STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated (complaint) survey was conducted 5/9/17 through 5/10/17. One complaint was investigated during the survey. The facility was cited past non-compliance whereby no corrections are required.

The census in this 169 certified bed facility was 141 at the time of the survey. The survey sample consisted of 3 resident reviews: 3 current residents (Residents #1 through #3).

F 221 SS=D — 483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS — F 221

§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).

42 CFR §483.12, 483.12(a)(2)
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 symptoms.

(a) The facility must-

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 1	F 221		

(1) Ensure that the resident is free from physical or chemical restraints imposed for 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 a complaint investigation, clinical record review, staff interviews and facility documentation, the facility failed to ensure freedom from physical restraint imposed for the purposes of convenience for 1 of 3 residents (Resident #1) in the survey sample.

Resident #1 was restrained when tied in her wheelchair with a blanket/throw to prevent rising while the assigned staff performed other nursing duties.

The findings include:

Resident #1 was admitted to the nursing facility on 3/7/17 with diagnoses that included vascular dementia with behavioral disturbance, Alzheimer's disease and aphasia, bipolar disorder and anxiety disorder.

The most recent Minimum Data Set (MDS) assessment dated 4/3/2017 coded the resident with short and long term memory and severely impaired in the cognitive skills for daily decision making. The resident was coded with mood problems that included trouble concentrating and was fidgety and restless. Behaviors exhibited were wandering and verbal behavioral symptoms

Past noncompliance: no plan of correction required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 2	F 221		

directed at others. The resident was assessed to require extensive assistance from two staff for bed mobility, transfers. She was coded dependent on one staff for locomotion on and off the unit and used a wheelchair as her major mode of transportation. The resident was coded on antianxiety, antidepressant, and antipsychotic medications.

The care plan dated 3/9/17 identified the resident was at risk for behavioral problems of wandering and attempting to get out of chair and walk. The resident was also identified with impaired communication and understanding of others, had unclear speech at times, inattention and disorganized thinking. Resident #1 was identified at risk for falls and had actively fallen in the facility, had impaired vision, poor safety awareness and was agitated at times. The goals set by the staff for the resident was that she not sustain fall related injury by staff utilizing fall precautions, resident needs would be anticipated and met, have fewer behavioral episodes. Some of the interventions the staff would use to accomplish these goals included reinforce positive behavior, administer and observe the effectiveness and side effects of psychotropic medications, encourage the resident to remain sitting, chair and bed alarms, bilateral mattresses on the floor, low bed, assist with transfers and refer to therapy as needed.

The care plan dated 4/17/17 identified the resident required a physical restraint to protect him/her from harm. The goal the staff set for the resident was that she would be free from injury secondary to the use of a physical restraint. Some of the interventions to accomplish this goal were monitor resident for increased

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 3	F 221		

agitation/mood/behavior problem, decreased mobility, contractures, skin problems increased incontinence and increased risk for falls. Screening for appropriateness of device to use, frequency of checking and removing restraint, physical restraint elimination assessment quarterly and as needed, obtain physical restraint informed consent from resident/responsible party, refer to therapy as needed, while resident is awake offer snacks and recreation as needed, the use of the Merry Walker chosen as best fit restraint to maintain resident's mobility (started 4/19/17).

The most recent follow-up psychiatric evaluation dated 4/27/17 indicated the resident was constantly ambulating the hallways in a Merri-Walker with staff, was fidgety, alert and oriented to self only, minimally verbally responsive, but nodded yes and no appropriately. The resident's Remeron was increased from 30 mg (milligram) to 45 mg because of sleep issues and trying to get out of bed at night. Other psychotropic medications to continue included: Clonazepam 0.125 mg one tablet twice a day for anxiety and trazodone 50 mg one tablet at hour of sleep as needed.

A physician's order was written on 4/19/17 for a Merri-Walker due to resident's constant movement and walking while awake to be used for safety, frequent checks every 2 hours and as needed while in Merri-Walker-remove resident from the Merry Walker every two hours and as needed, assess bony prominences while out of Merri-Walker. It was noted the resident was a frequent faller.

The pre-restraining evaluation was completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 4	F 221		

4/19/17 to justify need for a physical restraint, as well the informed consent.

