STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105038	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Center for Rehabilitation and Nursing	2810 South Atlantic Avenue New Smyrna Beach, FL 32169

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on interviews and record reviews, the facility failed to ensure that one (Resident #26) of 50 residents in the total sample, was free from any physical restraints imposed for purposes other than the resident's medical condition. Inappropriate use of restraints could result in injury, skin breakdown, asphyxia, and/or strangulation among other things. The findings include: On 03/25/24 at 2:25 p.m., Resident #26 was observed in bed with bruises on her chest and the left side of her face. Her bed was in low position with floor mats on both sides of the bed. She also had a scoop mattress and half siderails that were padded. She had crossed her left leg over her right leg and was resting it on the right siderail. A bandage was observed on the resident's left shin, dated 3/24/24. An attempt to speak with the resident was unsuccessful due to confusion. A review of the resident's medical record revealed she was admitted to the facility on [DATE] with a re-entry on 03/21/2024. Her diagnoses included, but were not limited to: unspecified dementia with unspecified severity and anxiety; vascular dementia, severe with anxiety; severe protein-calorie malnutrition; adult failure to thrive; generalized anxiety disorder; dependence on a wheelchair; cognitive/communication deficit with restlessness and agitation; atrial fibrillation; weakness; hypertension; pain; major depressive disorder; constipation and insomnia. Her physician's orders included the following: 01/27/2023 - Half side rails x2 may be be up for enhanced independence and mobility. Monitor behavior for anxiety. 04/03/2023 - Sertraline 50 mg (milligrams) one time a day for depression 11/22/2023 - Trazadone 150 mg, give 0.5 tablet two times a day for major depressive disorder and insomnia 08/30/2023 - Lorazepam 1 mg two times a day for anxiety 03/20/2024 - Lorazepam 0.5 mg every 8 hours as needed for anxiety (continued on next page)

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
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/21/2024 - Safety equipment: padded side rails related to poor safety awareness. 03/21/2024 - Safety check to be conducted every hour related to recent fall, every hour x 7 days. A Health Status note, dated 03/20/24 and authored by Licensed Practical Nurse (LPN) A, revealed: Resident noted to have discoloration to forehead, left side of face/neck this shift. No sign of pain/grimacing. Advanced Practice Registered Nurse (APRN) made aware of facial discoloration and order received to send resident out to emergency room (ER) for evaluation. Director of Nursing (DON) made aware. A facility report, dated 03/21/24 and authored by Registered Nurse (RN) B, read: CNA (certified nursing assistant) informed writer of bruising to resident's forehead around 5:00 p.m. Resident was restless at the start of shift. Not able to determine the cause of the bruising. Physician was notified and no new orders. A review of the resident's care plan, last revised on 02/27/24, noted that the resident had an Activities of Daily Living (ADL) Self-Care Performance Deficit related to weakness, poor endurance, activity intolerance, and impaired balance. Interventions included: Two half siderails may be up for enhanced mobility. Geri chair as needed for positioning and comfort. Requires assistance x2 for turning and repositioning and transfers. The care plan also indicated that the resident had impaired cognition and decision-making skills related to a diagnosis of dementia, and had a Determination of Incapacity (DOI) on file. A review of the Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/09/24, revealed that Resident #26 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The assessment also noted that the resident had no falls or wounds/skin tears, and bed rails were not used. In a joint interview on 03/27/24 at 12:44 PM with the Director of Nursing (DON) and Social Services Director (SSD), they stated LPN A informed the DON of the resident's forehead bruise on 03/20/24. The DON stated LPN A said she was not able to determine the origin of the injury but it appeared to have resulted from a fall. The DON stated she instructed LPN A to contact the resident's physician and have her sent to the emergency room for an evaluation. The DON also contacted the SSD and notified her of the concern. Staff involved were asked to write witness statements and none indicated knowledge of the origin of the injury. During the investigation on 03/21/23, RN B was interviewed by a representative from the Department of Children and Families and the SSD. RN B confirmed that she draped a sheet across the resident's siderails to keep the resident in bed. She reported the resident was restless but was still able to move all of her extremities freely and the sheet was not touching her body. The SSD and DON stated the facility did not use restraints. A review of the resident's Medication Administration Record (MAR) for March 2024 revealed that there were no behaviors noted. (Copy obtained) (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/24 at 