STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER: Soldiers and Sailors Memorial Hospital E C U		STREET ADDRESS, CITY, STATE, ZIP CODE: 418 North Main Street, Penn Yan, NY 14527	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46880 Based on observations, interviews, and record review conducted during an extended Recertification Survey and complaint investigation (NY00354636), for one (Unit One) of three units reviewed, the facility did not ensure that the residents were treated in a dignified manner. Specifically, there were multiple observations of approximately half the residents in the dining room waiting longer than one hour to receive their meals, while the other residents consumed their meals in their presence. Resident #65 was observed yelling out angrily because they had not received their meal. This was evidenced by the following: Review of the facility's meal delivery schedule documented the first lunch meal cart (Unit One) was scheduled to arrive on the unit at 11:46 AM and the second lunch meal cart was scheduled to arrive at 12:25 PM. Resident #65 had diagnoses including dementia, depression, and gastric esophageal reflux disease (digestive disease where stomach acid irritates the esophagus). The Minimum Data Set Resident Assessment, dated 09/30/2024, documented the resident had severely impaired cognition and verbal behavioral symptoms directed toward others. During observations on 10/28/2024 in the residential dining room on Unit One, approximately 16 residents were in the dining room at 11:06 AM awaiting lunch (7 residents had a drink in front of them). At 11:49 AM, there were 25 residents in the dining room when the first lunch cart arrived, and 11 residents were served. At 12:41 PM, the second lunch cart arrived and the last resident in the dining room was served at 12:49 PM. From 12:04 to 12:34, several residents were repeatedly asking where their lunch was. Resident #65 asked in an angry manner where their lunch was because everyone else had theirs. During an observation and interview on 10/30/2024 at 11:58 AM on residential Unit One, the first lunch meal cart arrived in dining room carrying approximately half the residents' meal trays. Several residents seated in the dining room, had not received their meal trays, and were observed falling asleep in their chairs, some were asleep with their heads resting on the table. At 12:40 PM, the second lunch meal cart arrived in the dining room (Unit One) and the last resident served at 12:48 PM. During an interview at this time, Licensed Practical Nurse #1 stated the first and second meal carts were not usually that long between delivery. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 12:35 PM, Certified Nurse Assistant #1 stated for the past week, the second lunch meal cart had arrived on the unit very late, the wait time for residents to receive their meals had increased, but added they had not called the kitchen to check the status of the second meal cart. Certified Nurse Assistant #1 stated residents would often fall asleep while waiting for their meals and although they were not all seated together, they could still see other residents who had already received their meals and were eating. During an interview on 11/01/2024 at 12:41 PM, Registered Nurse Manager #1 stated long wait times between the first and second meal cart deliveries was unacceptable. Registered Nurse Manager #1 also stated the wait time on 10/31/2024 was one hour and fifteen minutes. During an interview on 11/01/2024 at 5:14 PM, the Assistant Director of Nursing stated they were not aware of the long wait times for the second meal cart (Unit One) to arrive and would expect the unit manager to reach out to the kitchen to determine the delay. The Assistant Director of Nursing also stated they would expect the second meal cart to be delivered within ten minutes of the specified time on the meal delivery schedule. 10 NYCRR 415.5

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47642 Based on observations, interviews, and record review conducted during an extended Recertification Survey and complaint investigation (NY00354636), for three (Residents #13, #81, and #106) of seven residents, the facility did not ensure that residents who were dependent on staff for assistance received the necessary services to maintain grooming and personal hygiene. Specifically, Resident #81 did not receive assistance with shaving or obtaining a haircut, Resident #106 did not receive assistance with nail care, and Resident #13 did not receive assistance with daily hair grooming. This is evidenced by the following: Review of the facility policy Bathing and Grooming - ADL Care, dated 08/02/2022, included hairdresser appointments would be coordinated with bath/shower day, caregivers were responsible for cleaning fingernails weekly on the scheduled bathing day and as needed throughout the rest of the week, and special attention for nail cleaning needs should be completed with care and after meals. 1. Resident # 81 had diagnoses including dementia, hypertension, and metabolic encephalopathy (a chemical imbalance that affects brain function). The Minimum Data Set Resident Assessment, dated 10/10/2024, documented the resident had moderately impaired cognition and was independent with personal hygiene. Review of the Comprehensive Care Plan, last reviewed on 10/23/2024, and current Kardex (care plan used by Certified Nursing Assistants) revealed Resident #81 required assistance with bathing/showering and was independent with personal hygiene. Review of the October 2024 Treatment Administration Record revealed Resident #81 received a weekly skin and grooming check, to include nails and facial hair on Fridays. Review of October 2024 daily care documentation (input into the electronic medical record by the Certified Nursing Assistants) revealed Resident #81 was independent with personal hygiene and required no assistance from staff. During an observation and interview on 10/28/2024 at 11:12 AM, Resident #81's hair was long and down the back of their neck, a beard, a long mustache, and several days of hair growth on their cheeks. During an interview at this time, Resident #81 stated it had been a long time since they had a haircut and would like to be shaved. During an observation on 10/30/2024 at 10:34 AM, Resident #81 was in the dining room wearing a baseball cap, and continued to have long hair down the back of their neck and was unshaven. During an interview on 10/30/2024 at 12:29 PM, Beautician #1 stated they were at the facility every Wednesday and staff provided a list of residents who needed services. Beautician #1 reviewed the appointment schedule for the last several weeks and stated Resident #81 had not received any services during that time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 1:53 PM, Certified Nursing Assistant #3 stated shaving was a part of morning care and if a resident wanted or needed a haircut, they would let the receptionist know so they could be added to the list for the beautician. During an interview on 10/31/2024 at 11:54 AM, Registered Nurse Manager #2 stated a resident's shaving needs were to be taken care of daily and if a resident needed a haircut, any staff member could add the resident to the beautician's schedule. 