

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Springhill Post Acute & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 215 First Street N E Springhill, LA 71075	

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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>Based on record review and interviews the facility failed to ensure MDS (Minimum Data Set) assessments were completed and transmitted within the specified time frames for 3 (#1, #5, #12) of 26 sampled residents. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. An annual assessment had been completed for Resident #1. 2. A discharge assessment had been completed for Resident #5. 3. An entry assessment had been transmitted for Resident #12. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included, in part, cerebral infarction unspecified, metabolic encephalopathy, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, schizophreniform disorder, bipolar disorder, generalized anxiety disorder, and depression.</p> <p>Review of Resident #1's medical record revealed the following Accepted MDS assessments, in part:</p> <p>12/19/2023 Admission/Medicare-5 day MDS</p> <p>12/12/2023 Entry MDS</p> <p>Further review failed to reveal an annual MDS assessment had been completed and submitted within the specified timeframe.</p> <p>During an interview on 01/15/2025 at 9:01 a.m. S3 MDS Coordinator reviewed Resident #1's MDS assessments and reported the 12/11/2024 MDS assessment was completed and transmitted as a quarterly MDS and should have been completed and transmitted as an annual MDS assessment.</p> <ol style="list-style-type: none"> 2. <p>(continued on next page)</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's medical record revealed an initial admitted [DATE], and admission (reentry) date of 08/23/2024 and a discharge date of [DATE] with diagnoses that included, in part, cerebrovascular disease, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #5's progress notes revealed a note dated 09/02/2024 at 11:10 a.m.: Resident discharged home. All meds and personal belongings sent with resident. Condition stable.</p> <p>Review of Resident #5's medical record revealed the following Accepted MDS assessments, in part:</p> <p>8/23/2024 Entry MDS</p> <p>8/30/2024 Admission MDS</p> <p>Further review failed to reveal a discharge MDS assessment had been completed and transmitted.</p> <p>During an interview on 01/15/2025 at 8:59 a.m. S3 MDS Coordinator reviewed the MDS assessments and reported a discharge MDS had not been completed for Resident #5's 09/02/2024 discharge and should have been.</p> <p>3.</p> <p>Review of Resident #12's medical record revealed an initial admitted [DATE].</p> <p>Review of Resident #12's medical record revealed an Entry MDS assessment dated [DATE] was Export Ready.</p> <p>During an interview on 01/15/2025 at 8:51 a.m. S3 MDS Coordinator reported she did not transmit Resident #12's Entry MDS assessment dated [DATE] and should have.</p> <p>40015</p> <p>FACILITY</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record review and interview the facility failed to ensure a comprehensive person-centered care plan was developed for 1 (#50) of 26 sampled residents. The facility failed to ensure an activities care plan had been developed with interventions for Resident #50.</p> <p>Findings:</p> <p>Review of Resident #50's medical record revealed an initial admitted [DATE] with diagnoses that included, in part, anxiety disorder, essential (primary) hypertension, and depression.</p> <p>Review of Resident #50's 12/02/2024 Quarterly MDS (Minimum Data Set) revealed Resident #50 had a BIMS (Brief Interview Mental Status) score of 15, which indicated Resident #50 was cognitively intact.</p> <p>Review of Resident #50's 09/09/2024 Admission MDS, Section F-Preferences for Customary Routine and Activities revealed, in part:</p> <ul style="list-style-type: none"> -It was very important to listen to music Resident #50 likes. -It was somewhat important for Resident #50 to have books, newspapers, and magazines to read. -It was somewhat important for Resident #50 to go outside and get fresh air when the weather is good. <p>Review of Resident #50's care plan failed to reveal and activities care plan with interventions had been developed.</p> <p>During an interview on 01/15/2024 at 11:42 a.m. S3 MDS Coordinator reviewed Resident #50's care plan and confirmed Resident #50 did not have a care plan for activities and should have.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>Based on record review, observation, and interviews, the facility failed to ensure a resident received proper treatment to maintain and/or improve hearing for 1 (#12) of 1 (#12) residents reviewed for communication and sensory problems.</p> <p>Findings:</p> <p>Review of Resident #12's record revealed an initial admitted [DATE] and diagnoses including: unspecified abnormalities of gait and mobility; unspecified glaucoma; and impacted cerumen (earwax), unspecified ear.