2:48 PM, LPN A/Evening Supervisor, was interviewed. She stated on 03/20/24 around 5:00 p. m., RN B, who was assigned to Resident #26, contacted her and stated the resident had a bruise on her head, the Advance Practice Registered Nurse (APRN) was notified, and no new orders were given. She told RN B that she would assess the resident as soon as she had an opportunity. She was assisting with an admission at the time. At around 9:00 p.m., CNA C approached her and stated she was concerned about the bruises on Resident #26's face. CNA C also stated there was a sheet tied across the resident's siderails. LPN A said she immediately went to the resident's room and found a bed sheet tied across the resident's siderails over the resident's abdomenal area. She stated RN B had followed her to the resident's room. Both CNA C and RN B stated they were not sure who put the sheet on the siderails. LPN A and RN B took the sheet off the siderails. LPN A conducted a skin assessment, which revealed skin tears to the left elbow, left jaw line and lateral neck and bruising/discoloration to the resident's forehead, left side of her face, left neck, left chest area, and left arm. She stated as soon as she contacted the DON, the DON instructed her to complete a body audit and notify the APRN. When asked if she notified the DON that the resident was found with a sheet tied to her siderails, she said, Yes. When asked if she notified the APRN of the sheet tied to the siderails, LPN A stated she could not recall. She confirmed that she completed the transfer form and indicated that the resident had fallen. She said, I thought it was an unwitnessed fall. She was then asked if the resident was able to get herself up after the fall, and she replied, No. She added, The sheet was not touching the resident's body; therefore, I did not think the bruises could have resulted from it. In a telephone interview on 03/27/24 at 3:47 p.m., CNA C stated she had been employed by the facility since 2020. She added that the facility protocol, upon reporting on duty, was to check the schedule for the assignment. Once the assignment was identified, she was to conduct rounds with the off-going staff, then obtain resident vital signs. She confirmed that she worked on 03/20/24 on the 3-11 shift and was assigned to Resident #26. When she reported on shift, she obtained vital signs. Resident #26 was restless and no bruises or skin tears were observed. She returned to the resident's room at approximately 4:45 p.m. to provide incontinence care. When she entered the room, she found the resident with bruises on her face, the side of her neck, her chest and a skin tear on her shin. She notified her assigned nurse (RN B) that the resident had a new bruise on her face. She also called her co-worker, CNA D, to assist with ADL care. When the nurse came to the room around 5:00 pm while CNA C and CNA D were providing incontinence care, CNA C asked Resident #26 what happened. Resident #26 pointed to RN B and said, You know what happened. RN B stroked the resident's face in a calming manner and stated she would notify the supervisor. At 9:00 p.m., CNA C and CNA D went to assist Resident #26 with ADL care. At that time they found a bed sheet tied across the resident's siderails over her abdomen. They also noted bruises to the resident's chest. CNA C stated she went directly to the supervisor. The supervisor and RN B returned to the resident's room and they untied the bed sheet from the siderails. On 03/28/24 at 1:07 p.m., an interview was conducted with the Medical Director. He stated he was notified that the resident had bruises on her face. He added that after evaluating the resident, he thought the resident had a fall and someone did not report it. He added that the resident's family was in the facility and was able to speak with the resident in French, but the resident could not recall what happened. When asked if he was notified about the sheet found tied across the resident's siderails, he said, Yes, and that was not acceptable. The facility does not allow restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Siderails and Restraints (06/04/2020), revealed: It is the intention of the facility for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limit restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Restraints will not be used for staff convenience. Procedures: Upon admission, the admitting nurse will complete the evaluation. The initial assessment included: Observation of the resident's movement in bed and resident's ability to independently use partial siderails to assist with turning, positioning, moving up and down, exiting and entering the bed. Assess the resident's ability to follow directions for use of siderails. Interview of alert resident to identify their performance for use of partial siderails to assist with need for mobility. After evaluation of the resident, if it is determined that the use of the siderails or restraint is appropriate, the least restrictive restraint will be deemed appropriate for individual resident to attain or maintain his or her highest practicable physical and psychological well-being. If the resident/resident representative request, or the facility deems the use of siderails is appropriate for the resident, the admitting nurse or nurse responsible