2. Resident #106 had diagnoses that including dementia, muscle weakness, and depression. The Minimum Data Set Resident Assessment, dated 10/03/2024, documented the resident had moderately impaired cognition and required assistance with personal hygiene. Review of the Comprehensive Care Plan, last reviewed on 10/23/2024, and current Kardex revealed Resident #106 required assistance with bathing/showering and staff were to check nail length, trim, and clean them on the resident's scheduled bath day and as necessary. During an observation and interview on 10/28/2024 at 10:19 AM, Resident #106's had several long uncut fingernails. When interviewed at the time Resident #106 stated all of their nails should be cut and cleaned. During an observation on 10/29/2024 at 4:05 PM, Resident #106 continued with several long nails and several nails that were dirty with a dark substance underneath. During an observation 10/30/2024 at 11:31 AM, Resident #106 continued with long nails and several that were dirty with a dark substance underneath. During an observation and interview on 10/31/2024 at 2:46 PM, Certified Nursing Assistant #4 stated on a resident's shower day, care included the cleaning and trimming of fingernails and shaving. Certified Nursing Assistant #4 observed Resident #106 fingernails at the time with the surveyor and stated they had several fingernails that needed to be trimmed and cleaned. 3. Resident #13 had diagnoses including dementia with agitation, cerebral vascular accident (a stroke), and muscle weakness. The Minimum Data Set Resident Assessment, dated 08/12/2024, documented the resident had severely impaired cognition and required assistance with personal hygiene. Review of the Comprehensive Care Plan, revised on 08/12/2024, and current Kardex revealed Resident #13 required moderate assistance with personal hygiene. During observations on 10/29/2024 at 9:33 AM, 10/30/2024 at 11:08 AM, and 10/31/2024 10:54 AM, Resident #13 seated at the nurses' station. The resident's hair uncombed and appeared messy. During an observation and interview on 10/31/2024 at 11:54 AM, Resident #13 was seated in the dining room. The resident's hair was uncombed and appeared messy. During an interview at this time, Registered Nurse Manager #4 stated Resident #13's hair was not well-groomed and should have been combed. During an interview on 11/01/2024 at 11:49 AM, Registered Nurse Manager #4 stated a resident's grooming needs, including fingernail and hair care, should be completed daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 2:30 PM, the Director of Nursing stated all residents should be assisted with their grooming needs on shower days including shaving for both men and women, hair washing, brushing hair and teeth, and trimming and cleaning underneath fingernails. If a resident refused a shower or hygiene care, the Certified Nursing Assistant should notify the nurse, the nurse should reapproach the resident for care, and document if the care was completed or refused. 10 NYCRR 415.12(a)(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46526 Based on observations, interviews, and record reviews conducted during an extended Recertification Survey from 10/28/2024 to 11/04/2024, for one (Resident #22) of three residents reviewed, the facility did not ensure that residents with limited mobility received the appropriate services, equipment, and assistance to maintain mobility and prevent complications. Specifically, Resident #22 did not consistently receive a hand device (rolled cloth) for a hand contracture (a shortening of muscles, tendons, and skin) to prevent complications per Occupational Therapy's recommendations and as ordered by the physician. This is evidenced by the following: The facility policy Splint, Brace Usage, dated as reviewed/revised on 09/07/2023, included that Physical or Occupational Therapy would make recommendations for orthotic usage and schedule of application, and a physician would approve recommendations and an order would be written. The team leader/charge nurse would be responsible for ensuring that the orthotic device was applied as outlined in the plan of care, would be responsible for assuring the appropriate notation was made in the resident's care plan and assignment sheet, and monitoring, and evaluation of the resident's usage and tolerance was maintained. Resident #22 had diagnoses that included cerebral infarct (stroke), hemiplegia (paralysis on one side of the body), and depression. The Minimum Data Set Resident Assessment, dated 10/07/2024, documented Resident #22 was cognitively intact, had upper extremity impairment on one side of their body and did not have behaviors such as rejecting care at that time. Review of the Comprehensive Care Plan, dated as revised 08/01/2024, and current Kardex (care plan used by the Certified Nursing Assistant to direct care) revealed that Resident #22 had a self-care deficit due to limited mobility from a stroke and required a wrist splint as needed and a rolled cloth in their left palm daily. The care plan did not include that Resident #22 rejected the splint or the rolled cloth. In an Occupational Therapy Evaluation note, dated 06/13/2024, Occupational Therapist #1 documented Resident #22 required a rolled cloth to their left palm daily. A physician's order, dated 06/21/2024, included Occupational Therapy recommendation for a left wrist brace as needed, and a rolled cloth to the left palm daily. Review of the Treatment Administration Record October 2024 revealed that both a a left wrist brace and a rolled clothed were documented as administered three times a day by various nurses. Review of the Certified Nursing Assistants' documentation in the electronic medical record revealed the left wrist brace as needed and a rolled cloth to left palm daily were both documented as in place from 10/19/2024 to 11/01/2024. During observations on 10/29/2024 at 10:00 AM, 10/30/2024 at 11:06 AM, 10/31/2024 at 9:35 AM, and 11/01/2024 at 12:46 PM, Resident #22 was observed with a brace on their left wrist. There was no rolled cloth in Resident #22's left palm. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 1:00 PM, Occupational Therapist #1 stated if a resident had a level of immobility of an extremity, they would evaluate and make recommendations based on the resident's individual needs, which could include a splint or mechanical device. Occupational Therapist #1 stated all recommendations were documented in the resident's electronic medical record and were communicated to the unit nurse managers and during interdisciplinary morning meetings. Occupational Therapist #1 stated Resident #22 had a personal brace as needed for their left wrist and would sometimes prefer a rolled washcloth to their palm. Occupational Therapist #1 stated the purpose of the rolled cloth was to allow the hand to maintain a more functional/open position and to allow the hand (skin) to breathe. Occupational Therapist #1 stated the rolled cloth was indicated to be worn all times, but the resident would frequently decline it. During an interview on 11/01/2024 at 1:27 PM, Resident #22 stated facility staff had not offered them a cloth for their left hand, and if they did, the resident stated they would try it. During an interview on 11/01/2024 at 1:33 PM, Certified Nursing Assistant #2 stated their assignment sheets would tell them residents' transfer statuses, bathing preferences, and miscellaneous information including equipment. Certified Nursing Assistant #2 stated braces, splints, or cloths would be listed in the resident's electronic medical record and sometimes pictures of the item(s) would be posted above the resident's bed (with times on and off). Certified Nursing Assistant #2 stated they document if the item was on or not and why it was not done. Certified Nursing Assistant #2 stated if a task was not completed (or resident refused), they would reapproach and tell the nurse. Certified Nursing Assistant #2 stated Resident #22 had a brace to their hand which they wore regularly, but they did not think the resident was supposed to have a cloth in their left palm. Certified Nursing Assistant #2 stated they have never seen Resident #22 with a cloth (in their hand). Certified Nursing Assistant #2 stated their assignment sheet did not include that Resident #22's should have a cloth in their palm. During an interview on 11/01/2024 at 5:14 PM, Registered Nurse Manager #1 stated they would verbally tell staff of newly recommended equipment and any information therapy put into the resident's electronic medical record. They stated if a resident refused, the Certified Nursing Assistant should tell the nurse and write this in the electronic medical record, and the nurse should also document the refusal. Registered Nurse Manager #1 stated the nurses should document in the Treatment Administration Record, based on the order that was entered from therapy's recommendation. Registered Nurse Manager #1 stated the Treatment Administration Record would indicate if the cloth was in the resident's hand or indicate if it was refused and why. They stated they or Occupational Therapy should be notified by the nurses if the resident was refusing. Registered Nurse Manager #1 stated Resident #22 had their splint on, and the cloth was supposed to be on daily, but Resident #22 often did not want it on. Registered Nurse Manager #1 stated they had told the nursing staff that they should chart that Resident #22 did not want the cloth in their hand, and that the documentation should not include both the brace and the rolled cloth were being utilized. During an interview on 11/04/2024 at 9:50 AM, the Director of Nursing stated if a resident refused to wear a recommended piece of equipment, the Certified Nursing Assistants should tell the nurse and enter an alert in the electronic medical record, and the nurses should document and report (the refusal). The Director of Nursing stated if the resident consistently refused, the item would be discontinued (if applicable) and they would try to find the resident an alternative that was less bothersome. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12(e)(2)

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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 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. 34459 Based on observations and interviews conducted during an extended Recertification Survey from 10/28/2024 to 11/04/2024, for two (Unit 2 and Unit 3) of four resident units, the facility did not ensure the resident environment remained free of accident hazards. Specifically, there was an electric stove with hot surfaces that was fully operational and accessible to residents. The findings are: During observations on 10/29/2024 at 4:30 PM, an electric stove was easily accessible and operational in the Unit 2 and Unit 3 dining room. When tested for function, all four stove top burners and the oven were operational and remained extremely hot to the touch. Further observations included the dining room connected Unit 2 and 3 on the first floor and there were two residents sitting in the dining room at the time. During observations on 10/30/2024 at 11:34 AM, the electric stove in the Unit 2 and Unit 3 dining room was still operational with the burner surfaces very hot to the touch when tested . During an interview on 10/30/2024 at 1:45 PM, the Clinical Registered Nurse lead #4 stated activity staff may use the stove in the large dining room between Unit 2 and Unit 3 when they do activities in the room with residents. Clinical Registered Nurse lead #4 also stated that if staff was to see a wandering resident go into the dining room, they should follow them and only staff should have been using the stove. Clinical Registered Nurse lead #4 also stated the doors to the dining room are closed each night when activity staff leave for the day, however residents could move freely through the unit and could come into the dining room anytime they want. During an interview on 10/30/2024 at 3:15 PM, the Maintenance Supervisor and Maintenance Technician #2 both stated they were not aware the oven was functional and knew the oven was in the dining room, but did not think anyone used it. The Maintenance Supervisor also stated the oven should not be functional at all times, and there should be a relay switch installed to limit access to only staff when they wanted to use it. During an interview on 10/30/2024 at 4:10 PM, the Administrator stated they believed there was a shut off switch in a cabinet over the oven and it should have been shut off. They also stated they were shocked to know the oven was operational and it should not be left operational and only staff should use of the oven. 10 NYCRR: 415.12(h)(1), 415.29, 415.29(a)(1)

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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 40803

