

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Wagoner Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 205 North Lincoln Avenue Wagoner, OK 74467	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure admission assessments were accurate for 1 (#2) of 12 sampled residents whose assessments were reviewed.</p> <p>The administrator identified 46 residents resided in the facility.</p> <p>Findings:</p> <p>An admission assessment, dated 03/07/25, showed Resident #2, had a diagnosis of atrial fibrillation, had received an anticoagulant medication while a resident, during the look back period, and had a BIMS score of 15.</p> <p>The medication administration record and treatment administration record, dated March 2025, did not show the resident had received an anticoagulant medication.</p> <p>On 04/09/25 at 1:52 p.m., the MDS coordinator stated they had coded the assessment inaccurately and should not have coded the resident had received an anticoagulant.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were developed for 2 (#21 and #41) of 12 sampled residents whose care plans were reviewed.</p> <p>The administrator identified 46 residents resided in the facility.</p> <p>Findings:</p> <p>1. On 04/07/25 at 9:03 a.m., Resident #21 was observed in bed with a half bed rail, on the left side of the bed, in the up position.</p> <p>On 04/09/25 at 10:55 a.m., Resident #21 was observed in bed with a half bed rail, on the left side of the bed, in the up position.</p> <p>A policy titled Proper Use of Side Rails, dated December 2024, read in part, The use of side rails as an assistive devise will be addressed in the resident care plan.</p> <p>A quarterly assessment, dated 03/13/25, showed Resident #21 had a diagnosis of Alzheimer's disease, a BIMS summary score of three, which indicated the resident was severely impaired in cognition for daily decision making.</p> <p>A care plan, revised 03/18/25, did not show Resident #21 utilized a half side rail on the left side for bed mobility.</p> <p>On 04/09/25 at 1:56 p.m., the MDS coordinator stated Resident #21 utilized the half bed rail for bed mobility. They reviewed care plan and stated they had not developed a care plan related to the use of the half bed rail.</p> <p>2. On 04/08/25 at 4:36 p.m., Resident #41 was observed in bed with an oxygen nasal cannula in place.</p> <p>On 04/09/25 at 10:56 a.m., Resident #41 was observed in bed with an oxygen nasal cannula in place.</p> <p>A quarterly assessment, dated 12/25/24, showed Resident #41 had a diagnosis of congestive heart failure, was dependent on staff for toileting, personal hygiene, and showering, and required partial/moderate assistance from staff for dressing, and had a BIMS summary score of 14, which indicated the resident was intact in cognition for daily decision making.</p> <p>A care plan, revised 02/12/25, did not show the amount of assistance Resident #41 required for activities of daily living or the resident utilized supplemental oxygen.</p> <p>On 04/09/25 at 1:51 p.m., the MDS coordinator stated they had not developed a care plan to address the supplemental oxygen use for Resident #41. They stated they were not aware the resident routinely utilized supplemental oxygen.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/25 at 2:00 p.m., the MDS coordinator reviewed the care plan for Resident #41 and stated they must have missed developing a care plan for Resident #41's activities of daily living needs. 42171

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure assessments were completed and consents were obtained for the use of bed rails for 1 (#21) of 1 sampled resident who was reviewed for bed rails.</p> <p>The nurse manager identified two residents who utilized bed rails.</p> <p>Findings:</p> <p>On 04/07/25 at 9:03 a.m., Resident #21 was observed in bed with a half bed rail, on the left side, in the up position.</p> <p>On 04/09/25 at 10:55 a.m., Resident #21 was observed in bed with a half bed rail, on the left side, in the up position.</p> <p>The Evaluation for Use of Side Rails form, dated 10/04/23, did not show the resident was assessed for entrapment with the use of the bed rail or alternatives to the use of the bed rail before they were implemented.