

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 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>39496</p> <p>Based on record review and staff interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for falls for 1 of 1 resident reviewed who had actual falls, Resident ID #16.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was readmitted to the facility in December of 2023 with a diagnosis including, but not limited to, schizoaffective disorder.</p> <p>Record review of a facility document titled, Fall Prevention Program last revised 12/2010, states in part, .Fall risk assessments are performed as a part of the admission assessment, as part of the quarterly review, and as an annual and/or significant change of condition process of care plan review .Whenever a resident has a history of falls and/or scores high on the fall risk assessment form, or actually has a fall their record is to be reviewed .and a careplan is to be developed which establishes preventative measures or interventions to be taken to lower or eliminate the risk .any and all immediate fall prevention interventions are to be added to the resident's care plan at that time .</p> <p>Review of the resident's progress notes, dated 7/1/2024 through 10/3/2024, revealed that the resident had experienced falls on the following dates:</p> <p>-7/9/2024</p> <p>-8/14/2024</p> <p>Further record review failed to reveal evidence of a fall related care plan that identifies preventative measures or interventions to be implemented relative to the above falls.</p> <p>During a surveyor interview on 10/3/2024 at 1:11 PM with Registered Nurse, Staff A, she acknowledged that the resident did not have a care plan in place related to falls.</p> <p>During a surveyor interview on 8/21/2024 at approximately 3:00 PM, with the Director of Nursing Services, she was unable to provide evidence that a comprehensive person-centered care plan was developed and implemented to address the resident's falls.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	
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 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	41729		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41729</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 2 of 2 residents reviewed with physician orders for quarterly fall assessments, Resident ID #s 7 and 9, and 2 of 5 residents reviewed with psychiatric recommendations, Resident ID #s 9 and 21.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314, states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>1a. Record review revealed Resident ID #9 was admitted to the facility in December of 2011 with diagnoses including, but not limited to, dementia with mood disturbance and major depressive disorder.</p> <p>Review of a physician's order dated 1/30/2024 revealed an order for fall assessments to be completed quarterly and documented in the resident's record.</p> <p>Record review failed to reveal evidence that fall assessments had been completed quarterly as ordered, the last fall assessment was documented on 12/26/2023.</p> <p>1b. Record review revealed Resident ID #7 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, polyarthritis (arthritis in five or more joints at the same time), fibromyalgia (a chronic condition that causes widespread pain and tenderness in the body), muscle weakness, and a history of falling.</p> <p>Review of a physician's order dated 3/13/2024 revealed an order for fall assessments to be completed quarterly and documented in the resident's record.</p> <p>Record review revealed that a fall assessment was completed on admission in March of 2024. Additional record review failed to reveal evidence that a quarterly fall assessment was completed in June 2024, as ordered.</p> <p>2a. Review of a document titled, Psychiatric Evaluation &amp; Consultation dated 9/11/2024 revealed, Resident ID #9 was seen by a practitioner on this date for a follow up visit related to agitation and behavioral disturbance. Additional review of this consultation revealed a recommendation to restart Quetiapine (an antipsychotic medication that is used to treat mental and mood disorders) 25 milligrams (mg) daily, as needed for agitation, for 14 days.</p> <p>Record review failed to reveal evidence the physician was notified of the psychiatric recommendation to restart the resident on Quetiapine 25 mg daily, as needed.</p> <p>2b. Record review revealed Resident ID #21 was readmitted to the facility in August of 2023 with diagnoses including, but not limited to, schizophrenia and generalized anxiety disorder.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a document titled, Psychiatric Evaluation &amp; Consultation dated 9/2/2024 revealed, Resident ID #21 was seen by a practitioner on this date for a follow up and routine psychiatric evaluation related to complaints of depression. Additional review of this consultation revealed a recommendation for melatonin (a medication used to treat insomnia).</p> <p>Record review failed to reveal evidence the physician was notified of the psychiatric recommendation for melatonin.</p> <p>During a surveyor interview on 10/4/2024 at 1:58 PM with the residents' primary care physician, he indicated that he would expect the staff to notify him of any psychiatric recommendations. He further stated, I have no recollection of these recommendations. Additionally, he indicated that he would expect Resident ID #9's quarterly fall assessments to be completed, as ordered.