| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676094 | A. Building<br>B. Wing | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Focused Care at Orange | 4201 Fm 105<br>Orange, TX 77630 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 24 residents reviewed for range of motion. (Resident #48)<br><br>The facility failed to maintain Resident #48's contractures of the left hand. The resident did not have a palmar cushion (a soft, padded device used to support and protect the palm of the hand and reduce finger flexion contractures) in place to his left hand daily to maintain ROM and prevent a decline on 04/07/25 at 9:30 a.m and 2:30 p.m. and on 04/08/25 at 8:00 a.m<br><br>This failure could place the residents at risk for not receiving the care and services to maintain their highest level of well-being.<br><br>Findings included:<br><br>Record review of a face sheet dated 04/08/25 indicated Resident #48 was [AGE] years old and admitted to the facility on [DATE]. His diagnoses included hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness on one side of the body, often affecting the arms, legs, or face) following cerebral infarction (a pathological process that results in an area of necrotic tissue in the brain) affecting his left non-dominant side and contracture (a shortening and hardening of muscles, tendons, and other tissue, often leading to deformity and rigidity of joints) of multiple sites.<br><br>Record review of a physician order for Resident #48 dated 10/27/24 indicated: Apply palmar cushion to left hand at all times to prevent further contractures - worn daily except for hygiene with skin checks for redness every shift and frequent nail trims.<br><br>Record review of an annual MDS dated [DATE] indicated Resident #48 had a BIMS score of 11 indicating he had moderately impaired cognition, he had functional limitation of ROM of upper and lower extremities on one side and required maximal assistance for most ADLs.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of a care plan revised 03/17/25 indicated Resident #48 was to have a [NAME] cushion to his left hand at all times to prevent further contractures to be worn daily except for hygiene with skin checks for redness every shift and frequent nail trims. Interventions indicated to monitor/document/report and signs of complications related to arthritis, joint pain, joint stiffness, usually worse on wakening; selling; decline in mobility; decline in self-care ability; and contraction formation/joint shape changes.<br><br>During an observation and interview on 04/06/25 at 10:33 a.m., Resident #48's fingers on his left hand were curling toward the palm of his hand. He demonstrated that he was unable to move his left arm, hand, or fingers. He said he had not had a hand roll in his hand for weeks, but that his hand always felt better with a cushion in it.<br><br>During the following observations Resident #48 was without a palmar cushion to his left hand:<br><br>04/07/25 at 9:30 a.m.<br><br>04/07/25 at 2:30 p.m.<br><br>04/08/25 at 8:00 a.m.<br><br>During observation and interview on 04/08/25 at 8:05 a.m., LVN B she was not aware of an order Indicating Resident #48 required a palmar cushion for his left hand and she had never observed him with one in his hand or applied one to his left hand. Resident #48 said he had a palmar cushion, but he did not know where it was. LVN B searched his bedside table, found his palmar cushion, and placed it into his left hand. Resident #48 said he was glad to have it back and his left hand felt comfortable. LVN B said the purpose of the palmar cushion was to prevent further contractures of the resident's left hand. LVN B said therapy was responsible for applying the palmar cushions to Resident #48's left hand and for making sure he had it in place every day. After checking Resident #48's orders she said he had an order to have the palmar cushion every day, but the therapist had not entered the order so that it would appear on the MAR.<br><br>During an interview on 04/08/25 at 8:29 a.m., PT C said she entered the order for Resident #48's palmar cushion to his left hand because he was no longer receiving physical therapy and she wanted nursing to apply the [NAME] cushion daily on every shift. She said Resident #48 was to have the palmar cushion every day on every shift except during bathing to prevent further contracture and improve his ROM to his left hand. She said possible negative outcome of not utilizing the palmar cushion was worsening contractures and decreased ROM.<br><br>During an interview on 04/08/25 at 8;44 a.m., the DON said she had been informed nursing had not been applying Resident #48's palmar cushion daily on every shift to his left hand. She said she was in the process of entering Resident 48's therapy order into the system so they would appear on his MAR. She said the purpose of the palmar cushion was to increase mobility, prevent further contractures, and decrease pain. She said not using them as ordered could cause decreased mobility, increased pain, and worsening contractures.<br><br>During an interview on 04/08/25 at 11:40 a.m., the Administrator said the facility did not have a current policy that addressed resident contractures and their prevention and treatment. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460<br><br>Based observation, interview, and record review, the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #100) reviewed for incontinent Care.