

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4820 Medical Drive Bossier City, LA 71112	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45317</p> <p>Based on record review and interview the facility failed to ensure 1 (#87) of 5 (#9, #10, #30, #87, #317) residents reviewed for unnecessary medications were informed of the risks, benefits, and side effects of an antipsychotic medication prior to the start of the medication.</p> <p>Findings:</p> <p>Review of Resident #87's medical record revealed in part an admitted [DATE] with diagnoses including, but not limited to, dementia with psychotic disturbance and major depressive disorder.</p> <p>Review of Resident #87's Quarterly MDS (Minimum Data Set) dated 09/18/2024 revealed a BIMS (Brief Interview for Mental Status) of 11 indicating moderately impaired cognition. Further review of Resident #87's Quarterly MDS dated [DATE] revealed Resident #87 was taking an antipsychotic medication on a routine basis.</p> <p>Review of Resident #87's physician's orders revealed in part an order dated 09/03/2024 for Aripiprazole 2mg (milligram) by mouth every day.</p> <p>Review of Resident #87's electronic medication administration record for the month of September 2024 revealed Resident #87 received Aripiprazole as ordered.</p> <p>Review of Resident #87's medical record failed to reveal documentation Resident #87 or Resident #87's representative were informed of the risks, benefits, side effects and possible alternative treatment of an antipsychotic medication prior to the start of the medication.</p> <p>During an interview on 10/08/2024 at 11:13 a.m. S3 DON reported the facility did not have any documentation to confirm Resident #87 or Resident #87's representative had been informed of risk, benefits, side effects and possible alternative treatments of an antipsychotic medication.</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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>30115</p> <p>Based on observations and interview the facility failed to ensure the most recent survey results were posted in a place readily accessible to the residents, family or visitors to review.</p> <p>Findings:</p> <p>Review of Resident #22's Quarterly MDS (Minimum Data Sets) dated 10/02/2024 had a BIMS (Brief Interview of Mental Status) of 15 indicating intact cognition.</p> <p>An observation on 10/06/2024 at 10:00 a.m. failed to reveal the most recent survey results were posted in a place that was readily accessible for review.</p> <p>During an interview on 10/08/2024 at 12:30 p.m. Resident Council President, Resident #22 reported she did not see the survey results. Resident #22 further reported she did not know where the survey results were posted and was not aware she could read the past survey results.</p> <p>During an interview on 10/08/2024 at 2:15 p.m. S2 Corporate Nurse confirmed the survey results were not posted in a conspicuous place for residents, visitors and family to find.</p> <p>30669</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39897</p> <p>Based on observation, record review, and interview, the facility failed to ensure that a resident was free from physical restraints imposed for purposes of discipline or convenience for 1 (#74) of 1 (#74) residents investigated for restraints. The facility failed to ensure: 1) Resident #74 had a written consent for a self-releasing seatbelt, pommel cushion, scoop mattress and side rails and was able to intentionally remove those items in the same manner as they were applied by the staff, 2) a physician's order was in place for the use of restraints.</p> <p>Findings:</p> <p>Review of the facility's Restraint/Device Policy last revised 10/2022 revealed in part:</p> <p>Restraints and Safety Devices:</p> <p>It is the philosophy of this facility that a resident has the right to be free from any physical or chemical restraints not required to treat the residents medical symptoms. Restraints may not be used for the convenience of the nursing staff or as punishment to the resident.</p> <p>Physical Restraint Definition:</p> <p>Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove, restricts freedom of movement or normal access to one's body.</p> <p>Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This is not determined by a type of device or method, but can only be determined on an individual basis by evaluating the effect it has on the resident. Do Not focus on the type, intent, or the reason behind the use to determine if it should be classified as a restraint, focus on the effect. The Restraint Device Worksheet helps to make the determination of whether the device is a restraint or not. If it is determined not to be a restraint, it is a device. If the device being used could be considered a restraint, the Device/Physical Restraint Consent shall be completed.