STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014004	A. BUILDING: _____ B. WING _____	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHAIRE CENTER	1450 SHAIRE CENTER DRIVE LENOIR, NC 28645

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual survey on March 7-8, 2018.	D 000	This Plan of Correction is submitted to address non-compliance violation cited under 10A NCAC 13F.1004(j) Medication Administration. This is to state that we do not concur with this recommendation as stated for non-compliance or deficient practice. Upon finding stated non-compliance:	4/12/18
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration records (MARs) for 3 of 3 sampled residents (#3, #4, and #5) related to documenting administration of Oxycodone, Tramadol, Guaifenesin cough syrup with codeine, Xanax, and Ativan.	D 367	It is the policy of this facility to accurately and safely provide medication. The facility shall maintain a medication administration record to document all medications administered. PRN medications shall be provided as ordered by the physician and proper documentation of their usage shall be maintained. The Director of Nurses (DON) and Administrator developed the following process/procedure to assure compliance with proper medication administration and the documentation thereof: DON conducted a mandatory medication administration inservice/re-education meeting with all Medication Technicians (Med Techs) on March 21, 2018. All Med Techs were instructed on the need to document in all required areas for any and all medications that are administered. Documentation must include as a minimum the name and strength of the drug; dosage; method of administration; date and time of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard C. Howell — TITLE: Administrator — (X6) DATE: 4/12/18

Reviewed and accepted. B Boggs 4/19/18

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D 367	Continued From page 1 The findings are: 1. Review of Resident #5's current FL2 dated 8/25/17 revealed diagnoses included major depressive disorder, anxiety, dementia, and tremors. Review of physician orders, dated 9/27/17, revealed Xanax 0.50 mg every 6 hours as needed for anxiety. Review of the Controlled Drug Sheet for Xanax 0.50 mg as needed from 1/1/18 through 1/31/18 compared to the January 2018 Medication Administration Record (MAR) revealed: -Fifty-eight doses Xanax 0.50 mg were documented from 1/1/8 through 1/31/18 on the Controlled Drug Sheet with only 13 doses documented as administered on the front of the January 2018 MAR beside the Xanax 0.50 entry. -Only 10 doses Xanax 0.50 mg were documented on the back of the MAR with reason and effect. Review of the Controlled Drug Sheet for Xanax 0.50 mg as needed from 2/1/18 through 2/28/18 compared to the February 2018 Medication Administration Record (MAR) revealed: -Fifty-five doses Xanax 0.50 mg were documented from 2/1/8 through 2/28/18 on the Controlled Drug Sheet with only 16 doses Xanax 0.50 mg documented as administered on the front of the February 2018 MAR beside the Xanax 0.50 mg entry. -Fourteen doses Xanax 0.50 mg were documented on the back of the February 2018 MAR with reason and effect. Review of the Controlled Drug Sheet for Xanax 0.50 mg as needed from from 3/1/18 through	D 367	administration; reason(s) why medication was administered, withheld, not administered, or refused; and signature and title of the person administering the medications. Scenarios were given with rationales. All Med Techs were re-educated on the importance of assessing residents for signs and symptoms prior to the administration of PRN medications. All Med Techs were re-educated on the importance of re-assessing the results achieved or the statement no results achieved. Should the medication prove to be ineffective, the physician will be notified. DON will conduct a mandatory medication administration inservice/re-education meeting with all Medication Technicians (Med Techs) quarterly. Contract Pharmacist will observe medication administration of each Med Tech quarterly. DON will review and monitor all medication administration records for compliance weekly for a period of 2 weeks. DON will then monitor 20 medication administration records for compliance for a period of 4 weeks. Thereafter, DON will monitor 10 medication administration records compliance each quarter for the next 3 quarters. Any employee not following facility policy relating medication administration will have disciplinary actions taken on an	