<br><br>The facility failed to ensure that CNA F did not wipe Resident #100's perineal (area between the legs) area from back to front while providing incontinent care on 04/07/2025.<br><br>This failure could place the residents at risk of cross-contamination and development of urinary tract infections.<br><br>Findings included:<br><br>Record review of face sheet, dated 04/07/2025, indicated Resident #100 was a [AGE] year-old female admitted on [DATE] with a urinary tract infection.<br><br>Record review of quarterly MDS assessment dated [DATE] indicated Resident #100 was cognitively intact with a BIMS score of 15 and was always incontinent for bladder and bowel.<br><br>Record review of comprehensive care plan dated 01/27/2025 indicated Resident #100 required extensive assistance of 1 person for personal hygiene and toilet use. Resident #100 care plan was revised on 04/07/25 she was receiving Cipro 500 mg BID for 7 days for a urinary tract infection.<br><br>During an observation on 04/07/25 at 10:30 a.m. CNA F and CNA G was performing incontinent care on Resident #100. CNA F cleaned the peri area with wiping towards the rectum. CNA G assisted CNA F and they turned Resident #100 on her right side. Then CNA F cleaned the rectal area and she wiped towards the vaginal area x 1.<br><br>During an interview on 4/7/25 at 10:45 a.m., CNA F said she had been trained on incontinent care. She said she should have wiped from clean to dirty. She said the resident did not have stool, but she should have wiped the back side away from the frontside.<br><br>During an interview on 4/7/25 at 11:15 a.m., the DON said the facility used the check off sheet as their policy for incontinent care. She said her expectation was for the staff to wipe from the front to the back to prevent infections.<br><br>Record review of the Skill / Procedure: Peri / Incontinent Care dated 06/2013 indicated . 18. Clean rectal area. Use tissue or brief to remove any fecal matter present. Cleaned front to the back using separate section of the wipe for each individual stroke. |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460<br><br>Based on observation interview, and record review, the facility failed to ensure correct installation, use, and maintenance of bed rails, for 3 of 7 residents (Residents #70, #87, and #102) reviewed for bed rails.<br><br>The facility did not have the manufacturers' recommendations and specifications to follow for installing and maintaining the bed rails to prevent large gap in Resident #70's bed rail.<br><br>The facility failed to develop care plans to address the risk of entrapment and interventions to prevent entrapment due to the use of bed rails for the residents who had histories of falling out of the bed for Residents #70, #87, and #102<br><br>The facility did not follow their Bed Mobility Assessments indicating the bed rails were not recommended for use for Residents #70, #87, and #102.<br><br>The facility did not provide maintenance and monitoring of the bed rails per the manufacturer specifications/recommendations for residents with bed rails. The facility failed to maintain a copy of a manufacturer manual available for reference.<br><br>An Immediate Jeopardy (IJ) was identified on 04/23/25. The IJ template was provided to the facility on [DATE] at 6:43 p.m. While the IJ was removed on 04/25/25, the facility remained out of compliance at a scope of a pattern and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on bed rails and reporting broken rails.<br><br>These failures placed residents at risk for entrapment with serious injury or death.<br><br>Findings included:<br><br>1. Record review of a face sheet for Resident #70 dated 04/23/25, indicated she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses including dementia, anxiety, and hereditary ataxia (group of neurological disorders caused by genetic mutations and characterized by progressive decline in coordination of movement and speech).<br><br>Record review of Physician Orders, dated 04/23/25, indicated Resident #70 had 1/2 bed rails x 2 on the bed to facilitate with turning and repositioning every shift for bed mobility with a start date of 11/08/23.<br><br>Review of Resident #70's quarterly MDS, dated [DATE], indicated she had a BIMS score of 11 indicated moderately impaired cognitive skills for daily decision making. Resident #70's functional status indicated she was non-ambulatory and required a one person assist for bed mobility.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #70's care plan, revised 04/08/25, indicated the resident had a history of falls and was at a high risk for fractures from the falls. The care plan indicated Resident #70 required extensive assistance for bed mobility and required 2 persons with the mechanical lift for transfers. The care plan addressed the use of bed rails with interventions to evaluate and reevaluate for 1/2 bed rails quarterly on the quarterly assessment. The interventions included monitor for proper positioning and circulatory concerns any significant changes to physician promptly. The care plan did not include the risk of entrapement.<br><br>Record review of Resident #70's Bed Rail Mobility Device Assessment, dated 10/14/24, indicated no concerns for risks of entrapment and bed rails were installed for bed mobility post falls following prior interventions of a floor mat and bed in low position.<br><br>Record review of Resident #70's Bed Rail Mobility Device Assessment, dated 04/14/25, indicated bed rails were not recommended.<br><br>Record review of Resident #70' consent for bed rails had been signed on 08/02/21 by her family.