STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195502	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Retirement Manor	2500 E. Simcoe Street Lafayette, LA 70501

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 46149 Based on record review, observations and interview, the facility failed ensure correct use and installation of bed rails to avoid the risk of entrapment. The facility failed to: 1. Identify and use appropriate alternatives prior to using bed rails; 2. Ensure appropriate dimensions of the bed based on the resident's size and weight to ensure the resident's bed frame, mattress, and bed rails were compatible prior to instillation; 3. Ensure correct installation of bed rails including adherence to manufacturer's recommendations and/or specifications for adaptive devices to prevent entrapment; 4. Adequately assess the residents' risk for entrapment and safety prior to applying modified side rails with wooden boards that were not recommended per the manufacturer; 5. Appropriately monitor and supervise residents with bed rails in place. This failed practice occurred for 5 (#1, #R1, #R2, #R3, and #R4) of 5 (#1, #R1, #R2, #R3, and #R4) residents with these modified bed rails. This deficient practice resulted in an Immediate Jeopardy on 07/28/2024 at 1:00 p.m. when Resident #1 attempted to climb over the boarded side rail and became entrapped between the air mattress and the modified boarded bed rail attached to the resident's bed. An x-ray revealed the resident sustained a left femoral neck fracture which required transfer to the local hospital. Resident #1 underwent surgery for a closed reduction and percutaneous pinning for the left femoral neck fracture. Resident #1's bed was replaced upon his return from the hospital on 07/30/2024, but there continued to be a likelihood for severe harm, injury or death for Residents #R1- #R4 whose beds were still equipped with air mattresses with wooden boards attached to the outside of bilateral bed rails. These modified boarded bed rails were attached in the middle of the bed in the horizontal position spanning one third width of the side of the bed. S1DON (Director of Nursing) and S2ADM (Administrator) were notified of an Immediate Jeopardy situation on 08/07/2024 at 1:25 p.m. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Immediate Jeopardy was removed on 08/08/2024 at 5:13 p.m., as confirmed by onsite verification through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: On 08/08/2024 , a review of the facility's policy titled, Bed Safety and Bed Rails with a revision date of 08/06/2024 read in part: 4. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks .Use of Bed Rails .4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling of the bed .6. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of failing. 7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards: Review of the Bed Rail Entrapment Risk Notification Guide and Owner's Operator and Maintenance Manual for the facility's beds read in part: Proper patient assessment, equipment selection , frequent patient monitoring, and compliance with instructions, warnings, and this Bed Rail Entrapment Risk Notification Guide is essential to reduce the risk of entrapment. Accessories have been developed in the industry to reduce the openings in existing bed systems that could cause entrapment. Any modification through the use of accessories must be used in conjunction with proper patient assessment prior to intervention .Use of other manufacturer's products in conjunction with an .homecare bed , may significantly increase the risk of entrapment; as such .does not recommend their use. Mattresses must fit bed frame and assist rails snugly to reduce the risk of entrapment. Review of Resident #1's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE]. The resident's diagnoses included Anxiety Disorder, Alzheimer's disease, Lack of Coordination, and Age Related Osteoporosis without Current Pathological Fracture. Review of Resident #1's annual MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) of 3, indicating the resident's cognition was severely impaired. Review of Resident #1's plan of care, with a target date of 09/30/2024, revealed the following in part: Resident has self-care performance deficits and requires staff supervision and/or assistance with ADLs (Activities of Daily Living) and range of motion to maintain quality of life r/t (related to) generalized weakness, impaired mobility, dx (diagnosis) of lobar pneumonia, major recurrent depressive disorder, anxiety disorder, Alzheimer's disease . intervention for bilateral assist rails to HOB (head of bed). Further review of the resident's plan of care did not include interventions for the use of the bilateral bed rails including specific direct monitoring and supervision during use of the bed rails and interventions for safety to reduce the risk for resident entrapment. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 1's EHR revealed a document, MDS Bar/Side Rail Assessment, dated 07/02/2024, with the following: Section A. Assessment: History of falls; currently using side rails for positioning or support. The facility did not document or assess the resident's cognition, size and weight, medical diagnoses, conditions, symptoms, and/or behavioral symptoms. Review of Section B. Interventions revealed no interventions had been attempted before device use. Review of Section C. Recommendations revealed bilateral assist rails were indicated to provide a sense of security. Further review of the assessment revealed the comments section read: bilateral boarded assist rails for security. Further review of Resident #1's record did not reveal any evidence of ongoing monitoring for safe use of the boarded side rails. Review of Resident #1's nursing progress notes, dated 07/28/2024 at 4:34 p.m., read in part .While sitting at desk, inform resident stated his leg was hurting. Resident did try and climb OOB (out of bed) sometime after lunch. CNA (Certified Nursing Assistant) was able to put him in w/c (wheelchair) before climbing out, but leg was in between the mattress and footboard. Resident has been sitting in w/c without s/s (signs or symptoms) of pain. Resident c/o (complaints of) LLE (left lower extremity) pain during brief change per CNA @ (at) this time. Informed S1DON . Review of Resident #1's hospital record, dated 07/28/2024, revealed in part: resident presented after a fall after he got trapped in the railings of his bed. Patient severely altered at baseline due to his dementia .Left femoral neck fracture identified. Review of the resident's hospital discharge summary dated 07/30/2024 read in part .Patient seen by Ortho team and had a closed reduction and percutaneous pinning left femoral neck fracture. Review of a witness statement written by S4CNA, dated 07/28/2024, read in part: When I got in the room and I saw him laying on his left side with his legs stuck between the side rail and mattress. I asked if he was hurting, and he said no. I then stood on the side of the bed and moved the side rail while holding his legs. I then moved his legs back on the bed. And was able to get him to sit up on the side of the bed and he stood and I assisted him in sitting in his wheelchair .I then brought him near the nurses station the rest of the day until me and my partner went to change him around 3:30 p.m. We were putting him back in the wheelchair when he started to look like he was in pain when he stood up. When we finished, were brought him back to the front and told the nurse. On 08/06/2024 at 9:26 a.m., an interview was conducted with S4CNA. She stated that she worked with Resident #1 on 07/28/2024. She went into the resident's room because she heard his bed alarm going off, and found him stuck between his mattress and the side rail of the bed. His left leg was caught under the rail and his right leg was positioned as if he was trying to climb over or get out. She then removed his legs and body from in between the side rail and mattress, stood the resident up, and placed him in the wheelchair. The resident did not complain of pain at this time. She then notified the nurse. S4CNA stated the resident had the side rails because he could have fallen out of the bed without them and they were in place for his safety. She stated that she was in-serviced on not moving a resident if they were stuck in the side rails of the bed after the incident occurred, but the facility did not train her on what to do in that situation prior to that incident. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 9:58 a.m., an interview was conducted with S1DON (Director of Nursing). She stated that the side rails on the bed had the ability to be positioned vertically or horizontally. She stated that with the facility's older beds, mattresses, like the air mattresses, required assist rails with wooden boards attached to keep the mattress in place and for the resident to be able to turn and reposition due to the height of the mattress. The rails on the older beds were not tall enough, and the resident needed the boarded bed rails to increase the height of the rails to assist with turning and repositioning. S1DON also confirmed that Resident #1 had poor condition overall, and his cognition had been that way since he was admitted . S1DON also stated Resident #1 could potentially have rolled out of bed if he did not have those boarded bed rails in place with the older bed. S1DON stated that the CNAs were in-serviced on not moving a resident if they became entrapped in the side rails of the bed after the incident with the Resident #1. However, a situation like this had never occurred and was not common so there was no specific training on what to do if a resident became entrapped in the bed rails. S1DON also stated that the CNAs and nurses ensured that the bed rails were in place and residents were safe during their rounds by direct observation. Their charting on the MARs (Medication Administration Record) and CNA task records only required that they document that the bed rails were in place as ordered. Resident #1's care plan was then reviewed with S1DON. She confirmed that the use of bilateral bed rails was an intervention for the resident, but there were no specific interventions for monitoring or safety interventions for the use of the bed rails. Resident #R1. Review of Resident # R1's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE]. The resident had diagnoses including, but not limited to, Other Genetic Related Intellectual Disability, Gastrostomy Status, and Conversion Disorder with Seizures and Convulsions. Review of Resident #R1's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) Score of 5, indicating his cognition was severely impaired. Review of Resident #R1's August 2024 physician's orders revealed an order dated 07/07/2024 that read: Bilateral Boarded Assist Rails to HOB (Head of Bed) to aide in bed mobility and positioning due to low air loss mattress. Review of Resident #R1's plan of care revealed the following in part: Resident has self- care performance deficits and requires staff supervision and/or assistance with ADL'S (Activities of Daily Living) and range of motion to maintain quality of life with an intervention for bilateral assist bars to HOB to aide bed mobility, turning/repositioning while in bed. Further review of the resident's plan of care failed to include interventions for the use the bilateral assist rails including specific direct monitoring and supervision during use of the assist rails and interventions for safety to reduce the risk for resident entrapment. Resident #R2. Review of Resident #R2's EHR revealed she was admitted to the facility on [DATE]. The resident's diagnoses included, but not limited to, Anxiety Disorder, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non Dominant Side. (continued on next page)