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D 367	Continued From page 2 3/6/18 compared to the March 2018 Medication Administration Record (MAR) revealed: -Seven doses Xanax 0.50 mg were documented from 3/1/8 through 3/06/18 on the Controlled Drug Sheet with only 2 doses Xanax 0.50 mg documented as administered on the front of the March 2018 MAR beside the Xanax 0.50 mg entry. -There were no Xanax 0.50 mg documented on the back of the March 2018 MAR with reason and effect. Observation of Resident #5 on 3/7/18 at 3:15pm revealed she was in the facility hallway pacing and loudly verbalizing that she wanted to get out. Review of the Xanax 0.50 mg as needed Controlled Drug Sheet for Resident #5 revealed she was administered 1 dose Xanax 0.50 mg at 2:00pm on 3/7/18 by the first shift medication aide, with no documentation of administration of Xanax 0.50 mg on the front of the March 2018 MAR and no reason and effect documented on the back of the MAR. Interview with the second shift medication aide on 3/7/18 at 3:15 revealed: -She came to work at 3:00pm and the first shift medication aide administered Xanax 0.50 mg to Resident #5 at 2:00pm. -Sometimes it took "a while for the Xanax to kick in." -She had been trained to document on the front and the back of the MAR but she also had failed to document the administration of Xanax 0.50 mg to Resident #5 on the back and front of the MAR. -The first shift medication aide trained her on documenting the administration of controlled medications.	D 367	individual basis. The DON will document the audit results and report those findings monthly to the administrator. The Administrator will assess and modify the action plan as needed to ensure continued compliance.	

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D 367	Continued From page 3 Observations of Resident #5's medications on hand on 3/7/18 at 3:40pm revealed the number of Xanax 0.50mg on hand matched the count on the Controlled drug sheet. Interview with the first shift medication aide on 3/8/18 at 9:15am revealed: -She did administer Xanax 0.50 mg to Resident #5 at 2:00pm on 3/7/18 and it was not effective. -Usually the Xanax 0.50 mg was effective in calming Resident #5. -She had been trained to document all as needed medications on the front and back of the MAR but she had been failing to do so. Refer to facility's Medication Policies and Procedures. Refer to interview with the facility Nurse on 3/8/18 at 11:10am. 2. Review of Resident #4's current FL2 dated 11/6/17 revealed: -Diagnoses included dementia, degenerative joint disease, and encephalopathy. -A physician order for Oxycodone 20mg/ml soln, 0.25 ml every 2 hours as needed for mild pain and 0.50 ml every 2 hours as needed for severe pain. -A physician order for Ativan 1 mg every 4 hours as needed for needed for anxiety and agitation and 2 mg every 2 hours as needed for extreme restlessness. Review of the Controlled Drug Sheet for Ativan 1 mg and 2 mg as needed from 1/1/18 through 1/31/18 compared to the January 2018 Medication Administration Record revealed: -Ten doses Ativan 1 mg were documented on the Controlled Drug sheet with no documentation of	D 367		

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D 367	Continued From page 4 administration of Ativan 1 mg on the front of the MAR beside the Ativan 1 mg entry and no documentation on the back of the MAR with the reason and effect. -One dose Ativan 2mg was documented on the Controlled Drug Sheet and was documented as administered on the front of the MAR on 1/8 at 3:45pm beside the Ativan 2 mg entry, but was not documented on the back of the MAR with reason and effect. Review of the Controlled Drug Sheet for Ativan 1 mg and 2 mg as needed from 2/1/18 through 2/28/18 compared to the February 2018 Medication Administration Record revealed: -Nine doses Ativan 1 mg as needed was documented on the Controlled Drug sheet with only 1 dose documented as administered on the front of the MAR on 2/10/18 at 12:30pm beside the Ativan 1 mg entry and with documentation on the back justification and effect for the 1/10/18 administration. -There was no documentation on the front or back of the MAR for the other 8 doses Ativan 1 mg administered in February 2018. -There was no Ativan 2 mg as needed documented on the Controlled Drug Sheet for February 2018. Review of the Controlled Drug Sheet for Ativan 1 mg and 2 mg from 3/1/18 through 3/6/18 compared to the March 2018 Medication Administration Record revealed: -One dose Ativan 1 mg was documented on the Controlled Drug sheet on 3/2/18 at 12 noon. -There was no documentation of administration of any Ativan 1 mg on the front of the MAR beside the Ativan 1 mg entry and no documentation of the back of the MAR of the justification and effect. -There was no Ativan 2mg documented on the	D 367		