<br><br>During an observation on 04/06/25 at 08:38 a.m., Resident #70 was in her with the bed rails on the left side of Resident #70's bed had a gap approximately 14 inches - 18 inches between the scoop mattress on the bed and the rail.<br><br>During an observation and interview on 04/06/25 at 09:00 a.m., CNA A grabbed the left bed rail on Resident #70's bed and wiggled the rail. She said the left rail had been loose for 2-3 months. She said she thought the loose bed rail was reported 2-3 months ago but said she did not report. She said the bed rail would need to be reported to maintenance. She said the risk of the bed rail being loose and having a gap was the resident could fall from the bed.<br><br>During an interview on 04/06/25 at 09:30 a.m., the DON said Resident #70 bed rails were used to assist during care with turning and repositioning the resident. She said the rails needed to be fixed to prevent falls. The DON said she was not aware of the bed rail for Resident #70 was loose and a large gap.<br><br>During an interview on 04/07/25 at 10:30 a.m., the Director of Plant Operations said he was not aware Resident #70 bed rails were loose yesterday (04/06/25). He said after surveyor intervention, he had tightened the bed rails which fixed the gap in Resident #70 bed rails. He said he was responsible to check the bed rails in the facility and keep them secure. He said the bed rails should not have large gaps between the bed rail and the mattress.<br><br>During an interview on 4/8/25 at 11:00 a.m., the Executive Director of Operations said the Director of Plant Operations was responsible to check the side rails every quarter for need of repairs or gaps. He said they were checked last in February 2025. The Executive Director denied knowing that Resident #70 bed rail was loose and had a large gap.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an observation and interview on 04/23/25 at 8:30 a.m., the Director of Plant Operations said he was responsible for checking bed rails quarterly. He said after surveyor intervention, he tightened the loose rail, and the rail had no gap on Resident #70's bed on 04/06/24. He said yesterday (04/22/25) a staff member had reported the bed rail was loose again. He said he did not remember which staff had told him the bed rail was loose again. He said he was going to work on the bed rail for Resident #70 and said he had forgot. He said he did not have work order documentation and he did not use a log of any needed repair. He said most of the time the staff just tells him what needs to be fixed. Resident #70 was in her bed and there was 9-inch gap between the mattress and the left bed rail. He looked at Resident #70's bed rail and said there should not have that large of gap between the rail and the mattress. He got underneath Resident #70's bed and he said the bolts were stripped out on the bed rails. He said he would have to get new bed rails, or he would have to replace Resident #70's bed.<br><br>During an observation on 04/23/25 at 9:45 a.m. Resident #70 was in a new bed with assist bar and with her scoop mattress in low position with fall mats.<br><br>Record review of the incident report dated 05/15/24 indicated Resident #70 had an unwitnessed fall at 3:45 p. m., she told nurse she had fell from her bed.<br><br>Record review of the incident report dated 06/04/24 incident Resident #70 had an unwitnessed fall at 8:00 p. m., She was found bedside her bed and said she slid off the bed.<br><br>During an interview on 4/23/25 at 10:00 a.m., the Director of Plant Operations said he did not maintain records of what he had fixed before. He said he did not keep any documentation of the maintenance requests made by staff or residents. He said he did not use a log or documented when he repaired items. He said Resident #70's bed and bed rails were the property of the facility. He said he did not have the manuals for the bed or bed rails.<br><br>2. Record review of face sheet for Resident #87, dated 04/23/25, indicated she was a [AGE] year-old female admitted on [DATE] and had diagnoses hemiplegia (weakness on one side of the body), muscle wasting (muscles thinning and loss of strength), and anxiety disorder.<br><br>Record review of Resident #87's Significant Change MDS assessment, dated 01/21/25, indicated she was severely cognitively impaired with a BIMS score of 03. Resident #87's functional status indicated she was non-ambulatory and the assistance of 2 or more helpers was required for bed-to-chair transfer.<br><br>Record review of Physician Orders, dated 04/23/25, indicated Resident #87 had 1/2 bed rails x 2 on the bed to facilitate with turning and repositioning every shift for bed mobility with a start date of 03/12/25.<br><br>Record review of Resident #87's care plan, revised 12/18/24, indicated she had an ADL self-care performance deficit. She required extensive assistance of 2 persons with bed mobility. Interventions included the half siderails to be in the up position for safety during care provision and to assist with bed mobility, and to observe for injury or entrapment related to siderail use. Staff were to reposition the resident as necessary to avoid injury.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Bed Mobility Device Assessment for Resident #87, dated 11/27/24, indicated the resident was totally dependent on staff for bed mobility and the use of a bedrail, grab/assist bar was not recommended.<br><br>Record review of Bed Mobility Device Assessment for Resident #87, dated 02/27/25, indicated the resident was totally dependent on staff for bed mobility and the use of a bedrail, grab/assist bar was not recommended.