</p> <p>The annual assessment, dated 12/11/24, documented Resident #21 had a diagnosis of Alzheimer's disease, and the BIMS score was six, which indicated the resident was severely impaired in cognition for daily decision making.</p> <p>A policy titled, Proper Use of Side Rails, dated December 2024, read in part, When used for mobility or transfer, an assessment will include a review of the resident's .Risk of entrapment from the use of side rails . Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol .Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails.</p> <p>Review of the resident's chart did not show a consent for the use of the half bed rail.</p> <p>On 04/09/25 at 1:44 p.m., LPN #2 stated Resident #21 utilized the half bed rail to assist with bed mobility and transfers. They stated the DON assessed residents for the use of bed rails.</p> <p>On 04/09/25 at 2:11 p.m., the DON stated Resident #21 utilized the half bed rail on the left side of the bed for positioning.</p> <p>On 04/09/25 at 3:06 p.m., the DON stated the only documentation they completed for the use of bed rails was an assessment. They reviewed the resident's chart and stated they would check in medical records.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/09/25 at 5:27 p.m., the DON stated the only assessment that had been conducted for the use of bed rails for Resident #21 had been completed in October 2023. They stated they did not have a consent for the use of the bed rail or an assessment which indicated alternatives to the bed rail had been assessed.</p> <p>On 04/10/25 at 10:39 a.m., the DON stated residents were to be assessed annually for the use of bed rails and a consent should have been obtained.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure competencies were completed yearly and upon hire for 5 (LPN #1, LPN #2, CNA #1, CNA #2, and CNA #3) of 5 employees reviewed for competencies.</p> <p>Human Resources reported seven LPNs and 21 CNAs were employed by the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. LPN #1 had a hire date of 02/27/25. <p>On 04/09/25 at 4:30 p.m., LPN #1's employment file was reviewed, it did not show a competency/skills check had been completed upon hire.</p> <ol style="list-style-type: none"> 2. LPN #2 had a hire date of 09/18/19. <p>On 04/09/25 at 4:35 p.m., LPN #2's employment was reviewed, it did not show a competency/skills check had been completed upon hire.</p> <ol style="list-style-type: none"> 3. CNA #1 had a hire date of 11/11/24. <p>On 04/09/25 at 4:40 p.m., CNA #1's employment file was reviewed, it did not show a competency/skills check had been completed upon hire.</p> <ol style="list-style-type: none"> 4. CNA #2 had a hire date of 02/04/25. <p>On 04/09/25 at 4:45 P.m., CNA #2's employment file was reviewed, it did not show a competency/skills check had been completed upon hire.</p> <ol style="list-style-type: none"> 5. CNA #3 had a hire date of 08/25/24. <p>On 04/09/25 at 4:50 p.m., CNA #3's employment file was reviewed, it did not show a competency/skills check had been completed upon hire.</p> <p>On 04/09/25 at 5:26 p.m., the business office manager stated they did not have skills checks/competencies.</p> <p>On 04/10/25 at 11:09 a.m., the DON stated that competencies should be completed upon hire and annually. They also stated they had not completed competencies in over a year.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure treatment carts were secured for 3 (North hall treatment cart, [NAME] hall treatment cart, and the overflow treatment cart) of 5 medication/treatment carts observed.</p> <p>The DON identified five medication/treatment carts in the facility.</p> <p>Findings:</p> <p>On 04/07/25 at 7:32 a.m., the North hall treatment cart and the overflow treatment cart was observed by the nurses station to be unlocked and unattended.</p> <p>On 04/07/25 at 7:34 a.m., the treatment carts were observed to be locked in the front living room area, by the nurses station.</p> <p>On 04/08/25 at 9:25 a.m., the [NAME] hall treatment cart and the overflow treatment cart was observed to be by the nurses station, unlocked, and unattended.</p> <p>On 04/08/25 at 12:38 p.m., the overflow treatment cart was observed to be unlocked and unattended by the nurses station.</p> <p>On 04/09/25 at 10:53 a.m., the North hall treatment cart was observed to be unlocked and unattended.