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D 367	Continued From page 5 Controlled Drug Sheet for March 2018. Review of the Controlled Drug Sheet for Oxycodone 20mg/ml 0.25 ml every 2 hours as needed for mild pain and 0.50 ml every 2 hours as needed for moderate to severe pain from 1/1/18 through 1/31/18 compared to the January 2018 Medication Administration Record revealed: -Thirteen doses of Oxycodone 0.25 ml as needed was documented on the Controlled Drug sheet with no documentation of administration on the front of MAR beside the Oxycodone 0.25 ml entry and no documentation on the back of the MAR with justification and effect. -Nine doses of Oxycodone 0.50 ml as needed was documented on the Controlled Drug Sheet with no documentation of administration on the front of the MAR beside the Oxycodone 0.50 ml entry and no documentation on the back of the MAR with justification and effect. Review of the Controlled Drug Sheet for Oxycodone 20mg/ml 0.25 ml every 2 hours as needed for mild pain and 0.50 ml as needed for moderate to sever pain from 2/1/18 through 2/28/18 compared to the February 2018 Medication Administration Record revealed: -Six doses of Oxycodone 0.25 ml was documented on the Controlled Drug sheet with no documentation of administration of any Oxycodone 0.25 ml on the front of MAR beside the Oxycodone 0.25 ml entry and no documentation on the back of the MAR with reason and effect. -Three doses of Oxycodone 0.50 ml was documented on the Controlled Drug Sheet with no documentation of administration of Oxycodone 0.50 ml on the front of the MAR beside the Oxycodone 0.50 ml entry and no documentation on the back of the MAR with reason and effect.	D 367		

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D 367	Continued From page 6 Review of the Controlled Drug Sheet for 3/1/18 through 3/6/18 for Oxycodone 20mg/ml 0.25 ml every 2 hours as needed for mild pain and 0.50 ml as needed for moderate to severe pain revealed none was documented as administered. Interview with the first shift medication aide on 3/8/18 at 9:15am revealed: -She had been trained to document on the front and on the the back of the MAR but she had failed to document Resident #4's Ativan and Oxycodone on the front and back of the MAR. -The Ativan and Oxycodone were usually always effective for Resident #4. -She knew Resident #4 had anxiety when he talked real loud and could not be calmed down. -She knew Resident #4 was in pain when he told her he was in pain. Observation of Resident #4's medications on hand revealed on 3/7/18 at 3:20pm revealed the Ativan 1 mg count and the Oxycodone 20mg/ml level match the amounts listed on the last administration on the Controlled Drug Sheets. Refer to facility's Medication Policies and Procedures. Refer to interview with the facility Nurse on 3/8/18 at 11:10am. 3. Review of Resident #3's current FL-2 dated 9/8/17 revealed: -Diagnoses included heart failure, insulin dependent diabetes mellitus, hyperlipidemia, mitral regurgitation and kidney disease. -There was a physician's order for Tramadol 50mg 1 tablet every 6 hours PRN (As needed) for pain.	D 367		

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D 367	Continued From page 7 -There was a physician's order for Guaifenesin-codeine syrup 5ml three times per day PRN for cough. Review of Resident #3's Medication Administration Record (MAR) for January 2018 revealed: -Tramadol HCL 50mg tablet (Take one tablet every six hours ([PRN] as needed) for pain). -The medication was transcribed and documented as administered 5 times. -The back side of the MAR had 3 entries documented as administered with the effectiveness of the PRN medication. Review of Resident #3's Controlled Substance Log (CSL) for Tramadol 50mg available for review compared to the January 2018 eMAR revealed there were 16 doses documented as administered on the CSL with only 5 times documented on Resident #3's MAR. Continued review of Resident #3's MAR for February 2018 revealed: -Tramadol HCL 50mg tablet one tablet every 6 hours PRN. -The medication was transcribed and documented as administered 7 times. -The back side of the MAR had 1 entry documented as administered with the effectiveness of the PRN medication. Review of Resident #3's CSL for Tramadol 50mg available for review compared to the February 2018 MAR revealed there were 11 doses documented as administered on the CSL with only 7 times documented on Resident #3's MAR. Review of Resident #3's MAR for January 2018 revealed:	D 367		