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	195502	A. Building B. Wing	08/08/2024

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #R2's August 2024 physician's orders revealed an order, dated 06/25/2024, read: Low air loss pressure reducing mattress on bed. An order, dated 07/07/2024, read: Bilateral Boarded Assist Rails to HOB to aide in bed mobility and positioning. Low air loss pressure reducing mattress on bed. Review of Resident #R2's plan of care revealed the following in part: Resident has Self- care performance deficits and requires staff supervision and/or assistance with ADL'S and range of motion to maintain quality of life r/t (related to) CVA (Cerebrovascular Accident) with left sided hemiplegia, flaccid left extremities, non-ambulatory . with an intervention for bilateral assist bars to HOB to aide bed mobility, turning/repositioning while in bed. Further review of the resident's plan of care revealed no interventions for the use bilateral assist rails including specific direct monitoring and supervision during use of the assist rails and interventions for safety to reduce the risk for resident entrapment. Resident #R3. Review of Resident #R3's EHR revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to: Non ST Elevation Myocardial Infarction, Unspecified Lack of Coordination, and Anxiety Disorder. Review of Resident #R3's August 2024 physician's orders revealed an order, dated 05/02/2023, and discontinued on 08/06/2024, that read: Bilateral Boarded Assist Rails to HOB to aide in bed mobility and positioning per resident request. Further review revealed an order, dated 06/24/2024, and discontinued on 08/06/2024, that read: Boards to assist rails every shift for safety. Resident #R3 also had an order, dated 06/24/2024, that read: Low air loss pressure reducing mattress on bed. Review of Resident #R3's plan of care, with an initiation date of 06/11/2024, revealed the following in part: Resident has self-care performance deficits and requires staff supervision and assist for ADLs r/t generalized weakness, history of falls, decreased mobility .with an intervention for bilateral boarded assist bar in use to HOB due to low air loss mattress to bed. Further review of the resident's plan of care revealed no interventions for the use the bilateral assist rails including specific direct monitoring and supervision during use of assist rails and interventions for safety to reduce the risk for resident entrapment. Resident #R4. Review of Resident #R4's EHR revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to: Acquired Absence of Right Leg Above Knee, Anxiety Disorder, and Dementia. Review of Resident #R4's comprehensive MDS Assessment, dated 07/16/2024, revealed the Resident did not have a BIMS score because the resident was rarely or never understood. Review of Resident #R4's August 2024's physician's orders revealed an order, dated 07/16/2024, and discontinued on 08/06/2024, read: Bilateral Boarded Assist Rails to HOB to aide in bed mobility and positioning d/t (due to) low air loss mattress in use. Further revealed an order, dated 07/30/2024, and discontinued on 08/07/2024, that read: Bilateral Boarded Assist Rails to bed every shift. (continued on next page)

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	195502	A. Building B. Wing	08/08/2024

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #R4's plan of care with an initiation date of 04/24/2024 revealed the following in part: Resident has self-care performance deficits and requires staff supervision and/ or assistance with ADLs and range of motion to maintain quality of life r/t impaired mobility .with an intervention for bilateral assist bars to HOB to aide in bed mobility/ turning and repositioning. Further review revealed no interventions for the use the bilateral assist rails including specific direct monitoring and supervision during use of the assist rails and interventions for safety to reduce the risk for resident entrapment. Review of Residents #R1- #R4's MDS Bar/Side Rail Assessments, all dated 07/29/2024, revealed the facility did not assess each resident's size and weight to ensure bed dimensions were appropriate for the residents. Review of Section B - Interventions of the residents' assessments revealed interventions tried before device used- none of the above was documented. The facility did not assess Resident #R2's medical diagnoses, or behavioral symptoms, and did not assess Resident #R3 and #R4's cognition, medical diagnoses, or behavioral symptoms as indicated in Section A of the assessment. Further review of Residents #R1-#R4's records revealed no evidence of ongoing monitoring for safe use of the boarded side rails. On 08/06/2024 at 11:13 a.m., observations were made of Residents #R1- #R4's rooms. Observations revealed each residents' bed with an air mattresses and bilateral bed rails with