<br><br>Record review of an incident report dated 11/23/24 at 4:40 p.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 11/26/24 at 8:48 p.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 12/12/24 at 12:30 a.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 12/19/24 at 1:30 a.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 12/22/24 at 7:00 a.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 12/25/24 at 4:08 p.m., indicated Resident #87 fell from her bed.<br><br>Record review of an incident report dated 01/13/25 at 9:35 a.m., indicated Resident #87 fell from her bed.<br><br>Record review of Resident #87' consent for bed rails indicated the form had been signed on 03/12/25 by her family.<br><br>During an observation on 04/23/25 at 11:10 a.m., Resident #87 had two 1/2 bed rails, which were fitted with no gap greater than 4 inches.<br><br>3. Record review of face sheet for Resident #102, dated 04/23/25, revealed he was a [AGE] year-old male admitted on [DATE] and had diagnoses of intracranial injury (brain dysfunction due to injury), contractures to bilateral lower extremities (when muscles and tendons shorten), and was a functional quadriplegic (paralysis of all four extremities).<br><br>Record review of Physician Orders, dated 04/23/25, indicated Resident #102 bed rails to assist with bed mobility with a start date of 04/02/24.<br><br>Record review of Resident #102's Annual MDS assessment, dated 04/11/25, indicated he had severe cognitive impairment with a BIMS score of 03. Resident #102's functional status indicated he was non-ambulatory and dependent on 2 or more staff for ADLs.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #102's care plan, revised 06/07/24, indicated the resident required the use of 1/2 side rails to assist with bed mobility. The intervention was to evaluate and re-evaluate for 1/2 siderail use quarterly and as needed. The care plan did not address the resident's risk of entrapment. The care plan addressed the falls was revised on 01/23/25 indicated Resident #102 was high risk for increased falls and fractures and the goal was for resident to be free from falls.<br><br>Record review of Resident #102's consent for bed rails indicated the form had been signed on 04/02/24 by his family.<br><br>Record review of Bed Mobility Device Assessment for Resident #102, dated 01/04/25, indicated the use of a bed rail, grab/assist bar was not recommended.<br><br>Record review of Bed Mobility Device Assessment for Resident #102, dated 04/04/25, indicated the use of a bed rail, grab/assist bar was not recommended.<br><br>Record review of an incident report dated 05/10/24 at 4:00 p.m., indicated Resident #102 fell from his bed.<br><br>Record review of an incident report dated 05/12/24 at 11:00 p.m., indicated Resident #102 fell from his bed.<br><br>During an observation on 04/23/25 at 10:45 a.m., Resident #102 was in his bed and had 1/2 bed rails to both sides of the bed with no gaps.<br><br>During an interview on 04/23/25 at 11:00 a.m., the DON said if the bed mobility assessment indicated the resident was not recommended for the use bed rails. The DON said the nurse should have reported it to her (the DON) and the maintenance to remove the bed rails.<br><br>Review of facility policy, titled Bed Safety, effective 04/2021, indicated the following:<br><br>Policy will strive to provide a safe sleeping environment for the resident.<br><br>PROCEDURE<br><br>1.The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment.<br><br>2. To try to prevent deaths/injuries from the beds and related equipment (including the<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: a. An inspection should be done by the Director of Plant Operations at installation/before use and quarterly thereafter of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; b. Review that gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement, or bed position. c. Ensure that when bed system components are worn and need to be replaced, they are replaced with compatible components that meet manufacturer specifications; d. Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and . 10. When using side rails for any reason, the staff shall take measures to reduce related risks.<br><br>The Executive Director of Operations was notified of the Immediate Jeopardy on 04/23/25 at 6:43 p.m. and was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy.<br><br>The Facility's Plan of Removal was accepted on 04/24/25 at 5:36 p.m. and reflected the following:<br><br>On 04/23/2025 The Director of Plant Operations changed the bed for resident #70 with properly operating bed rails.<br><br>On 04/23/2025 The Charge Nurse reassessed resident #70 for bed mobility and the bed mobility assessment for resident #70 was updated. The use of side rails was recommended per assessment.<br><br>On 04/23/2025 The Charge Nurse reassessed resident #102 for bed mobility and the bed mobility assessment for resident #102 was updated. The use of side rails was not recommended per assessment. The Director of Plant Operations removed the assist bar for resident #102 per recommendations from assessment.<br><br>On 04/23/2025 The Charge Nurse reassessed resident #87 for bed mobility and the bed mobility assessment for resident #87 was updated. The use of one bed rail for turning and repositioning recommended per assessment. The Director of Plant Operation removed the right bed rail from resident #102's bed.