</p> <p>Residents with new restraints must be reviewed weekly at the High Risk Management meeting until stable and reviewed monthly thereafter. Re-evaluate resident at least quarterly for possible restraint reduction.</p> <p>The facility must attempt to use appropriate alternatives prior to installing a side rail. If used, the facility must assess the resident of risk of entrapment, review the risks and benefits with the resident or resident representative, obtain informed consent prior to installation, ensure bed dimensions are appropriate for the resident's size and weight, and follow manufacturer's directions for installing and maintaining side rails.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Restrained residents must be observed at least every 30 minutes. Restraints must be released at least every 2 hours, and the resident exercised, toileted, or repositioned.</p> <p>Review of Resident #74's medical record revealed an admitted [DATE] with diagnoses that include in part, spastic quadriplegic cerebral palsy, moderate intellectual disabilities, aphasia, major depressive disorder, bipolar disorder, mood affective disorder, and anxiety.</p> <p>Review of Resident #74's physician's orders failed to reveal an order for the use of device/restraints: seatbelt, scoop mattress, side rails and/or pommel cushion.</p> <p>Review of Resident #74's medical record failed to reveal a consent for use of Restraint/Device with risk and benefits discussed with Resident #74 or Resident #74's legal representative.</p> <p>Review of Resident #74's comprehensive care plan revealed in part the following risks/problems and interventions: current safety devices and special equipment initiated 08/29/2024: Anti roll back device, low bed with scoop mattress, seat belt with chest straps, side rails x 2, and wheelchair.</p> <p>Multiple observations during this survey 10/06/2024 through 10/09/2024 revealed Resident #74 sitting in her wheelchair with harness seatbelt and pommel cushion in use. Further observations revealed scoop mattress in place to Resident #74's bed with bed rails in use.</p> <p>During an interview on 10/09/2024 at 9:12 a.m. S2 Corporate Nurse reported when the Restraint/Positioning Device Worksheet was originally done the staff were answering the questions wrong and limiting the choices between restraints or devices. The facility did not consider the seatbelt, pommel cushion or side rails to be a restraint, but considered them a device and a device did not require a physician's order. S2 Corporate Nurse further reported the seatbelt was easy to remove, and was for Resident #74's safety and used as a device. S2 Corporate Nurse acknowledged Resident #74 could not remove the seatbelt herself.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39897</p> <p>Based on record review and interview, the facility failed to accurately assess the residents discharge status for 1 (#116) of 1 (#116) resident reviewed for resident assessments out of a total sample of 31 residents.</p> <p>Findings:</p> <p>Review of Resident #116's medical record revealed an admitted [DATE] and discharge date of [DATE] with diagnoses that included in part, aftercare following joint replacement surgery, and presence of right artificial knee joint.</p> <p>Review of Resident #116's nurses' notes revealed in part, on 07/15/2024 at 2:12 p.m. Resident #116 was discharged home today. Left per family vehicle with family.</p> <p>Review of Resident #116's discharge data collection form dated 07/16/2024 revealed in part, resident is being discharged to Home/Community. Type of discharge: unplanned.</p> <p>Additional Information: Resident discharged per self from facility, sister picked up, left with wheelchair that he brought with him on admit. He stated he just wanted to be home. Left with sister in private vehicle.</p> <p>Review of Resident #116's Discharge Minimum Data Set (MDS) dated [DATE] revealed in part, Section A: Identification Information: Discharge-return not anticipated. Planned .</p> <p>discharged to Short-term General hospital (acute hospital).</p> <p>During an interview on 10/07/2024 at 3:55 p.m. S6 MDS Coordinator acknowledged the discharge MDS was incorrect.