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D 367	Continued From page 8 -Guaifenesin AC cough syrup with codeine 5mg (three times per day as needed for cough). -The medication was transcribed and documented as administered 5 times. -The back side of the MAR had no entries documenting the effectiveness of the PRN medication. Review of Resident #3's CSL for Guaifenesin AC cough syrup with codeine 5ml available for review compared to the January 2018 MAR revealed there were 12 doses documented as administered on the CSL with only 5 times documented on Resident #3's MAR. Review of Resident #3's MAR for February 2018 revealed: -Guaifenesin AC cough syrup with codeine 5mg (three times per day as needed for cough). -The medication was transcribed and documented as administered 5 times. -The back side of the MAR had 5 entries documenting the effectiveness of the PRN medication. Review of Resident #3's CSL for Guaifenesin AC cough syrup with codeine 5ml available for review compared to the February 2018 MAR revealed there were 2 doses documented as administered on the CSL with 5 times documented on Resident #3's MAR. Refer to interview with the facility Nurse on 3/8/18 at 11:10am. Refer to facility's Medication Policies and Procedures. _____ Review of the facility's Medication Policies and	D 367		

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D 367	Continued From page 9 Procedures revealed: -"The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones." -"As required or indicated for a medication, the individual administering the medication will record in the resident's medical record any complaints or symptoms for which the drug was administered, any results achieved, and when those results were observed." -Under Policy Interpretation and Implementation, the "Documentation must include, as a minimum: ...Resident response to the medication, if applicable (e.g. PRN, pain medication, etc.)". Interview with the facility Nurse on 3/8/18 at 11:10am revealed: -All the medication aides had been trained and reminded many times to document justification and results for the as needed medications. -She was responsible for providing oversight for the accuracy of the Medication Administration Records (MARs) -She had not checked the MAR's for accuracy and documentation for the as needed medications for at least three months or more.	D 367		
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:	D 482	This Plan of Correction is submitted to address non-compliance violation cited under 10A NCAC 13F.1501(a) Use of Physical Restraints And Alternatives. This is to state that we do not concur with this recommendation as stated for non-compliance or deficient practice. Upon finding stated non-compliance:	4/16/18

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D 482	Continued From page 10 (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 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.	D 482	It is the policy of this facility that restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. On March 7, 2018 the Maintenance Director removed the assist bed rail (enabler) attached to the mid-section of each side of Resident #2 bed. Each half rail (enabler) was repositioned and attached to the top of the bed frame per manufacturer's recommendations. This bed rail repositioning allows for freedom of movement in and out of bed, and enhances Resident #2 ability to reposition one's self enhancing comfort. In addition, the Maintenance Director and DON inspected each resident bed for proper bed functioning and bed rail (enabler) placement. All beds were found to be in proper repair and in compliance. On March 21, 2018 a mandatory in-service/meeting with all Med Techs and shift supervisors was conducted by DON addressing	