wooden boards attached to the outside of the bed rails. These modified boarded bed rails were attached in the middle of the bed in the horizontal position spanning one third width of the side of the bed. On 08/06/2024 at 2:01 p.m. a joint interview was conducted with S1DON (Director of Nursing) and S2ADM (Administrator). S1DON stated that after Resident #1 became entrapped between the boarded bed rail and air mattress, Resident #1's bed was replaced with a new bed without boarded bed rails upon his return from the hospital on 07/30/2024. She and the MDS (Minimum Data Set) nurses assessed the residents who had air mattresses for safety. S1DON also stated there was a risk for any resident with bed rails to become entrapped between the bed rails and the mattress, but they felt the benefits of the boarded bed rails outweighed the risks of having them removed. She further stated the boarded bed rails were safe even if a resident was able to roll and become entrapped between the air mattress and boarded rail. She stated that maintenance installed the bed rails and attached the wooden boards to the rails for the residents with air mattresses as ordered. S1DON was asked if the facility utilized the manufacturer's guidelines to ensure the air mattresses were appropriate mattresses for the bed frames and bed rails. She replied that she would have to find those guidelines. S1DON then stated the air mattresses with bed rails with wooden boards attached had been in place when she began working at the facility over one year ago. S2ADM stated the facility was in the process of replacing the older beds in stages, but because of the cost, Residents #R1-#R4 were not given any of the new beds. S1DON confirmed that these 4 residents remained in the old beds with wooden boarded bed rails attached because those residents were just ordered to be on air mattresses within the last 1 to 2 months. S2ADM stated that there had not been any more orders for new electric beds as of 08/06/2024. S1DON also stated that the CNAs and nurses ensured that the bed rails were in place and residents were safe during their rounds by direct observation. Their charting only required that they document that the bed rails were in place as ordered. Resident #1's plan of care was then reviewed S1DON. She confirmed that the use of bilateral bed rails was an intervention for the resident, but there were no specific interventions or safety interventions for the use or monitoring of the bed rails prior to his accident. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 3:04 p.m., a joint interview was conducted with S1DON and S3MDSLPN (Minimum Data Set, Licensed Practical Nurse). S3MDSLPN stated that the MDS nurses were responsible for completing the bed rail assessments and creating and updating care plans for all residents who utilized bed rails. Review of the assessments for Residents #1, #R1-#R4 was reviewed with S3MDSLPN who confirmed the assessment was not completed appropriately to include assessments of the residents' height and weight and bed dimensions. She confirmed the assessment failed to include other interventions that had been attempted prior to the use of the bed rails. Residents #1, #R1-#R4's care plans failed to reveal any interventions for the safe use of bilateral bed rails with a wooden board attachment including increased monitoring or safety interventions to prevent entrapment. It was confirmed there was evidence of ongoing monitoring for safe use of the boarded side rails for these residents after Resident #1's accident. S3MDSLPN stated had worked at the facility for several years and the process of using the air mattress and wooden boarded bed rails had always been in place. S1DON asserted that there was no issue with use of the mattresses and boarded bed rails at this time. S1DON was asked again to provide the manufacturer's guidelines for the beds and mattresses, but she could not provide them. On 08/07/2024 at 8:57 a.m., an interview was conducted with S5MAINTSUP (Maintenance Supervisor). He stated that he had been in maintenance for two years at the facility, and they have always used the boarded bed rails for beds with air mattresses. He stated that due to the height of the mattress, the boarded side rails were needed as a fail-safe, to keep residents from falling out of bed. He stated maintenance attached the boards to the bed rails of the beds. He did not refer to any manufacturer's guidelines or recommendations for the mattresses or beds to ensure they were compatible, safe, and approved by the manufacturer. He stated he simply did what the facility had always done which was attach wooden boards to the outside of the side rails for those residents who required air mattresses. He received the orders for the air mattresses from the administrative nurses, and placed the mattresses on the beds and was not sure if they had referred to any manufacturer instructions. S5MAINTSUP further stated that maintenance routinely inspected the side rails to ensure they were functioning properly, but he did not have any documented evidence of the inspection. On 08/07/2024 at 6:16 p.m., an interview was conducted with S6REP (Medline -Mattress Representative). He stated that the mattresses were compatible with the bed frames and assist rails. However, the mattress stabilizers on the four corners of the beds were optional so they were currently being removed by maintenance, allowing the mattress to be flush to the bed frame. (continued on next page)

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	195502	A. Building B. Wing	08/08/2024

