STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265829	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Care Center of Perry County	800 South Kingshighway Perryville, MO 63775

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49150 Based on observation, interview and record review, the facility failed to assess and document for the use of a position change alarm (a device intended to monitor a resident's movement) to determine it if was a restraint (a device that limits a person's movement) and failed to obtain a physician's order for the device for five residents (Residents #59, #68, #84, #86, and #242) out of six sampled residents. The facility census was 91. Review of the facility's policy titled, Restraint Protocol, not dated, showed: - Contraindications for restraint use to include, at the very least, clinical contraindications, convenience of staff, or discipline of the resident; - Practices for informing the resident and obtaining consent when clinically feasible, and documenting the consent in the resident's record; - Practices for notifying the family or guardian, obtaining consent if the resident is unable to give consent, and documenting the consent in the resident's record; - Practices guiding the removal of restraints when goals have been accomplished. - The policy failed to identify the use of a position change alarm as a potential restraint. 1. Review of #59's medical record showed: - admitted [DATE]; - Diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), psychotic disturbance (a condition that causes people to lose touch with reality), unspecified lack of coordination (a muscle control problem that makes it difficult to coordinate movements), history of falling, spondylolisthesis of the lumbosacral region (a condition that occurs when the fifth lumbar vertebra moves forward and out of place, resting on top of the first sacral vertebra), and anxiety (a mental health condition that causes people to experience excessive, uncontrollable, and often irrational worry about everyday things); - No documentation of a physician's order for a position change alarm; (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of a position change alarm assessment. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 07/24/24, showed a bed and chair alarm used. Review of the resident's care plan, revised 05/04/24, showed: - The resident at moderate risk for falls; - A wheelchair alarm used as an intervention. Observations of the resident on 08/20/24 at 11:00 A.M., 08/21/24 at 3:20 P.M., and 08/22/24 at 11:15 A.M., showed: -The resident sat in a wheelchair in his/her room with a chair alarm attached to the back of the wheelchair and an alarm pad under his/her thighs and buttocks; - The resident was unable to remove the chair alarm. 2. Review of Resident #68's medical record showed: - admitted on [DATE]; - Diagnoses of type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), anxiety disorder, restless leg syndrome, high blood pressure, atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls), atrial fibrillation (irregular heart beat), Cerebral Infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe); - No documentation of a physician's order for a position change alarm; - No documentation of a position change alarm assessment. Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Independence with bed mobility; - A bed alarm and other alarm used. Review of the resident's care plan, revised on 08/15/24, showed: - Resident was a high fall risk; - Resident had a bed alarm; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident needed assistance with activities of daily living (ADLs). Observations of the resident on 08/19/24 at 10:50 A.M., 08/20/24 at 1:45 P.M., and 08/21/24 at 8:56 A.M. showed the resident lay in bed with a bed alarm in place under fitted bed sheet. During an interview on 08/20/24 at 1:45 P.M. Resident #68 said the bed alarm kept him/her from moving around in the bed for fear of it going off. 3. Review of Resident #84's medical record showed: - admitted [DATE]; - Diagnoses of Alzheimer's disease, dementia (a general term for a group of neurological conditions that affect the brain and cause a loss of cognitive functioning), unspecified lack of coordination, weakness, atherosclerotic heart disease, Sjogren syndrome with glomerular disease (a chronic autoimmune disease that affects multiple organs), osteoporosis (a condition in which there is a decrease in the amount and thickness of bone tissue), generalized anxiety disorder and difficulty walking; - No documentation of a physician's order for a position change alarm; - No documentation of a position change alarm assessment. Review of the resident's quarterly MDS, dated [DATE], showed a bed/chair and bed, chair, or motion sensor alarm not used. Review of the resident's care plan, revised 08/21/24, showed: - The resident at risk for falls; - A bed alarm used as an intervention. Observations of the resident on 08/20/24 at 11:25 A.M., 08/21/24 at 3:30 P.M., and 08/22/24 at 11:32 A.M., showed: - The resident lay in bed with a bed alarm attached to the side of the bed and an alarm pad under his/her thighs and buttocks; - The resident was unable to remove the bed alarm. 4. Review of Resident #86's medical record showed: - admitted [DATE]; - Diagnoses of Parkinson's disease without dyskinesia (a progressive brain disorder that causes movement problems, mental health issues, pain, and other health concerns), history of falling, dementia, muscle weakness, difficulty in walking, cognitive communication deficit (a difficulty with communication caused by a disruption in cognition); (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of a physician's order for a position change alarm; - No documentation of a position change alarm assessment. Review of the resident's quarterly MDS, dated [DATE], showed a bed and chair alarm used. Review of the resident's care plan, revised 08/21/24, showed: - The resident at risk for falls; - A wheelchair alarm used as an intervention. Observations of the resident on 08/19/24 at 4:20 P.M., 08/20/24 at 11:30 P.M., and 08/22/24 at 11:40 A.M., showed: - The resident lay in bed with a bed alarm attached to a alarm pad under his/her thighs and buttocks; - The resident was unable to remove the bed alarm. 