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30115</p> <p>Based on record review, observation and interviews the facility failed to ensure residents who were unable to complete their ADL (Activities of Daily Living) received the necessary services to maintain proper grooming for 2 (#20 and #104) of 3 (#20, #36, #104) residents reviewed for ADLs. The facility failed to ensure Resident #20 and #104 received nail care.</p> <p>Findings:</p> <p>Nail Care Policy:</p> <p>Purpose - To promote cleanliness, safety and a neat appearance and to observe skin condition on fingers and toes.</p> <p>Procedure -</p> <ol style="list-style-type: none"> <li>1. Perform hand hygiene.</li> <li>4. Soak the resident's hand and feet in a basin of warm water for 10-15 minutes before trimming or trim following a bath.</li> <li>7. Remove any debris from under the nails with the orangewood stick.</li> </ol> <p>Resident #20</p> <p>Review of Resident #20's medical record revealed the following medical diagnoses including, but not limited to, type 2 diabetes mellitus, muscle wasting and atrophy, and fibromyalgia.</p> <p>Review of Resident #20's Quarterly MDS (Minimum Data Sets) dated 09/18/2024 revealed a BIMS (Brief Interview of Mental Status) of 13 indicating intact cognition.</p> <p>Review of Resident #20's care plan dated 12/26/2023 revealed the following, but not limited to, needs assist x 1-2 staff with all ADLs.</p> <p>During an observation on 10/08/2024 at 8:27 a.m. Resident #20 had brown debris under the nail beds.</p> <p>During an interview on 10/08/2024 at 8:29 a.m. Resident #20 reported she just got back from her morning shower. When asked if the staff cleaned under her fingernails, she reported no.</p> <p>During an interview on 10/08/2024 at 4:07 p.m. S7 LPN (Licensed Practical Nurse) confirmed Resident #20's fingernails were dirty with brown debris under the nail beds and needed to be cleaned.</p> <p>Resident #104</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #104's MDS dated [DATE] revealed a BIMS score of 3 indicating severely impaired cognition.</p> <p>Review of Resident #104's care plan revealed the following including, but not limited to, needs assistance with ADLs, assist with ADLs as needed.</p> <p>An observation on 10/06/2024 at 2:04 p.m. revealed Resident #104's fingernails were long and yellow with brown debris under the nail beds.</p> <p>An observation on 10/08/2024 at 8:12 a.m. revealed Resident #104's fingernails were long and yellow with brown debris under the nail beds.</p> <p>During an interview on 10/08/2024 at 4:05 p.m. S7 LPN confirmed Resident #104's fingernails were dirty with brown debris under the nail beds and needed to be trimmed and cleaned.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30115</p> <p>30669</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure correct use and maintenance of bed rails by ensuring residents were accurately assessed for the risk of entrapment from bed rails and an informed consent was obtained from resident or resident representative prior to installation for 15 (#10, #18, #20, #24, #30, #36, #51, #53, #57, #66, #75, #96, #101, #104, #106) out of 17 (#10, #18, #20, #24, #30, #36, #51, #53, #57, #66, #75, #96, #101, #104, #106, #167, #367) residents reviewed for bed rails.</p> <p>Findings:</p> <p>Resident #10</p> <p>Review of Resident #10's medical record revealed a readmitted date of 03/21/2024 with diagnoses including the following, but not limited to, cerebral ischemia, long term use of insulin, presence of right artificial shoulder joint, long term use of aspirin, type 2 diabetes mellitus, and hemiplegia.</p> <p>Review of Resident #10's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>Review of Resident #10's Quarterly MDS (Minimum Data Sets) dated 07/24/2024 revealed a BIMS (Brief Interview of Mental Status) of 15 indicating intact cognition.</p> <p>An observation on 10/06/2024 at 4:00 p.m. revealed Resident #10 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/07/2024 at 2:15 p.m. revealed Resident #10 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/08/2024 at 7:55 a.m. revealed Resident #10 in bed eating breakfast with the bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #18</p> <p>Review of Resident #18's medical record revealed an admitted [DATE] with the following diagnoses including, but not limited to, adult failure to thrive, muscle weakness, lack of coordination, unspecified dementia, and major depressive disorder.</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 #18's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>Review of Resident #18's Quarterly MDS dated [DATE] revealed a BIMS of 11 indicating mildly intact cognition.