</p> <p>Review of Resident #12's physician order dated 11/04/2024 revealed an order for a referral by the ENT (Ear, Nose, and Throat doctor) for an audiogram (a hearing test).</p> <p>Review of Resident #12's care plan failed to reveal a care plan for hearing impairment.</p> <p>Review of Resident #12's medical record failed to reveal an appointment was scheduled for an audiogram.</p> <p>During an interview on 01/13/2025 at 02:12 p.m. Resident #12 reported she had increased hearing loss. Resident #12 further reported she was supposed to see a doctor about her hearing loss, but did not believe an appointment was ever made. Resident #12 reported in November of 2024 the ENT doctor told her she may have nerve damage in her ear. Resident #12 was waiting on an appointment because her hearing just keeps getting worse.</p> <p>An observation on 01/13/2025 at 2:12 p.m. revealed the surveyor had to speak loudly during the interview with Resident #12.</p> <p>During an interview on 01/15/2025 at 2:41 p.m. S2 DON (Director of Nursing) reported Resident #12 did not have a care plan for hearing impairment.</p> <p>During an interview on 01/15/2025 at 9:43 a.m. S13 LPN (Licensed Practical Nurse) reviewed Resident #12's medical record and reported Resident #12 had an appointment with an ENT doctor for ear wax removal on 10/14/2024 and further reported there was a referral for Resident #12 to have an audiogram. S13 LPN reported S14 Transportation CNA (Certified Nursing Assistant) was responsible for appointments.</p> <p>During an interview on 01/15/2025 at 12:20 p.m. S14 Transportation CNA reported she was responsible for follow-ups with referrals and transporting residents to their appointments. S14 Transportation CNA reported Resident #12 was transported to the local ENT doctor on 11/04/2024 and the ENT doctor referred Resident #12 to see an Audiologist. S14 Transportation CNA reported she failed to follow up with the referral and did not have a method to keep up with who had completed referrals.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident's environment remained free of accident hazards. The facility failed to ensure a resident's TV (television) was positioned in a secure manner for 1 (#12) of 4 (#4, #12, #23, #25) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of Resident #12's record revealed an admitted [DATE] and diagnoses including: Unspecified abnormalities of gait and mobility, muscle weakness, unspecified glaucoma, repeated falls and lack of coordination.</p> <p>Review of Resident #12's Quarterly MDS (Minimum Data Set) dated 12/24/2024 revealed the resident had severe impaired vision.</p> <p>An observation on 01/13/2025 at 1:56 p.m. revealed Resident #12's TV was positioned in a manner of which not all 4 legs were positioned on the nightstand.</p> <p>An observation on 01/15/2025 at 10:55 a.m. with S6 CNA (Certified Nursing Assistant) revealed Resident #12's TV was positioned on the nightstand with one of the 4 legs hanging off of the nightstand and another leg only halfway on the nightstand.</p> <p>During an interview on 01/15/2025 at 10:55 a.m. S6 CNA examined how Resident #12's TV was positioned on the nightstand and acknowledged the TV was not positioned in a secure manner and was unstable. S6CNA confirmed Resident #12 was visually impaired and could easily bump into the TV knocking it over.</p> <p>During an observation on 01/15/2025 at 1:40 p.m. Resident #12's TV remained positioned in an unstable manner, with one leg off and another leg halfway off of the nightstand.</p> <p>During an interview on 01/15/2025 at 1:40 p.m. S2 DON (Director of Nursing) and S7Maintenance Supervisor acknowledged the TV was unstable on the nightstand.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921</p> <p>Based on record reviews, observations and interviews, the facility failed to ensure correct use and maintenance of bed rails for 7 (#1, #4, #24, #25, #42, #48, #49) of 7 (#1, #4, #24, #25, #42, #48, #49) residents reviewed for the use of bed rails. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Residents #1, #4, #24, #25, #42, #48, and #49 were assessed for the risk of entrapment prior to the use of bed rails, less restrictive approaches were attempted prior to the use of bed rails, ongoing assessments for the risk of entrapment were conducted after bed rail installation, and residents were care planned with specific interventions for the use of bed rails, and; 2. Bed rails were securely attached to the bed for resident # 4, and #25. <p>Findings:</p> <p>Review of the facility's Bed Rails policy (undated) revealed in part:</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. The facility will use appropriate alternatives prior to installing a side or bed rail. 2. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including, but not limited to the following elements: <ol style="list-style-type: none"> a. Assess the resident for risk of entrapment from bed rails prior to installation f. Regularly inspect bed rails to ensure they have not become stiff or loosened over time. 3. If after a facility has attempted alternatives to bed rails and determined that these alternatives do not meet the resident's needs, the facility will assess the resident for the risks of entrapment and possible benefits of bed rails. In determining whether to use bed rails to meet the needs of a resident, the following components of the resident assessment should be considered including, but no limited to: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, size and weight, sleep habits, medications, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication, mobility (in and out of bed), risk of falling 4. In addition, the resident assessment must include an evaluation of the alternatives to the use of a bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. Possible alternatives include, but are not limited to foam bolsters, low bed, concave mattress. <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. The facility will conduct routine preventive maintenance of beds and bed rails according to manufacturer's recommendations and specifications to ensure they meet current safety standards and are not in need of repair.</p> <p>7. The facility will conduct ongoing assessments to evaluate risks and assure the bed rail is used to meet the resident's needs.</p> <p>8. The facility will document in the resident's care plan specific interventions and services for the use of the bed rail.</p> <p>1.</p> <p>Resident #1</p> <p>Review of Resident #1's record revealed an initial admitted [DATE] with diagnoses that included, in part: metabolic encephalopathy, unsteadiness on feet, other idiopathic peripheral autonomic schizophreniform disorder, unspecified bipolar disorder, generalized anxiety disorder, other seizures, generalized muscle weakness, unspecified altered mental status, cognitive communication deficit, and depression unspecified.</p> <p>Review of Resident #1's current physician orders revealed an order dated 11/22/2024 - may use AR (assist rail) x 1 to aid in bed mobility & define boundaries.</p> <p>Review of Resident #1's Quarterly MDS (Minimum Data Set) assessment with ARD (Assessment Reference Date) of 12/01/2024 revealed Resident #1 had a BIMS (Brief Interview for Mental Status) score of 15, indicating Resident #1 was cognitively intact. Further review of 12/01/2024 MDS revealed Resident #1 had an impairment to one side of upper and lower extremities in regard to ROM (Range of Motion).</p> <p>Review of Resident #1's State Optional MDS assessment with ARD of 11/06/2024 revealed Resident #1 required extensive assistance with bed mobility and transfers.</p> <p>Review of Resident #1's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #1's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident #1's Physical Restraint/Device Consent form indicated consent obtained from Resident #1's mother and brother on 10/26/2024, and revealed the section titled Less restrictive approaches tried and proven ineffective was left blank.</p> <p>Observation on 01/13/2025 at 11:18 a.m. revealed Resident #1 was positioned with the left side of his bed against wall (while lying on back in bed) and 1/4 bedrail up to Resident #1's right side of upper bed.</p> <p>Observation on 01/14/2025 at 1:07 p.m. revealed Resident #1 was asleep in bed with HOB (Head of Bed) up and 1/4 bed rail up x 1 to resident's right side of upper bed.</p> <p>Resident #4</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #4's record revealed an admitted [DATE] with diagnoses that included, in part: unspecified abnormalities of gait and mobility, cognitive communication deficit, other symbolic dysfunctions, abnormal posture, generalized muscle weakness, lack of coordination, repeated falls, unspecified psychosis not due to a substance or known physiological condition, and Alzheimer's disease.</p> <p>Review of Resident #4's current physician orders revealed an order dated 01/21/2024 - may use 1/2 SR x 2 (Side Rails times 2) to aid in bed mobility and define bed boundaries.</p> <p>Review of Resident #4's MDS assessments with ARD of 12/09/2024 (State Optional and Quarterly) revealed the resident had a BIMS score of 5, indicating a severe cognitive impairment. Further review revealed the resident required limited assistance with one person physical assist for bed mobility and transfers.</p> <p>Review of Resident #4's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #4's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident #4's Physical Restraint/Device Consent form signed by the resident's responsible party 10/23/2024 revealed the section titled Less restrictive approaches tried and proven ineffective was left blank.</p> <p>Resident #24</p> <p>Review of Resident # 24's record revealed an admitted [DATE] with diagnoses that included, in part: muscle weakness, metabolic encephalopathy, and sequelae of cerebral infarction.</p> <p>Review of Resident # 24's current Physician Orders revealed an order dated 11/22/2024 - may use 1/2 side rail to aid in bed mobility and define bed boundaries.