5. Review of Resident #242's medical record showed: - admitted [DATE]; - Diagnoses of senile degeneration of the brain (a decrease in cognitive abilities or mental decline), hyperlipidemia (an elevated level of lipids, like cholesterol and triglycerides in your blood), orthostatic hypotension, muscle weakness, repeated falls, high blood pressure, and adult failure to thrive (a gradual decline in older adults, often those with multiple chronic conditions); - No documentation of a physician's order for a position change alarm; - No documentation of a position change alarm assessment. Review of the resident's quarterly MDS, dated [DATE], showed a bed/chair and bed, chair, or motion sensor alarm not used. Observations of the resident on 08/19/24 at 10:10 A.M., 08/20/24 at 12:57 P.M., 08/21/24 at 10:45 A.M., and 08/22/24 at 10:15 A.M., showed: - The resident sat in a recliner with a chair alarm attached to the side of the chair with an alarm pad under his/her thighs and buttocks; - The resident was unable to remove the bed alarm. During interview on 08/22/24 at 9:30 A.M., the Director of Nursing (DON) said she would not expect to see an order or an assessment for a bed/chair alarm due to them using only if a resident was a fall risk to prevent injuries. The decision to place the bed/chair alarm was the nurse's decision and would notify administration after alarm was in place and being used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 9:45 A.M., the Administrator said that she would not expect to see an order or an assessment for a bed/chair alarm but would expect nurses to receive permission from her or the DON before using a bed/chair alarm. 49999

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a facility-initiated transfer when six residents (Resident #7, #47, #68, #71, #79, and #81) out of seven sampled residents transferred to the hospital. The facility's census was 91. Review of the facility's policy titled, Transfer/Discharge Notice, dated 05/2017, showed: - Before the facility transfers or discharges a resident, the facility will send a written notice to the resident in a language and manner reasonable calculated to be understood by the resident for planned and emergency discharges; - The notice will also be sent to any resident representative. 1. Review of Resident #7's medical record showed: - The resident transferred to the hospital for medical evaluation on 07/07/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 07/07/24. 2. Review of Resident #47's medical record showed: - The resident transferred to the hospital for medical evaluation on 02/18/24, and readmitted to the facility on [DATE]; - The esident transferred to the hospital for medical evaluation on 02/28/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 02/18/24 or 02/28/24. 3. Review of Resident #68's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/28/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 05/28/24. 4. Review of Resident #71's medical record showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 11/17/23, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 12/31/23, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 11/17/23 or 12/31/23. 5. Review on 08/22/24 of Resident #79's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/02/234, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 04/02/24. 6. Review of Resident #81's medical record showed: - The resident transferred to the hospital for medical evaluation on 06/11/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 06/11/24. During an interview on 08/21/24 at 9:30 A.M., the Director of Nursing (DON) said the facility just mailed a Transfer Notice form to the resident's representative. They mailed one form that contained the transfer notice at the top and the bed hold information at the bottom. They do not keep a copy of the forms, therefore there was no documentation that they were sent. During an interview on 08/22/24 at 1:20 P.M., the Administrator said she would expect a transfer/discharge notice to be given to the resident or their representative in writing. 49152 49999

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record view, the facility failed to inform the resident and family or legal representative of their bed hold policy at the time of transfer to the hospital for seven residents (Resident #7, #17, #47, #68, #71, #79, and #81) out of seven sample residents. The facility's census was 91. Review of the facility's policy titled, Bed Hold and Return to Facility, revised 12/07/20, showed: - It is the policy of of the facility that residents who are transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold duration and payment amount before the transfer; - The facility will provide the resident and resident representative a written notice which specifies the duration of the bed-hold policy at the time of transfer for hospitalization or therapeutic leave; - In case of an emergency transfer, notice at time of transfer means that the facility will send notice along with the necessary paperwork to the receiving setting and the resident representative will receive a notice sent on the next business day; - Documentation of bed hold notice will be completed in the individual medical record. 