for the resident at the time the determination is made, will compete the siderail evaluation and obtain informed consent for use. Whenever restraint use is considered, the facility will explain to the resident and or legal representative how the use of the restraint would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. The nurse responsible for the resident at the time of the determination is made for the restraint use will complete the Restraint Evaluation within the resident's electronic medical record. The facility will also explain the potential negative outcomes of restraint use which include, but are not limited to, decline in the resident's physical functioning (e.g. ability to ambulate) and muscle condition, delirium, agitation and incontinence, and obtaine a consent for device use. Before using a device for mobility or transfer, an evaluation should include a review of the resident's bed mobility and ability to transfer between positions and from bed or chair to stand and toilet. The resident will be re-evaluated for appropriate use of the least restrictive device in conjunction with the Resident Assessment Instrument. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Packet - Restraint Section revealed that the facility believed in the resident's right to remain free from physical and chemical restraints whenever possible, therefore strived to maintain a restraint-free facility. If any type of restraint becomes necessary, it shall be used only upon a physician's order, a thorough assessment, and permission from the resident's legal designated representative.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on observations, interviews, and record review, the facility failed to 1) Use appropriate alternatives prior to installing a siderail. 2) Review the risks and benefits of siderails with the resident or resident representative and obtain informed consent prior to installation, and 3) Re-assess the resident for risk of entrapment from siderails for one (Resident #26) of a total of 50 residents sampled. The findings include: On 03/25/24 at 2:25 p.m., Resident #26 was observed in bed. Her bed was in low position with floor mats on both sides of the bed. She also had a scoop mattress and half siderails that were padded. She had crossed her left leg over her right leg and was resting it on the right siderail. An attempt to speak with the resident was unsuccessful due to confusion. In an interview with Licensed Practical Nurse (LPN) G on 03/25/24 at 2: 30 pm in Resident #26's room, LPN G stated the resident understood minimal English. She added that the resident spoke French, but at times the family stated even her French did not make sense. LPN G was asked if the resident was at risk for falls and she replied, yes. She added that the resident had climbed over the siderail and had multiple falls. On 03/26/24 at 9:44 am, Resident #26 was observed in bed, lying on her back with her eyes closed. Her bed was in low position with padded half siderails and fall mats on both sides of the bed. On 03/27/24 at 11:19 am, the resident was observed in bed, lying on her back with her eyes closed. Her bed was in low position with padded half siderails and fall mats on both sides of the bed. A review of the resident's medical record revealed that Resident #26 was admitted to the facility on [DATE] with a re-entry on 03/21/2024. Her diagnoses included dementia with anxiety; vascular dementia, severe with anxiety; severe protein-calorie malnutrition; adult failure to thrive; generalized anxiety disorder; dependence on a wheelchair; cognitive/communication deficit; restlessness and agitation, atrial fibrillation; weakness, hypertension, pain, major depressive disorder, and insomnia. Her physician's orders included the following: 01/27/2023 - Half side rails x2 may be be up for enhanced independence and mobility. Monitor behavior for anxiety. 04/03/2023 - Sertraline 50 mg (milligrams) one time a day for depression 11/22/2023 - Trazadone 150 mg, give 0.5 tablet two times a day for major depressive disorder and insomnia 08/30/2023 - Lorazepam 1 mg two times a day for anxiety (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/20/2024 - Lorazepam 0.5 mg every 8 hours as needed for anxiety 03/21/2024 - Safety equipment: padded side rails related to poor safety awareness. 03/21/2024 - Safety check to be conducted every hour related to recent fall, every hour x 7 days. A facility note dated 02/26/24 read, Further investigation on discolored area, resident was noted with anticoagulants in place and recent incidents noted of resident grabbing side rails and pulling on them , scooting self closer to them. A review of the resident's care plan, last revised on 03/21/24, revealed that the resident was at Risk for Falls related to requiring assistance with transfers and toileting, impaired balance, cognitive deficit, restlessness, and resident climbs out of bed. The resident had an Activities of daily Living (ADL) Self-Care Performance Deficit related to weakness, poor endurance, activity intolerance and impaired balance. Interventions included Two half siderails may be up for enhanced mobility. Geri chair as needed for positioning and comfort. Requires assistance x 2 for turning and repositioning and transfers. Resident has impaired cognition