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/07/2024 at 7:00 p.m., an interview was conducted with administrative staff. S1DON, S2ADM, S3MDSLPN, S7ADON (Assistant Director of Nursing), S8SSD (Social Services Director), S9CNASUP (Certified Nursing Assistant Supervisor), S10MR (Medical Records), and S11IP (Infection Preventionist) were all present for the interview. S1DON stated MDS nurses were responsible for creating and updating resident care plans. S3MDSLPN denied there was anything in care plan that addressed monitoring the residents with boarded bed rails more frequently, nor any specific safety interventions related to the boarded rails in Residents #R1- #R4's care plan. S2ADM stated that the intervention to attach the wooden boards to the side rails of the beds for residents who required air mattresses was already in place when he became the administrator. He was not aware of the manufacturer's guidelines for the air mattress, the bed frame, or the manufacturer's safety recommendations for entrapment prevention when side rails were in use. He also stated that did question the wooden boards when he became administrator, but just went with it because there were no resident complaints or issues. He never checked the manufacturer's guidelines to ensure that the wooden boards were an appropriate attachment for the side rails. S2ADM confirmed the wooden boards were not an appropriate intervention to apply to the side rails. S2ADM confirmed S6REP (Medline Representative) reported that mattress stabilizers were on the corners of Resident #R1-#R4's bed that prevented the air mattress from lying flush on the bed frame causing the mattress to be unstable. S2DM confirmed these stabilizers were removed on 08/07/2024. It was unknown if Resident #1's bed had these stabilizers attached at the time of the accident.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46149 Based on interviews and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to provide appropriate oversight to ensure the well-being of residents. The facility failed to have a system in place for residents to ensure the appropriate use, assessment, and monitoring of bed rails according to mattress manufacturer's guidelines to prevent resident entrapment for 5(#1, #R1, #R2, #R3, and #R4) of 5 (#1, #R1, #R2, #R3, and #R4) residents. This lack of administrative oversight resulted in an Immediate Jeopardy on 07/28/2024 at 1:00 p.m. when Resident #1 attempted to climb over the boarded side rail and became entrapped between the air mattress and the modified boarded bed rail attached to the resident's bed. An x-ray revealed the resident sustained a left femoral neck fracture which required transfer to the local hospital. Resident #1 underwent surgery for a closed reduction and percutaneous pinning for the left femoral neck fracture. The Immediate Jeopardy continued as Residents #R1- #R4 had the same type of bed, air mattress and modified bed rail as Resident #1. The facility failed refer to the manufacturer's recommendations for the proper use of bed rails, and appropriately assess and monitor the four remaining residents for the high likelihood of entrapment leaving the residents vulnerable to serious injury, serious harm, serious impairment or death. S1DON (Director of Nursing) and S2ADM (Administrator) were notified of an Immediate Jeopardy situation on 08/07/2024 at 1:25 p.m. The Immediate Jeopardy was removed on 08/08/2024 at 5:13 p.m., as confirmed by onsite verification through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Cross Reference F700 Review of the facility's policy titled, Administration, with a last revised date of 08/07/2024, read in part: Policy Interpretation and Implementation .1. a. managing the day - to - day functions of the facility .i. ensuring manufacturing recommendations are being followed by staff. (continued on next page)

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	195502	A. Building B. Wing	08/08/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 2:01 p.m. a joint interview was conducted with S1DON and S2ADM. S1DON stated that after Resident #1 became entrapped between the boarded bed rail and air mattress, Resident #1's bed was replaced with a new bed without boarded bed rails upon his return from the hospital on 07/30/2024. She and the MDS (Minimum Data Set) nurses assessed the residents who had air mattresses for safety. S1DON also stated there was a risk for any resident with bed rails to become entrapped between the bed rails and the mattress. The facility's administration felt the benefits of the boarded bed rails outweighed the risks of having them removed. She stated the facility's administration still felt the boarded bed rails were safe even if a resident was able to roll and become entrapped between the air mattress and boarded rail. She stated that maintenance installed the bed rails and attached the wooden boards to the rails for the residents with air mattresses as ordered. S1DON was asked if the facility utilized the manufacturer's guidelines to ensure the air mattresses were appropriate mattresses for the bed frames and bed rails. She replied that she would have to find those guidelines. S1DON then stated the air mattresses with bed rails with wooden boards attached had been in place when she began working at the facility over one year ago. S2ADM stated the facility was in the process of replacing the older beds in stages, but because of the cost, Residents #R1-#R4 were not given any of the new beds. S1DON confirmed that these 4 residents remained in the old beds with wooden boarded bed