

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 R 10/02/2015
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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 482}	<p>10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives</p> <p>10A NCAC 13F .1501Use Of Physical Restraints And Alternatives</p> <p>(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:</p> <p>(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;</p> <p>(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;</p> <p>(3) the least restrictive restraint that would provide safety;</p> <p>(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.</p> <p>(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;</p> <p>(6) applied correctly according to the manufacturer's instructions and the physician's order; and</p> <p>(7) used in conjunction with alternatives in an effort to reduce restraint use.</p> <p>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</p>	{D 482}		

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{D 482}	<p>Continued From page 1</p> <p>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, interviews and record reviews, the facility failed to assure that a physical restraint was used only with a written order from a physician and used only after an assessment and care planning process had been completed for 1 of 2 sampled residents (#2). The findings are:</p> <p>Review of Resident #2's current FL-2 dated 9/6/2013 revealed:</p> <ul style="list-style-type: none"> - Diagnoses listed as dementia, stroke, lumbar stenosis, and osteoarthritis - Resident was described as being intermittently confused and non- ambulatory. - There was an order for a reclining chair with a tray table. <p>Review of Resident #2's Resident Register revealed she was admitted to the facility on 10/24/2013.</p> <p>Observation of Resident# 2 during tour of the facility on 10/1/2015 at 11:20am revealed Resident #2 sitting in a reclining chair leaned in a reclining angle with a tray table attached to the front of the table.</p> <p>Based on observation record review and interview, Resident was not interviewable.</p> <p>Interview with a personal care aide on 10/1/15 at</p>	{D 482}		

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{D 482}	<p>Continued From page 2</p> <p>4:45pm revealed:</p> <ul style="list-style-type: none"> - Resident #2 must be in her reclining chair with the back tilted and the tray attached whenever she was not in bed. - When Resident #2 was in bed she must have her full bedrails in the up position. - The reclining chair and bed rails were necessary to keep Resident #2 from falling out of the bed. - The resident was not able to move the tray from the table to get up, and she is also not able to move the bedrails or climb over the bedrails to get out of bed. - She turned Resident #2 every two hours when she was working and she was pretty sure other were doing it also, but there was not a form to document how frequent this was being done. <p>Interview with the Resident Care Coordinator (RCC) on 10/1/15 at 4:55pm revealed:</p> <ul style="list-style-type: none"> - Resident #2 ' s family requested bedrails and a reclining tilted chair with a tray attached to the front, to keep her in bed. - She was unable to find an order for the bedrails as a restraint. - She was unable to find an order for the reclining chair as a restraint. - She provided documentation of the Resident evaluation and care plan with alternatives that had been provided. - The personal care aides were responsible for doing 30 minute checks on resident with restraints and the medication aides were responsible for checking the documentation. - There had not been any documentation done for 30 minute checks or 2 hour releases for resident #2. <p>Review of The Resident Evaluation and Care Plan revealed:</p>	{D 482}		

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{D 482}	<p>Continued From page 3</p> <ul style="list-style-type: none"> - The bedrails and reclining chair were listed as an enabler. - There was a note describing the bedrails were used for resident safety. - There was a note explaining the family had discussed safety, and requested the use of bedrails to keep Resident #2 in bed. - The form was signed by the family, the RCC and the administrator. <p>Interview with the Medication aide/supervisor on 10/2/15 at 11:15am revealed:</p> <ul style="list-style-type: none"> - She put Resident #2 in the recliner in the morning before breakfast. - She checked in on all of her residents about every 30 minutes. - She released the tray table every 2 hours, to check incontinent care and change her position, when Resident #2 was in the recliner. - She took her out of the chair and put her in the bed after lunch. - She turned Resident #2 every 2 hours to change her position and check for incontinent care while she was in bed. - The staff did not document on any 30 minute check or 2 hour turn /position or incontinent care provided to Resident #2, because she did not have a restraint. <p>Review of bedrail order revealed:</p> <ul style="list-style-type: none"> - The order was written for bedrails to be used as an enabler. - The order was obtained and signed by the physician on 10/24/13. - The order was to be updated every 6 months. - The order was renewed on 7/28/14 and 9/23/15. <p>Observation of Resident #2 on 10/2/15 at 3:00pm revealed Resident #2 lying in bed with the side</p>	{D 482}		

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{D 482}	<p>Continued From page 4</p> <p>rails in the up position.</p> <p>Review of the Restraint policy and Procedures revealed:</p> <ul style="list-style-type: none"> - An order for a restraint was to be obtained. - Staff were to be trained on monitoring and caring for residents who are restrained. - Staff were to document type of restraint used, time applied, checked and released, behaviors, and care provided during restraint usage. <p>Interview with the Administrator on 10/2/15 at 3:10pm revealed:</p> <ul style="list-style-type: none"> - He will be writing new guidelines for the restraint process. - He was under the impression that Resident #2 did not move and therefore a restraint order was not required. - The family was intent on Resident #2 having the bedrails. - The facility had wanted to remove the bedrails, but the family insisted on keeping them. - He was aware when bedrails and tilted recliners with the tray tabled are used for safety there must be an assessment, a consent from the family, physician orders documenting what type of restraint was to be used an every 2 hour release along with documentation of the releases and 30 minute checks. - He will assure all of the required paperwork and documentation will be obtained as soon as possible. - The RCC faxed the paperwork to the physician and they are awaiting the verification. - The RCC will immediately assure all direct care staff are informed they must be documenting the 30 minute and 2 hours checks and position changes on the appropriate forms. - The RCC will be responsible for daily monitoring of the documentation on the restraint 	{D 482}		

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{D 482}	Continued From page 5 forms for compliance. Interview with the RCC on 10/2/15 at 3:45pm revealed: - She faxed the physician the alternatives that had been provided. And the resident ' s response to them. - She had received an order from the physician for the use of physical restraints due to dementia. - The physician ' s order listed the recliner with the tray and the bedrails as the recommended restraints. - The orders specified the Resident must be checked every thirty minutes and released every two hours. - The physician order was to be updated every 3 months. - She would instruct the staff to document on the 30 minute checks and 2 hour releases for Resident #2.	{D 482}		
{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	{D992}		

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{D992}	<p>Continued From page 6</p> <p>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 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 continues (from previous survey) in failing to assure that an offer of employment to 1 of 3 sampled staff (A) was conditioned upon an examination and screening for controlled substances. The findings are:</p> <p>Review of Staff A's personnel record revealed:</p> <ul style="list-style-type: none"> - She was hired on 5/4/15. - She was hired as a Personal Care Assistant. - There was no documentation in her personnel record that she completed an examination and screening for the presence of controlled substances. <p>Staff A was not available for interview.</p> <p>Interview with the Resident Care Coordinator on</p>	{D992}		

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{D992}	<p>Continued From page 7</p> <p>10/2/15 at 2:20 P.M revealed:</p> <ul style="list-style-type: none"> - She is responsible for making sure that when new staff is hired the drug screening is done. - She fills out the required form for the drug screening to be done at the laboratory. - After the results are received back, they go to the Administrator for his files. - Was not sure how they missed doing the drug screening for Staff A. <p>Interview with Administrator on 10/2/15 at 2:40 P.M. revealed:</p> <ul style="list-style-type: none"> - He was not aware that a drug screening was not done on Staff A. - They will start doing a double check list for drug screening on new hires. - Administrator will be monitoring that this new double check list is carried through. 	{D992}		