<br><br>Bed Rail Entrapment Assessment on 4/24/2025 The Director of Plant Operations was educated according to Manufacturers Guidelines on proper installation of bed rails. The Director of Plant Operations conducted a Bed Rail Entrapment Assessment throughout the building to identify any bed rail posing a risk of entrapment. The Executive Director of Operation obtained the manufacturer's guidelines for each type of bedrail in the facility, and they are compatible for use with the beds that we have. The bed rails are not universal they are made for the model of bed we have. Any non-compliant bed rail was either fixed or replaced to meet assessment standards and proper installation according to the manufactures guide.<br><br>The Director of Plant Operations will complete the Bed Rail Entrapment Assessment weekly x 4 weeks and quarterly thereafter. Completion date: 4/23/2025<br><br>(continued on next page) |

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| | 676094 | A. Building<br>B. Wing | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Focused Care at Orange | 4201 Fm 105<br>Orange, TX 77630 |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Clinical Audits, The Director of Clinical Operations and/or designee will conduct a 100% audit of bed mobility assessments to ensure proper evaluation and documentation. If the bed mobility assessment indicated that bed rails were not needed, they were removed by the Director of Plant Operations. Completion date: 4/24/2025<br><br>Staff Education & In-Service Training. The Director of Clinical Operations and/or designee will lead training sessions to ensure team members understand proper procedures for identifying and addressing bed rail concerns.<br><br>Topics included: Equipment Maintenance & Reporting, Team members must immediately report malfunctioning, broken, or non-working equipment to their Supervisor and the Director of Plant Operations via phone and on maintenance log. New team members will be educated regarding reporting any broken equipment during orientation.<br><br>1.The Executive Director completed educational training with the Director of Plant of Operations regarding the completion of the Bed Rail Entrapment Assessment quarterly per company policy. The assessment details what gaps in zones of the bed are acceptable. Zone 1 FDA recommended space is less that-less than 4-3/4 and Zone 3 FDA recommended space is less that 4-3/4. Zone 2, 4, and 5 are not used at our facility due to no bottom rails on any of our beds. Nursing staff and department managers educated on acceptable gaps for zone 1 and zone 3. Nursing staff will document on the licensed medication administration record daily the checks have been completed. Any gaps larger than 4-3/4 will be reported to the on-call phone and the maintenance log. Documentation will be completed on the company form for the assessment. The Assessment was previously completed on 2/10/2025 and 4/23/2025 by the Director of Plant Operations.<br><br>The Executive Director of Operations completed educational training with the Director of Plant Operations on the manufacturer's guidelines on bed rails installation for the Medline (FCE1232RSRN) and Joerns beds (F14SC). Completion date: 4/24/2025<br><br>2. Proper Bed Rail Assessment Procedures<br><br>Charge nurses must accurately complete bed rail assessments and determine if rails are suitable for resident use. Charge Nurses educated on how to accurately complete bed rail assessments. New charge nurses will be educated regarding completing an accurate bed rail assessment during orientation according to manufacturers' recommendation.<br><br>If an assessment indicates bed rails are recommended, the team member must notify both the Director of Clinical Operations and the Director of Plant Operations immediately. New charge nurses will be educated regarding immediate notification to the Director of Clinical Operations and the Director of Plant Operations during orientation. Completion date: 4/24/2025<br><br>Accident/Incident Prevention: The Director of Clinical Operation and/or Designee will complete training on accident/incident prevention, including types of interventions put into place to prevent any further fall. Completion date: 4/24/2025<br><br>Care Plan Updates & Compliance The Clinical Reimbursement Coordinator will conduct a 100% audit of resident care plans, ensuring appropriate documentation of bed rail concerns.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Care plans will be updated to specify bed rail risks and potential entrapment hazards. Completion date: 4/24/2025<br><br>Medical Director Notification On 4/23/2025 The Director of Clinical Operations notified the Medical Director of immediate jeopardy and reviewed bed rail policy and procedure. Plan of action reviewed with the Medical Director with no changes to the current policy. This practice will be reviewed monthly with the QA Committee to ensure no changes are needed to the current policy.<br><br>Commitment to Resident Safety All actions outlined in this plan will be monitored for ongoing compliance, reinforcing our commitment to providing a safe environment for residents.<br><br>On 04/25/25 at 1:45 p.m., the surveyor confirmed the facility implemented their Plan of Removal sufficiently to remove the Immediate Jeopardy (IJ) by:<br><br>During an observation on 04/23/25 at 1:00 p.m., Resident #70 was on new low bed with just the grab bars with less than a 4-inch gap between each side of the mattress.<br><br>During an observation on 4/23/25 at 1:30 p.m., Resident #102 was in his bed with left bed rail removed.