</p> <p>An observation on 10/07/2024 at 8:00 a.m. revealed Resident #18 was in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/08/2024 at 8:01 a.m. revealed Resident #18 awake and alert in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #20</p> <p>Review of Resident #20's medical record revealed an admitted [DATE] with the following diagnoses including, but not limited to, atherosclerotic heart disease, muscle wasting and atrophy, fibromyalgia, type 2 diabetes mellitus,</p> <p>Review of Resident #20's Quarterly MDS dated [DATE] revealed a BIMS of 13 indicating intact cognition.</p> <p>Review of Resident #20's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/08/2024 at 8:30 a.m. revealed Resident #20's was in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #24</p> <p>Review of Resident #24's medical record revealed in part an admitted [DATE] with diagnoses including, but not limited to, end stage renal disease and dependence on renal dialysis.</p> <p>Review of Resident #24's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</p> <p>Review of Resident #24's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/2024 at 8:45 a.m. revealed Resident #24 was sitting in bed with bed rails x 2 in the raised position at head of bed.</p> <p>During an interview on 10/06/2024 at 8:45 a.m. Resident #24 reported he does not use bed rails.</p> <p>An observation on 10/08/2024 at 7:55 a.m. revealed Resident #24 was in bed with bed rails x 2 in the raised position at the head 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>Resident #30</p> <p>Review of Resident #30's medical record revealed the following diagnoses including, but not limited to, malignant neoplasm of liver, not specified as primary or secondary, unspecified convulsions, chronic obstructive pulmonary disease, Parkinsonism, peripheral vascular disease and primary osteoarthritis.</p> <p>Review of Resident #30's Quarterly MDS assessment dated [DATE] revealed a BIMS score was not given.</p> <p>Review of Resident #30's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/07/2024 at 08:30 a.m. revealed Resident #30 was in bed. Resident #30's bed had bilateral bed rails installed that did not fit the bed properly. The bed rails were in the raised positioned with gaps between the side of the bed's mattress and the bed rails. The bed rails were bent inward.</p> <p>During an interview on 10/09/2024 at 08:30 a.m. Resident #30 reported she used her bed rails to try to turn and position herself in the bed.</p> <p>Resident #36</p> <p>Review of Resident #36's medical record revealed the following diagnoses including, but not limited to, hemiplegia and hemiparesis following a non-traumatic intracerebral hemorrhage affecting his left dominant side, type 2 diabetes and muscle weakness.</p> <p>Review of Resident #36's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>Review of Resident #36's most recent MDS dated [DATE] revealed a BIMS score was not given, but documented Resident #36 was severely cognitively impaired.</p> <p>An observation on 10/07/2024 at 8:30 a.m. revealed one quarter bed rail and one assist bed rail attached to Resident #36's bed. Resident #36 was non-verbal and unable to be interviewed.</p> <p>Resident #51</p> <p>Review of Resident #51's medical record revealed an admitted [DATE] with the following diagnosis including, but not limited to, acquired absence of right leg below knee.</p> <p>Review of Resident #51's 5 day MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</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 #51's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/2024 at 9:05 a.m. revealed Resident #51 sitting in a wheelchair at the bedside. Further observation revealed a bed rail to each side of bed in raised position at the head of the bed.</p> <p>During an interview on 10/06/2024 at 9:05 a.m. Resident #51 reported using the bed rails sometimes for bed mobility.</p> <p>An observation on 10/07/2024 at 2:00 p.m. revealed Resident #51 was sitting in a wheelchair at the bedside talking with family. Further observation revealed a bed rail to each side of the bed in the raised position at the head of the bed.</p> <p>Resident #53</p> <p>Review of Resident #53's medical record revealed an admitted [DATE] with the following diagnoses including, but not limited to, Pick's disease and mixed receptive expressive language disorder.</p> <p>Review of Resident #53's 5 day admit MDS dated [DATE] revealed a staff assessment of cognitive skills with a BIMS score of 3 indicating severely impaired cognition.