a couple of residents who might smoke in their rooms", but had not made any documentation about smoking in the building. - Staff was supposed to notify the supervisor of an incident and the supervisor notified the Administrator. - The Administrator would talk with residents about the 3 steps of smoking in the facility. - The 3 steps were 1. discussion, going over the rules; 2. confiscating smoking materials and discussion about having to leave the building; 3. leaving the building. - The Administrator had no documentation on any 	D 270		

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D 270	<p>Continued From page 9</p> <p>resident who smoked in the building.</p> <ul style="list-style-type: none"> - When asked about resident supervision, he provided no information about supervision of residents or a system for monitoring residents who smoked in the building. <p>Interview on 7/17/15 at 10:45 am with the Administrator who reported meeting with last night's 2nd shift staff to discuss supervision of residents (who smoked) and observing and documenting any incidents of the odor of(cigarette) smoke in the building.</p> <p>Interview on 7/17/15 at 3:40 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - He was aware of Resident #1 smoking in the facility. - He was not aware of Resident #6 smoking in the building. - No staff had told him about any incident with Resident #6. - Staff were to document in the shift notes and or resident records about smoking incidents. - Staff were to warn them and then tell or Administrator or Administrator-In-Charge (AIC) about the incident. <p>_____</p> <p>The Administrator provided a "Plan of Protection for residents. Effectively 7/17/15 "will check every 1/2 hour or at the smell of smoke. New Amendment to Resident Contract which states that 'residents can smoke only on the back porch'. Each shift is being trained to monitor potential violators as of July 16 (2015). All residents and family and responsible parties are being notified of amendment. Staff will write violation on incident form and hand it in to Administrator who will enforce 1. warning 2. the cigarette/lighter 3. cause for immediate</p>	D 270		

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D 270	Continued From page 10 discharge. Resident Council will be educated to policy. Each shift will be monitored be administration unannounced at least 2x weekly. Staff will have special inservices during the week of July 20 (2015). Reports monitored daily/weekly. Staff training, monitoring each alleged violation at least every 1/2 hours or at smell of smoke. All residents will sign the amendment and have individual counseling to be completed by September 1, 2015. Have meeting with family members to cover the issue is being planned and applied. Resident Council monthly meetings will re-enforce this policy. Monitoring each shift, checking violation areas and education." CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 31, 2015.	D 270		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would	D 482		

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D 482	<p>Continued From page 11</p> <p>provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure bed rail restraints were used only after trying alternatives, completing a team assessment and care plan and had written orders and a consent prior to use for 2 of 3 sampled residents (#2 and #4) . The findings are:</p>	D 482		

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D 482	<p>Continued From page 12</p> <p>1. Review of the FL-2 dated 11/14/14 for Resident #2 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of atrial fibrillation, hypertension, congestive heart failure, and immobility. - The FL-2 included the resident was semi-ambulatory. <p>Review of the Assessment and Care Plan dated 12/12/14 for Resident #2 revealed the resident needed supervision with eating; limited assistance with ambulation; extensive assistance with bathing, dressing, grooming and transfers.</p> <p>Review of emergency room notes dated 5/25/15 indicated the resident had vertigo.</p> <p>Review of hospital visit notes dated 6/24/15 revealed the resident had a non-epilepsy seizure.</p> <p>Review of facility notes from the speech language therapist dated 7/08/15 included a speech and language evaluation for oropharyngeal dysphagia had been completed.</p> <p>Review of an order for bedrails dated 7/09/15 included:</p> <ul style="list-style-type: none"> - Bedrails were to be used as an enabler. - They were to be used to turn in bed. - It indicated the resident was not able to get out of the bed secondary to weakness or immobility. <p>Observation of Resident #2 on 7/16/15 at 10:40 a.m. revealed:</p> <ul style="list-style-type: none"> - The resident was asleep on her side with bilateral full bedrails in the up position. - The hospital bed was not in the lowest down position. <p>Resident #2 was not interviewable due to record</p>	D 482		

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D 482	<p>Continued From page 13</p> <p>review and diagnoses.</p> <p>Interview on 7/16/15 at 10:42 a.m. with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Resident #2 had a "stroke" and was recently in the hospital for it. - She had been back to the facility for about a couple of weeks. - The resident was now total care for activities of daily living since hospitalization. - She was eating pureed food now with some help; required total assistance with dressing, bathing, grooming; can transfer with assistance and is now using a walker. - The resident has had physical therapy assistance and was improving. - The PCA said the resident had been confused when returned from the hospital two weeks ago and the full bedrails were now in the up position for this reason. - She said Resident #2 had gone around the bedrails and got out over the foot of the bed one time since her return to the facility. - The resident was checked on frequently as all residents were checked, every two hours. - There were no restraints in the facility. <p>Interview on 7/17/15 at 3:20 p.m. with another PCA revealed:</p> <ul style="list-style-type: none"> - The resident had seizures since the hospital visit. - The resident had slurred speech now. - The resident was weak on the right side. - The full bed rails were in the up position to prevent falls due to seizures and weakness. - No floor mats or other alternatives were used before the bedrails were were used. - The resident was observed by the PCA recently trying to climb over the bed rails by putting her legs over the rails and her arms over the rails. 	D 482		