<br><br>Record review of the in-service dated 04/23/25 indicated all licensed staff were trained on care plans updates and included entrapment risk for residents with assist bars and bed rails indicated all licensed staff were trained.<br><br>Record review of the in-services dated 04/23/25 indicated all licensed staff were trained which included assessments and the training included demonstration and staff demonstrating knowledge and location of bed mobility assessments in the electronic record.<br><br>Record review of the in-service dated 04/24/25 indicated all staff were trained on bed mobility zone gap recommendations and reporting broken or loose bed rails.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview and record review on 04/25/25 at 8:35 a.m., the Executive Director of Operations said the interdisciplinary team (the DON, MDS Coordinators, Activity Director, Social Worker, Director of Therapy, and the ADONs and himself) were retrained on the manufacturer's guidelines for the bed rails. The Executive Director of Operations said he downloaded the manufacturer's guidelines for the bed rails for the two types of beds in used in the facility and pulled the online manual up on his computer to review. He said the Director of Plant Operations was in-serviced on the recommendations of the mattress to bed rail gap in Zone 3 (the area on each side of the bed between the side rail and the mattress) of the mattress being less than 4 and 5/8 inches as he pointed to the diagram of a bed on his computer with bed rails and measurements. The Executive Director of Operations said it was important for staff to report any concerns with the assist bars/bed rails to the Director of Plant Operations and the DON. The Executive Director of Operation said the facility reassessed residents who had assist bars/bed rails to determine which residents were able to use assist bar/bed rail based on their ability to use the bar for bed mobility and if bed rails were not recommended due to entrapment risks. He said for the residents who no longer needed the bed rail/assist bar, which included Resident #70 who was using 1/2 bed rails, was placed in a new bed with just the grab bars. He said education was provided to all residents and representatives with side rails on the bed and risk of using them. He said the residents, families and physicians were notified prior to removing or changing the type of bed rails. He said physicians' orders and consent would be obtained by the nurses before applying bed rails. The Executive Director of Operations said all staff were trained on the recommendations of the mattress to bed rail gap in Zone 3 of the mattress being less than 4 and 5/8 inches.<br><br>During an interview on 04/25/25 at 9:10 a.m., the Director of Plant Operations said he received one-on-one in-services regarding the completion of the Bed Rail Entrapment Assessment quarterly per company policy. The assessment details what gaps in zones of the bed are acceptable. Zone 1 FDA recommended space is less that-less than 4-3/4 and Zone 3 FDA recommended space is less that 4-3/4. The Zone 2, 4, and 5 were not used at our facility due to no bottom rails on any of our beds He voiced a clear understanding of the risks related to gaps in the bed rails, on how to properly install the assist bars, and ensure the resident's safety. He said the facility would follow the manufacturer's guidelines. The Director of Plant Operations said he was checking beds weekly for proper installation and the need for repairs and all bed rails x 4 weeks to make sure the bed rails were not loose and there were no gaps greater than 4 and 5/8 inches from the mattress to the bed rail.<br><br>During an interview and record review on 04/25/25 at 10:00 a.m., the DON said she completed an audit of all the residents to obtain a list of which residents used an assist bar or bed rails and if their assessment to determine if were safe to use the bed rail. The DON said the MDS nurses updated the residents with assist bars/bed rails care plans to include the risk of entrapment. She said the bed rails/assist bars were removed from the beds of the residents who were identified as not recommended for using a bed rail for safety. Record review with the DON reflected the audit was performed for all residents with assist bars/bed rails to include the list of resident care plans that were updated to reflect the use of the bed rails. The residents' physician orders were updated to reflect the use of the bed rails on those residents identified in the audit. Record review of the bed rail assessments had been updated for Residents #70, #87 and #102. She said Resident #70's bed rail assessment was not correct. She said the nurses have been retrained completing the bed rails assessement. She said all residents who have bed rails have consents, orders and correct assessments.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 04/25/25 at 10:30 a.m. MDS J said she was retrained and had completed updating care plans on all the residents who have or had bed rails. She said she included the risk of entrapment for the residents who remained with bed rails.<br><br>During an interview on 04/25/25 at 10:50 a.m., the Medical Director said the facility notified him of the IJ related to bed rails and he confirmed the Administrator had notified him.<br><br>Record review of in-services, dated 04/24/25, indicated the licensed nursing staff were trained on the proper use of assist bars/bed rails to include assessments for assist bars on care plan prior to usage.