</p> <p>Review of Resident #53's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/24 at 8:10 a.m. revealed Resident #53 was in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/07/2024 at 2:30 p.m. revealed Resident #53 was in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/08/2024 at 8:15 a.m. revealed Resident #53 sitting up in a wheelchair at the bedside. Further observation revealed bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #57</p> <p>Review of Resident #57's medical record revealed the following diagnoses including, but not limited to, other intervertebral disc degeneration, lumbar region, other lack of coordination, and cognitive communication deficit.</p> <p>Review of Resident #57's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>Review of Resident #57's most recent MDS dated [DATE] revealed a BIMS score of 14 which indicating intact cognition.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4820 Medical Drive Bossier City, LA 71112	
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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 observations on 10/09/2024 at 08:30 a.m. revealed bilateral bed rails attached to Resident #57's bed.</p> <p>During an interview on 10/09/2024 at 9:35 a.m. Resident #57 reported she can only move her upper body and she uses the bed rails to help turn and reposition herself in bed.</p> <p>Resident #66</p> <p>Review of Resident #66's medical record revealed the following diagnoses including, but not limited to, chronic obstructive pulmonary disease with acute exacerbation, Crohn's disease, muscle wasting and atrophy.</p> <p>Review of Resident #66's MDS dated [DATE] revealed a BIMS score 13 indicating intact cognition.</p> <p>Review of Resident #66's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>During an observation on 10/07/2024 at 08:30 a.m. Resident #66 had bilateral bed rails attached to her bed.</p> <p>During an interview on 10/09/2024 at 9:00 a.m. Resident #66 reported she uses the bed rails to help position herself in the bed.</p> <p>Resident #75</p> <p>Review of Resident #75's medical record revealed an admitted [DATE] with the following diagnoses including, but not limited to, cerebral palsy, muscle weakness, moderate intellectual disabilities, spastic quadriplegic cerebral palsy, and cognitive communication disorder.</p> <p>Review of Resident #75's MDS dated [DATE] revealed a BIMS was not done due to the cognitive skills for daily decision making were severely impaired.</p> <p>Review of Resident #75's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/2024 at 2:22 p.m. revealed Resident #75 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/07/2024 at 8:00 a.m. revealed Resident #75 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #96</p> <p>Review of Resident #96's medical record revealed the following diagnoses including, but not limited to, chronic obstructive pulmonary disease, shortness of breath, major depressive disorder, other lack of coordination and pain in the right ankle.</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 #96's MDS dated [DATE] revealed a BIMS score 12 which indicates moderately impaired cognition.</p> <p>Review of Resident #96's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/07/2024 at 8:45 a.m. revealed bilateral bed rails attached to Resident #96's bed.</p> <p>During an interview 10/09/2024 at 09:00 a.m. Resident #96 reported she used her bed rails to assist her in standing and turning. Resident #96 reported the bed rail on the right side of her bed was loose and it made her feel like she was going to fall. Resident #96 reported this was the first time someone had asked her about the bed rails.</p> <p>Resident 101</p> <p>Review of Resident #101's medical record revealed an admitted [DATE] with the following diagnoses including, but not limited to, surgical aftercare following surgery of the circulatory system, atherosclerosis of native arteries of extremities with gangrene of left leg, and an open wound to the left foot.</p> <p>Review of Resident #101's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</p> <p>Review of Resident #101's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/2024 at 8:55 a.m. revealed Resident #101 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>During an interview on 10/06/2024 at 8:55 a.m., Resident #101 reported she used the bed rails sometimes to help her change positions in bed.