STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Manor	2333 Manor Dr Bryan, TX 77802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm 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** 49099 Based on observation, interview, and record review the facility failed to use appropriate alternatives prior to installing a side or bed rails, assess the resident for risk of entrapment, review the risk and benefits, and obtain informed consent prior to installation for 3 out of 6 residents (Residents #1, #2, and #3) reviewed for bedrails. The facility failed to assess and get signed consents for Residents #1, #2, and #3 prior to installing bed rails. This deficient practice could affect residents who utilized bed rails by placing them at risk for unintended entrapment of the head, neck, or limbs, restraints, and injuries. The findings included: Record review of Resident #1's face sheet dated 08/28/24 reflected a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of polyosteoarthritis (is a diagnosis of having arthritis in five or more joints at the same time), muscle weakness, difficulty in walking, altered mental status and cognitive communication deficit. Record review of Resident #1's admission MDS dated [DATE] reflected no BIMS summary score. Record review of Resident #1's care plan reflected no mention of bed rails. Record review of Resident #1's clinical physician orders reflected no orders for the use of side rails. Record review of Resident #1's consents reflected no informed consent on file for the use of bedrails. Record review of Resident #1's assessments reflected that there was no assessment completed for the risk of entrapment from bed rails prior to installation. An observation on 08/28/24 at 12:09 PM revealed Resident #1 was asleep in her bed with 1/4 length side rails in the up position on both sides at the head of the bed. (continued on next page)

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

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's face sheet dated 08/28/24 reflected a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of chronic diastolic (congestive) heart failure (a condition in which the left ventricle of the heart becomes stiff and unable to fill properly), hypertension (high blood pressure), COPD (a chronic lung disease that makes breathing difficult), hyperlipidemia (high cholesterol), and chronic atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart). Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Record review of Resident #2's care plan reflected no mention of bed rails prior to 08/28/24. Record review of Resident #2's clinical physician orders reflected no orders for the use of side rails. Record review of Resident #2's consents reflected no informed consent on file for the use of bedrails. Record review of Resident #2's assessments reflected that there was no assessment completed for the risk of entrapment from bed rails prior to installation. An observation and interview on 08/28/24 at 4:19 PM revealed Resident #2 sitting in her recliner at bedside. Her bed was observed to have 1/4 length side rails on the up position on both sides at the head of the bed. Resident #2 stated that she did not consent to have the side rails up and that she did not get an assessment for them; she stated they were just like that when she arrived. Resident #2 said that she will sometimes sleep in her recliner because in the past she had an accident that she believed was caused due to the side rails and so she was nervous about sleeping in her bed. Resident #2 stated the accident did not result in an injury and she fell on to the bed but that it still frightened her. Record review of Resident #3's face sheet dated 08/28/24 reflected a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of cerebral infarction due to embolism of right middle cerebral artery (also known as ischemic stroke, results in an area of necrotic or dead tissue in the brain), dysphagia following cerebral infarction (difficulty swallowing), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Record review of Resident #3's admission MDS dated [DATE] revealed no BIMS summary score. Record review of Resident #3's care plan revealed no mention of bed rails prior to 08/28/24. Record review of Resident #3's clinical physician orders revealed no orders for the use of side rails. Record review of Resident #3's consents revealed no informed consent on file for the use of bedrails. Record review of Resident #3's assessments revealed that there was no assessment completed for the risk of entrapment from bed rails prior to installation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 08/28/24 at 4:35 PM revealed Resident #3 was asleep in her bed with 1/4 length side rails in the up position on both sides at the head of the bed. An interview on 08/28/24 at 2:07 PM with the VPCO who stated that it was her expectation that all residents had an order for the use of side rails and that residents should be assessed and should be care planned for bed rails. She stated that PT will be doing assessments for those residents with side rails to ensure they are being safely used. An interview on 08/28/24 at 4:41 PM with the DON who stated that the bed rails were already on the beds prior to the residents being admitted . She stated that they are hospital beds that the facility had when the company acquired them, and they were not removed because the residents had been using them as enablers in assisting the residents to adjust themselves in bed. The DON stated that they are a no restraint facility and that they did not consider the bed rails as a restraint. She stated there was not a risk assessment completed for the side rails and no order on file. The DON stated that it was her expectation moving forward that all residents have a risk assessment completed when using side rails. She said they should also have an informed consent on file either by the representative or the RP. The DON also stated that there should be an order on file for the use of side rails, none of which she said these residents had. The DON stated that a potential negative outcome when using siderails when there was no consent or risk assessment was the potential for entrapment, risk for fractures or debilitations, and could be considered a restraint. The DON stated that they are working on making the side rails information a part of the admission packet and are immediately working with PT to assess the residents and their risk, as well as obtaining consents. An interview on 08/28/24 at 05:01 PM with the ADM who stated the bed rails were on the beds when the current facility company took over. She stated that the residents were currently being reviewed for the risk of entrapment and those that have no risk will keep them to use as enablers. The ADM stated that it was her expectation that there be a resident assessment on anyone with side rails to assess their risk for entrapment. She said, there has to be an order from the doctor and a consent from their RP if they are not own. She also said she expected bed rails to be care planned and that failure to do any of those steps could result in a resident being injured or entrapped. The ADM stated that to her knowledge there had not been any injuries resulting from the bed rail use. Review of the undated facility policy Proper Use of Bed Rails reflected: Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents' assessed needs. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: - Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Barrier to residents from safely getting out of bed. - Physical restraint (e.g., hinders residents from independently getting out of bed or performing routine activities). - Decline in resident function, such as muscle functioning/balance. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. The facility will assess to determine if the bed rail meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints. Informed Consent Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Appropriate Alternatives The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to: - Roll guards - Foam bumpers - Lowering the bed - Concave mattresses - Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms, or behavioral patterns for which a bed rail was considered.