1. Review of Resident #7's medical record showed: - The resident transferred to the hospital for medical evaluation on 07/07/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 2. Review of Resident #17's medical record showed: - The resident transferred to the hospital for medical evaluation on 06/05/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 3. Review of Resident #47's medical record showed: - The resident transferred to the hospital for medical evaluation on 02/18/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 02/28/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. 4. Review of Resident #68's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/28/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 5. Review of Resident #71's medical record showed: - The resident transferred to the hospital for medical evaluation on 11/17/23, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 12/31/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. 6. Review on 08/22/24 of Resident #79's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/02/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 7. Review of Resident #81's medical record showed: - The resident transferred to the hospital for medical evaluation on 06/11/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. During an interview on 08/21/24 at 9:30 A.M., the Director of Nursing (DON) said the facility just mailed a Transfer Notice form to the resident's representative. They mailed one form that contained the transfer notice at the top and the bed hold information at the bottom. They do not keep a copy of the forms, therefore there was no documentation that they were sent. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 11:45 A.M., the Administrator said when a resident went out to the hospital, the nurse explained the bed hold policy to the resident or their representative and gave them a copy of the form. The facility did not have them sign anything to show they recieved the copy, but the bed hold policy was explained to the resident or their representative at admission and they were given a copy in the admission handbook. 49152 49999

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49150 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #6) out of six sampled residents was transferred with safe transfer techniques. The facility census was 91. Review of the facility's policy titled, Two Person Transfer Using Gait Belt, not dated, showed: - Adjust bed height if needed to ensure bed is in locked position; - Position chair/geri-chair/wheelchair at side of the bed, facing head of the bed; - Lock chair wheels; - Apply gait belt; - Stand with one staff on each side of the resident; - Place your hands underneath the belt with one hand in the back and one hand in the front. Inform the resident that you will assist to stand/transfer; - Pivot your body and the resident's body toward the bed; - One staff to place his/her forearms around the resident's shoulders while the other staff places his/her forearms behind the resident's knees/calves. 1. Review of Resident #6's medical record showed; - admitted on [DATE]; - Diagnoses of Guillain-Barre Syndrome (a rare autoimmune disorder that causes the body's immune system to attack the peripheral nervous system, leading to nerve inflammation and muscle weakness), burkitt lymphoma (aggressive non-[NAME] B-cell lymphoma), muscle weakness, high blood pressure), anxiety disorder (a mental health condition that causes people to feel excessive and uncontrollable worry about everyday activities or events), and left hand contracture (a condition that causes one or more fingers to bend toward the palm of the hand); - Assistance of two staff for transfers needed; - Cognitively impaired; - Received hospice services. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quartely Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 05/16/24, showed: - Substantial/maximal assistance needed with eating, oral hygiene, and upper body dressing; - Resident is dependent on staff for toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. Observation of the resident on 08/21/24 at 1:37 P.M., showed: - The resident sat in a tilt-in-space wheelchair (a specialized wheelchair); - Certified Nurse Assistant (CNA) H and CNI I transferred the resident from the wheelchair to the bed without a gait belt; - CNA H placed his/her left arm under the resident's left upper arm with CNA H's right hand holding the back of the resident's pants and CNA I placed his/her right arm under the resident's right upper arm with CNA I's left hand holding the back of the resident's pants; - CNA H and CNA I lifted the resident up with pulling up on the back of the resident's pants to transfer from the chair to the bed; - CNA H and CNA I performed incontinent care; - CNA H and CNA I transferred the resident back to the wheelchair from the bed without a gait belt; - CNA H placed his/her left arm under the resident's left upper arm with CNA H's right hand holding the back of the resident's pants and CNA I placed his/her right arm under the resident's right upper arm with CNA I's left hand holding the back of the resident's pants. During interview on 08/21/24 at 2:20 P.M., with CNA H and CNA I, they both said that they feel it's safe to transfer resident's without using a gait belt as long as you have someone on each side with one arm each under resident's upper arms and hold back of pants during transfer. During an interview on 08/22/24 at 11:13 A.M., the Director of Nursing (DON) said he/she would expect staff to use proper techniques in transferring all residents. During an interview on 08/22/24 at 11:25 A.M., Licensed Practical Nurse (LPN) E said he/she would expect staff to use proper transfer techniques as needed to transfer residents.