</p> <p>On 04/09/25 at 10:54 a.m., LPN #2 was observed to exit a resident's room, lock the cart, and push it down the hall.</p> <p>On 04/08/25 at 9:25 a.m., the DON stated they were supposed to keep medication/treatment carts locked when unattended.</p> <p>A policy titled, Storage of Medication, dated 07/21/24, read in part, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) contained drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p> <p>On 04/08/25 at 9:29 a.m., LPN #1 stated the treatment carts were to be kept locked but they had forgotten to lock them 'out of habit.'</p> <p>On 04/08/25 at 12:44 p.m., LPN #2 stated they had accessed the overflow treatment cart and should have locked it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/10/25 at 11:11 a.m., the DON stated the staff were to lock the medication/treatment carts when they were unattended. The DON stated, I know you have seen them unlocked and unattended three or four times.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure menus were reviewed and approved by the dietician.</p> <p>The corporate nurse manager reported 46 residents received food from the kitchen.</p> <p>Findings:</p> <p>An undated policy titled Menus, read in part, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. The dietician reviews and approves all menus.</p> <p>A dietary menu, dated 04/02/25- 04/09/25, was reviewed. There was no documentation the menu had been approved by the dietician.</p> <p>On 04/09/25 at 10:15 a.m., the dietary manager stated they thought the menus were approved by the dietician and they would look for documentation. No documentation was provided.</p> <p>On 04/10/25 at 10:26 a.m., the social services director stated the menu had not been approved by the dietician.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>35474</p> <p>Based on observation and interview, the facility failed to provide palatable meals for 4 (#2, #17, #20, and #46) of 18 residents interviewed regarding food palatability.</p> <p>The corporate nurse manager reported 46 residents received food from the kitchen.</p> <p>Findings:</p> <p>On 04/07/25 at 1:02 p.m., a test tray was sampled for palatability. The Dorito casserole was lukewarm and not well seasoned. The mixed vegetables were soggy, bland, and lukewarm.</p> <p>On 04/08/25 at 12:33 p.m., a test tray was sampled for palatability. The Spanish rice was warm and bland, and the banana cake was dry and without icing.</p> <p>1. An admission assessment, dated 03/07/25, showed Resident #2 had a BIMS score (a test for cognitive functioning) of 15 which was indicative of independence for daily decision making.</p> <p>On 04/07/25 at 10:03 a.m., Resident #2 stated when they eat meals in their room the hot foods are not hot, and the cold foods are not cold.</p> <p>2. A quarterly assessment, dated 01/07/25, showed Resident #17 had a BIMS score (a test for cognitive functioning) of 15 which was indicative of independence for daily decision making.</p> <p>On 04/07/25 at 9:16 a.m., Resident #17 stated they only eat breakfast from the kitchen because lunch and dinner were not good.</p> <p>3. A quarterly assessment, dated 03/06/25, showed Resident #20 had a BIMS score (a test for cognitive functioning) of 12 which was indicative of moderate impairment for daily decision making.</p> <p>On 04/07/25 at 10:25 a.m., Resident #20 stated they ate most meals in their room, and they were usually not hot when they were served. They also stated the food was bland.</p> <p>4. An admission assessment, dated 12/26/24, showed Resident #17 had a BIMS score (a test for cognitive functioning) of 15 which was indicative of independence for daily decision making.</p> <p>On 04/07/25 at 10:17 a.m., Resident #46 stated the food was not good.</p> <p>On 04/09/25 at 10:15 a.m., the DM was made aware of the observations. They stated they tried to serve the hall cart as quickly as possible to ensure they were warm, they also stated the banana cake should have been served with icing.</p> <p>42171</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42171</p> <p>Based on observation, record review, and interview, the facility failed to ensure scoops were not left in bulk containers and the handwashing sink had hot water.</p> <p>The corporate nurse manager reported 46 residents received meals from the kitchen.