<br><br>Record review of the in services dated 04/24/25 indicated all staff were trained on reporting broken equipment and included the gap recommendation of less than 4-5/8 for Zone 3 located between bed rail and mattress.<br><br>During interviews on 04/25/24 from 10:30 a.m. to 11:30 a.m. indicated RN L, LVN L, LVN M, LVN N, LVN O, LVN P, LVN Q, LVN R, LVN S, LVN T, LVN U, LVN B, AND LVN V were trained on bed mobility assessments, care plans and how to report broken or bed rails with gaps. They were able to voice the dangers of improperly used or broken bed rails. They were knowledgeable about the consent, orders, and care plans. They all voiced if the bed rail needed repair or replaced and maintenance was not there, they would place the resident in a new bed if the bed rail could not be repaired would and notify the DON and the Executive Director of Operations. The LVNs were able to voice the space between the mattress and the bed rails could not be more than 4 and 5/8 inch.<br><br>During interviews on 04/25/24 from 11:35 a.m. to 12:30 p.m., indicated CNA G, CNA W, CNA X, CNA Y, CNA Z, CNA A, CNA AA, CNA BB, CNA CC, CNA DD, CNA EE, CNA FF, CNA GG, CNA HH, CNA JJ, CNA KK, CNA LL, CNA MM, CNA PP, CNA QQ, CNA F, CNA RR, CNA SS, AND CNA TT were trained on reporting broken or gapping bed rails. They were able to voice the positive uses for bed rails as to enable the resident to participate with turning and maintain their mobility and the staff were aware of the dangers of bed rails. They all said they would report to the charge, if they saw the bed rails not being appropriate for the residents or problems with the bed rails. The CNA staff said the bed rails should be no more than 4 and 5/8 inch away from the mattress and the rail should fit snug and not wiggle.<br><br>During an interview on 4/25/25 at 1:00 p.m., the DON said all staff who had not received the in-services and trainings, would be trained prior to their next shift and new hires would be trained as part of the new hire training. She said new admissions would be assessed for bed rails before they were placed in a bed with rails.<br><br>The Executive Director of Operations was informed the Immediate Jeopardy was removed on 04/25/25 at 2:15 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>41057<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles on 1 of 3 medication carts observed. (Hall 100 Rooms 109 - 120 medication cart) observed in that:<br><br>LVN B was not aware of a loose pill and scattered debris, powdery and sticky substance in the bottom of the Hall 100 medication cart drawers and did not remove the loose pill or clean scattered debris, powdery and sticky substance in the medication drawers.<br><br>These failures could place residents at risk of not receiving prescribed drugs or contaminated medication.<br><br>Findings included:<br><br>During an observation and interview on 04/08/25 at 8:45 a.m., during review of the Hall 100 medication cart with LVN B, she said she was giving patient medication off this cart today. The cart review revealed the 3rd drawer contained 1 loose unidentified pill that was not labeled and not sealed in packaging, scattered debris from medication card pill packs, and a whitish brown powdery substance with sugar like crystals scattered about 1/2 inch width along the back of the drawer with a sticky brown substance in the bottom crease of the drawer containing resident's prescribed medications. The 4th drawer contained debris from medication card pill packs, a whitish brown powdery substance with sugar like crystals about 1/4 inch width along the back of the drawer with a sticky brown substance in the bottom crease of the medication drawers containing resident's prescribed medications, and a sticky pinkish/ brown substance sticking a box of insulin syringes to the bottom of the drawer. LVN B said the cart should be cleaned and no loose pills should be in the drawers. She said Maintenance pressure washes the carts sometimes and the nurses that use the cart were responsible for wiping down the bottles on the cart. She said she was educated to keep the cart clean. She said the resident medication was not at risk due to the medication was sealed with no holes in the packages, but the medication cart should be wiped down.<br><br>During an interview on 04/08/25 at 9:46 a.m., the DON said the ADON's were responsible for ensuring the medication carts were clean and all expired medication and loose pills removed. She said the nurse's giving medication off the medication cart were the back up to ensure the medication carts were clean and no loose pills were on the cart. She said the dirty medication cart was possibly overlooked. The DON said the nurses were all educated to ensure the medication carts were clean and the ADONS reviewed and cleaned them weekly and as needed. She said the resident risk of a dirty medication cart was a possible risk of resident infection. The DON said her expectation was all medications carts were cleaned weekly and as needed.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/08/25 at 10:30 a.m., ADON D said she was responsible for station A and ADON E was responsible for station B that included the Hall 100 medication cart. She said the ADONs were supposed to check and clean the medication carts for their stations weekly. She said the dirty medication cart was possibly missed or overlooked. ADON D said ADON E had worked nights and were unavailable for interview at this time. She said the nurses giving medication off the medication cart were the back up to ensure the medication carts were clean with no expired medications on them. ADON D said the resident risk of a dirty medication cart was possible spread of infection.