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview and record review, the facility failed to assess residents for the risk of entrapment and review possible risks and benefits of bed rails prior to installation or use. The facility also failed to obtain informed consent from the resident or if applicable, the resident representative for six residents (Resident #1, #14, #19, #40, #55, and #68) out of 19 sampled residents. The facility census was 91. The facility did not provide a bed rail policy. Review of the Federal Drug Administration (FDA) documents entitled, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated [DATE], showed 413 people died as a result of entrapment events in the United States. Further review revealed those among the most vulnerable for these entrapment type events are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Review of the FDA document entitled, Practice Hospital Bed Safety, dated February 2013, showed seven different potential zones of entrapment. The guidance characterizes the head, neck, and chest as key body parts that are at risk for entrapment. Review of the FDA document entitled, Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, showed the potential risks of bed rails may include: - Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress; - More serious injuries from falls when patients climb over rails; - Skin bruising, cuts, and scrapes; - Inducing agitated behavior when bed rails are used as a restraint; - Feeling isolated or unnecessarily restricted; - Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; (continued on next page)

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	265829	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Care Center of Perry County	800 South Kingshighway Perryville, MO 63775

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of quadriplegia (partial or complete paralysis of both the arms and legs), obstructive hydrocephalus (a blockage of the cerebral spinal fluid pathways), convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), and intracranial (within the skull) injury without loss of consciousness; - Side rail assessments, dated [DATE] and [DATE], documented four half rails will be used and padded for seizure precautions for the resident; - An order for side rail times four with rail pads for seizure precautions, dated [DATE]; - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly Minimum Data Set (MDS - a federal mandated assessment completed by facility staff), dated [DATE], showed: - Severe cognitive impairment; - Dependent for bed mobility; - Did not use bed rails. Review of the resident's care plan, revised on [DATE], showed: - Resident was a low fall risk; - Half rail times four with padding for seizure precautions; - Resident required extensive/total dependence with activities of daily living (ADLs). Observations of the resident on [DATE] at 2:18 P.M., and [DATE] at 9:30 A.M., showed the resident lay in bed with four padded half bed rails in the upright position on both sides of the bed. 2. Review of Resident #14's medical record showed: - admitted on [DATE]; - Diagnoses of quadriplegia and muscle weakness; - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dependent for bed mobility; - Did not use bedrails. Review of the resident's care plan, revised on [DATE], showed: - Resident was a low fall risk; - Side rail times two; - Resident was total dependence of all ADLs. Observations of the resident on [DATE] and 9:48 A.M., and [DATE] at 7:45 A.M., showed the resident lay in bed with upper left and both lower side rails in the upright position. During an interview on [DATE] at 10:29 A.M., the resident said the bed rails were used to prevent him/her from rolling out of bed. 3. Review of Resident #19's medical record showed: - admitted on [DATE]; - Diagnoses of muscle weakness, difficulty in walking, lack of coordination, history of falling, and cognitive communication deficit; - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly MDS, dated [DATE], showed: - Moderately impaired cognition; - Dependent for bed mobility; - Did not use bedrails. Review of the resident's care plan, dated [DATE], showed: - Resident was at risk for falls; - Side rails times two; - Resident was total dependence for transfers. Observations of the resident on [DATE] at 10:26 A.M. and [DATE] at 8:56 A.M., showed the resident lay in bed with both upper half side rails in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:56 A.M., the resident said he/she used the side rails to position him/herself in bed. 4. Review of Resident #40's medical record showed: - admitted on [DATE]; - Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life), colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall), encephalopathy (any brain disease that alters brain function or structure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), diverticulosis (a condition in which small, bulging pouches develop in the digestive tract), and repeated falls; - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Supervision for bed mobility; - Did not use bed rails. Review of the resident's care plan, revised on [DATE], showed: - Resident was a high fall risk; - Side rail times one. Observation of the resident on [DATE] at 2:07 P.M., showed the resident lay in