</p> <p>During a surveyor interview on 10/4/2024 at 2:18 PM with a Psychiatric Nurse Practitioner, Staff B, he indicated that he made the above-mentioned psychiatric recommendations after his visit with Resident ID #'s 9 and 21. Staff B indicated that after his visits with the residents, he notifies the staff of all recommendations including medication recommendations. Those recommendations are then uploaded into the electronic medical record within 48 hours of his visit. Additionally, Staff B indicated that the staff has access to his recommendations that are uploaded in the residents' electronic medical records.</p> <p>During a surveyor interview on 10/4/2024 at approximately 1:15 PM and a subsequent interview on 10/4/2024 at approximately 2:50 PM with the Director of Nursing Services (DNS), she acknowledged that Resident ID #7 did not have a quarterly fall assessment completed as ordered, in June of 2024. Additionally, she acknowledged that Resident ID #9 did not have a fall assessment completed quarterly as ordered, since 12/26/2023. Furthermore, the DNS could not provide evidence the physician was notified of the psychiatric recommendations for Resident ID #'s 9 and 21 after Staff B assessed the residents.</p> <p>42399</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>41729</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight for 1 of 4 residents reviewed for significant weight loss and/or gain, Resident ID #9.</p> <p>Findings are as follows:</p> <p>Record review of the facility's policy titled, Weight Monitoring and Weight Loss/Gain Protocol states in part, . Procedure: Residents who are at risk for a nutritional decline are to be weighed weekly .How to weigh the resident .6. Weights that are + [plus] or minus 3 pounds from the last reading must be reported to the nurse who will then be required to supervise an immediate re-weigh to double check the accuracy of the reading. The nurse is to initial the supervised reading to verify accuracy .a significant weight loss/gain is defined as a difference of 3 pounds or more in one week (if resident on weekly weights); a loss/gain of 5% or greater within one month .WHEN A SIGNIFICANT WEIGHT LOSS IS NOTED, THE FOLLOWING INTERVENTIONS MUST OCCUR:1 Reweigh the residents who are reported to have a significant weight loss in order to assess the accuracy of the weight. The reweigh shall be done within 24 hours .If the re-weigh is accurate and there has been a significant weight loss/gain, nursing must notify: physician, dietician, DNS [Director of Nursing Services] .</p> <p>Record review revealed the resident was admitted to the facility in December of 2011 with diagnoses including, but not limited to, diabetes (a chronic disease that occurs when the body has too much glucose, or blood sugar, in the blood) and dementia.</p> <p>Review of a care plan dated 12/6/2023 revealed, the resident is a nutritional risk due to dysphagia (difficulty in swallowing) and requires a mechanical soft diet. Staff interventions include, but are not limited to, monitoring the resident's weights as ordered.</p> <p>Review of a physician's order dated 7/12/2024 revealed an order to obtain weekly weights on Tuesdays and if the weight is plus or minus 3 pounds (lbs.) from their previous weight, the resident should be re-weighed.</p> <p>Review of a document titled Vital signs: Weight revealed the following weights were obtained:</p> <ul style="list-style-type: none"> <li>- 8/20/2024: 166 lbs.</li> <li>- 8/27/2024: 150 lbs.</li> <li>- 9/3/2024: 166 lbs.</li> <li>- 9/10/2024: 183 lbs.</li> <li>- 9/17/2024: 164 lbs.</li> </ul> <p>Record review revealed the resident had the following documented significant weight losses:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 8/20/2024 to 8/27/2024: 16 lb. weight loss, which is 9.64% in one week.</p> <p>- 9/10/2024 to 9/17/2024: 19 lb. weight loss, which is 10.38% in one week.</p> <p>Record review revealed the resident had the following documented significant weight gains:</p> <p>- 8/27/2024 to 9/3/2024: 16 lb. weight gain, which is 9.64% in one week.</p> <p>- 9/3/2024 to 9/10/2024: 17 lb. weight gain, which is 10.24% in one week.</p> <p>Record review failed to reveal evidence the resident was re-weighed within 24 hours of the above-mentioned dates when s/he had a documented significant weight loss or weight gain, as indicated in the facility's policy and per the physician's order.</p> <p>Record review revealed the resident was last evaluated by the dietician on 7/15/2024 and has not been reevaluated since the above weight discrepancies .</p> <p>Additional record review failed to reveal evidence that the physician, the dietician, and the Director of Nursing Services (DNS) were notified of the significant weight losses or weight gains, as indicated in the facility's policy.</p> <p>During a surveyor interview on 10/3/2024 at 1:29 PM with the primary physician, he acknowledged the weights documented were indicative of significant weight loss and weight gain. However, he could not provide evidence of being notified by the staff of the resident's significant weight losses or gains. The physician further indicated that he would expect the nurse to re-weigh the resident to ensure the weights were accurate.</p> <p>During a surveyor interview on 10/3/2024 at 1:42 PM with the DNS, she indicated that she would expect the staff to re-weigh the resident if the weights were up or down 3 lbs. from the previous weight obtained. Additionally, the DNS could not provide evidence that the physician was notified of the documented significant weight losses or gains, as indicated in the facility's policy.