<br><br>During an interview on 04/08/25 at 11:00 a.m., the Administrator said the charge nurse's providing medication off the medication cart were responsible for ensuring the medication cart was clean. He said the ADON's were the backup, they were responsible for weekly audits to ensure the medication carts were clean. The Administrator said the medication cart was possibly overlooked. He said the resident risk of a medication cart that was not clean was possible cross contamination. The Administrator said his expectation was for all medication carts to be clean.<br><br>Record review of a policy revised August 2024, titled, Storage of Medications indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.9. Medication storage areas are kept clean, . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>36214<br><br>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen reviewed for dietary services.<br><br>The facility failed to ensure all staff wore hair restraints while working inside the kitchen.<br><br>The facility failed to ensure the fryer was clean and free from brown crusty particles in the fryer baskets above the open cooking oil and brown and black particles along the side ledges and large front ledge surrounding the open oil.<br><br>These failures could place residents who ate meals prepared in the kitchen at risk of foodborne illnesses.<br><br>Findings included:<br><br>During observation and interview on 04/06/25 during initial tour of the kitchen at 08:30 a.m. the following was observed:<br><br>* [NAME] H was observed standing between the stove and counters without a hair restraint covering her hair. She reached into her pocket and got her hair covering and began putting it on while tucking stray strands of hair underneath the covering. She said she had been washing dishes and had gotten hot and sweaty and took her hair restraint off and forgot to put it back on. She said a hair restraint should be worn at all times while in the kitchen to keep hair from falling into the food being prepared for the residents.<br><br>* Dishwasher I was in the dishwashing area inside the kitchen without a hair restraint. She said she had just forgotten to put on a hair restraint. She said she had been instructed by the facility to always wear a hair restraint while in the kitchen to keep hair from falling into the food or equipment.<br><br>* The facility deep fryer had 2 baskets sitting above the open cooking oil. The baskets had dime to quarter size pieces of dried brown crusty substances. What appeared to be smaller size pieces of the same brown crusty substance missed with black particles were covering the side ledges and the wide front ledge of the fryer. [NAME] H said the particles were probably left over from the lunch service on 04/04/25 when the facility served fried fish for lunch. She said the fryer baskets and ledges should have been cleaned after frying the fish.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/06/25 at 08:57 a.m., the Dietary Manager (DM) said hair restraints were always to be worn by staff when inside the kitchen. She said they had all been trained to wear hair restraints. She said not wearing hair restraints in the kitchen could result in food falling into food being prepared or into equipment and contaminating food served to residents. She said the fryer baskets should have been cleaned and not left with food particles in them. She said the ledges should have been cleaned of the food debris left on them. She said the possible negative outcome of not cleaning the fryer baskets and ledges could be cross contamination of food served to residents. She said the fryer was on the weekly cleaning schedule and she had witnessed staff change the oil in the fryer and clean the fryer on 04/03/25. She said the particles on the fryer and baskets were most likely from the fried fish served for lunch on 04/04/25.<br><br>During an interview on 04/07/25 at 7:55 a.m., the Administrator said he was the DM's direct supervisor. He said he expected all kitchen staff to wear hair restraints while in the kitchen. He said hair restraints were worn to prevent cross contamination of food with hair falling into food being prepared. He said he could not comment on the condition fo the fryer during initial tour because he did not see it before it had been cleaned. He said he expected the fryer to be kept clean and without food debris to prevent cross contamination.<br><br>Record review of a facility policy titled Sanitation - Personnel Hygiene last revised October 2023 indicated . Food and Nutritional Services staff will follow hygiene and sanitary procedures to prevent the spread of foodborne illness. 13. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.<br><br>Record review of a facility policy titled Sanitation - Kitchen Cleaning Schedule last revised November 2023 indicated . Food and Nutritional Services Personnel will be responsible to maintaining the cleanliness and sanitation of kitchen.<br><br>According to the US Food and Drug Administration Food Code dated January 18, 2023:<br><br>. 2-402.11<br><br>(A) . Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers the body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single-serve and single-use articles.<br><br>. 6-601.11<br><br>(B) . The food contact surfaces of cooking equipment and pans shall be kept from encrusted grease deposits and other soil accumulations. |