bed with an upside down U shaped assist bar attached to the right side of the bed. 5. Review of Resident #55's medical record showed: - admitted on [DATE]; - Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), muscle weakness, difficultly in walking, and high blood pressure; - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly MDS, dated [DATE] showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Severe cognitive impairment; - Dependent for bed mobility; - Did not use bedrails. Review of the resident's care plan, revised on [DATE], showed: - Resident is a high fall risk; - Grab assist bar times one; - Resident was an assist of two for ADLs and Hoyer lift (an assistive device that allows residents to be transferred between a bed and a chair or other similar resting places by the use of electrical or hydraulic power) for transfers. Observation on [DATE] at 2:10 P.M., of the resident's incontinence care showed: - The resident lay in bed with an upside down U shaped assist bar on the right side of the bed up against the wall and a half side rail on the left side of the bed; - The Resident was not able to use the assist bar to assist in bed mobility. Observation on [DATE] at 2:10 P.M. of the resident showed he/she lay in bed with an assist bar on the right side of the bed up against the wall and a half side rail on the left side of the bed. 6. Review of Resident #68's medical record showed: - admitted on [DATE]; - Diagnoses of type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), restless leg syndrome, high blood pressure, atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls), atrial fibrillation, stroke, chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe); - No documentation of an informed consent signed explaining the risks and benefits; - No documentation of an entrapment assessment completed. Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Independence with bed mobility; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Did not use bed rails. Review of the resident's care plan, revised on [DATE], showed: - Resident was a high fall risk; - Side rails times one for bed mobility; - Resident needed assistance with ADLs. Observation on [DATE] at 10:50 A.M., and [DATE] at 8:56 A.M., of the resident showed he/she lay in bed with a half bed rail on the left side and the right side of the bed against the wall. Observation on [DATE] at 1:45 P.M., of the resident showed he/she sat on the edge of the bed with half bed side rail attached to left side of the bed. During an interview on [DATE] at 3:28 P.M., Licensed Practical Nurse (LPN) B said residents were assessed upon admission and as needed for side rails. If side rails were needed, they were care planned, a side rail assessment was completed, an order and signed consent were obtained, and he/she was unaware of any bed assessment or entrapment assessment. During an interview on [DATE] at 1:10 P.M., the Administrator said she would expect side rail risks and benefits to be explained to the resident or their representative at admission or when side rail use was initiated. The facility did not have the resident or their representative sign anything indicating their understanding of the risks and benefits. 47678 49999

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47447 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during wound care for two residents (Residents #14 and #71) out of three sampled residents, catheter (a tube that inserted into the bladder to drain urine) care for one resident (Resident #14) out of two sampled residents, and while passing trays during meal time. The facility's census was 91. Review of the facility's policy titled Infection Control, dated 08/12/19, showed: - Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO's) that employ targeted gown and glove use during high contact resident care activities; - Nursing staff initiates EBP for any resident that has a wound or indwelling catheter medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO's; - Nursing staff ensures the resident and staff are aware of the need to use EBP and that the necessary supplies are provided; - Provide readily available personal protective equipment (PPE), including gowns and gloves; - Good handwashing using soap and water or waterless antiseptic before and after each resident contact, after using the bathroom, after handling soiled material, and after eating is mandatory for all staff. 1. Observation on 08/20/24 at 9:28 A.M., of Resident #14's catheter care showed: - Licensed Practical Nurse (LPN) C and Certified Nursing Assistant (CNA) D did not put on a gown prior to beginning the catheter care; - LPN C provided catheter care to the resident while CNA D assisted; - During the catheter care, LPN C and CNA D leaned against the resident and the resident's bed; - LPN C and CNA D failed to wear a gown for EBP. 2. Observation on 08/20/24 at 9:48 A.M., of Resident #14's wound care showed: - LPN C and CNA D did not put on a gown prior to providing the wound care; - LPN C provided wound care to the resident while CNA D assisted; - During the dressing change, LPN C and CNA D leaned against the resident and the resident's bed; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN C and CNA D failed to wear a gown for EBP. During an interview on 08/20/24 at 2:06 P.M., CNA D said they did not wear any extra PPE for residents with catheters or wounds unless the resident had an infection. During an interview on 08/20/24 at 2:10 P.M., LPN C said no extra precautions were initiated for residents with catheters or wounds unless the resident had an infection and needed isolation. 