</p> <p>Findings:</p> <p>On 04/07/25 at 7:27 a.m., an initial tour of the kitchen was conducted. A scoop was observed in a bulk container of flour and the handwashing sink did not have hot water.</p> <p>An undated facility policy titled Food Receiving and Storage, read in part, Foods shall be received and stored in a manner that complies with safe food handling practices.</p> <p>On 04/09/25 at 10:15 a.m., the dietary manager stated that scoops should not be left in bulk containers, and that the handwashing sink should be repaired.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <p>a. ensure enhanced barrier precautions were utilized for residents with wounds for 1 (#32) of 1 sampled resident who was reviewed for wound care;</p> <p>b. ensure infection control was maintained and enhanced barrier precautions were utilized during urinary catheter care for 2 (#17 and #46) of two sampled residents who were reviewed for urinary catheter; and</p> <p>c. ensure clean laundry was covered when transported to resident rooms.</p> <p>The DON identified four residents with wounds, 4 residents with urinary catheters, and 45 residents whose laundry was processed by the facility.</p> <p>Findings:</p> <p>1. On 04/08/25 at 2:43 p.m., LPN #2 was observed to provide wound care for Resident #32. LPN #2 was not observed to utilize a gown during wound care. Signage regarding enhanced barrier precautions was not observed near the resident's room.</p> <p>A policy titled, Enhanced Barrier Precautions, dated August 2022, read in part, EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . wound care .Signs MAY BE posted in the door or wall outside the resident room indicating the type of precautions and PPE [personal protective equipment] required.</p> <p>A quarterly assessment, dated 03/03/25, showed Resident #32 had a stage four pressure ulcer, and had a BIMS summary score of four, which indicated the resident was severely impaired in cognition for daily decision making.</p> <p>On 04/08/25 2:50 p.m., LPN #2 stated wound care for Resident #32 only required gloves.</p> <p>On 04/09/25 at 1:27 p.m., the IP stated staff should implement EBP when providing wound care for Resident #32.</p> <p>On 04/09/25 at 1:35 p.m., the DON stated staff were to implement EBP when they provided wound care. They stated the only way staff would know a resident was on EBP was if they knew Resident #32 had a wound. They stated they did not utilize signage to indicate EBP.</p> <p>2. On 04/08/25 at 10:18 a.m., CNA #2 was observed to don three gloves on each hand and CNA #1 was observed to don two gloves on each hand and assist the resident with positioning. CNA #2 was not observed to change gloves during catheter care. Signage regarding enhanced barrier precautions was not observed near the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A policy titled, Enhanced Barrier Precautions, dated August 2022, read in parts, EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device care .urinary catheter .Signs MAY BE posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</p> <p>An admission assessment, dated 12/26/24, showed Resident #46 had a diagnosis of unspecified abnormal findings in urine, had an indwelling urinary catheter, and a BIMS summary score of 15, which indicated the resident was cognitively intact for daily decision making.</p> <p>On 04/08/25 at 11:31 a.m., CNA #2 stated they wore three pairs of gloves during catheter care because they had watched a video online that informed them to utilize three pairs of gloves at one time. They stated they were supposed to discard the outer glove when it had become soiled, but they had forgotten.</p> <p>On 04/09/25 at 7:47 a.m., CNA #2 stated the nurse usually informed the CNAs if a resident was on any type of precautions which required PPE other than gloves.</p> <p>On 04/09/25 at 1:23 p.m., the IP stated staff were to utilize one pair of gloves at a time. The IP stated residents with urinary catheters were to be placed on EBP. The IP stated they communicated with staff if a resident was on EBP.</p> <p>On 04/09/25 at 1:35 p.m., the DON stated they had inserviced staff about utilizing gowns and gloves when they provided catheter care. They stated staff knew to utilize EBP if they observed the resident had a urinary catheter. The DON stated staff were to change gloves and sanitize anytime they went from soiled to a clean task when providing care. The DON stated staff should never wear more than one pair of gloves at a time during the provision of care.