</p> <p>During a subsequent interview on 10/3/2024 at 1:50 PM with the Registered Dietician, she acknowledged that she was not aware of the resident's significant weight losses or weight gains. Additionally, the dietician further indicated that she has recently been hired and has not assessed this resident since she began working at the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39496</p> <p>Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biological's in accordance with currently accepted professional principles for 1 of 2 medication storage rooms, and 1 of 2 medication carts observed.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, .Storage and expiration dating of medication and biological's last revised on [DATE] states in part, .Facility should ensure that medications and biological's that .have an expired date on the label .have been retained longer than recommended by manufacturer or supplier guidelines .are stored separate from other medications until destroyed or returned to the pharmacy or supplier .Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container .when the medication has a shortened expiration date once opened .</p> <p>1. During a surveyor observation of the 1st floor medication storage room on [DATE] at 9:10 AM, in the presence of Registered Nurse, Staff A, the following was revealed:</p> <ul style="list-style-type: none"> <li>- A 10 dose box of Fluzone (a flu vaccination) vaccine; with 5 doses remaining in the box, with a manufacturer's expiration date of ,d+[DATE]</li> <li>- A 10 dose box of High Dose Fluzone vaccine; with 5 doses remaining in the box, with a manufacturer's expiration date of ,d+[DATE]</li> </ul> <p>During a surveyor interview immediately following the observation with Staff A, she acknowledged that the above-mentioned vaccinations were expired.</p> <p>2. During a surveyor observation of the 1st floor Certified Medication Technician medication cart on [DATE] at 1:30 PM, in the presence of Staff A, the following was revealed:</p> <ul style="list-style-type: none"> <li>-2 bottles of Latanoprost Solution (an eye drop used to treat glaucoma) 0.005% opened and undated. Manufacturer's instructions indicate to discard the eye drops 6 weeks after opening.</li> <li>-1 Wixela (an inhaler used to treat asthma),d+[DATE] micrograms (mcg), opened (not in a foil pouch) and undated. Manufacturer's instructions indicated to discard 1 month after removal from the foil pouch.</li> <li>-2 Trelegy Ellipta (an inhaler used to treat asthma) ,d+[DATE].5 mcg inhalers, opened and undated. Manufacturer's instructions indicate to discard 6 weeks after opening.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview immediately following the above observations with Staff A, she acknowledged that the above-mentioned medications were opened and undated and that they should be dated when opened.</p> <p>During a surveyor interview on [DATE] at 1:52 PM with the Director of Nursing Services, she acknowledged that the Fluzone vaccines were expired. She further revealed that she would expect the staff to date medications when opening them and discard them appropriately based on the manufacturer's instructions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>41729</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 3 of 4 residents reviewed for side rails, Resident ID #s 11, 21, and 25.</p> <p>Findings are as follows:</p> <p>Review of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Last revised 8/8/2024, states in part, .Regardless of mattress width, length, and/or depth, the bed frame, bed rail and mattress should leave no gap wide enough to entrap a resident's head or body .Facilities must also conduct routine preventive maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair .</p> <p>1. Record review revealed that Resident ID #11 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, osteoarthritis, and joint disorders.</p> <p>During surveyor observations on the following dates and times the resident was observed with 2 half side rails on his/her bed:</p> <p>-10/1/2024 at 9:59 AM</p> <p>-10/2/2024 at 11:05 AM</p> <p>-10/3/2024 at 8:45 AM</p> <p>2. Record review revealed that Resident ID #21 was readmitted to the facility in August of 2023 with diagnoses including, but not limited to, hemiplegia (one sided paralysis or weakness) affecting the right dominant side.</p> <p>During surveyor observations on the following dates and times the resident was observed with 2 half side rails on his/her bed:</p> <p>10/1/2024 at 8:48 AM and 11:40 AM</p> <p>10/2/2024 at 9:49 AM</p> <p>10/3/2024 at 9:26 AM</p> <p>3. Record review revealed that Resident ID #25 was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, spinal stenosis (narrowing of the space inside of the spinal column) and a burst fracture (a serious spinal injury that occurs when a vertebra breaks into multiple pieces after being crushed by a strong force) of T9-T10 vertebrae.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Harris Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  833 Broadway East Providence, RI 02914	

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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During surveyor observations on the following dates and times the resident was observed with 2 half side rails on his/her bed:</p> <p>10/1/2024 at 8:40 AM and 10:44 AM</p> <p>10/3/2024 at 8:47 AM, 9:12 AM and 11:59 AM</p> <p>During a surveyor interview with the resident on 10/1/2024 at 10:44 AM, s/he revealed that s/he uses the bed rails for turning and repositioning in bed.</p> <p>Record review failed to reveal evidence that entrapment assessments were completed for the above-mentioned residents.</p> <p>During a surveyor interview on 10/3/2024 at 1:38 PM with the Director of Nursing Services, she could not provide evidence that the entrapment assessments were completed.</p>