</p> <p>Review of Resident #24's Quarterly MDS revealed a BIMS was not done due to Resident #24 is rarely/never understood. Further review revealed Resident #24 required extensive assistance with one person physical assistance.</p> <p>Review of Resident #24's comprehensive care plan revealed no specific focus/interventions or services for the use of bed rails per facility policy.</p> <p>Review of Resident #24's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident # 24's Physical Restraint/Device Consent for 1/2 side rails times 2 signed by Resident #24's family member on 11/23/2024 revealed the section titled less restrictive approaches tried and proven effective was blank.</p> <p>Observation on 1/13/2025 at 1:31 P.M. revealed Resident #24 sitting in day area in a wheel chair.</p> <p>Observation of Resident #24's room on 1/13/2025 at 1:31 p.m. revealed Resident #24 had 1/2 side rails in raised position on each side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/13/2025 at 10:00 p.m S15 CNA confirmed side rails were used when Resident # 24 was in bed.</p> <p>Resident #25</p> <p>Review of Resident #25's record revealed an admitted [DATE] and diagnoses that included, in part: anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, generalized muscle weakness, unspecified abnormalities of gait and mobility, and Alzheimer's disease.</p> <p>Review of Resident #25's current physician orders revealed an order dated 11/21/2024 - May use 1/2 SR x 2 to aid in bed mobility and define bed boundaries.</p> <p>Review of Resident #25's MDS assessments with ARD of 10/21/2024 (admission) revealed the resident had a BIMS score of 4, indicating a severe cognitive impairment. Further review revealed the resident required extensive assistance with 2 plus persons physical assist for bed mobility and transfers.</p> <p>Review of Resident #25's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #24's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident #25's Physical Restraint/Device Consent form signed by the resident's responsible party 10/23/2024 revealed the section titled Less restrictive approaches tried and proven ineffective was left blank.</p> <p>Resident #42</p> <p>Review of Resident #42's record revealed an initial admitted [DATE] with diagnoses that included, in part: vascular dementia unspecified severity with agitation, postural orthostatic tachycardia syndrome [POTS], unspecified anxiety disorder, unspecified depression, essential (primary) hypertension, and generalized muscle weakness.</p> <p>Review of Resident #42's current physician orders revealed an order dated 11/21/2024 - may use 1/2 SR X1 to aid in bed mobility and define bed boundaries.</p> <p>Review of Resident #42's MDS assessments with ARD of 11/06/2024 (State Optional and Quarterly) revealed Resident #42's BIMS was not conducted as Resident #42 rarely /never understood. Further review revealed Resident #42 required extensive assistance with bed mobility and transfers.</p> <p>Review of Resident #42's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #42's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident #42's Physical Restraint/Device Consent form indicated consent obtained from Resident #42's son on 10/26/2024, and revealed the section titled Less restrictive approaches tried and proven ineffective was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/13/2025 at 11:18 a.m. revealed Resident #42 was in bed with HOB slightly elevated and bed against wall on Resident #42's left side, and upper 1/4 bed rail up on Resident #42's right side.</p> <p>Resident #48</p> <p>Review of Resident #48's record revealed an initial admitted [DATE] with diagnoses that included, in part: malignant neoplasm of retroperitoneum, lumbago with sciatica unspecified side, other osteoporosis without current pathological fracture, other idiopathic peripheral autonomic neuropathy, and unspecified depression.</p> <p>Review of Resident #48's physician orders revealed an order dated 01/14/2025 - may use 1/2 SR X2 to aid in bed mobility and define bed parameters.</p> <p>Review of Resident #48's MDS assessments with ARD of 10/30/2024 (State Optional and Significant Change) revealed Resident #48 had a BIMS score of 09, which indicated a moderate cognitive impairment. Further review of MDS revealed Resident #48 had an impairment to one side of upper and lower extremities in regard to ROM and required extensive assistance with bed mobility and transfers.</p> <p>Review of Resident #48's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #48's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident #48's Physical Restraint/Device Consent form indicated consent obtained from Resident #48's daughter on 11/05/2024, and revealed the section titled Less restrictive approaches tried and proven ineffective was left blank.</p> <p>Observation on 01/13/2025 at 11:21 a.m. revealed Resident #48 lying on back in bed with HOB elevated and 1/4 bed rails up on each side of upper bed.</p> <p>Observation on 01/14/2024 at 1:14 p.m. revealed Resident #48 lying in bed on back with 1/4 bed rails up on each side of upper bed.