On 4/3/17, the Physical Therapy (PT) department screened and treated the resident to assess for alternatives to restraints that included therapeutic exercises, gait training to negotiate obstacles, balance activities while sitting on side of bed and while standing and walking. The PT department also trialed the use of the Merri-Walker with the resident during therapy from 4/4 to 4/19/17 and it was determined on 4/19/17 it was an appropriate device for use out of bed on the unit.

The nurse's notes dated 4/19/17 to current 5/10/17 indicated the resident was using the Merri-Walker with staff supervision while out of bed on the unit. It was noted the resident was taken out of the Merri-Walker and placed in a wheelchair with chair alarm at times and all the time during meals. The nurse's notes also revealed the staff toileted resident frequently and offered naps.

The Complaint Intake Information sent to the State Survey and Certification Agency indicated on 4/16/17, Resident #1 was observed physically restrained, tied with a sweater in her wheelchair. Several staff visualized the resident and it was captured via surveillance camera that also validated the event.

On 5/9/17 at 1:00 p.m., the Director of Nursing (DON) stated she was not at work at the time of the incident on 4/16/17, but initially reported it to all pertinent State agencies, the physician and Resident Representative (RR) when she returned to work on 4/19/17. The follow-up was sent the State survey and certification agency on 4/20/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 5	F 221		

The DON stated it was reported to her the aide used a blanket to restrain the resident to keep her from falling from her wheelchair. She stated she immediately suspended the aide (Certified Nursing Assistant #1) on 4/19/17 during the investigation period for 3 days. She stated an Activity Assistant saw the resident, who was near the nurse's station, tied with what they thought was a sweater, but it was a thin throw type blanket. He immediately informed the Registered Nurse #1 (RN) on the unit and the throw blanket was removed. She stated based on the surveillance camera the resident may have been tied for 15 minutes before it was removed and the resident stayed with a nurse for constant observation.

During the above interview, the DON said CNA #1 was disciplined and called in for special training, as well as 100% training for all staff regarding restraint usage, abuse and neglect. The DON also presented a Facility Plan of Action that identified the problem/opportunity for improvement in staff knowledge, corrective actions that in included specific assessments for the resident and identifying any other residents that could be affected by the same practice, measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur, description of the quality assurance and process improvement program that would be put in place to track and trend over time to ensure action plan met the initially identified goals. The compliance date was 4/25/17.

The DON continued to say during the interview that CNA #1 had training for abuse and neglect and restraint usage when she was hired about 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 6	F 221		

months ago as a new CNA, but told her because Resident #1 had so many falls, she was attempting to keep her safe while she took a meal tray to another unit on the fourth floor. The DON felt it was an opportunity to educate her an all staff about restraints, abuse and neglect. The Administrator at the time and the DON concluded that they could not substantiate abuse because the resident was taken to near the nursing station, when it was observed by other staff, and they removed the throw blanket and the resident did not appear to be in distress as exhibited in the surveillance video. The DON stated the facility was a restraint free facility, but had to do something for Resident #1 and after a through assessment, screening and trying the least restrictive measures for the resident's safety, the Merri-Walker has been a successful choice. She stated the staff remove her from the Merri-Walker frequently for meals, activities and toileting.

The Interim Administrator was interviewed on 5/9/17 at 3:30 p.m. He stated it was his first day on the job as the Interim Administrator, but the previous Administrator was still employed. He stated he knew it was said Resident #1 had been tied with a "sheet" to the wheelchair for about 10-15 minutes by CNA #1, but was never left alone and taken near the nurses station while the assigned CNA did some other things. He stated he knew the "sheet" was quickly recognized by other staff and removed. He stated he knew the State agencies were informed and Adult Protective Services (APS) came out to conduct an investigation. He stated from what he knew of the outcome of APS's investigation, it was favorable.

The following interviews were conducted from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 7	F 221		

staff that had some awareness of the event:

The Activities Assistant who first saw the resident tied with what he described in his written statement as a "sweater" no longer worked for the nursing facility and was not available for a telephone interview. The Activities Assistant indicated in his statement that on 4/16/17 between 9:15 a.m. and 10:00 a.m., during his mail rounds and room visits, he saw what he thought was a "sweater" of dark colors around her waist and tied by the arms at the back of the wheelchair. He documented he immediately told RN #1 who was at the end of the long hall on the Third floor.