Based on observations, interviews, and record review conducted during the Recertification Survey from 10/28/2024 to 11/04/2024, the facility failed to ensure correct installation, use, and maintenance of bed rails (side rails) to ensure there were no entrapment zones (an event in which a resident was caught, trapped, or entangled in the spaces in or about the side rail, mattress, or hospital bed frame), or safety hazards for six (6) (Resident # 17, 29, 52, 71, 106, and 110) of 31 residents reviewed for bed rails. Specifically, Residents #29 and #52 were identified by the facility with bed rails that were loose, and that the residents' head, body, or extremities were small enough to pass between the bed rail bars or through gaps between the mattress and bed rails. Resident #110's bilateral bed rails were not in position as care planned for which created two entrapment zones. Resident #17's bed rails were observed loose and unsecured to the bed frame. For Residents #17, #29, #52, #71 and #106, the facility failed to provide evidence of routine inspections of the mattress and bed rails for areas of possible entrapment. Additionally, the facility did not evaluate alternatives to bed rails, did not review the risks and benefits of bed rails with the resident or resident representative and did not obtain informed consent prior to the installation of bed rails. This resulted in Immediate Jeopardy for Residents #29, #52 and #110 and placed the remaining 28 residents with bed rails at risk for the likelihood of serious injury, serious impairment, serious harm, or death. The evidence includes, but is not limited to the following:

The facility's Bed Rail Use policy, revised 04/06/2022, documented a bed rail was a device attached to the bed frame that may assist in bed mobility. Bed rails include side rails, safety rails, grab bars, and assist bars. The use of bed rails may be necessary for resident safety, to assist with bed mobility and transfers, or may be requested by the resident. Bed rails could present a safety risk for entrapment if the rails have spaces or gaps that could cause injury or entrapment. Residents most at risk for entrapment were the frail or elderly or those who had conditions such as agitation, delirium, confusion, pain, or uncontrolled body movement. A Bed Rail Assessment would be completed by a Registered Nurse prior to the implementation of bed rail devices. The assessment would include an evaluation of the resident's preference related to bed rail use, the resident's mobility, safety, fall and injury risk. Alternatives to bed rail use must be considered prior to installation. A therapy evaluation may be needed to assess the resident's bed mobility and transfer status. The procedure documented:

-Prior to installing a bed rail, the resident or resident representative would be informed of the risks and benefits of bed rail use, and alternatives attempted. The Registered Nurse would obtain informed consent for the use of bed rails and document this in the medical record.

-The resident's bed mobility status would be assessed. If the resident had the potential to improve bed mobility or transfer skills, a referral for a therapy evaluation for the most appropriate bed rail/transfer device and determine if therapy services were warranted to optimize mobility status.

-The resident's fall and injury risk would be assessed. If the resident had a risk for falls from the bed or had a history of attempting to get out of bed unsafely, a bed rail alternate should be considered.

(continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The resident's risk for entrapment and to ensure the bed dimensions and bed rails were appropriate for the resident's size and weight, the bed rail has no spaces or gaps within the rail or between the rail and mattress that could cause injury or entrapment. -Bed rails would be installed and maintained in accordance with manufacturer's instructions to ensure proper fit. Ensure precautions with use of bed rails with specialty air filled mattress or therapeutic air-filled bed. -The resident's care plan would indicate the number and type of bed rails used. -Bed rail use would be re-evaluated quarterly by therapy to ensure continued appropriateness. The use of bed rails would be documented in the resident's care plan. The U.S. Food & Drug Administration (FDA) Bed Rail Safety, Recommendations for Health Care Providers about Bed Rails, updated 05/10/2016, documented to follow the recommendations in their guidance Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 2006, Dimensional limits for entrapment Zones 1- 4 to reduce the risk for entrapment. Specifically, Zone 3 was the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and degree of play from loosened rails. The recommendations were for a dimension of less than 4 3/4 inches because the head is presumed to enter the space before the neck. Zone 4 was the space under the rail at the ends of the rail. This space was the gap that formed when the mattress was compressed by the resident and the lowermost portion of the rail, at the end of the rail. Factors that could increase the gap size were mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails. This space poses a risk for entrapment of the resident's neck. The recommendations were for dimension of less than 2 3/8 inches to reduce the risk of neck entrapment. On 10/30/2024, the facility provided a list of 30 residents who had bed rails on their beds. One resident (Resident #22) was not identified on this list but was observed with raised bilateral bed rails in use during the survey. 1. Resident #29 had diagnoses including schizoaffective disorder (mental health illness), muscle weakness, and dementia. The Minimum Data Set Resident assessment dated [DATE] documented the resident had moderately impaired cognition, had no behaviors, did not reject care, had no impairments to their upper or lower extremities, required substantial/maximum assistance with bed mobility (rolling right to left, sitting to lying, and sitting to standing) and partial to moderate assistance for transfers. The Comprehensive Care Plan revised 08/07/2024 and the current Kardex (care plan used by the Certified Nursing Assistant for daily care) documented the resident had an activity of daily living self-care performance deficit related to disease process and weakness, was at risk for falls and unaware of safety needs. Interventions included to have two caregivers for all resident care, the use of bilateral bed rails for bed mobility, and staff should observe for injury or entrapment related to bed rails. In a Fall assessment dated [DATE], Documentation Coordinator Registered Nurse #3 documented Resident #29 was at high risk for falling. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The Occupational Therapy Discharge Summary dated 10/11/2024 completed by Occupational Therapist #1 documented recommendations that Resident #29 required maximum assistance with bilateral side rails for bed mobility and a stand aide (specialized mechanical lift to assist individuals with limited mobility in transitioning from a seated to a standing position) for all functional transfers. In a Bed Rail Assessment, dated 10/22/2024 Clinical Leader Registered Nurse #1 documented per a therapy evaluation Resident #29 required an assistive device to turn and reposition in bed, and the resident's head, body, or extremities were small enough to pass between bed rail bars or through a gap between the mattress and bed rail. The assessment included that bed rails were indicated with two upper bed rails utilized, there was a 6-inch opening on them, the bed rails were loose, and maintenance was notified. The questions regarding if bed rail alternatives had been tried, if the resident or representative was informed of the medical need for the bed rails and risks and benefits, or a consent to bed rail usage obtained were all blank. Review of the Certified Nurse Task form (a tracking form in the resident's electronic medical record for the Certified Nursing Assistants to document daily that the bed rails were checked for safety) from 10/02/2024 to 10/31/2024 revealed on 10/19/2024 at 7:45 PM, 10/23/2024 at 11:56 PM, and 10/24/2024 at 9:26 PM, staff documented the mattress did not fit snug with the bed rails and on 10/27/2027 at 3:56 AM, staff had documented the resident's bed rails were loose or unstable. There was no documentation in the resident's medical record that the Certified Nursing Assistant's observations were followed up on. During observations on 10/29/2024 at 4:12 PM and 10/30/2024 at 9:30 AM, the resident's bed was against the wall with bilateral upper bed rails raised which were not securely fastened to the bedframe. During an observation on 10/30/2024 at 11:25 AM, the bilateral upper bed rails were raised, the bed rails were not securely fastened to the bedframe and the mattress was not snug between the bed rails and moved when light pressure was applied. During an observation and interview on 10/30/2024 at 1:55 PM, Resident #29 was in their chair in their room, both bed rails were up, and the bed was against the wall. The left bed rail had excessive movement when checked for a secure fit. There were no brackets on the bed frame to hold the mattress secure in place, Zone 3 measured 5.5 inches (versus the recommended 4 3/4 inches) and Zone 4 measured 3.5 inches (versus the recommended 2 3/8 inches). Review of Resident #29's electronic medical record revealed no documented evidence any alternatives were trialed prior to the use of bed rails. 2. Resident #52 had diagnoses including muscle weakness, age-related debility, and a pressure ulcer. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact and had no upper or lower extremity impairment. The resident required substantial/maximal assistance with bed mobility and chair to bed transfers, and partial/moderate assistance with sitting to standing. The Comprehensive Care Plan dated 10/16/2024 documented the resident had an activity of daily living self-care deficit and used a left side bed rail to assist with bed mobility. Staff were to monitor for injury related to bed rail use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soldiers and Sailors Memorial Hospital E C U	418 North Main Street Penn Yan, NY 14527

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an Occupational Therapy Discharge Summary dated 10/22/2024 Occupational Therapist #1 documented Resident #52 required maximum assistance with rolling left to right, moderate assistance with sitting to lying, and supervision with lying to sitting using a left sided bed rail. In a Bed Rail assessment dated [DATE] Clinical Leader Registered Nurse #1 documented per therapy evaluation Resident #52 required an assistive device to turn and reposition in bed. Under Safety/Entrapment risk, the assessment included the resident's head, body, or extremities were small enough to pass between bed rail bars or through a gap between mattress and bed rail. Bed rails were indicated, one upper bed rail utilized, there was a 6-inch opening on the bed rail, the bed rail was loose, and maintenance was notified. The questions regarding if bed rail alternatives had been tried, if the resident or representative were informed of the medical need for the bed rails, the risk and benefits, or if consent had been provided prior to bed rail usage, were all blank. Review of Certified Nurse Task for monitoring bed rails for safety in the electronic medical record dated 10/14/2024 -10/30/2024 revealed staff had documented the mattress did not fit snug with the bed rails on 10/19/2024 at 7:54 PM, 10/23/2024 at 11:59 PM and on 10/24/2024 at 9:37 PM. There was no documented evidence maintenance was notified. During observations on 10/28/2024 at 11:03 AM and 10/29/2024 at 9:00 AM and 4:18 PM, Resident #52 was seated in their chair in their room. Their bed was against the wall, had one bed rail raised that was not securely fastened to the bedframe and there was an alternating pressure reducing mattress on the bed. During an observation on 10/30/2024 at 11:27 AM, the resident remained in their chair, their bed was against the wall with one bed rail raised which was not securely fastened to the bedframe. The bed had an alternating pressure reducing mattress on that did not fit snug against the bed rail and moved when light pressure was applied. At 3:05 PM, the resident remained in their chair. Their bed remained against the wall with one rail up. There were no brackets on the bed frame to hold the mattress secure in place, Zone 3 measured 5.5 inches (versus the recommended 4 3/4 inches) with nothing in place to prevent the mattress from moving and Zone 4 measured 4 inches (versus the recommended 2 3/8 inches). Review of Resident #52's electronic medical record revealed no documented evidence the risk and benefits of side rail usage were discussed with the resident, that informed consent regarding the usage of side rail had been obtained or that any alternatives had been trialed prior to the installation of the side rail. 3. Resident #110 had diagnoses that included Huntington's disease (affects a person's movements, thinking ability and mental health), muscle weakness, and chronic pain. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact, had no upper or lower extremity impairment, required supervision/touching assistance with bed mobility and transfers. The Physical Therapy Discharge Summary dated 09/13/2024 documented recommendations for one-person assist and a walker with transfers. The summary did not document the use of any bed rails. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Comprehensive Care Plan revised on 10/02/2024 and the current Certified Nursing Assistant Kardex documented Resident #110 had an activity of daily living deficit related to limited physical mobility and used bilateral bed rails to maximize independence with turning and repositioning in bed. Additionally, staff were to monitor bed rail use for injury. Review of Certified Nurse Task for in Resident #110's electronic medical record from 10/03/2024 -10/31/2024 revealed the task for checking bed rails for safety was checked off as completed and no issues were identified. In an observation on 10/28/2024 at 1:41 PM, both upper bed rails were up. In an observation on 10/30/2024 at 2:54 PM, the right upper side rail was raised. There were no brackets on the bedframe to hold the mattress securely in place. When observed at 3:03 PM, Resident #110 was lying in bed and the right upper side rail remained raised. Entrapment zone 3 measured 5 inches (recommended was 4 3/4 inches) and entrapment zone 4 measured 3.5 inches (recommended was 2 3/8 inches). The full extent could not be tested as the resident was in bed and did not engage with surveyors. There was no documented evidence a Bed Rail Assessment had been completed for Resident #110. 