</p> <p>42171</p> <p>3. On 04/08/25 at 09:45 a.m., LPN #1 was observed flushing Resident #17's catheter. She was observed to don gloves and position the resident, then they doffed the gloves and did not perform hand hygiene. LPN #1 then proceeded to the hallway to obtain supplies, upon returning to the room, LPN #1 donned a pair of gloves without performing hand hygiene. LPN #1 then flushed the resident's catheter, went to the bathroom to retrieve paper towels and returned to the resident. LPN #1 then doffed the gloves and exited the room without performing hand hygiene. LPN #1 was not wearing a gown while flushing Resident #17's catheter.</p> <p>On 04/08/25 at 11:07 a.m., CNA #3 and CNA #4 were observed providing catheter care to Resident #17. They were not wearing gowns.</p> <p>A physician order, dated 11/13/24, showed an order to provide catheter care every shift.</p> <p>A quarterly assessment, dated 01/07/25, showed Resident #17 had a BIMS score (a test for cognitive function) of 15. Which was indicative of independence for daily decision making. The assessment also showed Resident #17 had an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Wagoner Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 205 North Lincoln Avenue Wagoner, OK 74467	

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician order, dated 02/28/25, showed an order for the catheter to be flushed every Monday, Wednesday, Friday and as needed.</p> <p>On 04/08/25 at 9:55 a.m., LPN #1 stated they should perform hand hygiene when changing gloves and should change gloves when moving from dirty to clean, they also stated gowns should be worn when providing direct care to residents with a catheter.</p> <p>4. On 04/07/25 at 9:06 a.m., Laundry #1 was observed transporting clean clothes uncovered.</p> <p>On 04/07/25 at 11:35 a.m., Laundry #1 was observed transporting clean clothes uncovered.</p> <p>On 04/08/25 at 8:46 a.m., Laundry #1 was observed transporting clean clothes uncovered.</p> <p>On 04/10/25 at 9:55 a.m., Laundry # 1 stated they did not know clean linens were supposed to be covered.</p> <p>On 04/10/25 at 11:45 p.m., the infection preventionist stated clean clothes should be covered while transporting them.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure beds/bed rails were monitored for safety for 1 (#21) of 1 sampled resident who was reviewed for bed rails.</p> <p>The nurse manager identified two residents who utilized bed rails.</p> <p>Findings:</p> <p>On 04/07/25 at 9:03 a.m., Resident #21 was observed in bed with a half bed rail in the up position on the left side. The bed rail was observed to be loose when moved side to side and back and forth.</p> <p>On 04/09/25 at 10:55 a.m., Resident #21 was observed in bed with a half bed rail in the up position on the left side. The bed rail was observed to be loose when moved side to side and back and forth.</p> <p>A policy titled, Bed Safety, dated June 2024, read in part, Inspection by maintenance staff of all beds and related equipment as part of regular bed safety program to identify risks and problems including potential entrapment risks.</p> <p>The annual assessment, dated 12/11/24, documented Resident #21 had a diagnosis of Alzheimer's disease, and had a BIMS score was six, which indicated the resident was severely impaired in cognition for daily decision making.</p> <p>On 04/07/25 at 9:03 a.m., Resident #21 stated, It's wiggly when they were asked about their bed rail.</p> <p>On 04/09/25 at 3:53 p.m., the maintenance supervisor stated they did not monitor bed rails once they had installed them. They stated if the staff reported the bed rails were loose they tightened them. The maintenance supervisor stated they had recently installed the bed rail for Resident #21. The maintenance supervisor observed the bed rail and stated, Oh wow, this is really loose, someone must have loosened that.</p> <p>On 04/10/25 at 10:59 a.m., the administrator stated the CNAs documented in the maintenance log if they noticed bed rails were loose. They stated they did not know why maintenance were not inspecting beds/bed rails for safety, including entrapment.</p>