3. Observation on 08/22/24 at 11:05 A.M., of Resident #71's wound care showed: - LPN E did not put on a gown prior to beginning the wound care; - LPN E provided wound care to the resident; - LPN E failed to wear a gown for EBP. During an interview on 08/20/24 at 2:23 P.M., the Infection Preventionist said the facility did not currently use EBP because they did not have any residents who were colonized with a MDRO. 4. Observation on 08/21/24 of the lunch meal in the assisted dining room showed: - At 12:35 P.M., Nursing Assistant (NA) G delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray; - At 12:36 P.M., Universal Worker (UW) F delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray; - At 12:37 P.M., NA G delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, opened a resident's silverware for them; - At 12:38 P.M., NA G delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and assisted a resident to eat; - At 12:45 P.M. UW F delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, delivered another resident's meal tray, and touched the resident's straw when placing it in the resident's cup. During an interview on 08/21/24 at 3:33 P.M., NA G said hand washing or sanitizing should be done before passing trays, before assisting a resident to eat, and after touching the trash can. During an interview on 08/22/24 at 9:18 A.M., UW F said that he/she would wash or sanitize hands after touching the trash can with both hands but that he/she just used one finger to lift the trash can lid, so he/she did not think hand washing was necessary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 1:12 P.M., the Director of Nursing (DON) said staff were expected to wash or sanitize their hands after touching soiled surfaces. During an interview on 08/22/24 at 1:15 P.M., the DON and the Administrator said staff were expected to follow the Center for Disease Control (CDC) recommendations for EBP. 47678 49999

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility staff failed to conduct regular inspections of all bed frames, mattresses and side rails as part of a regular maintenance program for six residents (Residents #1, #14, #19, #40, #55, and #68) out of 19 sampled residents. The facility's census was 91. The facility did not provide side rail maintenance policies. Review of the Federal Drug Administration (FDA) documents entitled, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated [DATE], showed 413 people died as a result of entrapment events in the United States. Further review revealed those among the most vulnerable for these entrapment type events are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Review of the FDA document entitled, Practice Hospital Bed Safety, dated February 2013, showed different potential zones of entrapment. The guidance characterizes the head, neck, and chest as key body parts that are at risk for entrapment. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident on [DATE] at 2:18 P.M., and [DATE] at 9:30 A.M., showed the resident lay in bed with four padded half rails in the upright position on both sides of the bed. 2. Review of Resident #14's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident on [DATE] at 7:37 A.M., and 9:48 A.M., and [DATE] at 7:45 A.M., showed the resident lay in bed with the upper left and both lower half side rails in the upright position. 3. Review of Resident #19's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the resident on [DATE] at 10:26 A.M., and [DATE] at 8:56 A.M., showed the resident lay in bed with both upper half side rails in the upright position. 4. Review of Resident #40's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident on [DATE] at 2:07 P.M., showed the resident lay in bed with an upside down U shaped assist bar to the right side of the bed. 5. Review of Resident #55's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident on [DATE] at 2:10 P.M., and [DATE] at 2:10 P.M., showed the resident lay in bed with an upside down U shaped assist bar on the right side of the bed up against the wall and a half side rail on the left side of of the bed. 6. Review of Resident #68's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident on [DATE] at 10:50 A.M., [DATE] at 1:45 P.M., and [DATE] at 8:56 A.M., showed the resident lay in bed with both upper half side rails in the upright position. During an interview on [DATE] at 8:45 A.M., the Maintenance Director said maintenance placed the bed rails after the nursing assessment was completed. Maintenance replaced the rails if the staff reported they were loose. They did not perform any bed or entrapment assessments. During an interview on [DATE] at 1:15P.M., the Director of Nursing (DON) said the maintenance department checked the side rails regularly but that they didn't document it anywhere. During an interview on [DATE] at 1:14 P.M., the Administrator said she expects maintenance to regularly inspect the side rails for entrapment risks. 47678 49999