STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195258	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Nursing Home	1181 Hwy 19 Slaughter, LA 70777

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 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** 48537 Based on observations, interviews and record review, the facility failed to ensure residents were assessed for risk of entrapment from bed rails and obtain informed consent for bed rails for 1 (#1) of 6 (#1, #R4, #R5, #R6, #R7, and #R8) residents identified for having bed rails in use. Findings: Review of the facility's undated policy titled Bed Rails, revealed the following: Policy Interpretation and Implementation Use of Bed Rails 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes. 3. The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; 7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: (2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER: Grace Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1181 Hwy 19 Slaughter, LA 70777	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. Review of Resident #1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Dementia, and Generalized Muscle Weakness. Review of Resident #1's Quarterly MDS with an ARD of 04/02/2024 revealed the resident had a BIMS of 3, which indicated severe cognitive impairment. Review of Section GG titled Functional Abilities and Goals revealed Resident #1 required partial/moderate staff assistance for bed mobility. Review of Resident #1's Clinical Record revealed no documentation of an Entrapment Risk Assessment for bed rails. Further review revealed no documentation of a Consent for bed rails. Review of Resident #1's Nursing Notes revealed the following: 05/12/2024 at 6:15 a.m.: LATE ENTRY for 05/11/2024 at 4:30 a.m. This nurse was on MCU when S6CNA informed this nurse that Resident #1 had a skin tear to her left elbow resulting from Resident #1 holding onto the bed rail while S6CNA was turning her onto her left side during a brief change. This nurse noted that her left mid forearm to fist knuckles on that hand appeared discolored. Signed by: S5LPN Review of the facility's Incident Investigation Report dated 05/13/2024 at 10:00 a.m. revealed the following: Statement from Staff Involved: Resident #1's left arm got caught under the bed rail on the bed during a turn. S6CNA did not realize it was there until she saw a skin tear. S6CNA reported the skin tear to S5LPN. S6CNA stated Resident #1 was in bed against the wall on her left side when she went to turn and clean the resident. S6CNA stated she turned her to the left side, she did not realize the left arm was under the hand grip. Signed by: S3ADON Review of Resident #1's Skin and Wound Report dated 05/13/2024 revealed the following: Wound #1 Type of Wound: Bruise Location: Left outer forearm Dimensions: 15.3 cm x 4.1 cm, Area is 18.5 cm2 Wound #2 Type of Wound: Skin tear Location: Left outer forearm Category: Category I: Linear - Linear type (full thickness): Epidermis and dermis are pulled in one layer from supporting structures. The wound is incision-like in appearance. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dimensions: 9.8 cm x 3.4 cm, Area is 20.6 cm2 Wound Bed: Bleeding, pink or red Periwound: Non-attached edges; surrounding tissue discoloration black/blue On 06/04/2024 at 1:50 p.m., an interview was conducted with S8TN. She stated she assessed Resident #1 on 05/13/2024 after she was notified by S3ADON of a new skin tear to her left elbow and bruising to the left hand and arm. She confirmed Resident #1 did have a skin tear to the left elbow and bruising to the left hand and arm. On 06/05/2024 at 8:32 a.m., an interview was conducted with S6CNA. She stated she went to Resident #1's room around 4:00 a.m. on 05/11/2024 to change Resident #1's brief. She stated Resident #1 had assist bars on her bed. She stated Resident #1's bed was pushed against the wall on the left side with the assist bar attached to the left side of the bed against the wall. She stated Resident #1 was lying on the left side of the bed near the wall and assist bar. She stated when she went to roll Resident #1 to the right side to complete the brief change, Resident #1's left arm was caught on the assist bar and she had a skin tear to her left elbow. On 06/05/2024 at 9:13 a.m., an interview was conducted with S5LPN. She stated she was notified by S6CNA around 4:30 a.m. on 05/11/2024 that Resident #1 had sustained a skin tear to her left elbow during her brief change. She stated her left arm was caught and her hand was holding on to the assist bar during the turn. She stated she noticed some bruising to Resident #1's left arm. She stated the assist bars were always on Resident #1's bed. On 06/05/2024 at 11:29 a.m., a telephone interview was conducted with S4RNS. She stated she called S6CNA on 05/11/2024 when it was reported to her Resident #1 had bruising to her left hand, arm and shoulder and a skin tear to the left elbow. S4RNS stated S6CNA was in the room changing Resident #1's brief on 05/11/2023 around 4:00 a.m. or 4:30 a.m. S4RNS stated S6CNA when she was turning her over to her right side, Resident #1's left arm had become tangled in the assist bar on the left side of the bed and caused a skin tear to Resident #1's left elbow. On 06/05/2024 at 12:12 p.m., an interview was conducted with S3ADON. He stated the facility does not use bed rails, but did use hand grab assist bars for residents. He stated a bed rail was a railing affixed to the side of the bed that can be moved up and down and is half the length or full length of the bed. He stated there was no formal entrapment assessment, consent, or monitoring for residents who use the assist bars. On 06/05/2024 at 11:10 a.m., an observation was made of an assist bar attached to a bed on the MCU. The assist bar measured 8 inches wide by 15 inches tall and had two metal rungs in the middle length wise which created three openings 6 inches wide by 4.5 inches tall between the metal rungs of the bar. On 06/05/2024 at 11:05 a.m., an interview was conducted with S7MDS. She stated the facility did not use bed rails. She confirmed there was no consents or entrapment risk assessments performed prior to installation of the assist bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2024 at 12:49 p.m., an interview was conducted with S2DON. He stated the facility did used assist bars or hand grabs on resident beds if requested by family and/or staff, as was the case with Resident #1. He stated since the assist bars are put in place by family request, he was not sure if any other interventions had been put into place prior to installation of the assist bar for Resident #1. He stated there was no resident risk assessment completed prior to use of the assist bars. He stated there is no consent completed and signed prior to use of the assist bars. He stated the facility only used one type of assist bars on the resident beds. He confirmed the observed assist bar on a resident bed in the MCU was the assist bar used in the facility. On 06/05/2024 at 1:05 p.m., an interview was conducted with S1ADM. He stated bed rails were a risk for entrapment. He stated the facility used assist bars.