and decision-making skills related to a diagnosis of dementia and has a Determination of Incapacity (DOI) on file. A review of the Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/09/24, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of a possible 15 points, indicating severe cognitive impairment. In an interview on 03/27/24 at 12:50 pm, the Director of Nursing (DON) stated siderail assessments were done on admission and as needed. Staff should obtain consent from residents' families for residents who were unable to give consent. In an interview on 03/27/24 at 1:31 pm, the Director of Rehabilitation (DOR) stated physical Therapy (PT) as well as Nursing could conduct siderail assessments and make recommendations. When asked about Resident #26's functional status, the DOR stated the resident required maximum assistance for bed mobility and transfers. He added that the resident was on caseload for PT, occupational therapy (OT) and speech therapy (ST). When asked if his department had made any siderail recommendations for this resident, he said, As far as I can recall, my department has not made any recommendation for siderails. The resident is totally dependent with bed mobility and I don't think she can use the siderails for positioning. A review of the PT evaluation notes, dated 03/20/24, revealed that the resident was totally dependent with bed mobility and transfers without attempts to initiate. (Copy obtained) A review of the available Siderail/Entrapment Screenings, dated 01/27/23 and 05/16/23 revealed that the resident was confused, safety impaired, could not retain safety precautions or state her preference about siderails. The assessment noted that the resident representative requested the siderails. (Copies obtained) There was no consent obtained for siderail use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/24 at 12:30 pm, LPN E/Unit Manager confirmed that Resident #26 used half siderails for safety. She also confirmed that the resident could not release the siderails if needed. She stated she padded the siderails because the resident was climbing over the rails and was getting skin tears. When asked if the resident was assessed for the siderails, LPN E stated the DON and Assistant Director of Nursing (ADON) should have those assessments. On 03/28/24 at 1:07 pm, an interview was conducted with the Medical Director. When he was asked about the resident's siderails, he stated initially the siderails were used as enablers for positioning, but he was made aware that the resident had a functional decline and therefore, the siderail use should have been reassessed. He added, Siderails do not prevent falls and per the Centers for Medicare and Medicaid services (CMS), siderails have been found to cause injuries. He also stated the facility should not use siderails unless they are assessed for reasonable use. A review of the facility's policy and procedure titled Siderails and Restraint Reduction (6/4/2020) revealed that It is the intention of the facility for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limit restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Restraints will not be used for staff convenience. Procedures: Upon admission the admitting nurse will complete the evaluation. The initial assessment include: Observation of the resident's movement in bed and resident's ability to independently use partial siderails to assist with turning, positioning, moving up and down, exiting and entering the bed. Assess the resident's ability to follow directions for use of siderails. Interview of alert resident to identify their performance for use of partial siderails to assist with bed mobility. After evaluation of the resident, if it is determined that the use of the siderails or restraints are appropriate, the least restrictive restraint will be deemed appropriate for the individual resident to attain or maintain his or her highest practicable physical and psychological well-being. If the resident/resident representative request or the facility deems the use of siderails is appropriate for the resident, the admitting nurse or nurse responsible for the resident at the time of the determination is made will competed the siderail evaluation and obtain informed consent for use. Whenever restraint use is considered, the facility will explain to the resident and/or legal representative how the use of the restraint would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. The nurse responsible for the resident at the time of the determination is made for the restraint use will complete the Restraint Evaluation within the resident's electronic medical record. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will also explain the potential negative outcomes of restraint use which include, but are not limited to declines in resident's physical functioning (e.g. ability to ambulate) and muscle condition, delirium, agitation, and incontinence, and obtain a consent for device use. Before using a device for mobility or transfer, evaluation should include a review of the resident's bed mobility and ability to transfer between positions from bed or chair to stand and toilet. The resident will be re-evaluated for appropriate use of the least restrictive device on conjunction with the Resident Assessment Instrument. .