4. Resident #17 had diagnoses including major depressive disorder, muscle weakness, and seizures. The Minimum Data Set Resident assessment dated [DATE] documented the resident had moderately impaired cognition, had no upper or lower extremity impairments and was dependent on staff for bed mobility and transfers. The Comprehensive Care Plan revised on 10/08/2024 documented the resident had a self-care deficit related to limited physical mobility, impaired balance, and weakness. Interventions included two-person assist and the use of bilateral upper bed rails to assist with bed mobility. Additionally, staff were to observe for injury or entrapment risk related to the bed rail usage. The resident was at high risk for falls and the bed should be in a low position against the wall. The Occupational Therapy Functional Assessment Quarterly Screen dated 06/27/2024 completed by Occupational Therapist #1 documented the resident remained appropriate to use bilateral upper bed rails. In a Bed Rail assessment dated [DATE], Clinical Leader Registered Nurse #1 documented per therapy evaluation, Resident #17 required assistive devices to turn and reposition in bed, had a history of falls from bed and the side rails were stable and secure to the bed frame. The questions regarding if bed rail alternatives had been tried, if the resident or representative were informed of the medical need for the bed rails, the risk and benefits, or if consent had been provided prior to bed rail usage, were all blank. The current Kardex documented Resident #17's bed should be in a low position and against the wall and the resident was able to use bilateral bed rails to assist with bed mobility. Staff were to observe for injury or entrapment related to bed rail use. (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 Certified Nurse Task for monitoring bed rails for safety in the electronic medical record dated 10/06/2024 -10/30/2024 revealed on 10/24/2024 at 1:20 AM and at 9:57 PM, staff documented the mattress was not snug against the bed rails and on 10/27/2024 at 4:00 AM, staff documented the bed rails were loose or unstable. During observations on 10/28/2024 at 11:57 AM and on 10/29/2024 at 8:57 AM Resident #17 was in bed with bilateral upper side rails raised, their bed against the wall and an alternating pressure mattress in place. The bilateral upper side rails were not secure to the bed frame. During observations and interviews on 10/30/2024 at 11:59 AM, Resident #17 was seated in their wheelchair with their family member present in the room. The resident's bed was against the wall, had bilateral upper side rails raised and had an alternating pressure mattress in place. The bilateral upper rails were not secure to the bed frame. When interviewed at this time, a family member stated the resident has had both upper rails for a while and no one had ever discussed the risks or benefits of the bed rail usage with them. At 3:07 PM the resident was in bed and both bed rails raised. The resident stated the bed rails were loose and wobbly. There were no entrapment zones identified at the time and both bed rails had excessive movement and were not securely fastened to the bed frame. During an interview on 10/31/2024 at 10:58 AM, Registered Nurse Unit Manager #2 stated therapy staff assessed the residents for bed mobility and the need for bed rails, and if recommended, they communicated this to the nursing staff who would enter a work order so maintenance could install the bed rails. The resident's care plan should be updated to include the usage of bed rails and a Registered Nurse would complete the Bed Rail Assessment form prior to installation. The assessment should be completed quarterly, annually, and as needed with any changes and would determine if there was any risk for entrapment or safety concerns. The Registered Nurse who completed the assessment should provide education regarding the risk and benefits of bed rail usage, obtain informed consent and it should be documented in their care conference note. The Certified Nursing Assistants checked the bed rails every shift and documented in the electronic medical record. If any issues with a bed rail were observed, staff should alert the nurse so maintenance could be notified and address the issue. Registered Nurse Unit Manager #2 stated if bed rails were loose, it could pose a safety risk such as entrapment. During an interview and observation on 10/31/2024 at 10:58 AM, Clinical Leader Registered Nurse #4 stated Resident #29's bed side rails moved slightly, and the mattress was not secure. During an interview on 10/30/2024 at 3:06 PM, Certified Nursing Assistant #2 stated they had not received any training regarding bed rail use, and they did not inspect the bed rails but were supposed to check the rails each shift for movement. If any issues with the rails, they were supposed to let the nurse know who would alert maintenance. During an interview on 10/30/2024 at 3:11 PM, Licensed Practical Nurse #2 stated they were assigned to the hallway where Residents #29 and #52 resided. If the Certified Nursing Assistants observed any issues with the bed rails, they should notify the nurse so maintenance could be notified to fix the issue, including if they observed the mattress not fitting snug. Licensed Practical Nurse #2 stated it was important to monitor the bed rails for safety issues and none of the Certified Nursing Assistants had alerted them today to any issues with loose bed rails or mattresses not fitting snug. Licensed Practical Nurse #2 added the nurses did not check the bed rails. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/30/2024 at 3:30 PM, the Maintenance Supervisor and Maintenance Technician #2 both stated the maintenance department installed and removed bed rails from a resident's bed if a work order was placed. Once placed the maintenance staff would review the order to determine the severity of the issue and address accordingly. They were unsure if clinical staff were assessing the residents for appropriateness or entrapment zones. They stated maintenance staff had not been educated on how to check for entrapment zones, did not know what the entrapment zones were and did not check for entrapment zones. All beds should have brackets on them to hold the mattress in place and if they were missing, a work order should be placed. They added maintenance staff did not do routine inspections on beds. The facility's electronic work orders from October 1, 2024, to October 29, 2024, did not include any work orders regarding any issues with loose bed rails. During an interview on 10/31/2024 at 10:53 AM, Clinical Leader Registered Nurse #1 stated they completed the Bed Rail Assessments and Therapy would evaluate the resident to determine if they were appropriate to use the bed rails. A Bed Rail Assessment would then be completed by a Registered Nurse and maintenance would install the bed rails as indicated on the work order. Clinical Leader Registered Nurse #1 stated when they completed the bed rail assessment, they checked to see if bed rails were loose or if there were any gaps (between rails or between rails and mattress). If the resident was able to answer, they would ask them to see if they understood why they had the bed rail and if they wanted them. If they identified any issues with the bed rails, they notified the nurse manager or whoever was available to place a work order. Clinical Leader Registered Nurse #1 stated if bed rails were loose by pulling on them it was an issue that needed to be fixed. Many of the residents at the facility have had bed rails for a long time and they thought education and informed consent had been completed prior to installing the bed rails and that the Bed Rail Assessment form should be completed quarterly, annually, and as needed and that many residents used the bed rails for positioning and mobility in bed. Clinical Leader Registered Nurse #1 stated they were unsure who maintained the bed rails for safety and during their recent audit, they did find that some of the bed rails were loose and there were some gaps. The Registered Nurse Manager had not been available, so they took the audit results to the Administrator the day they completed the audit (10/22/2024). Residents #29 and #52 had loose bed rails and there were gaps identified and this was noted on the audit provided. They did not enter a work order but had documented in the assessments that maintenance was notified as the facility's Administrator told them it would be taken care of. Clinical Leader Registered Nurse #1 stated any issues with loose bed rails or gaps could pose a safety risk such as injury or entrapment and should be corrected. Their 10/22/2024 audit was completed for safety reasons, and they did not review all residents to determine if informed consent had been obtained or alternate interventions trialed prior to installing the bed rails. They were concerned with the bed rail issues identified and informed the Administrator of their findings. They were under the assumption the issues were fixed. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/31/2024 at 11:35 AM, the Administrator stated bed rail use was determined by an assessment and therapy evaluation and installed by the maintenance department. Clinical Leader Registered Nurse #1's audit was completed as part of quality assurance and if any issues were identified on the audit regarding any loose bed rails or gaps, they should have completed a maintenance request to have the issues corrected. They would want to be made aware of any safety issues that could possibly result in imminent concern and they had not been made aware of any risk for entrapment when Clinical Leader Registered Nurse #1 completed their audit. When asked if any corrective action had been initiated following the audit's identified potential risk for entrapments prior to survey starting on 10/28/2024, no answer was given. During a follow up interview at 12:28 PM, the Administrator stated Clinical Leader Registered Nurse #1 identified an issue and provided them with the audit last week and if they recalled the conversation correctly, no entrapment issues were identified. If any issues were discussed, they would have had them corrected. During an observation and interview on 11/01/2024 at 2:12 PM, Clinical Leader Registered Nurse #4 examined Residents' #29, #52, and #110 beds (beds identified with entrapment issues) and stated they were all the same type of bed and referred to them as the crank style. During an interview on 11/04/2024 at 9:50 AM, the Director of Nursing stated it was important to monitor the bed side rails for safety reasons and if staff identified any issues a nurse should be made aware so a work order could be placed. They were not aware of any issues identified when Clinical Leader Register Nurse #1 completed their audit the previous week regarding safety concerns over possible entrapment issues. During an interview on 11/04/2024 at 11:09 AM, the Medical Director stated they did not provide input regarding bed rail usage at the facility. They had not been made aware of any issues identified with Clinical Leader Registered Nurse #1's audit and would want to be made aware if the facility did not act upon any entrapment issues immediately. They expected the entrapment zones to be assessed for safety purposes and were not aware this was not being done. *** Immediate Jeopardy was identified, and the Administrator was notified on 10/31/2024 at 6:35 PM. Prior to survey exit the Administrator was notified on 11/01/2024 at 8:50 PM that Immediate Jeopardy was lifted effective 11/01/2024 at 8:45 PM based on the following corrective actions: -Six residents (#17, 29, 52, 71, 106, 110) beds were reviewed and observed for loose rails and mattress-rail gaps, with no safety concerns being identified. Additionally, the Administrator provided an attestation that the remaining 24 residents with devices attached to their beds would be inspected and deemed free from loose rails or gaps. -The facility audit was provided and reviewed. There is a therapy recommendation for the residents to have the bed rails and a care plan is in place for all bed rails. -Bed rail assessments for 6 of 6 residents were provided and reviewed. Education completed and consents were obtained and documented alternatives being attempted. -Manufacturer information pertaining to bed rails was provided and reviewed. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The preventative maintenance program, which consisted of a monthly bed inspection audit form and a preventative maintenance bed inspection policy were provided and reviewed. 10 NYCRR 415.12(h)(1)