</p> <p>Resident #49</p> <p>Review of Resident # 49's record revealed an admitted [DATE] and diagnoses that included, in part: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of Resident #49's current Physician Orders revealed an order dated 12/31/2024 - may have 1/2 side rails to aid in bed mobility and define bed parameters every shift.</p> <p>Review of Resident #49's Quarterly MDS dated [DATE] revealed a BIMS of 6 which indicated a severe cognitive impairment. Further review revealed the resident required limited assistance with one person physical assist for bed mobility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Springhill Post Acute & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 215 First Street N E Springhill, LA 71075	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #49's Comprehensive Care Plan revealed no specific interventions or services for the use of the bed rails per facility policy.</p> <p>Review of Resident #49's record failed to reveal any assessments for risk for entrapment.</p> <p>Review of Resident # 49's Physical Restraint/Device Consent for 1/2 side rails x 2 signed by the resident's family member on 10/24/2024 revealed the section titled less restrictive approaches tried and proven effective was blank.</p> <p>Observation on 1/13/2025 at 3:20 p.m. revealed Resident #49 sitting in day area in a wheel chair.</p> <p>Observation on 1/13/2025 at 3:20 p.m. revealed Resident #49 had 1/2 side rails in raised position on each side of the bed.</p> <p>During an interview on 01/15/2025 at 1:48 p.m., S2 DON (Director of Nursing) reported there were no documented initial or ongoing resident assessments for the risk of entrapment or less restrictive approaches attempted prior to the use of bed rails for Residents #1, #4, #24, #25, #42, #48, and #49 and there should be. S2 DON further confirmed the residents were not care planned with specific interventions for the use of bed rails and should have been.</p> <p>2.</p> <p>Resident #4</p> <p>Observation on 01/13/25 at 9:50 a.m. Resident #4 in room seated in her wheelchair. Resident #4's bed was positioned with the left side up against the wall, and 1/2 metal bed rail to right side of bed in raised position-fits bed, but not firmly attached-moves freely back and forth parallel to bed.</p> <p>Observation on 01/14/2025 at 2:18 p.m. revealed Resident #4 lying in bed with eyes closed, 1/2 metal bed rail to right side of bed in lowered position, but still loose.</p> <p>Observation on 01/14/2025 at 9:30 a.m. revealed Resident #4 up in wheelchair. The 1/2 metal bed rail to right side of bed was in the lowered position, but still loose.</p> <p>During an interview on 01/14/2025 at 9:50 a.m. S10 CNA reported she was familiar with Resident #4. S10 CNA reported Resident #4 used the bed rail on her bed for positioning and mobility when she was in bed, and they were lowered when she got out of bed. S10 CNA observed the right rail on Resident #4's bed and confirmed it was loose and needed to be tightened. S10 CNA tried to turn the knob that adjusts the rail and said it was as tight as it would go.</p> <p>Resident #25</p> <p>Observation on 01/13/2025 at 10:00 a.m. Resident #25 lying in bed. Further observation revealed bilateral 1/2 metal bed rails affixed to the upper half of Resident #25's bed in the raised position. The rails were not firmly attached and moved freely back and forth.</p> <p>During an interview on 01/13/2025 at 10:00 a.m., Resident #25 reported she used the rails to assist with positioning when staff turn her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Springhill Post Acute & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 215 First Street N E Springhill, LA 71075	

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/14/2025 at 10:50 a.m. revealed S8 CNA performing incontinence and catheter care for Resident #25 assisted by S9 CNA. Resident #25 was observed to be use bilateral bed rails to assist with positioning during the incontinence care. Both bed rails were observed to be loose and freely moveable back and forth and side to side.</p> <p>During an interview on 01/14/2025 at 10:51 a.m. S9 CNA confirmed the right bed rail attached to the upper half of Resident #25's bed moved freely back and forth and side to side, and needed to be tightened.</p> <p>During an interview on 01/14/2025 at 10:52 a.m. S8 CNA confirmed the left bed rail attached to the upper half of Resident #25's bed moved freely back and forth and side to side, and needed to be tightened.</p> <p>Observation on 01/15/2025 at 9:00 a.m., revealed bilateral 1/2 metal bed rails affixed to Resident #25's bed in the raised position. Both bed rails were observed to be loose and freely moveable back and forth and side to side.</p> <p>During an interview on 01/15/2025 at 3:20 p.m., S7 Maintenance viewed Resident #4 and #25's bed rails with the surveyor and confirmed they were loose and needed to be tightened.</p> <p>37867</p> <p>40015</p>