rails attached because those residents were just ordered to be on air mattresses within the last 1 to 2 months. S2ADM stated that there had not been any more orders for new electric beds as of 08/06/2024. S1DON further stated that CNAs (Certified Nursing Assistants) were in-serviced on not moving a resident if they become entrapped in the side rails of the bed after the incident occurred with Resident #1, however there was no specific training on resident entrapment prior to or after Resident #1's accident. S1DON also stated that the CNAs and nurses ensured that the bed rails were in place and residents were safe during their rounds by direct observation. Their charting only required that they document that the bed rails were in place as ordered. Resident #1's plan of care was then reviewed S1DON. She confirmed that the use of bilateral bed rails was an intervention for the resident, but there were no specific interventions or safety interventions for the use or monitoring of the bed rails prior to his accident. On 08/06/2024 at 3:04 p.m., a joint interview was conducted with S1DON and S3MDSLPN (Minimum Data Set, Licensed Practical Nurse). S3MDSLPN stated that the MDS nurses were responsible for completing the bed rail assessments and creating and updating care plans for all residents who utilized bed rails. Review of the assessments for Residents #1, #R1-#R4 was reviewed with S3MDSLPN who confirmed the assessment was not completed appropriately to include assessments of the residents' height and weight and bed dimensions. She confirmed the assessment failed to include other interventions that had been attempted prior to the use of the bed rails. Residents #1, #R1-#R4's care plans failed to reveal any interventions for the safe use of bilateral bed rails with a wooden board attachment including increased monitoring or safety interventions to prevent entrapment. It was confirmed there was evidence of ongoing monitoring for safe use of the boarded side rails for these residents after Resident #1's accident. S3MDSLPN stated had worked at the facility for several years and the process of using the air mattress and wooden boarded bed rails had always been in place. S1DON asserted that there was no issue with use of the mattresses and boarded bed rails at this time. S1DON was asked again to provide the manufacturer's guidelines for the beds and mattresses, but she could not provide them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195502	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Retirement Manor	2500 E. Simcoe Street Lafayette, LA 70501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/07/2024 at 8:57 a.m., an interview was conducted with S5MAINTSUP (Maintenance Supervisor). He stated that he had been in maintenance for two years at the facility, and they have always used the boarded bed rails for beds with air mattresses. He stated that due to the height of the mattress, the boarded side rails were needed as a fail-safe, to keep residents from falling out of bed. He stated maintenance attached the boards to the bed rails of the beds. He did not refer to any manufacturer's guidelines or recommendations for the mattresses or beds to ensure they were compatible, safe, and approved by the manufacturer. He stated he simply did what the facility had always done which was attach wooden boards to the outside of the side rails for those residents who required air mattresses. He received the orders for the air mattresses from the administrative nurses, and placed the mattresses on the beds and was not sure if they had referred to any manufacturer instructions. S5MAINTSUP further stated that maintenance routinely inspected the side rails to ensure they were functioning properly, but he did not have any documented evidence of the inspection. On 08/07/2024 at 7:00 p.m., an interview was conducted with administrative staff. S1DON, S2ADM, S3MDSLPN, S7ADON (Assistant Director of Nursing), S8SSD (Social Services Director), S9CNASUP (Certified Nursing Assistant Supervisor), S10MR (Medical Records), and S11IP (Infection Preventionist) were all present for the interview. S1DON stated MDS nurses were responsible for creating and updating resident care plans. S3MDSLPN denied there was anything in care plan that addressed monitoring the residents with boarded bed rails more frequently, nor any specific safety interventions related to the boarded rails in Residents #R1- #R4's care plan. S2ADM stated that the intervention to attach the wooden boards to the side rails of the beds for residents who required air mattresses was already in place when he became the administrator. He was not aware of the manufacturer's guidelines for the air mattress, the bed frame, or the manufacturer's safety recommendations for entrapment prevention when side rails were in use. He also stated that did question the wooden boards when he became administrator, but just went with it because there were no resident complaints or issues. He never checked the manufacturer's guidelines to ensure that the wooden boards were an appropriate attachment for the side rails. S2ADM confirmed the wooden boards were not an appropriate intervention to apply to the side rails. S2ADM confirmed S6REP (Medline Representative) reported that mattress stabilizers were on the corners of Resident #R1-#R4's bed that prevented the air mattress from lying flush on the bed frame causing the mattress to be unstable. S2DM confirmed these stabilizers were removed on 08/07/2024. It was unknown if Resident #1's bed had these stabilizers attached at the time of the accident.