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D 482	Continued From page 11 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a physician's order for assist bed rails (enablers) attached to the mid-sections of 1 of 1 resident's bed frame (Resident #2) being used to keep the resident, with a history of falls, from voluntarily getting out of bed. The findings are: Observations during the initial tour of Resident #2's bed revealed: -Resident #2 was lying on the bed. -There was an assist bed rail (enabler) attached to the mid-section of each side of the bed frame. -Each enabler was approximately 28 inches wide and 18 inches from bed frame to the top of the rail. -The position of the enablers would prevent the easy exit of the resident from the bed. Review of Resident # 2's most current FL2 dated 12/21/17 revealed: -Diagnoses included dementia and status post right hip fracture. -A physician's order to "Use a pad alarm at all times when in bed, wheelchair or recliner." Review of Resident #2's Falls Risk Assessments revealed: -"If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls." -"If the total score is 10 or greater, a prevention protocol should be initiated immediately and documented on the care plan." -The assessment completed on 3/21/17, the score was 7.	D 482	restraints being used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints must be documented. The need to obtain a physician order prior to the use of any restraints was reviewed. Proper bed functioning and use of bed rails (enablers) was reviewed with the importance of reporting to DON and Maintenance Director any beds found in ill repair or with misplaced bed rails (enablers) for immediate correction. The Maintenance Director will assess all beds for proper function and placement of bed rails (enablers) per manufacturer recommendations weekly for a period of 4 weeks. The Maintenance Director will then assess all beds for proper function and placement of bed rails (enablers) per manufacturer recommendations monthly for a period of 3 months. Thereafter, the Maintenance Director will assess all beds for proper function and placement of bed rails (enablers) per manufacturer	

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	HAL014004	A. BUILDING: _____ B. WING _____	03/08/2018

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D 482	Continued From page 12 -The assessment completed on 6/22/17, the score was 9. -The assessment completed on 9/15/17, the score was 15. -The assessment completed on 12/15/17, the score was 15. Review of Resident #2's Care Plan dated 12/6/17 revealed: -The Care Plan had been completed in response to a "significant change" in the resident's condition. -The resident was alert but confused with a significant loss of memory and sometimes disorientated. -The resident was semi-ambulatory and had a wheelchair the staff propels. -The resident was to use a pad alarm when up in her wheelchair and recliner. -There was no fall prevention protocol documented on the care plan. Review of Resident #2's Licensed Health Professional Support review and evaluation (LHPS) form dated 12/8/17 revealed: -The resident was "alert but confused, very forgetful." -The resident was able to stand and pivot and required 1 person to assist with transfers from the bed to wheelchair. -The resident was a "High Fall Risk, had fallen and fractured her hip." -"She is no longer ambulatory but tries to get up unassisted." -A pad alarm had been ordered on 8/16/17 to be used at all times. -"The reason for the restraint: No safety awareness."	D 482	recommendations quarterly. Any deviation or omission of facility procedure will be immediately corrected by the Maintenance Director. In addition, on March 21, 2018, the facility assigned fall prevention coordinator was re-educated as to the importance of follow-up and investigation of any and all incident/accident reports. Upon the completion of their investigation, any preventive recommendations must be discussed with the Director of Nurses. At such time all new preventative measure will be implemented and plan of care will be updated. On April 16, 2018 the facility will conduct a mandatory meeting/in-service for all nursing staff to discuss and review fall prevention, use of restraints, and incident/accident reporting. Facility policies and procedures pertaining to each area will be reviewed. Information will be shared as to the amount of creativeness needed to individualize the fall prevention measures some residents may require. The need to think outside the box will be emphasized. The need to look at all possible factors and variables pertaining to each situation will be emphasized. The DON in collaboration with the fall prevention coordinator will review incident/accident reports for accurate documentation and	

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D 482	Continued From page 13 Review of staff notes in Resident #2's record revealed: -On 7/29/17, the resident had been walking down the hall with her cane and fell sustaining a laceration in front of her right ear and a right hip fracture and was admitted to the hospital. -On 8/16/17, the resident had been very confused and forgetful, had removed and thrown the Personal Safety Alarm (PSA - an alarm that is attached to the bed or wheelchair and clipped to the resident's clothing to alert staff when the resident attempts to get up), climbed out of left side of bed and fell. No interventions had been documented as a result of the fall. -On 9/8/17, the resident had gotten out of bed, tried to walk and fell and hit the back of her head. "The pad alarm was not on." No interventions had been documented as a result of the fall. -On 12/14/17, the resident had been sitting in her wheelchair, stood up and slipped to floor. No injuries. No interventions had been documented as a result of the fall. -On 12/30/17, the resident had fallen trying to get out of the recliner. No interventions had been documented as a result of the fall. -On 2/17/18, the resident tried to climb out of bed and sustained a skin tear on the back of her left leg. Review of the physician's orders in Resident #2's record revealed: -An order dated 8/14/17, and signed by the physician on 8/29/17, for a "PSA in recliner, bed and wheelchair. Risk falls with injury." -An order dated 8/16/17 to "D/C (discontinue) PSA. Start pad alarm, use in wheelchair and bed. Risk falls with injury. Forgetful and confused." -There were no other physician's orders for interventions documented in the record.	D 482	implementation of facility procedures for a period of 4 weeks. The DON in collaboration with the fall prevention coordinator will then review incident/accident reports for accurate documentation and implementation of facility procedures bi-weekly for a period of 4 weeks. Thereafter, the DON in collaboration with the fall prevention coordinator will review incident/accident reports for accurate documentation and implementation of facility procedures quarterly. Any deviation or omission of facility procedure will be immediately corrected by the DON and/or fall prevention coordinator. Any employee not following facility policy relating to incident reporting, fall prevention, or use of restraints will have disciplinary actions taken on an individual basis. The Director of Nurses and nursing investigator will collaborate documentation and report findings of the monthly falls meeting to the Administrator for quality assurance.	