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D 482	<p>Continued From page 14</p> <ul style="list-style-type: none"> - The PCA thought she would be too weak to get over the rails but possibly could get injured. - The resident did not get injured when doing this. - There had not been any injuries since using the bedrails. - Resident #2 was checked every two hours like other residents. - She was not aware of any increased supervision for the resident due to the use of bedrails. - There were no restraints in the facility. <p>Interview on 7/17/15 at 4:22 p.m. with Resident #2's Power of Attorney/family member revealed:</p> <ul style="list-style-type: none"> - The family was satisfied with the care received in the facility. - Resident had dementia. - The resident had been back in the facility about 3 weeks from hospitalization. - She required more help from weakness than before, but was progressing. - The bedrails were used to protect the resident from falls if got out of the bed due to weakness. - The resident might be able to use the bedrails to turn over in the bed. - The facility had not discussed the bedrail use with him and he had not signed a consent for the use of the bedrails. <p>Review of the record for Resident #2 revealed:</p> <ul style="list-style-type: none"> - There was no documentation of a team assessment and care planning for the use of the bedrails as restraints. - There was no documentation of alternatives used prior to the use of the bed rails and there was no order nor consent for the use of the bedrails as restraints. <p>Refer to interview on 7/17/16 at 1:15 p.m. with the</p>	D 482		

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D 482	<p>Continued From page 15</p> <p>Administrator-In-Charge (AIC).</p> <p>2. Review of the FL-2 dated 2/18/15 for Resident #4 included diagnoses of paraplegia, suprapubic catheter for a neurogenic bladder, hypertension, and psychosis.</p> <p>Review of the Assessment and Care Plan for Resident #4 dated 2/13/15 included:</p> <ul style="list-style-type: none"> - The resident needed limited assistance for eating. - Extensive assistance was required with ambulation/locomotion (electric wheel chair). - Totally dependent for toileting, transfers, grooming and personal hygiene, dressing, and bathing. <p>Record review of a bedrail order for Resident # 4 dated 12/23/14 revealed:</p> <ul style="list-style-type: none"> - Bedrails were ordered to be used as an enabler. - The resident was not able to get out of the bed secondary to weakness and or immobility. <p>Interview on 7/16/15 at 10:45 a.m. with a Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Resident #4 had bedrails because, "He could flip himself out of the bed." - The resident needed help with bathing, grooming, dressing and transfers. - The resident could not hold onto the rails well but used to try to hold the overhead trapeze to move in the bed. - There were no restraints in the facility. - There were no alternatives used instead of the bed rails for Resident #4. - There was no releasing of the bedrails while the resident was in the bed. - There were no different observation checks for Resident #4 due to use of the bedrails. 	D 482		

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D 482	<p>Continued From page 16</p> <p>Observation on 7/17/15 at 8:30 a.m. revealed Resident #4 was sitting up in bed with bilateral full bedrails in the up position.</p> <p>Interview on 7/17/15 at 8:30 a.m. with Resident #4 revealed:</p> <ul style="list-style-type: none"> - The resident could move his arms but could not move his legs. - The resident could lean on the bedrails but his hands could not grab the bed rails very well due to weakness and contractures of the hands. - The resident thought the bedrails were there to keep him in the bed because he had rolled out of the bed before. - He could not remember how long ago he rolled out, but the rails had been used for a long time, about 2 months, to keep him in the bed. <p>Interview on 7/17/15 at 3 p.m. with the Adminsitrator-In-Charge (AIC)revealed:</p> <ul style="list-style-type: none"> - After discussion with the surveyor about Resident #4's bedrail use, the AIC agreed the bedrails were restraints. - She said the resident had been know to roll out of the bed a few months ago. - The bedrails were used to keep the resident from rolling out of the bed. - A team assessment and care plan for the use of the bedrails as a restraint had not been completed. <p>Review of the record for Resident #4 revealed:</p> <ul style="list-style-type: none"> - There was no documentation of orders for the bedrails to be used as restraints. - There was no team assessment and care planning nor a consent for the use of the bedrails to keep the resident from falling out of the bed. - There was no documentation of alternatives used prior to the use of the bedrails. 	D 482		

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D 482	Continued From page 17 Refer to interview on 7/17/16 at 1:15 p.m. with the AIC. Interview on 7/17/16 at 1:15 p.m. with the Administrator-In-Charge (AIC) revealed: - There was only one restraint at this time in the facility - Resident #6. - There were no other assessments for restraints except this one resident. - There were bedrails used in the facility, but they were ordered as enablers and not as restraints. - Used of bedrails as enablers were not reassessed to assure they were still used as enablers and not restraints when residents' abilities changed.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to provide care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision for residents who smoked.	D912		

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D912	Continued From page 18 Based on observation, record review, and staff and resident interviews, the facility failed to provide supervision for 2 of 2 sampled residents who smoked cigarettes inside the facility (Resident #1, #6). [Refer to Tag D, 0270, 10A NCAC 13F .0901(b). (Type B Violation)]	D912		
D992	G.S.§ 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates	D992		

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D992	<p>Continued From page 19</p> <p>the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an offer of employment to 1of 3 sampled staff (C) was conditioned upon an examination and screening for controlled substances. The findings are:</p> <p>Review of the employee record for Staff C revealed:</p> <ul style="list-style-type: none"> - Staff C was hired on 1/14/15 as a personal care aide. - There was no documentation of a controlled substance screen/examination consent and/or screening result in the record. <p>Staff C was not available for interview.</p> <p>Interview on 7/17/15 at 4:45 p.m. with the Administrator-In-Charge revealed:</p> <ul style="list-style-type: none"> - Staff C was a medication aide who worked the night shift since hired. - The facility had not completed a controlled substance screen on Staff C before hire nor since she was hired. - She would get one completed on Staff C. 	D992		