STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to have a documented medical symptom for 1 of 1 residents for the use of a restraining device related to the secured table top tray on the front of the wheelchair (Resident #2). The findings included: Resident #2 was admitted to the facility on 11/10/2015 with diagnosis which included recurrent urinary tract infection, degenerative disease of the basal ganglia, Alzheimer ' s disease, diabetes mellitus type 2, muscle weakness and unsteadiness on feet. Review of the closed medical record for Resident #2 included a quarterly Minimum Data Set (MDS) dated 02/09/2016 which indicated that Resident #2 had intermittent confusion with severe cognitive impairment. Vision was coded as poor as well as having been non ambulatory and dependent on wheelchair use for locomotion, required 2 staff assist with a mechanical lift for transfers. The MDS was coded as Resident #2 being at risk for falls. The section for Physical Restraints documented that a restraint was not in use. An updated care plan on 02/19/2016 indicated Resident #2 was at risk for fall and fall related injury due to dependent for transfers related to weakness and Alzheimer ' s disease. Use of a	F 221	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Corrective action cannot be achieved for the identified resident as this resident was discharged from the facility. Corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice by: All charts were audited for compliance by the DON for utilization of the restraint assessment and the documentation of the least restrictive device on 4/30/16. The charts will be audited for the utilization of a restraint assessment and if there is a need for a restraint, that the least restrictive device is being utilized and documented by using the following methods: All orders will be reviewed by the DON or her designee daily to identify if an order for a restraint has been written. All newly admitted residents will have a restraint assessment completed by the admitting nurse. The DON or her designee will review each	5/16/16

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

Electronically Signed | 05/16/2016

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F 221	Continued From page 1 wheelchair when out of bed with a back cushion, lateral supports and lap tray for positioning. The goal was to be free from major fall injury should any fall occur through the next review. Approaches included to monitor attempts to get out of bed or wheelchair unassisted, encourage the use of non -skid shoes daily, assist of 2 staff and use of mechanical lift for transfers, keep call light in reach, bed in lowest position, ensure adequate lighting, monitor adverse medication effects and to monitor fall risk assessment quarterly Review of a Fall Risk Evaluation completed on 02/19/2016 indicated Resident #2 had intermittent confusion, had 1-2 falls in the past 3 months, was chair bound and had poor vision. Resident #2 was unable to ambulate or balance when standing, received 1 to 2 psychotropic medications, cardiovascular medication, diuretic or narcotic medication that could have caused lethargy or confusion either currently or in the past 7 days. Resident #2 also had predisposing diseases and a history of falls. The score of the evaluation was 18 which indicated a high risk for potential falls and a prevention protocol should have initiated immediately and documented on the care plan. There was no Restraint Assessment Form or Documentation of Least Restrictive Device form initiated for resident #2 during the closed record review. A review of a physician order on 11/19/2015 indicated that Resident #2 had an anti- thrust cushion and dycem placed on the seat of her wheelchair. A physician order dated 01/05/2016 stated that a Geri chair was to be used for Resident #2 when out of bed along with a RoHo cushion (a type of dry floatation cushion made of inter connected air cells that mimic the properties	F 221	newly admitted resident's chart the day after admission to ensure that a restraint assessment was completed and the least restrictive device was implemented. The DON will keep a current list of all identified restraints for the facility. Measures put into place to ensure that the deficient practice will not occur are: The DON educated the nurses on the utilization of the restraint assessment on all newly admitted residents and the importance of the least restrictive device being implemented for the resident on 5/2/16, and 5/14/16. The charts will be audited for the use of a restraint assessment using the following methods: All orders will be reviewed by the DON or her designee daily to identify if an order for a restraint has been written and the least restrictive device is implemented and documented for the resident. All newly admitted residents will have a restraint assessment completed by the admitting nurse. The DON or her designee will review each newly admitted resident's chart the day after admission to ensure that a restraint assessment was completed and the least restrictive device was implemented and documented for the resident. The facility will monitor its performance to make sure solutions are sustained by: The administrative staff will review the resident's charts on a weekly basis through the Resident Risk Committee for one (1) month, bi-weekly for two (2)	