</p> <p>An observation on 10/08/2024 at 10:00 a.m. revealed Resident #101 in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #104</p> <p>Review of Resident #104's medical record had a re-admitted [DATE] with the following diagnoses including, but not limited to, orthopedic conditions, hypertension, depression, and psychotic disorder.</p> <p>Review of Resident #104's MDS dated [DATE] revealed a BIMS of 3 indicating severely impaired cognition.</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 #104's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>An observation on 10/06/2024 at 2:08 p.m. revealed Resident #104 was in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/07/2024 at 2:34 p.m. revealed Resident #104 was awake in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>An observation on 10/08/2024 at 8:12 a.m. revealed Resident #104 awake in bed with bed rails x 2 in the raised position at the head of the bed.</p> <p>Resident #106</p> <p>Review of Resident #106's medical record revealed the following diagnoses including, but not limited to, encounter for orthopedic after care following surgical amputation, muscle weakness, diabetes type 2 and chronic kidney disease.</p> <p>Review of Resident #106's MDS dated [DATE] revealed a BIMS score of 15 which indicating intact cognition.</p> <p>Review of Resident #106's medical record failed to reveal an informed consent was obtained from the resident or the resident's representative prior to installation of the bed rails and failed to reveal an entrapment assessment had been completed.</p> <p>During an observation on 10/07/2024 at 08:30 a.m. revealed Resident #106 had bilateral bed rails attached to his bed.</p> <p>During an interview on 10/08/2024 at 3:14 p.m. S3 DON (Director of Nursing) confirmed Resident #10, #18, #20, #24, #30, #36, #51, #53, #57, #66, #75, #96, #101, #104, #106 did not have a consent for the use of bed rails.</p> <p>During an interview on 10/09/2024 at 9:55 a.m. S2 Corporate Nurse confirmed the facility did not have consents signed for the use of bedrails and resident assessments for entrapment had not been completed correctly.</p> <p>45317</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39897</p> <p>Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by 1) having dirty equipment, and food preparation items used to prepare and/or distribute resident meals in the kitchen, 2) Resident meal plates and saucers stored in an upright position, and 3) the flour scoop was left inside the flour storage container.</p> <p>Findings:</p> <p>Observation of the kitchen on 10/06/2024 at 8:00 a.m. with S4 Morning Cook, revealed the following:</p> <ol style="list-style-type: none"> <li>1) The large upright mixer was covered with crumbs and white powder.</li> <li>2) The oven/warmer had dried food spills and streaks running down the front.</li> <li>3) Resident meal plates and saucers were stored in an upright position.</li> <li>4) Plate lids on the meal serving line had food crumbs inside the covers/lids and dried food particles on the serving plates.</li> <li>5) The flour scoop left inside the flour storage container.</li> </ol> <p>During an interview on 10/06/2024 at 10:30 a.m. S5 Dietary Manager acknowledged the dirty kitchen equipment, incorrect plate storage, and storage of the flour scoop in the flour container was a problem that had to be corrected.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>45317</p> <p>Based on record reviews and interviews, the facility failed to electronically submit accurate direct care staffing information, based on payroll, to CMS (Centers for Medicare and Medicaid Services) as required.</p> <p>Findings:</p> <p>Review of the PBJ (Payroll Based Journal) Report for FY (Fiscal Year) Quarter 3 2024 (April 1 - June 30) revealed triggers for the following: One Star Staffing Rating and Excessively Low Weekend Staffing.</p> <p>Review of the Facility's weekend staffing pattern forms for FY Quarter 3 2024 (April 1 - June 30) revealed the facility provided more hours than required and failed to reveal any days in which the facility did not provide the required number of hours.</p> <p>During an interview on 10/09/2024 at 8:55 a.m. S8 Human Resources reported all information for staffing pattern forms completed were pulled directly from daily hours actually worked by nursing staff from the Cronos Payroll system which is directly linked to the facility's fingerprint time clock.</p> <p>During an interview on 10/09/2024 at 9:45 a.m. S1 Administrator reported he did not know why the facility would trigger for excessively low weekends in April through June because the facility provided more hours than required.</p>