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D 482	Continued From page 14 Review of the staff notes in Resident #2's record revealed: -On 8/14/17, the resident had returned to the facility from rehabilitation at a skilled nursing facility. -On 8/16/17, the resident had removed and thrown the PSA, climbed out of bed and fell. -The PSA was discontinued and a pad alarm order was received from the physician for use in wheelchair and bed due to a risk of falls with injury. -On 12/1/17, the staff documented a visible decline in the resident. -On 12/4/17, the resident had been seen by her physician and a Hospice referral had been made. Interviews on 3/7/18 and 3/19/18 with four Personal Care Aides (PCAs) revealed: -The rails were on Resident #2's bed "to keep her in the bed." -"She thinks she can walk but she can't." -"If the rails weren't up she would try to get out and fall on the floor." Interview on 3/7/18 at 11:45am with the facility nurse revealed: -Resident #2 had been on another hall when she had fallen and fractured her hip. -When she returned from rehabilitation at the skilled facility, she had been moved to her current room, closer to the nursing desk "so the staff could watch her better." -The only restraint orders for the Resident #2 were for a PSA (discontinued) and now for the pad alarm. -"The bed rails are not being used as restraints." -She did not know why the staff said the rails were being used to keep Resident #2 in the bed. -"When Hospice admits our residents, they put those rails on the resident's bed."	D 482		

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D 482	Continued From page 15 -She thought the rails had been on the bed in Resident #2's current room when she returned from the skilled facility on 8/14/17. -Resident #2 had been admitted to Hospice the beginning of December 2017. -She had discussed the alarms with the resident's physician and POAs (Powers of Attorneys). -She had not discussed the bed rails with the physician or the POAs because she did not consider them a restraint. -She would have them removed immediately. Interview on 3/8/18 at 9:45am with one of Resident #2's POA's revealed: -The resident had fallen multiple times at the facility and in July 2017 had broken her right hip. -The facility had discussed using the alarms for Resident #2. -The facility had never discussed using bed rails as a restraint. -When visiting the facility, the resident was usually up in a wheelchair. -The POA "never really paid attention to the rails on the bed." Interview on 3/8/18 at 11:54am with a second of Resident #2's POA's revealed: -The resident had fallen in July 2017, fractured her hip and had not been walking since that time. -"She had physical therapy when she got back from the nursing home but because of her dementia, she wasn't progressing, so it was stopped." -"She doesn't remember she can't walk." -"The facility had discussed using the alarms after she got back from the nursing home." -"I don't remember seeing rails on her bed. The nurse never mentioned them to me. I'm sure the staff puts them up at night to keep her safe."	D 482		

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D 482	Continued From page 16 Interview on 3/8/18 at 12:30pm with Resident #2's physician revealed: -The facility nurse had discussed the use of alarms for this resident and he had written the orders. -He did not know there were assist bed rails on the resident's bed that were being used to keep the resident from exiting her bed. -The nurse had not discussed the use of the rails with him. -If he had been asked, he would not have agreed with their use.	D 482		