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40803 Based on observations, interviews and record review conducted during an extended Recertification Survey from 10/28/2024 to 11/04/2024, for six (Residents #17, #29, #52, #71, #106, and #110) of 31 residents reviewed, the facility did not conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment (when a person is trapped in a hospital bed's rails, mattress or frame, preventing them from moving). Specifically, Residents #29, #52, and #110 were observed to have loose bed rails and entrapments zones that exceeded the United States Food and Drug Administration's recommended dimensional limits. For Residents #17, #71, and #106, bed rails were observed to be loose and not properly secured to the bedframes. This is evidenced by, but not limited to, the following: Review of the facility policy Bed Rail Use, dated 04/06/2022, included bed rails should be installed and maintained in accordance with manufacturer ' s instructions to ensure proper fit. During an interview on 11/01/2024 at 2:20 PM, the Maintenance Director stated the beds in use for Residents #29, #52, and #110 were the crank-style, Drive Bed and the manual for that bed style should be followed for bed inspections. Review of the Drive Bed Assembly and Operating Manual, dated 10/21/2018, included reference to the Food and Drug Administration guidelines - Hospital bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006, that identified potential entrapment areas within the bed frame, rails, and mattress and specific dimensional criteria on gaps and spaces that could occur between bed components, such as side rails when improperly installed. Incompatible mattress and side rails could create hazards; ensure mattress was the correct size for bed frame and the bed rails were secured to the frame to decrease the risk of entrapment. Accurate assessment of the resident and monitoring of correct maintenance and equipment use were required to prevent entrapment. It was important for facility staff to recognize they had an equal role in complying with the Food and Drug Administration guidelines to help ensure resident safety and avoid injuries. 1. Resident #29 had diagnoses including schizoaffective disorder, muscle weakness, and dementia. The Minimum Data Set Resident Assessment, dated 09/30/2024, included the resident had moderately impaired cognition and required assistance with bed mobility and transfers. Review of the Comprehensive Care Plan, last reviewed 10/23/2024, revealed Resident #29 required assistance with activities of daily living related to their disease process and weakness. Interventions included, but were not limited to, two caregivers for care, the use of bed rails (bilateral assist bars) for bed mobility, and to observe for injury or entrapment related to bed rail use. Review of a Bed Rail Assessment form, dated 10/22/2024, revealed Resident #29 used two upper bed rails for bed mobility, the bed rails had a 6-inch opening on them, the rails were loose, and maintenance was notified. (continued on next page)

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/30/24 at 1:55 PM, Resident #29's bed had bilateral rails that were loose, and the bedframe had no brackets to hold the mattress in place. Bed Rail Entrapment Zone Three (the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head) measured 5.5 inches, exceeding the Food and Drug Administration recommended dimensional limit of less than 4.75 inches. Bed Rail Entrapment Zone Four (the gap that forms between the mattress when compressed by the resident, and the lowermost portion of the rail, at the end of the rail) measured 3.5 inches exceeding the Food and Drug Administration recommended dimensional limit of less than 2.375 inches. During an interview at this time, Resident #29 stated the mattress slid around when they were in the bed. 2. Resident #110 had diagnoses including Huntingtonss disease (a progressive brain disorder that affects movements, thinking ability and speech), muscle weakness, and chronic pain. The Minimum Data Set Resident Assessment, dated 09/19/2024, included the resident was cognitively intact and required assistance with bed mobility and transfers. Review of the comprehensive care plan, last reviewed 10/02/2024, revealed Resident #110 required assistance with activities of daily living related to their disease process. Interventions included, but were not limited to, the use of bed rails (two enabler bars) for bed mobility, and to monitor for injury related to bed rail use. During an observation on 10/30/24 at 3:03 PM, Resident #110's bed had one rail installed on the right side. Bed Rail Entrapment Zone Three measured 5 inches exceeding the Food and Drug Administration recommended dimensional limit. Bed Rail Entrapment Zone Four measured 3.5 inches, exceeding the Food and Drug Administration recommended dimensional limit. 3. Resident #52 had diagnoses including muscle weakness, age-related debility, and stage three pressure ulcer. The Minimum Data Set Resident Assessment, dated 09/27/2024, included the resident was cognitively intact and required assistance with bed mobility and transfers. Review of the comprehensive care plan, dated 10/16/2024, revealed Resident #52 required assistance with activities of daily living related to trauma. Interventions included, but were not limited to, the use of a left-sided bed rail (enabler bar) for bed mobility, and to monitor for injury related to bed rail use. Review of a Bed Rail Assessment form, dated 10/22/2024, revealed Resident #52 used one upper bed rail for bed mobility, the bed rail had a 6-inch opening, the rail was loose, and maintenance was notified. During an observation on 10/30/24 at 3:05 PM, Resident #52's bed frame did not have brackets to hold the mattress in place and there was one bed rail installed. Bed Rail Entrapment Zone Three measured 5.5 inches, exceeding the Food and Drug Administration recommended dimensional limit. Bed Rail Entrapment Zone Four measured 4 inches, exceeding the Food and Drug Administration recommended dimensional limit. Both entrapment zones had the potential to have larger gaps as the mattress was not secured in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Soldiers and Sailors Memorial Hospital E C U		STREET ADDRESS, CITY, STATE, ZIP CODE 418 North Main Street Penn Yan, NY 14527	

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 3:30 PM with the Maintenance Supervisor and Maintenance Technician #2, they stated maintenance staff would install and remove bed rails when work orders were entered to do so and did not address any concerns without a work order in place. The Maintenance Supervisor and Maintenance Technician #2 stated they did not check bed rails for entrapment, had not received education or training on how to check for entrapment zones, and were not aware of Food and Drug Administration recommendations for entrapment zones. They stated all bed frames should have brackets to hold mattresses in place, were not aware of any concerns related to broken or missing brackets and did not have any work orders related to those concerns. The Maintenance Supervisor and Maintenance Technician #2 stated they did not conduct routine inspections on beds. During an interview on 10/31/2024 at 10:53 AM, Clinical Leader Registered Nurse #1 stated they were unsure who maintained the bed rails for safety and during their audit, completed on 10/22/2024, they did find that some of the bed side rails were loose and there were some gaps. During an interview on 11/04/2024 at 11:09 AM, the Medical Director stated they expected bed rail entrapment zones to be assessed for safety purposes and was not aware this was not being done. 10 NYCRR 415.29(b)