On 5/9/17 at 2:00 p.m., CNA #1 was interviewed to say, "The resident had fallen again a week ago and had black eyes, so I thought I didn't want her to fall again when I went upstairs to take a breakfast tray to them and I tied a 'sheet' kinda knit type loosely around the resident and tied in the back until I got back. When I got back, around 10 minutes, the 'sheet' was undone and I was told I could not do that. The DON called me, suspended me for three days and re-educated me on abuse, neglect and restraints. I did not mean anything, this was my first CNA job and yes I had training when I started, but I did not think I was doing anything wrong. I learned my lesson and I am thankful for it."

On 5/9/17 at 2:35 p.m., Licensed Practical Nurse (LPN) #1 stated during an interview that she was the nurse on the floor caring for the resident and knew CNA #1 had gone into the resident's room to provide care, afterwards bringing her out in her wheelchair placing her near the nursing station. She stated RN #1 saw it and called out to her at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 8	F 221		

the end of the hall. She stated when she approached the resident, it looked like a throw type blanket of many dark colors was positioned in a "V" in the front of the resident and tied in the back. She stated it was immediately removed and she reiterated to CNA #1 that she could not do that, no matter how loose she had it because it prevented the resident's movement. LPN #1 stated Resident #1 was very busy, had frequent falls and rose up from her wheelchair on a consistent basis. She stated the Merri-Walker had been great for the resident because it offered the walking the resident desired and was safe for her. She stated all staff had mandatory training on abuse and neglect and restraint usage.

On 5/9/17 at 3:05 p.m., RN #1 was interviewed to say the activity person came to her, as she was passing medications, to say he observed Resident #1 tied to the wheelchair with a "sweater". She stated she also called out to LPN #1 to see what was going on. She said she saw a knit type blanket/throw and immediately untied it. She said she saw CNA #1 coming off the elevator and told her she could not ever tie any resident to a chair or wheelchair. She stated she had never saw the resident tied in the wheelchair before that day. She stated the staff on the floor took turns watching the resident and took her with them, as they had done before, on the medication pass and at nurse's station. She stated one of the problems is that the resident wants to walk all the time and was not always steady during ambulation, so she rises from the wheelchair and had some falls from the wheelchair. According to RN #1, she and all staff had mandatory re-training on abuse/neglect and restraints since the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 9	F 221		

The following observations were made of Resident #1:

On 5/9/17 at 1:45 p.m., Resident #1 was ambulating with various nursing staff throughout the hallways in her Merri-Walker. She was pleasantly responsive to the nursing staff, but had no desire to sit much.

On 5/10/17 at 10:00 a.m. to 12:00 p.m., Resident #1 was in her Merri-Walker ambulating constantly through the hallways. At 12:15 p.m., a CNA #3 removed the resident from the Merri-Walker and placed in her wheelchair at a table in the activity's room for her lunch meal. The resident consumed 100% of her meal with cueing and supervision from the CNA, but fully fed herself. CNA #3 stated the nursing staff took turns to be with the resident, but she was safe and could move like she wanted in the Merri-Walker.

On 5/10/17 at 1:00 p.m., Resident #1 was back in her Merri-Walker happily ambulating with nursing staff throughout the hallway.

Based on the above presentation of the Corrective Action Plan, staff interviews, review of the investigative documentation/statements, observations of the resident and other residents, the deficient practice was corrected. The issue of unauthorized restraint usage did not exist since the incident of 4/16/17 nor while the current survey was in progress, thus Past Non Compliance was granted to the facility.

The facility's policy and procedure titled 'Use of Restraints' revised 11/22/16 indicated that "Restraints only may be used for the safety and well-being of the resident(s), and only after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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	Continued From page 10	F 221		

consideration, evaluation, and the use of all other viable alternatives, All residents have the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation...Physical restraints are defined as any manual method, or physical or mechanical device, material, or equipments attached or adjacent to the resident's body that an individual cannot remove easily and which restricts the resident;s freedom of movement or normal access to his/her body. The device itself does not determine whether it is a 'restraint'. If a resident cannot remove a device in the same manner applied it, and this restricts a resident's ability to change his/her physical position or place, the device may be considered a restraint."

COMPLAINT DEFICIENCY