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F 221	Continued From page 2 of water to help reduce the development of pressure ulcers) and lateral supports. On 01/06/2016 the physician discontinued the Geri - chair and ordered a wheelchair with a RoHo cushion, back cushion, lateral supports and a lap tray for positioning. A physician order dated 02/19/2016 stated to discontinue the anti- thrust cushion. A nurse note dated 01/23/2016 at 5:00AM indicated that Resident #2 had a lap tray for her wheelchair. A nurse note dated 01/30/2016 at 6:20 PM revealed that a lap tray was in use on the wheelchair of Resident #2. A review of the monthly physician orders dated for 02/01/2016 through 02/29/2016 included an order for Resident #2 to have a lap tray for positioning when in the wheelchair with a start date of 02/12/2016. The Treatment Administration Record (TAR) dated 02/01/2016 through 02/29/2016 for Resident #2 included to use a wheelchair with back cushion, lateral supports and lap tray for positioning when Resident #2 was out of bed. The Daily Care Guides dated 02/01/2016 through 02/29/2016 that were used by the nursing aides (NAs) in caring for Resident #2 indicated the resident required 2 staff members to use a mechanical lift for transfers to the wheelchair daily, encourage use of non- skid shoes daily, give verbal reminders not to ambulate or transfer without assist, keep bed in lowest position when resident is in bed and keep call light and personal items in reach, lock wheelchair brakes before transfers, maintain half side rails when in bed, and to remind Resident #2 not to lean forward when sitting in the wheelchair. Review of physician discharge summary dated 03/01/2016 indicated that in 01/06/2016 the physical therapist recommended a back cushion	F 221	months, and monthly for six(6) months to ensure all restraint assessment have been completed and the least restrictive device is implemented and documented. The QA committee will review the facility's progress for six (6) months for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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with lateral supports to the wheelchair for comfort.
During an interview with nurse #3 on 04/28/2016 at 9:56 AM revealed that Resident #2 sat in a reclining high backed wheelchair when she was out of bed and that at times, a table top tray was placed across the arms of the wheelchair and belted securely behind the back of the wheelchair. Nurse #3 revealed that the table tray was used only if Resident #2 was observed leaning sideways or forward in the wheelchair and that the belt release was behind the chair and that the resident could not remove the table tray by herself. The nurse stated that she thought that the table top tray had been requested by a family member, but she could not be certain.
An interview with the physical therapist (PT) on 04/28/2016 at 11:17 AM revealed that she could not recall the exact date, but that a family member of Resident #2 had stated to the PT that there was a concern that Resident #2 was leaning to 1 side while sitting in the Geri chair and that it was requested that he would prefer a wheelchair to be used with lateral positioning cushions, but that Resident #2 kept leaning and the lateral supports would not remain in place to prevent leaning. The family member requested the use of a table top tray placed across the arms of the wheelchair. The PT agreed and placed the table tray on the chair which prevented leaning, but that it did not need to be used at all times because sometimes Resident #2 had been able to sit up straight in the high backed wheelchair. The PT described that the tray rested on the arms of the wheelchair and that it had a strap that hooked around the back of the wheelchair with a seatbelt lock to secure it. The PT was not aware that the physician had been involved in the decision to use the table top tray and that after a thorough evaluation and attempts made with

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other chairs and positioning devices, that the family member, the PT and the nurse staff had decided that the table top tray was the most appropriate for the resident. The PT did not consider the tray as a restraint because the family member of Resident #2 had made the request. The PT also stated that Resident #2 could not have remove the tray in any way.
An interview conducted with the Director of Nurses (DON) on 04/28/2016 at 11:29 AM revealed that a family member of Resident #2 had requested that the table top tray be used on the wheelchair of the resident and that it had been discussed with the PT, but the table top tray was not used at all times because Resident #2 was able to sit straight in the wheelchair at times. The DON stated that Resident #2 could not walk and would likely have had a fall if she tried to get out of the chair of the table top tray. The DON stated that they were following the request of the family member for Resident #2. The DON stated that she was unable to locate any documentation in the medical record of Resident #2 that revealed a medical symptom for the use of the restraint.
During an interview with NA #4 on 04/28/2016 at 1:55 PM the NA stated that she recalled caring for Resident #2 and that 2 staff were need to use a mechanical lift for transfers in and out of bed. NA #4 stated that resident specific care was directed from the Daily Care Guide, but she did not recall if the table top tray for Resident #2 being on the Care Guide or not, but to the best of her recollection, a nurse had told her the tray was to be used at all times when Resident #2 was out of bed in the wheelchair and that NA #4 always made sure it was on the chair and secured in the back of the chair.